EU-MiCare

Training the EU Health Workforce to Improve Migrant and Refugee Mental Health Care

EU-MiCare

Course Introduction

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Redacted in December 2024 by **Babel Day Centre**, under Syn-Eirmos NGO of Social Solidarity, with the collaboration of all project partners, as part of Work Package n°3 – The EU-MiCare Methodology and Training

Welcome to the EU-MiCare e-learning course!

This course is the result of a collaborative effort involving partners from Cyprus, Germany, Greece, Italy, and Spain. It has been designed to support professionals and volunteers in their work with migrants and refugees by providing a robust framework grounded in both theory and practical applications. By exploring key psychosocial dimensions, this training aims to deepen understanding of migration as a complex and multifaceted experience.

Understanding the Migrant Condition

Migration is not merely the crossing of borders; it is a profound upheaval that disrupts identity, community, and the sense of home. People migrate for various reasons – some seeking better opportunities, others fleeing conflict or persecution. Each journey is unique, and the experiences of migrants and refugees upon arrival in a new country vary widely. The migration process typically unfolds across three overlapping stages: pre-migration, migration, and post-migration, each influencing mental health in distinct ways. Vulnerable groups, such as women, children, older adults, and LGBTQ+ individuals, encounter compounded challenges during their journey.

Adjusting to a new culture, or acculturation, can be a significant stressor, heightened by experiences of xenophobia, racism, and the pressure to assimilate. Often, being identified primarily as a migrant can further complicate integration, leaving individuals struggling to find a sense of belonging. Despite these challenges, many migrants and refugees exhibit remarkable resilience, demonstrating a wide spectrum of responses and often thriving despite adversity.

Particularly as it relates to poor mental health outcomes, it is increasingly recognized that the development of mental health disorders among migrants arises from a combination of factors, including life stories, current circumstances, social support, access to care, and integration policies. Effectively addressing these issues requires a comprehensive approach that goes beyond merely providing psychological or protection services, integrating other critical components of psychosocial

care. This involves implementing measures and developing multidisciplinary, multi-level psychosocial interventions that consider the broader social and systemic determinants impacting well-being.

For refugees in particular, a central aspect of these experiences is the involuntary loss of home, a common thread for all who have been displaced due to various upheavals. Though they may not always express it clearly, the search for a new home often lies at the heart of their journey. The role of field workers is to accompany them in this process, offering support as they navigate this difficult transition. This requires stepping outside one's comfort zone and engaging genuinely with those being served, acknowledging their full humanity and unique experiences.

The *Synergic Therapeutic Complexity* Approach

This training draws on the *Synergic Therapeutic Complexity* approach developed by Renos Papadopoulos (2021), which emphasizes three core principles:

- **Complexity:** Recognizing that the experience of migrants and refugees is shaped by the interplay between individuals, those who assist them, and the broader sociopolitical context. This also involves considering the diverse range of responses (whether negative, neutral, or positive) that people exhibit in response to the adversities they face.
- **Uniqueness:** Understanding that each migrant and refugee's experience is distinct and continuously evolving.
- **Totality:** Seeing beyond the status/label of 'migrant' or 'refugee' to honor people's full humanity while recognizing them as active agents of change in their own lives.

As professionals and volunteers involved in the care of people who have fled their homelands, the role is not only to alleviate suffering but also to advocate for greater openness and humanity in addressing the issues they are faced with. This entails approaching people with compassion without overemphasizing pathologization or medicalization and ensuring that psychosocial support remains a dignified and respectful response to their needs. The synergic approach also calls for field workers to

reflect on biases and assumptions, recognizing how societal narratives and professional practices may inadvertently perpetuate stereotypes or reduce individuals to oversimplified categories.

Course Objectives and Outcomes

The EU-MiCare e-learning course invites professionals and volunteers to embrace a human-centered, psychosocial framework for engaging with migrants and refugees. Through a combination of theoretical grounding, experiential exercises, reflective activities, and practical frameworks such as the *Adversity Grid*, the *Ulysses Scale*, and the *Wheel of Privilege and Power*, this course aims to help participants identify and respond to the diverse impacts of migration and drive meaningful change in their work.

Participants will gain:

- **Knowledge:** A deeper understanding of the psychosocial dimensions of migration, including the unique challenges faced by migrants and refugees across different stages of their journey.
- **Skills:** Practical tools to deliver compassionate, effective support while moving beyond trauma-centered approaches to recognize and address the full spectrum of responses to adversity.
- **Attitudes:** A reflective, culturally attuned perspective that embraces the complexity, uniqueness, and totality of everyone's experience.
- **Connections:** Opportunities to engage with a network of service providers and experts from all over Europe, fostering collaboration and shared learning in migrant and refugee mental health.

Course Target Groups

The primary target groups of the course include:

- Health professionals (e.g., psychologists, social workers, physicians, nurses) and other practitioners (e.g., cultural mediators, interpreters, counselors, caregivers of unaccompanied minors) working with migrant and refugee populations in settings across Europe such as reception camps, non-profit organizations, public mental health centers, hospitals, and shelters.

- Vocational Education and Training (VET) providers, VET developers, and academic institutions, who will further use and promote the training.
- Relevant professional associations, public sector bodies, and civil society organizations involved in migrant and refugee health.

Course Structure

The curriculum content has been developed using participatory methodologies, incorporating the input of field workers throughout the training design process. Additionally, the perspectives of migrants and refugees (adults, families, and children) have been indirectly represented through the expertise of partner organizations providing mental health and social care services to these populations. The course follows a logical progression from general to specific topics and is comprised of 4 modules and a total of 17 units, with detailed descriptions provided below. Modules 2 and 3 are offered in two separate streams to cater to different professional roles.

Module 1: Foundations of Psychosocial Care in Migration Contexts

(estimated average time for the module completion 13.5 hours)

- **Unit 1.1 – Psychosocial Well-Being in the Context of Migration:** Overview of key concepts that will appear throughout the curriculum.
- **Unit 1.2 – Social Determinants of Mental Health:** The nonmedical factors that influence health and mental health across time and throughout different migration phases.
- **Unit 1.3 – Risk, Protective, and Promotive/Resilient Factors**: Factors affecting the well-being of migrants and refugees, including specific groups, such as women, older adults, and LGBTQ+ individuals.
- **Unit 1.4 – Psychological Dimensions of the Migration Process**: Main theories and conceptualizations of the complex psychological journey of migrants and refugees.
- **Unit 1.5 – Common Mental Health Conditions Among Migrants and Refugees**: Overview of epidemiology and manifestations of mental health challenges faced by migrants and refugees.

Module 2: Improving Skills in Recognizing and Assessing Migrants' Mental Health Needs

(Two Separate Streams: Mental Health Professionals, Other Professionals)

(estimated average time for the module completion 12.5 hours)

- **Unit 2.1 – Understanding the Influence of Culture on Mental Health**: The relationship between culture and mental health.
- **Unit 2.2 – Intersectional Perspectives on Migration and Mental Health**: Migration and well-being through the lens of intersectionality.
- **Unit 2.3 – Mental Health Screening Approaches for Migrants and Refugees**: Overview of culturally-sensitive approaches for identifying mental health needs.
- **Unit 2.4 – Psychological First Aid (PFA)**: How to provide immediate support in the aftermath of a crisis.

Health Professionals Stream: This stream is designed for professionals who are comfortable with clinical language and conduct mental health screenings, assessments, diagnoses, or treatment/therapy within their respective contexts. This includes physicians, psychologists, psychotherapists and nurses.

Other Professionals and Volunteers Stream: This stream targets professionals and volunteers working closely with migrants and refugees in non-clinical capacities, such as cultural mediators, interpreters, social workers, counsellors, caregivers of unaccompanied minors and volunteers.

Module 3: Improving Skills in Managing Migrants' Mental Health Needs

(Two Separate Streams: Interpreters/Cultural Mediators, Other Professionals)

(estimated average time for the module completion 13.5 hours)

- **Unit 3.1 – Effective Communication**: Techniques for supportive and non-violent communication.
- **Unit 3.2 – Cultural Awareness**: Understanding and respecting cultural differences.
- **Unit 3.3 – Collaborating for Effective Interpretation and Cultural Mediation**: Guiding principles towards an effective collaboration with interpreters and cultural mediators.
- **Unit 3.4 – Interdisciplinary Collaboration in Mental Health and Psychosocial Support**: Exploring multi-sectoral approaches to psychosocial interventions.

- **Unit 3.5 – Responding to the Special Situation of Children:** Addressing the unique needs of younger people in the context of migration, including unaccompanied and separated minors.

Interpreters and Cultural Mediators Stream: This stream focuses on individuals responsible for bridging cultural and linguistic gaps in the work with migrants and refugees, such as interpreters and cultural mediators.

Other Professionals Stream: This stream is open to all other professionals and volunteers who do not fit the profiles outlined above but still work with migrants and refugees in various capacities such as physicians, psychologists, psychotherapists, nurses, social workers, counsellors, caregivers of unaccompanied minors and volunteers

Module 4: Self-Care and Staff Well-Being

(estimated average time for the module completion 9.5 hours)

- **Unit 4.1 – Effects Among Professionals and Volunteers Working in the Context of Migration:** Psychological consequences of the nature of the work.
- **Unit 4.2 – Self-Care:** Practical strategies for maintaining your own mental health.
- **Unit 4.3 – Staff Care:** Supporting the well-being of colleagues and team members within an organizational context, with special attention paid to the needs and challenges faced by volunteers.

Although an average estimated time frame is provided for the reading duration of each module, completion times may vary. Therefore, participants are encouraged to assess the time required for each unit and pace themselves accordingly. The modules consist of readings, videos, multimedia resources, and interactive learning activities.

Assessment and Certificate of Completion

The assessment will be made through a series of assessment questions and four vignettes, each corresponding to one of the course modules. These vignettes are based on real-life stories from the field, addressing diverse scenarios that professionals and volunteers might encounter in their work with migrant and refugee populations.

Upon completion of all post-module assessment questions, participants will be eligible to receive a certificate of completion.

Learning Tools and Resources

- **Theoretical Foundations:** Each unit includes a detailed literature review and references, drawing from current global research on migrant and refugee care.
- **Reflective Exercises:** Practical activities designed to deepen understanding and enhance skills in addressing migrant and refugee mental health.
- **Glossary:** A comprehensive resource in the Repository providing definitions of key migration terms, available in English.
- **Supplementary Materials:** Additional tools, including videos, graphics, and other helpful resources, accessible through the Repository (English language only).
- **Community of Knowledge:** A dedicated, independently operated forum connecting learners across Europe to exchange ideas, share insights, network, and build a community of practice.

eLearning Icons and Visual Indicators

📖	Repository
◎	Key Point
💻	Video
🕘	Reflection Break
mental health	Definition of term provided in Glossary (English language only)

In Closing…

Migration is a journey marked by complexity and profound change. Those who support migrants and refugees play a vital role in helping individuals and communities toward rebuilding a sense of home and belonging. By the end of the course, participants will be better prepared to address the needs of migrants and refugees with competence and cultural humility, contributing to improved outcomes in their work.

EU-MiCare

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EU-MiCare Curriculum

Colophon

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Colophon

This learning curriculum was created through the collaborative efforts of a diverse team of experts and partner organizations, each contributing their knowledge, skills, and dedication to advancing accessible learning in migrant and refugee mental health.

Lead Partner of the EU-MiCare Methodology & Training Package (WP3):

- **Babel Day Centre / Syn-Eirmos NGO of Social Solidarity**, Greece

Collaborating Partner Organizations:

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- **Zadig Srl, società benefit**, Italy
- **Prolepsis Institute** (Institute of Preventive Medicine, Environmental and Occupational Health), Greece
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Module 1.

Foundations of Psychosocial Care in Migration Contexts

*Content drafted by **Babel Day Centre** (Syn-Eirmos NGO of Social Solidarity – Greece), **Ethno-Medical Center/EMZ** (Ethno-Medizinisches Zentrum e.V. – Germany), and the **Research Institute on Social Welfare Policy** (POLIBIENESTAR, Universitat de València – Spain), and edited by **Babel Day Centre** (Syn-Eirmos NGO of Social Solidarity – Greece)*

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Module: Foundations of Psychosocial Care in Migration Contexts

Responsible Partners: Babel Day Centre/Syn-Eirmos, EMZ, Polibienestar

Module Overview

This module offers a comprehensive foundation in the area of mental health and psychosocial care for professionals and volunteers working with migrant and refugee populations. Unit 1.1 introduces course participants to key mental health concepts and frameworks, while discussing the complexities of the migrant condition. It also draws attention to the role of culture in shaping mental health. Unit 1.2 discusses the social determinants of mental health and outlines how social, economic, and structural inequalities influence both the journey of migration and the resettlement process. Unit 1.3 uses a socio-ecological framework to explain how different factors at the individual, family, community, and systemic/structural levels influence mental health outcomes. Special attention is given to the significance of resilience, particularly the concept of adversity-activated development. Unit 1.4 emphasizes the emotional journeys migrants and refugees may go through before, during, and after fleeing their home countries. The unit draws attention to the importance of understanding these processes not only as responses to trauma but also as part of the broader psychological adaptation to migration. Finally, Unit 1.5 provides a detailed exploration of the mental health challenges that migrants and refugees frequently face. It emphasizes the complex interplay between the migration experience and mental health, recognizing that exposure to various stressors (including stressors in the host society or resettlement context) can contribute to a range of mental health conditions. In addition to enhancing knowledge, this module equips participants with practical strategies for recognizing the nuances of the experiences of migrants and refugees.

Module Learning Outcomes:

Upon completion of this Module, participants should be able to:

- Define key concepts and frameworks relevant to psychosocial care in migration contexts
- Understand the complex relationship between migration, culture, and mental health
- Review the topic of migrant and refugee mental health through a social determinants' framework rather than a biomedical/individualistic lens
- Recognize the range of factors that influence the mental health of migrants and refugees
- Evaluate how structural inequalities and socio-economic factors affect mental health outcomes throughout the migration journey
- Apply a socio-ecological framework to understand risk and protective factors influencing migrant mental health
- Identify key promotive and resilience factors that help mitigate mental health challenges in migrant populations
- Understand the complex psychosocial journeys experienced by migrants and refugees
- Identify common mental health conditions among migrant and refugee populations
- Recognize how host society stressors and cultural dimensions affect the mental health and psychosocial well-being of migrants and refugees

Units in this Module:

Module 1. **Foundations of Psychosocial Care in Migration Contexts**
Unit 1.1: Psychosocial Well-Being in the Context of Migration
Unit 1.2: Social Determinants of Mental Health
Unit 1.3: Risk, Protective, and Promotive/Resilience Factors
Unit 1.4: Psychosocial Dimensions of the Migration Process
Unit 1.5: Common Mental Health Conditions among Migrants and Refugees

Unit 1.1: Psychosocial Well-Being in the Context of Migration

Unit Overview
This training unit examines key concepts and frameworks for understanding mental health and psychosocial well-being in the context of migration. It emphasizes the significance of language and terminology in this field. The unit also addresses the role of culture in working with migrants and refugees, incorporating various theoretical perspectives. Drawing from IOM's broad perspective on migration, the unit concludes by providing a comprehensive look at different facets of the condition of being a migrant.

Unit Sections:

1. Introduction

International migration is a complex phenomenon expected to grow in size and intricacy in the coming years. In 2020, there were approximately 1 billion migrants worldwide, representing about one in eight of the global population [1]. Migrants and refugees are a diverse and heterogeneous group, moving away from their usual places of residence for a variety of reasons. Their circumstances may include escaping conflict or violence, seeking better financial opportunities, reuniting with family, or accessing education, among many others.

Migration journeys vary widely, from short and straightforward to long and hazardous, with risks such as trafficking and interception by authorities. Once they arrive in a different country, their experience may be shaped by their legal status, the political environment, and aspects related to housing, healthcare, and employment [1-3].

In recent years, Europe has seen a significant increase in migrants seeking new beginnings. In 2022, nearly 3.5 million people received their first residence permits across the EU, primarily for work, family reunification, and education [4]. In 2023, over a million people applied for asylum, marking an 18% increase from the previous year and a 62% rise compared to pre-pandemic levels in 2019 [5]. Countries such as Germany, Spain, France, Italy, and Greece have become key destinations for those on the move. According to data from the United Nations High Commissioner for Refugees (UNHCR), by the end of 2023, Europe, including Türkiye, hosted about one-third of all refugees globally [6]; the number of refugees rose from 12.4 million at the end of 2022 to 13 million by the end of 2023, largely due to the ongoing influx of refugees from Ukraine.

This dynamic migration landscape means that **health professionals** (including psychologists, psychiatrists, social workers, physicians, nurses, counselors, and others) **increasingly work in a multicultural world**. Cultural differences alongside structural factors significantly impact how care is approached and provided to migrant and refugee populations [2]. **Understanding the complexity, uniqueness, and totality of the migrant experience is crucial not only for the well-being of the migrants themselves, but also for the societies they become part of** [7].

This unit seeks to provide a foundation of some key definitions and conceptual issues for approaching mental health and psychosocial well-being in the context of migration. It builds upon the overarching principle that **the mental health of migrants and refugees** is not merely the absence of mental disorders but **is closely tied to respecting their fundamental rights, advocating for dignity in administrative processes, and recognizing the contributions they can bring to their receiving communities.**

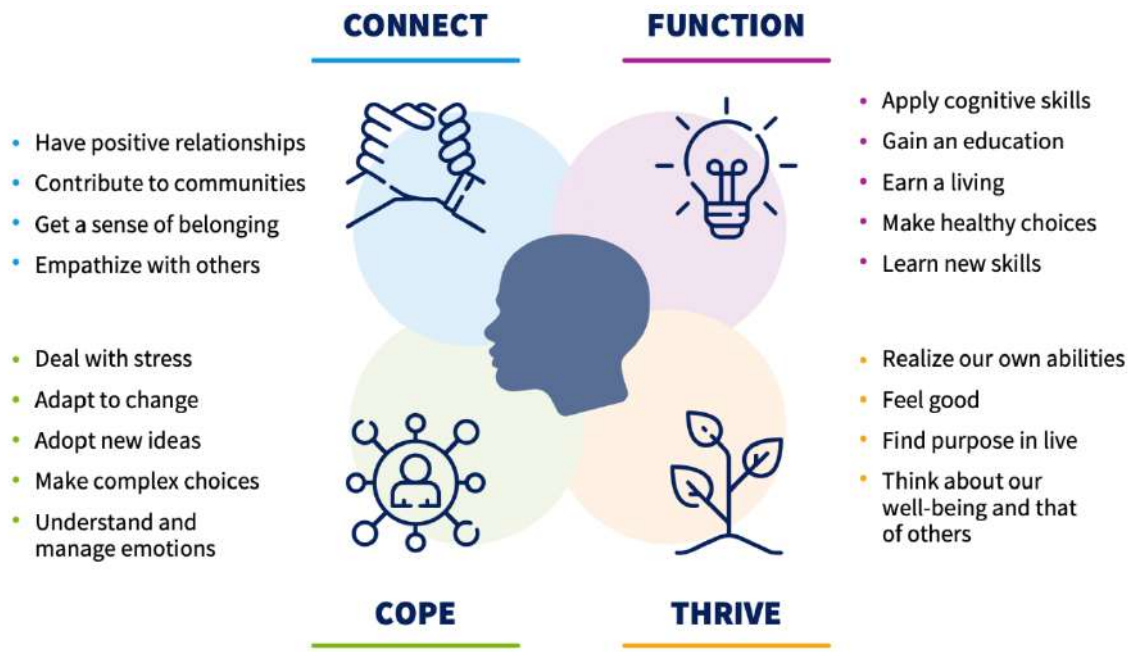
2. Key Concepts in Mental Health

Mental Health

The World Health Organization (WHO) offers a broad definition of ***mental health*** as "*a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and*

contribute to their community" [8]. This definition **emphasizes the holistic nature of mental health,** which includes **emotional, psychological, and social well-being**. It also highlights the importance of **adaptability** and **effective functioning**, both crucial in navigating the challenges often presented by migration. **There is no health without mental health.** In other words, **mental health is a fundamental aspect of our lives; it always impacts our capacity to connect, function, cope, and thrive**, even when we are not consciously aware of it (see Figure 1.1.1) [9].

Figure 1.1.1. "*Mental health has intrinsic and instrumental value, helping us to connect, function, cope, and thrive*"



Note: Graphic sourced from the World Health Organization, 2022, World Mental Health Report, p. 11, Geneva

Mental health exists on a complex continuum, ranging from an optimal state of well-being to severe states of emotional suffering and impairment. **It is not merely the absence of mental disorders, but a dynamic state influenced by a myriad of individual, social, and structural factors**. Our mental health can fluctuate **in response to changing life situations and stressors,** with different experiences presenting varying degrees of difficulty and distress [9]. For instance, conditions such as depression and anxiety can range

from mild episodes and very brief induration to prolonged periods that can be highly debilitating. Importantly, individuals experiencing mental health challenges can still achieve elevated levels of well-being, just as someone with a physical health condition can be physically fit. Understanding mental health as a continuum is important for **recognizing the diverse and fluid nature of migrants' and refugees' responses to adversity** and **moving away from binary notions that individuals are either mentally healthy or ill** [7].

Psychosocial Well-Being

Psychosocial well-being is a recent concept that has emerged within the context of complex and multidimensional problems, such as conflicts, natural disasters, or displacement. In essence, it refers to **the dynamic interplay between individual psychological processes and the social environment** [10]. In the field of migrant and refugee care, the term '*psychosocial*' is often considered better suited to describe people's responses to adversity. This is because it challenges the biomedical model of health, where the focus is commonly placed on biological factors, often excluding psychological, environmental, and social influences [11].

As will be further elaborated in the upcoming units, **psychological and emotional experiences cannot always be explained by biological factors alone**. The psychosocial perspective seeks to **understand the combined influence of three main aspects relevant to an individual**: (i) **intrapsychic aspects**, which refer to psychological experiences within a person (such as feelings, fears, hopes, and wishes); (ii) **interpersonal aspects**, which refer to interactions with others and the realities and emotions these bring; and (iii) **socio-political aspects**, which refer to the broader social and cultural context influencing these interactions [7].

◎ Key Point: ***What is MHPSS?***

The composite term ***Mental Health and Psychosocial Support*** (MHPSS) is often used to describe **any type of support aimed at protecting or promoting psychosocial well-being and/or preventing or treating mental health conditions** [12]. MHPSS includes a wide range of activities and interventions

that are designed to address the psychological and social needs of individuals and communities affected by crises. The term highlights the **interconnectedness of mental health** (the psychological aspects) **and psychosocial well-being** (the social aspects) and calls for a comprehensive response in supporting the needs of affected populations. MHPSS interventions can include counseling, community support programs, stress management activities, and efforts to rebuild social networks and community structures.

Although closely related, '*mental health*' and '*psychosocial support*' often reflect different yet complementary approaches for field workers [12]. As seen above, the psychosocial approach entails a relational, multilevel thinking that views people as relational beings; in this view, human experience is inextricably linked to relationships with oneself, others, and the world. **Distress arises when these relationships are disrupted**. Consequently, MHPSS interventions aim to **help individuals and communities process these ruptures** and **move toward a more cohesive experience of themselves and their surroundings** [7].

→ **VIDEO:** *What is MHPSS?* 💻

3. The Meaning of Culture

Culture **is a complex construct**; over the years, there has been considerable debate within the scientific community regarding its precise definition [13]. For our purposes here, we adopt the broad perspective as put forth by the International Organization of Migration (IOM) [14]. Culture is seen as a **system of shared beliefs, symbols, behaviors, values, and customs that members of a society use to make sense of their world and interact with each other**. These elements are passed down through generations, helping to create a distinct and cohesive community identity. People from a common culture often feel a sense of belongingness with each other while also feeling different from other groups.

Culture can't be understood as a closed system. It rarely exists as a perfect combination of one language and religion within a single social group in one territory. It is not static or universal; it evolves over time and often arises from the coexistence of subcultures, each with its distinct characteristics. For example, a 70-

year-old and a 17-year-old may share a culture while at the same time belonging to different subcultures within that culture. Subcultures allow for mutual recognition and shared interests among people, even if they belong to different ethnic/racial groups, such as migrants and members of the host communities who share a subcultural identity (e.g., individuals connecting on the basis of the same religion, same musical culture, or their LGBTQI+ identity) [14].

Culture includes both tangible and intangible elements that can offer **protective, restorative, and transformative support to individuals and communities**. It promotes participation, continuity, acceptance, resilience, and positive social interactions [14]. Understanding culture is crucial for effectively addressing the mental health needs of migrants and refugees, as **cultural differences influence the way we interact with one another**.

→ **VIDEO:** *What is Culture?* 💻

◎ **Key Point:** ***Theoretical Perspectives on Culture***

In cultural theory, there are two primary streams of culture definitions [13]:

- ***Culture as a static concept:*** This perspective views culture as a homogenous influence on all individuals within a society, shaping behaviors and responses uniformly. Prof. Geert Hofstede's work, which divides culture into six dimensions, remains influential in understanding various cultural aspects and conceptualizing situations in fixed categories, which can be helpful in navigating unfamiliar or ambiguous contexts. According to Hofstede, culture is *"a software of the mind"* and each person carries within themselves *"patterns of thinking, feeling, and potential acting which were learned throughout their lifetime"* [15]. In the context of the work with migrants and refugees, this perspective implies that culture becomes a defining aspect of individual identity, influencing people's behaviors and responses.
- ***Culture as a fluid concept:*** This perspective views culture as a dynamic process characterized by *"intersubjective, multilayered value systems"* that shape the lived realities of communities. This

understanding largely stems from the work of anthropologist Clifford Geertz, who outlined the evolving nature of culture as a blend of traditions and more contemporary shared human experiences, creating a *"web of significance"* that defines individual identity [16]. For example, in the dominant American culture, the rapid evolution of technology represents a shared contemporary experience. In contrast, deep-seated values such as individualism, freedom, and self-determination (which remain relatively unchanged over time) reflect cultural traditions. The notion of culture as fluid implies that it is *"an active process of meaning-making"* [17]: culture is not a distinct unit – instead, **people create culture**, which changes all the time in both subtle and noticeable ways.

4. Understanding the Migrant Condition

Definition(s) of Migration

Broadly speaking, ***migration*** is defined as **the movement of people from one location to another**, which can be **temporary or permanent**. These movements are often motivated by various factors such as economic opportunities, conflicts, or environmental changes. The impact of migration is not limited to the physical relocation but also extends to the **social, economic, and cultural dynamics of both the origin and destination communities** [18]. At the international level, **there is no agreed-upon definition of the word *'migrant'***; definitions vary widely within legal, administrative, research, and statistical contexts [19,20]. Although the 1951 Refugee Convention legally defines the word *'refugee'* [21], no equivalent source defines *'migrant'*, leading to an ongoing debate. This variability is more than just a matter of semantics; it complicates research and policy, as different definitions of people on the move impact our understanding of their experiences, as well as their rights and access to services [20,22,23].

According to IOM, a ***migrant*** is *"any person who is moving or has moved across an international border or within a State, away from his or her habitual place of residence, regardless of the person's legal status, whether the movement is voluntary or involuntary, what the causes for the movement are, or what the length of the stay is"* [20]. In this broad definition, the word *'migrant'* is used as an **umbrella term** and represents

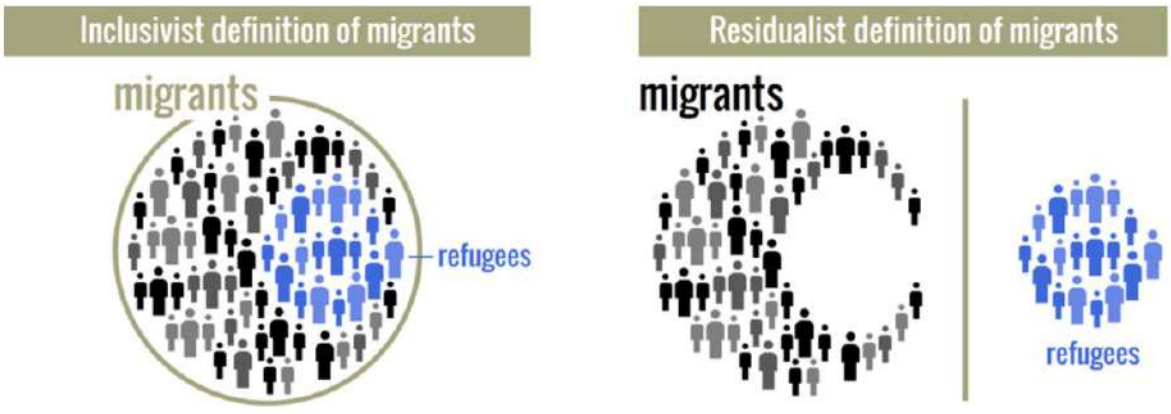
groups of people who enjoy different sets of rights and have different life paths. However, it has received significant criticism, particularly from UNHCR, which argues that including refugees under this definition might associate them with negative perceptions of migrants and undermine the special rights they are entitled to under international law [22].

◎ Key Point: ***A Note on Terminology***

What is the meaning of '*migrant*'? According to Jørgen Carling, Research Professor at the Peace Research Institute Oslo (PRIO) [23], at the heart of this topic lie two different perspectives:

- ***The inclusivist perspective***, adopted by IOM, views migrants as those who have moved from their habitual residence, regardless of their legal status (documented or undocumented) or drivers for movement. This view encompasses refugees, foreign workers, survivors of trafficking, and international students. It is therefore argued that '*migrants*' form a broad category, in which refugees exist as a specific subcategory.

- ***The residualist perspective***, adopted by UNHCR, sees migrants as those who have moved for reasons other than fleeing conflict and therefore excludes refugees from its definition. According to this view, *"migrants choose to move not because of a direct threat of persecution or death, but mainly to improve their lives by finding work, or in some cases for education, family reunion, or other reasons"* [22].



Note: Graphic sourced from the information resource meaningofmigrants.org, 2017, Prof. Jørgen Carling, Oslo

Despite differences in perspective, both views recognize that the terms '*migrant*' and '*refugee*' are not interchangeable. More information can be found in the one-page overview here. This document has also been included in the 🕮 **Repository** for further review (see Module 1, Useful Resources).

This course attempts to balance both these approaches: while being more in alignment with IOM's inclusive definition of people on the move, we also recognize that persons who have survived severe forms of adversity, such as violence and persecution, face challenges requiring specific considerations, particularly in terms of mental health. It must also be noted that many migrants may have limited or no choice but to migrate, often due to circumstances beyond their control rather than personal preference. Therefore, the term 'economic migrant' should be avoided. All migrants, regardless of their status, have fundamental human rights in their countries of origin, transit, and destination, including the rights to life, health, physical integrity, non-discrimination, and labor rights [24].

Phases of Migration

IOM views migration as **a continuum occurring across multiple dimensions**, starting before migrants arrive in the receiving country and extending beyond their initial settlement. Each migrant story is unique, with diverse reasons and methods of movement [25]. The following section explores IOM's framework on the different phases of the migration process and the specific issues that may arise at each stage [26].

Phases of Migration	
Pre-departure *(preparation and decision-making around embarking on a migration journey)*	Each person's migration process varies based on **whether they migrate through regulated or irregular channels**. Some people may have ample time to prepare, following precise documentation requirements set out by their country of origin and/or country of destination (e.g., passports, visas, job offers, financial records, health assessments). For others, the pre-departure phase may often be compressed by events outside their control. Someone embarking on a migration journey through unregulated channels will decide how to begin the process, considering the risks involved (e.g., obtaining a tourist visa, crossing borders alone, engaging a smuggler). In either case, financial preparation is essential and may take years.

Transit *(physical relocation from the country of origin to the intended destination)*	This can be **a direct journey from the country of origin to the destination country** or involve **multiple domestic and international stops**. In the case of displacement, people may be forced to leave immediately after the outbreak of a conflict, natural disaster, or other urgent circumstances. When transit is staggered, individuals might choose to stay temporarily at each stop to prepare for their final destination (e.g., handling practical or bureaucratic matters to increase their likelihood of staying in their intended destination) or because they are forced to due to financial constraints or border barriers. This can result in people being stranded in transit countries, unable to return home or proceed to their destination, without regularized status or access to opportunities. IOM refers to people in this situation as '*stranded migrants*.
Arrival *(arrival in country of destination/transit via air, sea, or land)*	Migrants moving through regular channels are typically inspected at border control points and may need a visa unless exempt. Those caught attempting irregular entry face proceedings to determine if they should be denied admission. They may be offered voluntary return or placed in removal proceedings if apprehended after entry. The duration of these processes varies due to systemic issues such as case backlogs, difficulties in arranging legal representation, and individual case complexities. The arrival stage is critical, as having the necessary documentation can significantly impact the subsequent steps in the migration process.
Stay *(admission and stay in country of destination/transit for a specific or indefinite period)*	Admission to a country is **typically temporary**, though it can sometimes lead to permanent residency. During the period of stay, immigrants must adhere to laws and visa requirements, including maintaining employment if on a work visa. States are obligated to protect the human rights of all foreign nationals, with migrants traveling through regular channels having additional rights under international and national laws. States are also required by international law to allow those travelling through irregular channels to stay and regularize their status, adhering to the principle of non-refoulement, which prevents returning refugees, asylum seekers, or those facing severe human rights violations to danger.
Circular Migration *(repeated movement of people between two or more countries)* **and return** *(return of migrants into their home society)*	Some individuals never return to their place of origin, while others do, either voluntarily or involuntarily. Returns can be categorized into three types: (1) **voluntary return *(success)*:** achieved objectives such as employment or education abroad; (2) **voluntary return *(perceived failure)*:** return due to inability to meet goals, often a complex decision influenced by factors similar to initial migration; (3) **forced return:** inability to maintain legal status in the host or transit country. The circumstances surrounding return are a key aspect in the final decision and the activation of specific measures. In deportation cases, individuals may seek support for voluntary returns and re-integration programs in their country of origin. In any case, each return can be experienced as a new migration process.
Sustainable Integration *(mutual adaptation between migrants and the societies in*	As will be discussed in subsequent units, the experience of integration and/or reintegration will substantially depend on factors in the **social ecology of the person**, such as gender, age, sexual orientation, financial resources, language proficiency, literacy, etc. **Social and cultural rules as well as new roles may be learned at this stage**. Sustainable integration and/or reintegration is typically associated with achieving

which they live) **and Reintegration** *(re-incorporating returning migrants into their home society)*	economic self-sufficiency, social stability, and psychosocial well-being, which can support individuals in coping with potential destabilizing factors related to migration or return to their home country. The extent of shared space and social interaction between host and migrant communities is crucial for achieving sustainability. Ultimately, the long-term success of integration and/or reintegration depends not only on the migrants themselves but also on policy choices at individual, community, and structural levels, including those related to migration, employment, health, society, housing, and the environment.

The Refugee Experience

The term 'refugee' dates to the 1680s. It originates from the French word *réfugié* meaning *"one who flees to a refuge or shelter or place of safety"*, which, in turn, derives from the Latin *re-* (*"back"*) and *fugere* (*"to flee"*). The word implies **fleeing from danger, persecution, or political unrest** [27]. UNHCR defines a ***refugee*** as a person who *"is forced to flee their own country and seek safety in another country. They are unable to return to their own country because of feared persecution because of who they are, what they believe in or say, or because of armed conflict, violence, or serious public disorder"* [28]. This is in line with Article 1 of the 1951 Refugee Convention, a historical international treaty that was developed in response to the large-scale displacement of people in the aftermath of World War II, with the aim to provide a consistent and fair approach to refugee protection [21].

But what does it mean to flee one's home? A concept that clarifies the **broad spectrum of experiences involved in making the difficult decision to flee** is that of *'involuntary dislocation'* [7,29]. Involuntary dislocation refers to the experience of individuals who are compelled to leave their homes due to various upheavals that make their living conditions **unsafe or untenable.**

Unlike terms such as *'forced migration'* or '***displacement***' that tend to focus on the physical act of moving (or being *forced* to move) from one location to another, involuntary dislocation addresses **the overarching experience of loss and disruption in people that results from being uprooted from the various contexts that have associated with a sense of home.** It can result from a vast array of adverse events and precipitating situations, such as political turmoil, military conflicts, natural disasters, climate changes, or social marginalization.

Key Point: ***Involuntary Dislocation***

The concept of ***involuntary dislocation*** was first introduced by Prof. Renos Papadopoulos, Founder and Director of the Centre for Trauma, Asylum and Refugees (CTAR) at the University of Essex. It encompasses two key aspects: (i) the **initial emotional disconnection** from one's home (including the emotional, familial, cultural, social, ethnic, linguistic, spiritual dimensions of a home), and (ii) the **subsequent physical and geographical movement away**. It therefore captures both the emotional/psychological (internal) and physical (external) aspects of being uprooted [7,29]. In essence, it suggests that people:

- have been made, due to various hardships and adverse circumstances, to experience their homes as no longer safe or livable.
- are compelled to abandon their homes in search of new places to live.
- if they had a genuine choice, they would not have left their homes.

It should be noted that the term 'involuntary dislocation' **does not carry any specific legal, psychiatric, psychological, sociological, or other technical connotations**, nor should be associated with other specialist terms in academic or professional fields. Rather, **it is meant to describe the human experience of the events it refers to**. It also does not imply or suggest any particular causes or effects of dislocation, such as how bad it was, how long it lasts, what sectors of life were affected, and so on.

Reflection Break: ***Engage in personal reflection***

Remember a time when you became aware of being different from other people and how you dealt with it. Perhaps you were visiting another country and did not speak or read the language; how did you manage?

Sourced from culturallyconnected.ca

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Unit 1.2: Social Determinants of Mental Health

Unit Overview
This training unit examines the relationship between migration and health from a global public health equity perspective. Using a social determinants of health framework (SDH), it outlines the layered social and structural factors that affect the health and mental health of migrants and refugees throughout their migration journey. The unit concludes by addressing how different social determinants impact the mental health and psychosocial well-being of migrant populations. Supplementary material is provided with findings from recent research studies on the subject.

Unit Sections:

1. Introduction

Factors such as poverty, structural racism, discrimination, isolation from family and traditional social supports, and limited access to health care are primary drivers of ***mental health inequities*** among migrants and refugees [1]. Migrants and refugees are also known to be **disproportionately impacted by recent crises** such as the COVID-19 pandemic, climate change, and conflict, as well as food and cost-of-living crises [2]. Although little is known about how to effectively address and reduce differences in mental health outcomes across different groups of people, the World Health Organization (WHO) highlights **the interconnectedness of social, economic, political, and environmental factors in shaping well-being** [1-3].

In this unit, we seek to provide a clearer understanding of the mental health of migrants and refugees using WHO's social determinants of health (SDH) framework. Building on the ideas of Dahlgren and Whitehead

[4], we see the mental health of migrants and refugees as determined, among other factors, by **the circumstances in which they live and work, as well as the impact of these circumstances over the life course.**

→ **VIDEO:** *Health Equity* 💻

2. Key Concepts

Social Determinants of Health

According to WHO, "*the **social determinants of health** (SDH, or SDoH) refer to the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life, including people's access to power, money, and resources*" [1,2,5]. **The social determinants of health affect everyone**. At their best, they can be protective of good health. Many people, however, particularly among historically disadvantaged populations, experience **numerous social factors that contribute to adverse health outcomes**, including increased morbidity and mortality [6].

→ **VIDEO:** *Social Determinants of Health* 💻

In the past decades, numerous models have been developed to illustrate the various determinants that impact health and well-being. **The Dahlgren-Whitehead rainbow**, developed in 1991 by Göran Dahlgren and Margaret Whitehead [4], **is the most influential and widely used model for tackling inequities in public health**.

The model is often depicted as a rainbow (see Figure 1.2.1), in which the individual lies at the center and is surrounded by various concentric layers, each representing different levels of influence on health. Unlike medicalized models that focus on the biological causes of specific diseases, **the rainbow model outlines various influences on health (or determinants) at multiple hierarchical levels** – ranging from individual factors to general socioeconomic, cultural, and environmental conditions.

Figure 1.2.1. *"The Wider Determinants of Health"*

Note: Graphic sourced by the Victorian Government, 2019, Victorian Public Health and Wellbeing Plan 2019–2023, p.6, State of Victoria (adapted from the Dahlgren-Whitehead Rainbow Model, September 1991)

1. **Individual Factors:** The innermost layer refers to *personal characteristics*, including genetic/hereditary factors such as age, sex, ability. Individual lifestyle factors refer to personal health behaviors such as diet, physical activity, alcohol and substance use, and others. **In the context of migration, individual lifestyle factors may include personal experiences, coping strategies, and resilience.**
2. **Social and Community Networks:** The next layer encompasses *social circumstances*, including family and broader social circles. **For migrants and refugees, this layer may include experiences of social inclusion or exclusion and sources of support, such as family, friends, neighbors, and local community networks.**
3. **Living and Working Conditions:** This layer focuses on the *broader living and working conditions* that influence health, such as housing, access to healthcare, education and welfare services, and occupational health and safety. **For migrants and refugees, this may include living in overcrowded or unsafe conditions, challenges in meeting basic survival needs, inability to pursue income-generating activities, precarious employment situations, and limited access to healthcare.**
4. **General Socioeconomic, Cultural, and Environmental Conditions:** The outermost layer represents the *wider socioeconomic, cultural, and environmental factors* shaping health. These factors pertain to the forces and systems shaping the conditions of daily life, including income inequality, social norms and values, development agendas, and environmental determinants of health. **Examples in the context of migration include discrimination and xenophobia; hostile immigration policies; labor market policies, including differentials by race and gender in employment settings; and broader geopolitical factors.**

Upstream, Midstream, and Downstream Determinants

Within the broad field of public health, the concept of 'upstream', 'midstream', and 'downstream' determinants has been used for many years as an analogy for levels of intervention with individuals, groups, and communities. The 'upstream-downstream' metaphor gained prominence in the form of a story in 1975 (see video below) and has since been employed to illustrate **the futility of solely dealing with the symptoms of a problem without tackling the root cause** [7].

→ **VIDEO:** *Upstream Public Health* 💻

As the metaphor suggests, **what occurs 'upstream' will be felt 'downstream'**. Upstream factors set the broad context within which individual choices and behaviors (downstream factors) occur. For instance, societal norms and economic policies (upstream) can influence personal lifestyle choices and health behaviors (downstream) [8,9].

- ***Upstream* factors** represent *structural determinants that affect communities in a broad and inequitable way.* Income disparity, institutional discrimination, and social marginalization are examples of upstream factors that prevent optimal health.
- ***Midstream* factors** represent *social needs and operate within communities, neighborhoods, and local institutions*. They include homelessness, food insecurity, poor access to education, and lack of availability of resources.
- ***Downstream* factors** refer to the more *immediate needs of people at an individual or family level*. They include individual lifestyle choices, health behaviors, disease, and intentional or unintentional injury.

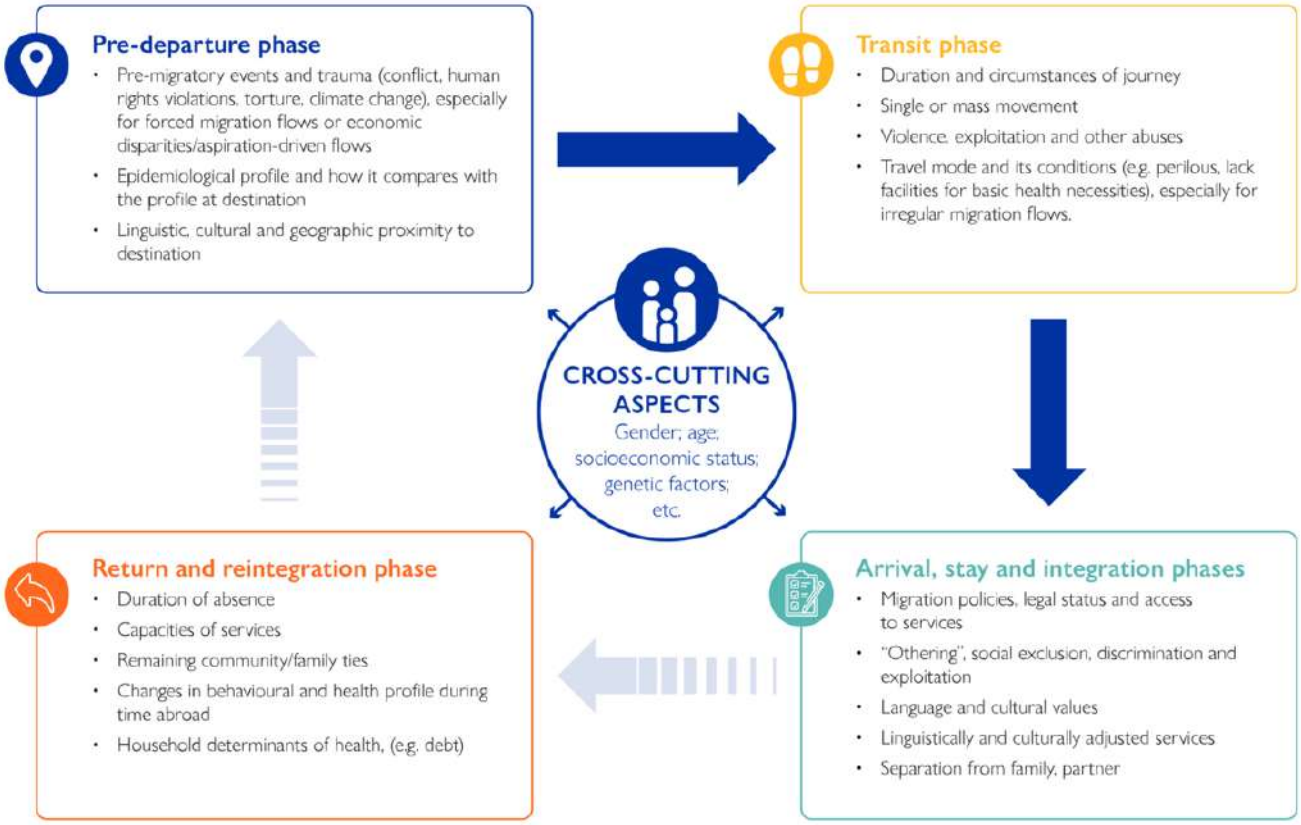
So how do we look 'upstream', to the so-called causes-of-the-causes of poor health? A useful graphic provided in the 🕮 Repository illustrates some examples of interventions at all three levels. It can serve as a guide for professionals and volunteers to see what their personal and collective impact can be at every level (see 1.2 – Figure 1.2.1-R *"Social Determinants and Social Needs: Moving Beyond Midstream"*).

More practical information on the subject, particularly regarding the concept of *structural competency* (i.e., the ability to recognize the impact of the social structure on a social group or individual [10]), will be provided in Module 3, Unit 3.2: Cultural Awareness.

3. The Relationship between Health and Migration

WHO's Constitution defines ***health*** as *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"* [11]. Migrant health can be defined as the differences in the physical, mental, and social well-being of migrants and populations in both communities of origin and destination and across all stages of the migration process [12]. **Migration processes can impact health outcomes just as health status can impact migration outcomes** (see Figure 1.2.3 concerning the phases of migration discussed in Unit 1.1) [13].

Figure 1.2.3. *"Aspects of the various migration phases that can affect migration health"*



Note: Graphic sourced from the International Organization of Migration, 2023, Migration health throughout the migration phases, EEM2.0 Handbook – Health and Migration (adapted from Vearey, Hui, and Wickramage, 2019)

Migration does not inherently constitute a health risk. However, **conditions surrounding the migration process** (such as unsafe travel, changes in disease distribution, and poor nutrition) can contribute to poor health outcomes. Migration can also impact the mental health of migrants by **worsening pre-existing vulnerabilities and challenging their resilience** [14].

This is particularly evident for those who migrate involuntarily, including individuals fleeing natural or manmade disasters, conflicts, and human rights violations, as well as those who find themselves in an irregular situation. For instance, migrants who cross international borders without authorization may face risks such as exploitation by traffickers, leading to abusive and harmful situations that further compromise their mental and physical well-being [13].

◎ Key Point: ***Migration Health in Detail***

→ *Health hazards before departure*

Often, the conditions present before departure set the stage for the health and well-being of migrants and refugees throughout their journey. Particularly in the context of displacement, the pre-departure phase is compressed by events outside of the person's control. Prior to migration, people may have already experienced:

- compromised health due to inadequate nutrition, limited access to health care or lack of public health programs, including routine childhood immunization
- difficult living conditions that contributed to their fleeing their country of origin
- violence, trauma, or abuse, further exacerbating their health vulnerabilities

→ *Health hazards during the migration journey*

The transit phase can negatively impact the health of migrants and refugees due to the following factors:

- long and unsafe journeys for those who are forced to migrate without legal documents
- travel conditions which may include long days hidden in a truck or being cramped in a small space on a boat (commonly used to cross the Atlantic or the Mediterranean) or under moving trains
- traveling alone or in a large group, with specific challenges arising for certain groups including children (particularly unaccompanied minors), women, and those with disabilities
- challenges related to the capacities of health systems to accommodate large groups of people along the migratory routes due to an acute disaster or rising sea levels (environmental displacement)

→ *Health hazards in destination countries*

Migrants and refugees can be at risk of ill health in destination countries due to a range of factors, such as:

- poor living conditions
- limited or no access to health and other services
- separation from family and loved ones
- changes in lifestyle and adaptations to the health practices, dietary habits, and activity patterns of the destination country, which can lead to an increased risk of obesity, diabetes, and cardiovascular disease
- xenophobic attitudes from receiving communities, including health providers, which can aggravate migrants' health outcomes as well as result in social exclusion, discrimination, and exploitation

- on an existential and spiritual level, the loss of a sense of omnipotence (i.e., the idea of having absolute power over their own lives), which results in a loss of self-esteem and confidence and – in the absence of opportunities for new meaning-making – in a more permanent sense of existential loss and isolation

4. Social Determinants of Mental Health in the Context of Migration

As discussed in the previous unit, WHO conceptualizes mental health as a "*state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community*" [5]. The following list provides some examples of social determinants of mental health which can influence mental health outcomes in positive and negative ways:

- Housing, basic amenities, and the environment
- Income and social protection
- Education
- Employment
- Language skills and interpretation
- Legal status and the asylum-seeking process
- Access to affordable health services of decent quality
- Culture, spirituality, and religious background
- Social inclusion and social isolation
- Prejudice, racism, and structural discrimination

A more comprehensive review of how each one of these determinants can impact the mental health and psychosocial well-being of migrants and refugees is provided in the 🕮 Repository (see 1.2 – Handout 1. "*Social Determinants of Mental Health in Detail*").

Addressing the social determinants of mental health in the context of migration and displacement requires **an in-depth approach that goes beyond treating individual symptoms**. Interventions should have **psychosocial elements** at their core, further taking into consideration **the broader conditions that shape the lived experience of migrants and refugees** [1,2,5,15].

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Unit 1.3: Risk, Protective, and Promotive/Resilience Factors

Unit Overview
This training unit explores risk, protective, and promotive/resilience factors for the mental health of migrants and refugees. It highlights the importance of different factors at the micro-, meso-, and macro-level that influence the mental health of people who have survived different forms of adversity. Drawing from global literature and WHO's recent guidance, the unit concludes by offering supplementary material on the challenges and protective influences that are unique to specific groups.

Unit Sections:

1. A Socio-Ecological Framework of Understanding Migrant and Refugee Mental Health

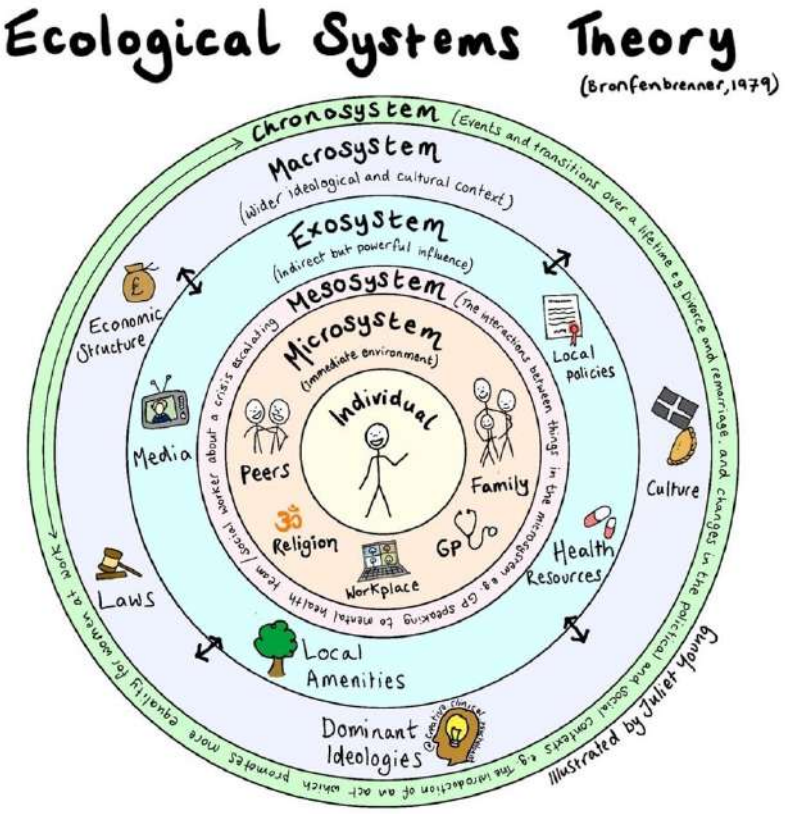
The **Socio-Ecological Model (SEM)** (broadly referred to as '***ecological systems theory***') was conceptualized by Russian-born American psychologist Urie Bronfenbrenner in the '70s, to better understand human development. It was later formalized as a theory in the '80s. Bronfenbrenner's Socio-Ecological Framework argues that **to grasp human growth, we must consider the entire ecological system in which development occurs** [1].

The model has had many adaptations and interpretations over the years. Still, at base level, it suggests that individual behavior is embedded within a complex network of intrapersonal, interpersonal, institutional, community, and public policy factors, emphasizing the reciprocal nature of interactions between individuals and their environments. This network includes **systems in which the individual is directly**

involved, such as neighborhoods or schools, as well as **systems that are more distant from direct interaction or influence**, such as community, policy, and society [2].

The social determinants of health (SDH) framework discussed in the previous unit and the socio-ecological model (SEM) are related concepts that emphasize **the importance of various factors impacting health outcomes**. However, SDH focuses on specific conditions and environments affecting health outcomes, whereas SEM provides a **comprehensive framework for understanding the multi-level interactions that shape individual behavior and well-being**. SEM also recognizes that **factors can intersect and operate at multiple levels**, affecting people differently based on their cumulative and intersecting experiences [2,3]. More information on the concept of intersectionality as it relates to migrant and refugee mental health is provided in Module 2, Unit 2.2: Intersectional Perspective on Migration and Mental Health.

Figure 1.3.1. *"Bronfenbrenner's Ecological Systems Theory in the Context of Community Psychology"*



Note: Graphic produced by Clinical Psychologist Dr. Juliet Young, August 2021

The above graphic (Figure 1.3.1) provides an illustrative example of the **various factors at the individual, family, organizational, community, and societal levels** (micro-, meso-, exo-, and macro-level or system) that influence mental health and well-being **over time** (also described as chronosystem). The University of Minnesota has produced a more detailed graphic that reflects what we know from research through a socio-ecological lens [3]. This document has been included in the 🕮 **Repository** for further review (see Module 1, Useful Resources).

While research alone cannot fully capture people's lived experiences, it provides a foundational framework that may assist us in understanding mental health in the context of migration and displacement. This model promotes a holistic view of mental health, emphasizing **a strengths-based approach that focuses on resilience and recovery rather than illness**. It applies to everyone and considers the entire lifespan [3].

The videos below provide more information on the ecological perspective and the history and development of Bronfenbrenner's ecological systems theory.

→ **VIDEO:** *What is Ecological Perspective? Community Psychology Core Principles and Key Concepts* 💻

→ **VIDEO:** *Bronfenbrenner's Ecological Systems: 5 Forces Impacting Our Lives* 💻

2. Risk and Protective Factors

Risk and Protective Factors

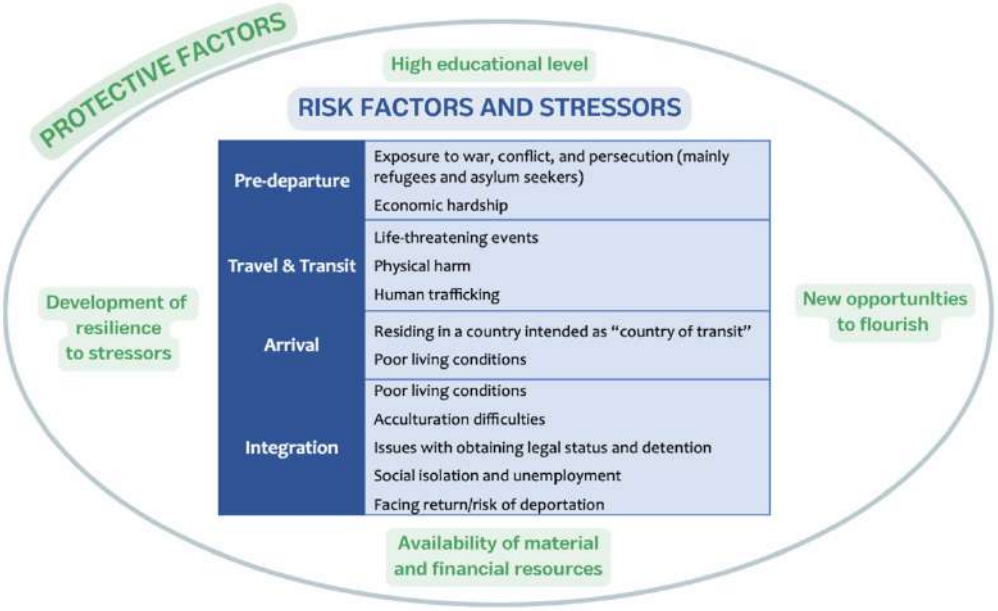
According to WHO, *"throughout our lives, multiple individual, social, and structural determinants may combine to protect or undermine our mental health and shift our position on the mental health continuum"* [4]. Individual psychological and biological factors such as emotional skills, substance use, and genetics can increase susceptibility to mental health challenges. As seen in the previous unit, unfavorable social, economic, geopolitical, and environmental conditions – such as poverty, violence, inequality, and environmental deprivation – also elevate the risk of poor mental health. **These risks (or risk factors) can**

manifest at all stages but can be particularly harmful during sensitive developmental periods, especially in early childhood.

Protective factors, also occurring throughout our lives, **serve to reduce or buffer against the risk of negative mental health outcomes by enhancing our ability to cope in otherwise adverse circumstances.** They include social and emotional skills, positive social interactions, quality education, decent employment, safe neighborhoods, and strong community ties. Risk and protective factors are key elements in the development of resilience which is often referred to as the ability to withstand adversity and bounce back from difficult life events [5].

Risk and protective factors **operate at various societal levels.** Local threats impact individuals, families, and communities, while global challenges such as economic downturns, disease outbreaks, humanitarian crises, forced displacement, and climate change, threaten entire populations [4-6]. Protective and risk factors in the context of migration are outlined in detail below (Figure 1.3.2).

Figure 1.3.2. *"Risk and Protective Factors for Mental Health in Refugees and Migrants"*



Note: Graphic re-produced by the EU-MiCare team based on information by the World Health Organization (WHO, 2018, Mental health promotion and mental health care in refugees and migrants, p. 4, Copenhagen)

The reproduction of this graphic does not imply endorsement by WHO.

Each risk and protective factor alone have limited predictive power. Most people do not exhibit mental health symptoms and can fully recover despite exposure to multiple adversities, while some may develop mental health conditions without any apparent risk factors. The interplay of various determinants shapes mental health, and multiple stressors can collectively lead to psychological distress [6].

As stated by the International Federation of Red Cross and Red Crescent Societies (IFRC), *"it does not need to be a single massive event that leads to psychological distress or mental health conditions; it can be a buildup of multiple different stressors. At any one time, a diverse set of individual, family, community, and structural factors may combine to protect or undermine mental health"* [7]. **Although most people are resilient, those exposed to adverse circumstances are at higher risk.**

Additional information can be found in the 🕮 Repository (see 1.3 – Table 1.3.1-R *"Risk and Protective Factors to Promote Resilience"* and Table 1.3.2-R *"Additional Risk and Protective Factors for Migrants and Refugees"*.

3. Promotive/Resilience Factors in the Face of Adversity

So, what is resilience? In general terms, ***resilience*** is regarded both as **an individual's capacity to endure experiences of trauma and stress** and as **the ability to remain actively engaged in life's tasks**, particularly in the effort to restore resources lost during periods of adversity [8]. The guiding assumption is that **all humans possess an inherent drive to acquire, maintain, foster, and protect resources they value for their survival and well-being**. Many factors, including our biology, psychology, social interactions, and culture, influence resilience, all working together to shape how we handle stress [9].

When talking about resilience, it is important to clarify if we see it as a personal characteristic, a process, or an outcome. It is easy to think of resilience as something you either have or don't have, but, in reality, **resilience exists on a continuum. Resilience can vary in strength and appear to different extents in different areas of life** [9].

Promotive/resilience factors enhance mental health and psychosocial well-being in the face of adversity and explain why not all those who have been exposed to adverse circumstances develop negative mental

health outcomes [10]. Promotive/resilience factors also encompass a range of activities, scenarios, and circumstances, such as supportive relationships, the ability of the person to cope and adapt to changing circumstances, good working environments, and others [11,12].

○ Psychological Resilience

Psychological resilience has been defined in different ways. At its heart, it is **the ability to recover from shocks and overcome adversity**. As mentioned above, current conceptualizations of psychological resilience include individual capacities and societal and environmental supports. The role of resilience in producing health, particularly mental health, has been extensively researched among migrant groups, leading to its recognition as **an important factor for psychosocial well-being** [5,12]. It varies according to certain individual characteristics, with older age, protracted displacement, and ongoing hardship decreasing resilience while better living/working conditions, being younger, and having higher levels of support enhancing resilience and, ultimately, improving mental health [8,9,12].

A useful graphic including some factors that promote resilience can be found in the 🕮 Repository (see 1.3 – Figure 1.3.1-R *"Five Factors that Promote Resilience"*). Note that many factors promote resilience. **Resilience is not a trait that a person simply possesses or lacks; it is a dynamic process influenced by various interacting elements.**

○ Post-Traumatic Growth

In the context of displacement, ***post-traumatic growth*** refers to **how migrants and refugees engage in meaning-making and interpret their experiences** – this reflective process results in positive gains in their lives [13]. Post-traumatic growth functions as **a promotive/resilience factor**, protecting migrants and refugees against the negative impact of adversity such as the development of post-traumatic stress disorder (PTSD), depression, and anxiety [14]. Studies exploring post-traumatic growth in migrants and refugees have highlighted its benefits, which include the **ability to cope with multiple losses, higher tolerance to the uncertainty and unpredictability of their circumstances, reduction in psychological distress, increased life satisfaction**, and **positive post-migration experiences** [13-15].

○ Adversity-Activated Development (AAD)

'*Adversity-Activated Development*' (AAD) refers to the newly developed **positive characteristics, skills, and habits that arise in the aftermath of enduring highly challenging or adverse life circumstances** [16]. These positive traits were either absent, hidden, or not consciously appreciated before the hardships occurred. Importantly, these outcomes do not exclude – and often coincide with – negative or neutral reactions to adversity [16,17]. In other words, **an individual who fled their homeland may show resilience and AAD in some areas of their life while exhibiting vulnerability in others**. The ability to manage major life challenges and adapt rapidly does not mean being free from distress, just as feeling profoundly sad and disoriented does not mean a lack of progress in other areas.

◎ Key Point: ***The Adversity Grid***

In traditional discourses within the field of 'refugee care', there is a strong focus on trauma, which is a severe and valid response to adversity. However, this emphasis **oversimplifies the varied experiences of migrants and refugees**. To better capture the broad range of responses to adverse situations, it is recommended to use the ***Adversity Grid***.

The grid is **not a psychometric test or a standardized assessment tool**; instead, it provides **a framework to assess and understand the different and varied ways in which individuals, families, communities, and broader societies respond to adversity**. It is useful in reminding us of the complexity, uniqueness, and totality of all people affected by adversity, thus counteracting unhelpful polarizations and generalizations. This is particularly important in the context of our work, which often views adversity survivors exclusively as helpless victims. The Adversity Grid categorizes responses to adverse events (such as displacement, war, and persecution) into three types: (i) negative responses, (ii) unchanged responses, and (iii) positive responses. The grid is in line with the socio-ecological systems theory discussed earlier in this unit by locating difficulties and new opportunities within the entire spectrum of the ecology surrounding migrants and refugees. IOM, in collaboration with Prof. Renos Papadopoulos, has developed a supplementary resource on the use of the Adversity Grid as part of their manual on Community-Based Mental Health and Psychosocial Support (MHPSS) in Emergencies

and Displacement [18]. More information on how to use the grid can be found in the 🕮 Repository (see 1.3 – Handout 1. *"Adversity Grid in Detail"* and Useful Resources).

4. Challenges and Protective Influences Unique to Specific Sub-Populations

Certain migrant and refugee groups require population-specific considerations regarding risk and protective factors, and the barriers and facilitators they face when it comes to accessing care. Based on available evidence, WHO has identified five interrelated themes as relevant across various groups, contexts, and stages of the migration process:

1. self-identity and community support;
2. basic needs and security;
3. cultural concepts of mental health and stigma;
4. exposure to adversity and potentially traumatic events;
5. navigating mental health and other systems and services [5].

Supplementary information on these themes as well as the challenges and protective influences faced by specific sub-populations (such as women, people with experiences of torture, LGBTQI+ individuals, older adults, persons living with disabilities) is provided in the 🕮 Repository (see 1.3 – Handout 2. *"Challenges and Protective Influences Unique to Specific Sub-Populations"*). A more comprehensive review of the challenges and protective influences faced by children and young people is available in Module 3, Unit 3.5: Responding to the Special Situation of Children.

🕘 **Reflection Break:** ***Engage in self-reflection (or group reflection with your peers) and consider how multiple factors intersect to influence migrants' vulnerability and resilience***

On the following page, you will find four examples that illustrate the interaction of factors at the micro-, meso-, and macro-level. As discussed previously, these factors may impact (in a positive, negative, or neutral way) the ability of migrants to avoid, resist, cope with, or recover from the various types of adversity they are frequently faced with.

Now, taking into consideration the socio-ecological model and the theory on risk, protective, and promotive/resilience factors, consider possible responses that might support the psychosocial well-being of the individuals in each one of the scenarios below.

Example 1

A middle-aged man having a high level of education, enjoying good health and belonging to a powerful segment of society would typically have a low level of vulnerability. However, he could find himself vulnerable to extortion and violence if he were to engage in unsafe migration practices, such as hiring migrant smugglers to help him gain access to a country through irregular means, particularly if he were to travel with the smugglers through countries with no mechanisms to protect smuggled migrants from violence.

Example 2

A family that experiences a crisis, such as the loss of employment owing to a health emergency for the primary wage earner, might make migration decisions that heighten the vulnerability of one or more family members to labour exploitation. However, it would be less likely to make such decisions if it could turn for support to extended family members, community members and/or social welfare programmes. The household/family risk factors would be mitigated by protective factors at the community level.

Example 3

People who regularly face discrimination, harassment and barriers in accessing services because of their status as migrants are more likely to be vulnerable to violence, exploitation and abuse. If they cannot turn to other members of the community for assistance, and if they cannot access the same services as others, they are likely to become isolated and vulnerable to being targeted by those who would abuse or exploit them.

Example 4

Members of a community displaced by a natural disaster may face increased risks of trafficking, as traffickers often target displaced populations. However, if local and national leaders act quickly to mitigate the trafficking risk by providing displaced persons with accurate and timely information and by taking effective law enforcement action against trafficking, then the community members are likely to be adequately protected from the risk.

Sourced from IOM, The Determinants of Migrant Vulnerability, and adapted by the EU-MiCare team for the purposes of this course.

The adaptation of this graphic for the purpose of this exercise does not imply endorsement by IOM.

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Unit 1.4: Psychosocial Dimensions of the Migration Process

Unit Overview
This unit offers an overview of various models that explore the psychosocial processes involved in migration. First, it introduces psychological phases in a general context of migration. Next, it examines two models addressing the complexities tied to displacement and 'involuntary dislocation'. Finally, the concept of 'migratory mourning' is discussed. Supplementary material is provided with information on acculturation, acculturative strategies, and acculturative stress.

Unit Sections:

1. Introduction

Migration is a complex and dynamic process involving significant psychological adjustments. It is a process that **begins long before the actual act of migrating** and **continues well after arriving at the new destination**. Understanding the psychological journey of migration may help field workers better understand the experience of the people they assist while adjusting their supportive interventions according to their needs. As discussed in Unit 1.3, the context in which migration occurs and the circumstances surrounding it will determine both risk and protective factors. Following the complex interplay of these factors, individuals may develop resilient coping responses or mental health challenges with varying degrees of severity.

The primary objective of this unit is to provide a framework that allows professionals and volunteers understand **the complex psychological journeys of migrants and refugees**. This deeper understanding

allows us **to move beyond the reductive view of the so-called 'migrant and refugee experience' as a singular, traumatic event**. Too often in the broad field of migrant and refugee care, **support focuses narrowly on the devastation and upheaval that triggered migration and displacement while overlooking the lives that came *before* and the ongoing challenges that persist *after* resettlement**. By expanding our perspective to consider the full arc of psychosocial processes (before, during, and after migration), we develop a more nuanced understanding of the profound ways the experience of losing one's home reshapes their life and identity.

2. Psychosocial Processes of Migration

When working with people with migratory biographies, it is important to recognize **the common tendency to confuse an event itself with the unique way it is experienced by an individual, family, or community**. An error that occurs in our field is when the incorrect belief that all individuals react to adversity uniformly, comes to replace the correct assumption that every person experiences external events differently (due to contributing factors such as their personal and collective histories, cultural and societal influences, broader dominant narratives, dynamics of power, etc.). **This leads to the oversimplified notion that all people exposed to adversity, such as war or natural disasters, will inevitably become 'traumatized'.**

Such a view collapses the complex reality of individual experiences into a single, homogenous narrative**. A proper understanding of adversity requires identifying its distinct components**, which include: (a) the event itself, (b) the experience of the event, (c) the impact of this experience, (d) the overall response to the impact, and (e) how all the above are communicated to others [1]. Often, there is a tendency to let the initial, simplified perception of the event (i.e., migration as 'crisis' or 'trauma') dominate the interpretation of all these elements. Frameworks that examine the so-called 'psychological phases of migration' offer a holistic understanding, as **they consider not only the external stressors but also the individual psychosocial processes that migrants undergo as they navigate their new lives**.

→ **VIDEO:** *Chimamanda Ngozi Adichie: The danger of a single story | TED* 💻

This broader perspective invites a fundamental shift in our epistemological approach to care. Rather than pathologizing suffering or assuming trauma as an inevitable outcome, **we are encouraged to discern the subtleties of how events are experienced and processed over time** [1]. This also means **differentiating distress from disorder** [2] and **recognizing the diverse ways in which individuals and communities respond to adversity and hardship**. In effect, this deeper understanding pushes us to engage with the people we assist as **whole persons shaped by a continuum of experiences rather than static victims of singular events**. It shifts our focus from crisis intervention to **an ongoing process of psychosocial care that honors the complexity of migration as a transformative, multifaceted journey.**

◎ Key Point: ***Psychosocial Dimensions of the Migration Process – Putting the Theory into Practice***

But how can we apply these in the context of our day-to-day work? When working with a person or a family, it can be helpful to consider: (1) **the migration phase they are in**, (2) **the challenges they are currently facing**, and (3) **the emotional processes associated with these challenges** [1].

The difficult circumstances associated with the lived experience of migrants are in constant dialogue with the external and internal resources at their disposal. For instance, as seen in previous units, if an individual does not speak the language of the host society and has significant financial struggles but is also highly adaptive with a strong social support network, they may be less likely to develop severe mental health issues. Conversely, an individual facing similar challenges who lacks these resources will be more prone to adverse mental health outcomes. Even if a migrant has functionally adapted to the host society, it is still vital for field workers **to remain sensitive towards their needs, capacities, and resources and the way these evolve throughout the migration process**.

The following section describes the psychosocial processes migrants and refugees are likely to experience when they flee their homelands. It is divided into two parts: the first one presents a general conceptualization outlining the phases migrants may go through in terms of key emotional aspects and family dynamics, while the second one focuses on the particularities of the refugee experience.

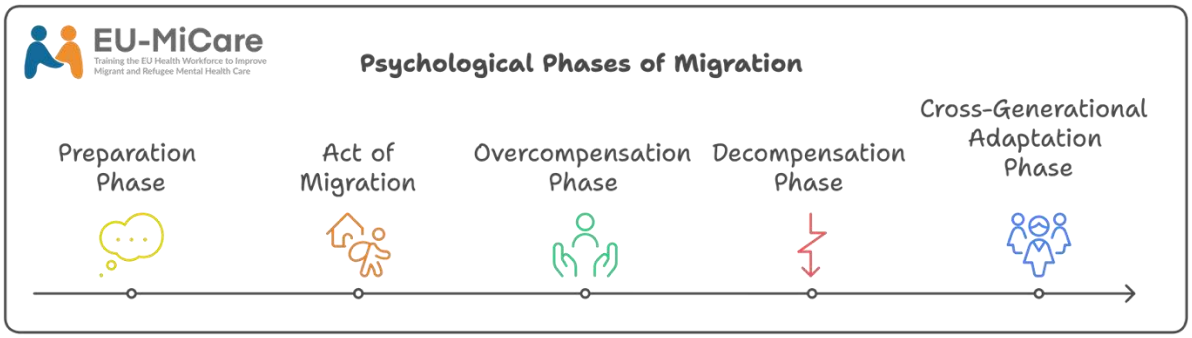
General Psychological Phases of Migration

The first process described in this unit pertains to the psychological experiences of individuals who are driven to migrate. We reference two key authors in this area: Carlos E. Sluzki [4], an Argentine psychiatrist and expert in migration and family therapy, and Prof. Wielant Machleidt [5], a German psychiatrist known for his work in transcultural psychiatry and migration-related mental health.

Sluzki developed a foundational model outlining the psychological phases of migration, focusing on ***functional adaptation***. In the context of migration, functional adaptation refers to **the process through which individuals adjust to and manage the challenges posed by their new environment, particularly in terms of psychological and social functioning**. This adaptation includes **learning how to navigate the social norms, laws, and cultural practices of the host society, while maintaining the ability to cope with the stressors of migration.** Successful functional adaptation is marked by a person's ability to integrate into the new environment and preserve their mental and emotional well-being, often by developing **new coping strategies and support systems** [4].

This model laid the groundwork for subsequent contributions, such as those by Machleidt [5], who emphasized **the emotional aspects of migration**. The model proposes that the psychological process of migration can be divided into five phases experienced by all migrants (Figure 1.4.1), irrespective of their cultural background. By recognizing **the cyclical nature of emotions**, **the effects of social exclusion**, and **the importance of *cultural integration*** professionals and volunteers can engage with migrant populations more meaningfully, while supporting their sustainable adjustment to new homes.

Figure 1.4.1. *"Psychological Phases of Migration"*



Note: Graphic developed by the EU-MiCare team based on information by Sluzki (2010) and Machleidt (2013)

[Sluzki, C.E. (2010). Psychologische Phasen der Migration und ihrer Auswirkungen. In T. Hegemann & R. Salman (Hrsg.), *Handbuch Transkulturelle Psychiatrie* (p. 108-123). Berlin: Psychiatrie Verlag; and, Machleidt, M. (2013). *Migration, Kultur und psychische Gesundheit. Dem Fremden begegnen.* (1st Ed). Stuttgart. W. Kohlhammer GmbH.]

In the following table, we outline each phase in more detail, integrating both models and specifying the key emotional aspects and family dynamics that may emerge [4,5].

Psychological Phases of Migration[1]		
Phase	**Key Emotional Aspects**	**Family Dynamics**
Preparation Phase *The decision-making process. This phase includes decision-making, planning, and anticipation before migration.*	• **Fear** • **Uncertainty** • **Euphoria and hope**	• **Discussions regarding the decision to migrate** • **Conflicts** because of the separation of the family or because the migration involves a whole family nucleus and may not be a decision shared by all family members
Act of Migration *The actual process of relocating, which can be brief or prolonged.*	• **Stress and anxiety** due to uncertainty about the journey and arrival and the emotional impact from separation.	• A **'farewell mourning'** [5] may occur, involving the loss of familiar roles (i.e., being caregiver of a family) and environments.

[1] As discussed in Unit 1.1, **many so-called 'voluntary' or 'economic' migrants are driven by coercive circumstances**, making their **decision less about true volition and more about survival**. Even if they are not fleeing direct crises or painful adversities (such as violent conflict or climate disasters), structural forces such as economic hardship, political instability, social inequality, and environmental degradation often compel them to migrate.

Overcompensation Phase *The initial period after arrival is marked by a 'honeymoon phase' [5], characterized by idealization of the host culture. It can last from six months to one or two years. The main objective is to find one's own way around while securing livelihood in the host country.*	• **High optimism and enthusiasm** • **Mixed emotions:** curiosity, fear, shame, sadness, and joy • **Gradual emotional processing** through interactions with others in similar situations • **Functional stress management** (i.e., the ability to navigate life's stressors in a healthy way) **at its highest**	• **Conflicts stay in the background** • **Typical family dynamics and norms emphasized;** i.e., close families may show closer emotional dynamics between different family members; already distanced families may show increased distance
Decompensation Phase Two main subphases: 1. **Critical Adaptation Phase** *(struggle to adjust to the new environment)* 2. **Mourning Phase** *(emotional mourning over leaving the country of origin)*	• **Disillusionment and idealization** of the home culture • Slow transition from **euphoria to mourning** • ***Acculturative stress***, i.e., the psychological strain from adjusting to a new culture, may have a considerable impact • **Anxiety and frustration, marking a cyclical pattern of emotions** from the previous phase • **Mental health issues and crises** may arise	• **Questioning identity, old coping strategies may be less effective;** loss of previous role in society or family • **Possible cultural clashes** due to children and adolescents adapting quicker to the new culture than other family members • **Changes in family roles and structures** due to new work situations and school • **Impact on the resources that the family already has**
	Health Risks • **Increased risk of stress-related mental health challenges** due to highly stressful experiences • **Adjustment difficulties leading to higher distress levels** • **Previous adverse experiences and psychological difficulties may get reactivated** by stressful situations faced in the present	
Cross-Generational Adaptation Phase *Integration of traditional values with new cultural norms. It aligns with the Sustainable Integration Phase (see Unit 1.1) described by the IOM, where individuals begin to view the host country as their own.*	• **Internal changes,** including emotional resilience and coping strategies for stress • **Attainment of a level of efficacy** in the new environment • **Adjustments in attitudes towards the new culture** • **Adjustments in original cultural habits** • **Development of intercultural competence** with the acquisition	• **Potential conflicts between generations** (e.g., migrant parents and their children who were born and/or raised in the host country) **over language, behavior, or values** • **Lifestyle of later generations is increasingly similar** to that of the host society • **Role reversal,** with children of migrants born in the new country (second-generation immigrants)

	of skills needed to effectively navigate and communicate in the new culture • **Sense of belonging in both cultural contexts, increasing self-esteem and emotional well-being.** Failure to achieve this balance may lead to feelings of alienation from both cultures • **Emotional ambivalence,** characterized by a combination of pride and resentment, loyalty and detachment, when it comes to one's heritage	often tasked with **the role of balancing the two distinct cultures surrounding them,** serving as **'cultural intermediaries'** within their families of origin and/or with new immigrants/newcomers from their home country • **Younger generations may be driven by hopes for a better life,** motivating success at an academic or professional level but creating emotional pressure to meet family expectations • **Varying degrees of identification with the culture** of the family of origin in second, third, and fourth generations
Bi- or Multicultural Identity and Inclusion Phase *Focuses on how individuals and families navigate and harmonize two (or more) cultural identities. It relates more to individual identity formation than to family dynamics. In this phase, people create a coherent identity that blends and balances elements from both cultures.*	• **Internal conflict and emotional tension between the multiple cultural identities,** feeling pulled between their heritage culture and the norms of the host society • **Confusion, anxiety, or guilt,** particularly if these cultural aspects appear incompatible • **Sense of pride, belonging, and stability** that develop over time • **Being able to authentically express aspects of both cultures without fear of rejection**	• **Tension between older family members** (who may hold more strongly to traditional values) **and younger generations** (who typically adapt to the host culture more quickly) • **Balancing differing cultural expectations within the family,** such as honoring traditional cultural values while adapting to new societal norms

→ **VIDEO:** *Michael Rain: What it's like to be the child of immigrants | TED* 💻

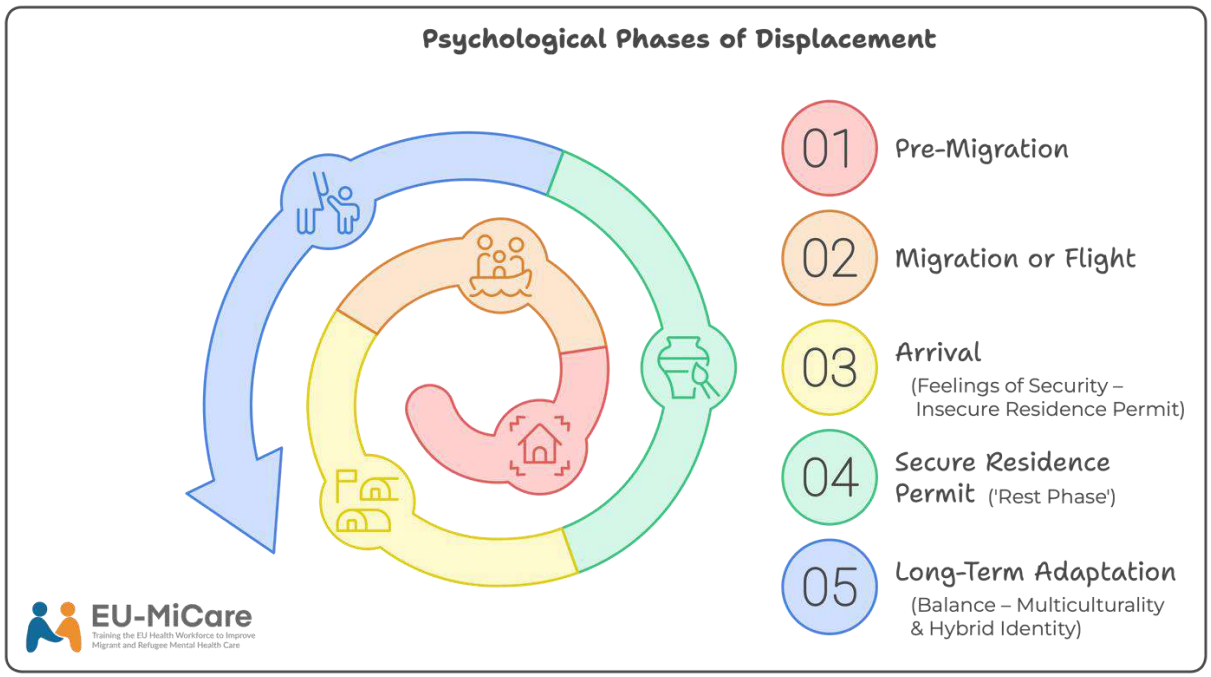
Psychological Phases of Displacement

The psychological journey of those displaced by conflict, persecution, or environmental disasters differs greatly from those migrating under less distressing circumstances. Often, the critical adaptation phase

overlaps with the process of displacement, which may intensify mental health struggles. Additionally, known coping mechanisms and support networks from one's home country may not be present in the new environment, leading to identity crises [6].

It is important to reflect on the idiosyncrasies of the different phases in this context because each phase represents unique challenges and opportunities and requires different forms of support (including psychological assistance, humanitarian aid, and community resources). The following graphic (Figure 1.4.2) offers a brief overview of the psychological phases of displacement.

Figure 1.4.2. "*Psychological Phases of Displacement*"



Note: Graphic developed by the EU-MiCare team based on information by Kizilhan (2012)

[Kizilhan, J.I. (2012). *Kultursensible Psychotherapie.* Berlin: VWB.]

A more thorough review is available in the 🕮 **Repository** (see 1.4 – Handout 1. "*Psychological Phases of Displacement*"), highlighting key emotional processes at each stage [6,7]. Figure 1.4.1-R in the same handout, created by German psychologist and trauma expert Dr. Jan Ilhan Kizilhan, provides **a visual depiction of the processes involved in both mixed migration and displacement** as discussed in this unit.

◎ Key Point: ***Internal and External Processes of Involuntary Dislocation***

Prof. Renos Papadopoulos proposes a model consisting of **six segments** and **four phases** of what he terms 'involuntary dislocation' [1], also referred to here as 'displacement'. As discussed in Unit 1.1, involuntary dislocation should be understood as a longitudinal process, not as a single event occurring at one point. **This journey moves from *dislocation*** (the initial sense that home no longer feels like home, followed by the departure from home) **to *relocation*** (the search for, discovery of, and inhabiting of a new home) **and involves both internal and external dimensions**. By distinguishing these aspects, we can better appreciate the nuances of the following six stages (or segments) of this process [1]:

1. ***Internal dislocation:*** The initial sense of no longer feeling 'at home' in one's familiar space, where home is no longer experienced as safe or viable.
2. ***External dislocation:*** The forced abandonment of one's physical or symbolic home due to it becoming unsafe, which may involve fleeing a geographical space or being cut off from cultural, spiritual, or psychological elements of home.
3. ***Yearning for a new home:*** The search for a new space that offers safety and the possibility of creating a viable sense of belonging.
4. ***Identifying a new home:*** Finding a place that holds the potential to become a new, safe home.
5. ***Settling in:*** The struggle to establish a new home and recreate a sense of comfort and security in this new space.
6. ***Making sense of the experience:*** Processing and understanding the complex layers of dislocation and their emotional, psychological, and existential impacts.

Complementing these segments are the four phases below [1], offered as an alternative to other classifications of the migration and refugee process, such as the ones mentioned above.

1. **Anticipation**: This phase focuses on the period before leaving home. Individuals are aware of imminent danger and must make rapid, high-stakes decisions not only for themselves but also for their loved ones. They face the uncertainty of whether to leave or stay, under intense pressure due to limited time and the consequences of each decision. This phase can be divided into two

subphases: (1) when home is still perceived as safe, and (2) when they begin to accept the reality of the 'initial dislodgement', i.e., the moment they first confront the fact that they must leave their home and that departure is inevitable.

2. **Devastating Events**: This phase marks the eruption of feared events, including traumatic ones (such as perilous threats to one's life). These experiences form a core part of the individual's narrative, shaping their emotional and psychological response to dislocation. This is also the phase usually referred to as '*the trauma*'.
3. **Survival**: Here, the focus shifts to immediate survival; securing shelter, food, water, and safety. Individuals experience a lack of control as decisions about their daily structure are often made for them, leaving them in a temporary state in which they have little to no decision-making power. Survival may also encompass seeking medical attention, reuniting with family members, and navigating emergency aid and assistance.
4. **Adjustment**: As individuals settle into longer-term accommodations, uncertainty decreases. They begin facing new challenges (for example, adapting to a different culture, learning a new language, and managing daily life) while envisioning a future in the new environment, though migration laws may influence this outlook.

Each person experiences these processes uniquely, influenced by their particular circumstances. **The movement from *dislocation* to *relocation* may involve phases of struggle, adjustment, and reconciliation with the losses incurred during dislocation, as well as efforts to rebuild a coherent sense of self in a new context** [1].

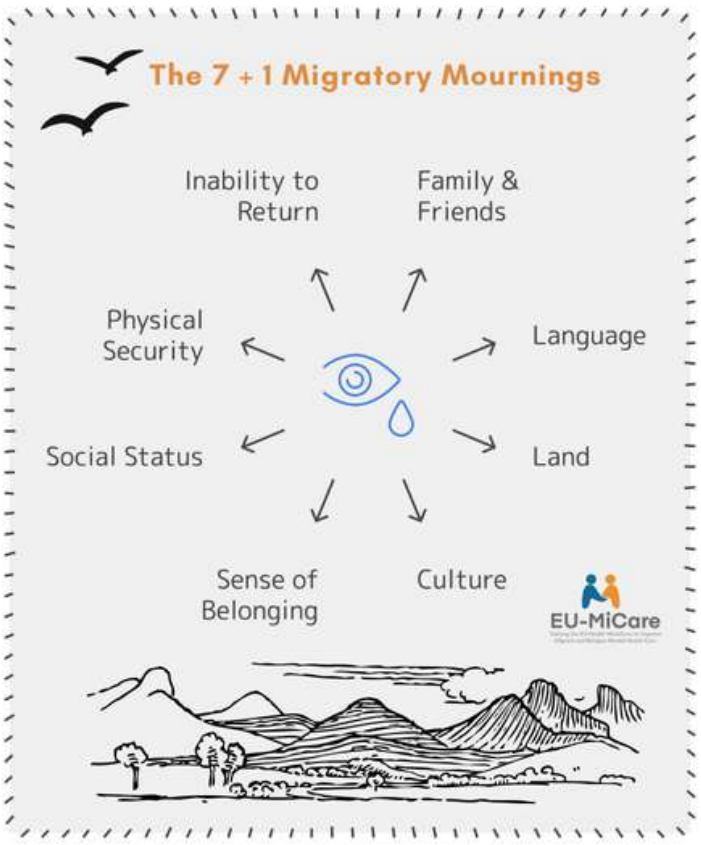
3. Migratory Mourning

Ulysses Syndrome, also known as '***migratory mourning***' or 'the syndrome of the immigrant with chronic and multiple stress', is a concept introduced in 2002 by Spanish psychiatrist Dr. Joseba Achotegui [8] to describe the psychological and emotional challenges migrants face during the process of migration. Inspired by the mythical journey of the Greek hero Odysseus (Ulysses), this model may help field workers identify specific areas in migrants' lives that need special attention to promote resilience and prevent severe mental health challenges.

Similarly to the above, rather than pathologizing psychological responses to migration, the model serves as a framework for identifying the psychological adaptations migrants undergo due to multiple losses and ongoing challenges [9]. The following graphic and table present the seven mourning areas of Ulysses Syndrome, along with an additional area proposed by Prof. González Calvo, who has contributed to expanding Achotegui's theory by identifying key characteristics of migratory grief, such as its partial, recurrent, and multiple nature [10,11]. More information on the practical application of this theory is available in the 🕮 **Repository** (see 1.4 – Handout 2. *"Migratory Mourning"*) .

→ **VIDEO:** *Ulysses Syndrome and Ways to Heal* 💻

Figure 1.4.3. *"The 7 + 1 Migratory Mournings"*



Note: Graphic developed by the EU-MiCare team based on information by Achotegui (2024)

[Achotegui, J. (2024). Migratory grief, as partial, recurrent and multiple grief. *International Journal of Family & Community Medicine*, *8*(2), 44–47. https://doi.org/10.15406/ijfcm.2024.08.00348]

As part of their "The Ulysses Syndrome and Ways to Heal Project", Hui International, in collaboration with Dr. Joseba Achotegui, has developed a series of multilingual resources (including English, Arabic, Farsi, Pashto, and Ukrainian) **to raise awareness of the stressors, or migratory mournings, faced by migrants and refugees globally**. A useful 4-page info sheet is available here. This document, along with other materials from the same project, are included in the 🕮 **Repository** (see Module 1, Useful Resources).

The 7 + 1 Migratory Mournings

Family & Friends	Emotional pain from leaving behind family, friends, and familiar social networks.
Language	Frustration and isolation from losing the ability to communicate fluently in a new language.
Land	This type of mourning encompasses the concept of 'earth' more broadly: the landscapes, colors, smells, luminosity, climate, etc.
Culture	Challenges in adapting to a new culture with different norms, habits, and values. It relates to the ***acculturation*** process.
Sense of Belonging	Loss of our group of belonging, where we are identified and recognized. Experiences of prejudice, racism, xenophobia, marginalization, and exclusion in the host country can enhance psychological distress.
Status	Loss of social status (e.g., taking on an underpaid job). Limitations on account of an insecure residential situation can also represent a loss of status (e.g., refugees that have specific limitations related to housing or professional opportunities due to restricted recognition of their previous professional education).
Physical Security	Anxiety about physical danger during the journey or in the host country. In many cases, the risks present are not as high as those left behind.
Inability to Return [10]	For some people, the feeling and desire to return often persist and are never entirely abandoned. For some migrants, if economic conditions and administration make it possible, it may be possible to return at some point, even if only to visit loved ones. For others, this will not even be an option due to conflicts, political persecution, economic instability, and others.

Reflection Break: ***Engage in personal reflection***

Consider a person you are currently assisting or are in contact with.

- What phase do you think they are experiencing right now? Can you identify a phase they have already passed?
- Using the theory of Migratory Mourning, combined with the rest of information outlined above, which areas could serve as a resource for this person in their new environment? Where are their current struggles, and where might they be experiencing deeper mourning?
- What interventions or referrals can you initiate from your field of work to support their functional adaptation and promote their mental health in the new environment?

Adapted from the Ulysses Syndrome Project

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Unit 1.5: Most Common Mental Health Conditions among Migrants and Refugees

Unit Overview
This training unit offers an overview of the varied findings and limitations of existing research on mental health conditions in the context of migration. It also emphasizes the importance of distinguishing between severe psychiatric conditions and normal responses to adversity. A brief description of common diagnostic categories is provided, along with cultural considerations. An argument is made for shifting from the biomedical approach within dominant psychiatry to a holistic understanding of the social, contextual, and structural factors that impact the psychosocial well-being of migrants and refugees.

Unit Sections:

1. Introduction

As seen in the previous units, WHO defines mental health as a state where individuals realize their potential, cope with life's stresses, work productively, and contribute to their community [1]. **Migration can threaten this state due to stressful reasons for leaving home, harsh travel conditions, and difficulties encountered in the new environment**.

These stressors can lead to negative psychological outcomes and, specifically among refugees, to a "*normal response to abnormal circumstances*" that includes, among other phenomena, nostalgic disorientation – a longing for the past while feeling lost in the present [2]. However, **not all migrants will**

only experience or respond to stress negatively; for most, migration also signifies an opportunity for new meaning-making and rebuilding a new normal.

Distinguishing between normal psychological reactions and potential mental health disorders in individuals who have undergone stressful migration journeys is crucial. Normal psychological reactions to migration-related stress might include temporary feelings of sadness, anxiety, and trouble sleeping. These reactions are usually **proportional to the stressor** and **tend to decrease as the person adapts to the new environment**.

However, when these symptoms **persist**, **intensify over time**, or **significantly impair one's ability to function**, they may indicate the presence of a mental health disorder [3-6]. Symptoms that may signal the development of a pathology include prolonged depression, severe anxiety, continuous sleep disturbances, or intrusive thoughts **that persist despite other forms of psychosocial support** and **do not alleviate with time**. It is therefore essential for professionals and volunteers to monitor these symptoms carefully to differentiate between adaptive responses resulting from exposure to adversity and signs of more serious conditions that require specialized intervention.

2. Currently Available Evidence of Mental Health Problems in Migrants and Refugees

Research in the area of mental health and migration shows mixed results, making it **difficult to generalize findings**. Studies typically focus on anxiety, depression, post-traumatic stress disorder (PTSD), and, to a lesser extent, psychotic disorders. For refugees in particular, the American Psychiatric Association reports a broad variation in the prevalence of mental health disorders [7]:

- 4% to 40% for anxiety
- 5% to 44% for depression
- 9% to 36% for PTSD

This wide variation across different studies can be attributed to the fact that often, studies **do not account for the relationship between mental health conditions and different types of migration, socio-economic**

factors, culture, and context. Variations also arise from issues related to sample size and selection, reliability and cultural adaptation of tools, lack of longitudinal studies, and an over-reliance on self-reports [8]. It is important to note that alarmist statistics on mental illness among migrant populations are **not always supported by systematic reviews**. The prevalence of mental disorders **varies significantly** among people of different cultural backgrounds, and will be influenced by a series of personal, social, and cultural factors [8,9]; in other words, **migration can be a stressful process, but not every migrant will respond to stress in the same way**.

◎ Key Point: ***An Insight from Research on the Mental Health of Migrants and Refugees***

A review of studies in Europe found **no substantial difference in mental disorders between migrant and non-migrant populations** [10]. Only PTSD was more prevalent among refugees compared to non-refugees. Still, it is not the most common disorder – depression is, affecting only a small percentage of people, similar to the general population.

In fact, studies indicate that migrants' mental health issues often relate to their integration process and the social factors that they are faced with in the host country [11,12]. Experiences of violence, exploitation, and detention increase vulnerability to mental disorders [11-13], with survivors of human trafficking being more prone to develop PTSD [14].

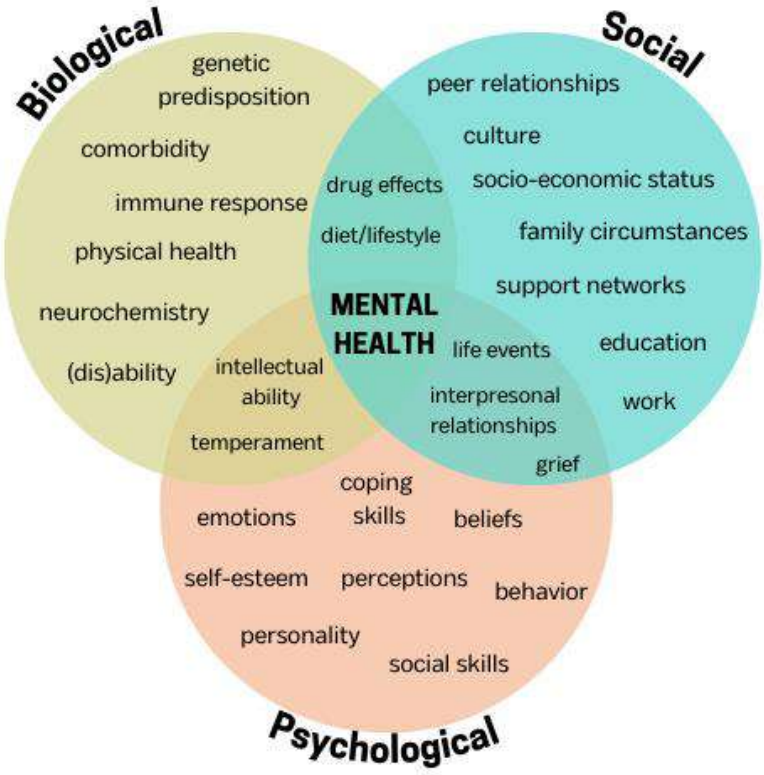
3. Considerations for Interventions with Migrants Who Face Mental Health Conditions

These considerations highlight the need for service providers to respond to the people they work with in a way that reflects **the complexity, totality, and uniqueness of their experience**. This means **understanding their symptoms within their social and cultural contexts** and **moving beyond traditional diagnostic approaches**.

Professionals – particularly health and mental health professionals who, in accordance with national regulations, are tasked with the provision of treatment through specialized interventions such as

pharmacotherapy and psychotherapy – should use a multi-faceted approach such as the ***biopsychosocial model*** [14]. As with the socio-ecological systems theory discussed in Unit 1.3, this model looks at mental health issues as the result of various interconnected factors (biological, psychological, and social). This approach acknowledges that **mental health challenges stem from multiple aspects of a person's life** and **affect their overall well-being.**

Figure 1.5.1. *"The Biopsychosocial Model in Mental Health"*



Note: Graphic developed by the EU-MiCare team based on Engel's influential biopsychosocial model proposal

[Engel G. L. (1977). The need for a new medical model: a challenge for biomedicine. Science (New York, N.Y.), 196(4286), 129–136. https://doi.org/10.1126/science.847460]

The latest versions of the two major manuals used in most European countries for the purposes of assessing mental health disorders, the World Health Organization's ***ICD-11*** [3] and the American Psychiatric Association's ***DSM-5*** [4], were designed with greater cultural sensitivity in mind in order to improve diagnosis and care across diverse populations.

So how do we respond to the diverse needs of people we come across in the daily practice of our work? WHO produced a guidance note on supporting the mental health and psychosocial well-being of refugees, asylum seekers, and migrants in Europe. It details the challenges they face and the varied mental health responses they may experience, which can change over time [15]. This document is included in the 🕮 **Repository** (see Module 1, Useful Resources). **Detailed information on skills for recognizing and assessing migrants' mental health needs will be provided in Module 2.**

4. Common Diagnostic Categories

According to WHO, *"**mental disorder** is characterized by a **clinically significant disturbance in an individual's cognition, emotional regulation, or behavior**. It is usually associated with distress or impairment in important areas of functioning. Mental disorders may also be referred to as mental health conditions. The latter is a broader term covering mental disorders, psychosocial disabilities and (other) mental states associated with significant distress, impairment in functioning, or risk of self-harm"* [5].

In the following section, we describe the common presentation of some diagnostic categories or 'disorders' often attributed to migrants and refugees, along with a number of cultural considerations based on recommendations provided by WHO [3,5,15,16]. A more thorough review of culture as it relates to mental health will be provided in Module 2, Unit 2.1: Understanding the Influence of Culture on Mental Health.

The section below is intended to enhance the skills of all professionals and volunteers working with these populations. However, it is **not a comprehensive guide** and **should not be used for diagnostic purposes**, which should always be carried out by medically trained professionals. Conditions that will not be covered in this section include harmful substance use, traumatic brain injury, and neurodevelopmental disorders, such as dementia and intellectual disabilities.

A critical factor to consider when working with diagnostic labels is that **they will never fully capture the experience of the people they concern** [17].

Migrants' mental health needs are complex and multifaceted; failure to see them as such can result in misdiagnosis (that is, the incorrect identification of a psychological condition; it includes both overdiagnosis, where a condition is mistakenly identified when it is not there, and underdiagnosis, where an existing condition is missed).

Misdiagnosis among migrants and refugees has serious implications. Overdiagnosis **can cause psychiatric stigma** and **distract from issues such as institutional discrimination and systemic oppression** that produce mental health inequalities in the first place [18]. Underdiagnosis can result in **ineffective treatment, delays in care, and higher medical costs** [19].

- **Depression**

> According to ICD-11 [3], "*depressive disorders are characterised by* ***depressive mood*** *(e.g., sad, irritable, empty) or* ***loss of pleasure accompanied by other cognitive, behavioral, or neurovegetative symptoms that significantly affect the individual's ability to function***". As with all other mental health conditions, management for depressive disorders should only be considered if the person has persistent symptoms over several weeks and as a result has considerable difficulties carrying out daily activities [5].

Symptoms of depression may include impairments in concentration, energy, memory, thinking, and organization and initiation of tasks; hopelessness about the future; and suicidal thoughts or acts [5]. Depression may be less recognizable in migrants and refugees due to **cultural differences in expressing distress**.

Alongside typical symptoms such as diminished mood and a lack of interest in pleasurable activities (including those that were previously enjoyable), migrants and refugees might experience unexplained physical symptoms, referred to as '**somatization**' or '**somatoform symptoms'**, and express emotional distress through physical pain, fatigue, and discomfort [17,20]. Although one can never be certain that a physical cause won't be found in the future, these symptoms are often seen as physical expressions of emotional issues [17].

- **Anxiety and Fear-Related Disorders**

> According to ICD-11 [3], *"anxiety and fear-related disorders are characterized by **excessive fear and anxiety**, and related behavioral disturbances, with symptoms **severe enough to result in significant distress or impairment in functioning**. Fear and anxiety are closely related phenomena: fear represents a reaction to perceived imminent threat in the present, whereas anxiety is more future-oriented, referring to perceived anticipated threat".*

For the specific diagnosis of generalized anxiety disorder, marked symptoms of anxiety are required, manifested in either an uneasy set of mind (also referred to as 'apprehensiveness' or 'free-floating anxiety') and an excessive worry about negative events occurring in different aspects of everyday life. Even when anxiety is severe, diagnosis can be tricky.

Anxiety and worry are normal responses to stress; at healthy levels, they can help with problem-solving. For most migrants and refugees, anxiety and worry are **manageable** and **do not interfere with daily life**. People in extremely stressful situations (e.g., living in precarious housing conditions) might experience intense anxiety and worry appropriate to their circumstances. **Realistic worries** (such as language barriers, fear of deportation, and family separation) **can be misjudged as excessive without proper context**. These should not be considered signs of generalized anxiety disorder if they only occur in such conditions [3,16]. In generalized anxiety disorder, anxiety and worry are excessive, persistent, and intense, negatively impacting functioning.

Additionally, cultural features can influence how anxiety presents. Some groups may show **more physical symptoms than worry**, such as dizziness or feeling heat in the head. Migrants and refugees might experience anxiety beyond the descriptions of generalized anxiety and panic disorders, including **culturally specific syndromes** such as the "ataques de nervios" in Latino communities, characterized by intense emotional distress and physical symptoms [21].

- **Post-Traumatic Stress Disorder (PTSD)**

According to ICD-11 [3], *"post-traumatic stress disorder (PTSD) may develop following* ***exposure to an extremely threatening or horrific event or series of events"*** [2]. When a specific, characteristic set of symptoms (re-experiencing, avoidance, and heightened sense of current threat) persists for more than a month after a potentially traumatic event, the person may have developed PTSD [5].

PTSD is generally characterized by several symptom clusters: intrusive symptoms (e.g., recurrent distressing memories or dreams related to the traumatic experience), avoidance symptoms (e.g., avoiding external reminders of the event), negative alterations in cognition and mood, and changes in arousal and reactivity.

The symptoms of PTSD can vary greatly across people from different backgrounds [3]. In some groups, **anger might be the most prominent and culturally appropriate way to express distress**, while in others, **nightmares may have significant cultural meanings**. Symptoms such as headaches, dizziness, and gastrointestinal distress might be common in some cultures but not typically included in standard PTSD descriptions, leading to potential misdiagnosis. Cultural differences also affect **how PTSD develops and how adversity is perceived**. For example, in some cultures, **adversity that affects family members is viewed as being more severe than adversity that one has survived themselves**, or people may become particularly distressed by the **inability to perform funeral rituals**. Lastly, some symptoms such as intrusive thoughts might be seen as normal in certain contexts.

It should be noted that many people who have survived extremely threatening or horrific events may develop adjustment disorder rather than PTSD. Adjustment disorder can result from **any type of stress**, not just severe events, and **it can worsen with limited family or community support**, especially in individuals who come from collectivist cultures, as is often the case with migrants and refugees [3]. However, **there is a risk of labeling culturally normal, adaptive responses as illness,** particularly when the professional is unfamiliar with the person's culture [16].

[2] **Different events will be experienced differently by different people.** Instead of the terms 'trauma' or 'traumatic event', in our daily work with migrants and refugees, we recommend using the more inclusive term 'adversity'.

For refugees and asylum seekers facing prolonged uncertainty and anxiety, it can be difficult to judge what is truly 'maladaptive'. Similar to PTSD, diagnosing adjustment disorder requires identifying a specific stressor or multiple stressors, implying a clear cause. This approach does not fit well for those who have faced **multiple, long-term adversities affecting many aspects of their lives and relationships, especially when adversity is ongoing** [22].

- **Psychotic Spectrum Disorders**

> According to ICD-11 [3], psychotic spectrum disorders are *"a grouping of disorders characterized by significant impairments in reality testing, and alterations in behavior as manifested in symptoms such as delusions, hallucinations, formal thought disorder (typically manifested as disorganized speech) and disorganized behavior"*. **Individuals with psychosis may strongly believe in or perceive things that are not real**. Their beliefs and experiences **are usually seen as abnormal by their communities**. People with psychosis often do not realize they have a mental health condition and are frequently unable to function normally in many areas of their lives [5].

Beliefs and expressions of distress vary across cultures; therefore, **something that may seem odd or 'psychotic' in one culture might be normal in another** [19]. For example, beliefs in witchcraft or supernatural forces or fears of cultural taboos are common in many cultures [3]. Normal manifestations of grief might be shown in ways that resemble psychotic symptoms, such as seeing spirits, which is often the case among Hispanic/Latinx and southern Chinese communities. Misunderstandings between individuals and service providers from different cultures can complicate diagnosis, so **input from family or community can help**.

Ethnic minorities and migrants are often more diagnosed with psychotic disorders, which might result from misdiagnosis of the stress of migration and discrimination [3]. It is important to be careful when diagnosing through interpreters or in a second language to avoid misinterpreting cultural expressions as psychosis. Vulnerability to psychotic disorders in migrants can be triggered **by the experience of displacement, chronic stress, social isolation, and cultural disorientation**. Additional factors include **a history of mental illness, inadequate access to healthcare, and the use of substances as coping mechanisms against stress** [22].

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Repository

Module 1. Foundations of Psychosocial Care in Migration Contexts

The information provided hereafter is supplementary and not part of the core material of this Module.

However, learners seeking a more thorough understanding of the subject matter are strongly advised to review this document in addition to the main curriculum.

Unit: 1.2 Social Determinants of Mental Health

Figure 1.2.1-R. *"Social Determinants and Social Needs: Moving Beyond Midstream"*

So how do we look 'upstream', to the so-called *causes-of-the-causes* of poor health? This useful graphic below illustrates some examples of interventions at all three levels. It can serve as a guide for professionals to see what their personal and collective impact can be at every level.

Note: Graphic sourced from the de Beaumont Foundation and Trust for America's Health, January 2019, "Health Affairs: Meeting Individual Social Needs Falls Short Of Addressing Social Determinants Of Health"

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Handout 1: *"Social Determinants of Mental Health in Detail"*

As health and mental health professionals, social workers, cultural mediators, and volunteers working with migrants and refugees, understanding the numerous factors influencing people's mental health and psychosocial well-being is essential for providing effective and targeted support and advocating for policy changes that address the root causes of health disparities.

A more comprehensive review of studies on how different social determinants impact the mental health of migrants and refugees is provided below.

- **Housing, basic amenities, and the environment**

Poor housing conditions are associated with adverse health outcomes. Research reveals that migrants and refugees face a multitude of mental health challenges due to a combination of insufficient support, inadequate housing, and structural discrimination. Studies have demonstrated that migrants and refugees experiencing housing insecurity had a difficulty accessing mental health support services. Lack of housing also hindered people's capacity to improve language proficiency or participate in ESOL (English for Speakers of Other Languages) classes, consequently affecting their prospects for long-term integration [1]. Additionally, **prolonged stays in refugee camps and the associated daily stressors** (lack of freedom of movement, concerns regarding safety, substandard living conditions) **have been linked to poor mental health outcomes** [2,3]. Improving housing quality – by integrating adequate ventilation, moisture control, heating-cooling systems, and insulation to combat issues like dampness, mold, indoor air pollution, and extreme temperatures – can decrease the likelihood of respiratory diseases, cardiovascular issues, cancer, and mental health conditions [4].

- **Income and social protection**

Income and social security have been found to be **among the most important determinants of mental health**. Regardless of their original socio-economic background, refugees are often forced to leave behind their material possessions, livelihoods, savings, and professional credentials when fleeing their homelands. While some manage to retain resources, many arrive in a state of relative poverty, which can persist for years. Studies comparing refugee mental health to that of resident populations consistently show an association between refugees' economic opportunities in the host country (including the right to work, access to employment, and socio-economic status) and their mental well-being. Studies have shown **that refugees who were unemployed, had infrequent contact with social support networks, perceived their job as of a lower level than their skills and qualifications, and found money management difficult,** were significantly **more likely to have poorer mental health outcomes than others** [5-7].

- **Education**

Education serves as a critical social determinant for the mental health for migrant and refugee populations by providing **a sense of stability, fostering social connections, enhancing self-esteem, improving economic prospects, and reducing stigma**. In a mixed-method study from Germany that combined interviews with gatekeepers (teachers and school psychologists) and longitudinal surveys with refugee adolescents, school and social activities were found to be major stabilizers and sources of support for refugee mental health [8]. An additional critical finding was that schools that were predominantly attended by migrant and low-income children were understaffed to meet the complex developmental and educational needs of a multicultural and socially disadvantaged student body, which in turn led to significant barriers to accessing mental health services, including delayed or nonexistent help-seeking on behalf of the students. On the contrary, **the more positively refugee adolescents viewed their school environment, the fewer barriers they anticipated in accessing mental health services**.

- **Employment**

A growing number of research suggests that **situational factors contributing to unemployment and underemployment are linked to adverse mental health outcomes**, including depression, high levels of stress, and anxiety [9]. **Unemployment disrupts established routines and time structures**, which can have negative effects on psychological well-being. Employment not only provides a sense of structure but also fosters shared experiences, expanding social connections beyond familial relationships. Migrants and refugees experiencing underemployment or unemployment often feel **marginalized and frustrated**, which can exacerbate mental distress.

Unlike voluntary migrants who often have more agency in their migration decisions, refugees encounter greater obstacles in securing suitable employment due to factors beyond their control (e.g., labor market restrictions during the asylum-seeking process). This includes arriving in a new country with limited proficiency in the official language. Additionally, refugees may encounter difficulties in having their qualifications recognized. While credential recognition is a common challenge for migrants, studies suggest that refugees may face even greater hurdles, often finding themselves overqualified for the jobs they manage to secure [10]. This **mismatch between qualifications and employment status** has been associated with lower self-reported mental health, as it impacts **people's sense of self-worth** in profound ways.

- **Language skills and interpretation**

The ability to speak the official language of the host country – or access proper interpretation – both emerge as critical factors influencing mental health outcomes. Being able to speak, read, and write in the local language is vital for effective communication with healthcare providers and integration into social settings. For migrants and refugees, language consistently poses **a barrier to accessing health and social care services, impeding**

access to preventative treatment and screening, and **leading to fragmented care and delayed linkage to appropriate services** [11]. The absence of qualified, professional interpreters also emerges as a frequent issue in health settings; interpreters often have undefined roles, which can result in the delivery of unclear information and compromise the quality of care [12]. Addressing these barriers is crucial for providing culturally responsive and people-centered services, and for empowering people to be active agents in the decisions that concern their health and well-being.

- **Legal status and the asylum-seeking process**

Within the legal system, asylum seekers are those who have submitted their application for being recognized as refugees but have not yet been granted refugee status. As a result, they do not have the same legal rights as those who are legally recognized as refugees. Apart from the pre-migration stress and the difficulties they are faced with in the host country, they also have to deal with issues related to the asylum-seeking process. For instance, they may face an **insecure residency status** and have to **wait for an indefinite amount of time** to receive the outcome of their application [13]. This indefinite waiting period can be **extremely stressful**, and its length has been associated with **increased risk of poor mental health outcomes** [14]. Asylum interviews are also perceived as stressful by asylum seekers and have a negative impact on their mental well-being [15].

- **Access to affordable health services of decent quality**

Migrants and refugees often face numerous barriers in accessing health services, ranging from **discriminatory behavior by healthcare professionals**, **unaffordable fees**, **low health literacy**, and **lack of culturally sensitive care** [16,17]. They may also find it difficult to gain access to healthcare professionals who are culturally and linguistically appropriate and sensitive to their needs. With health systems becoming increasingly digitized, it is also common for migrants and refugees to become 'digitally excluded' and thereby unable to access information and help related to their health [18].

- **Culture, spirituality, and religious background**

The experience of involuntary dislocation is a highly stressful event in a person's life that disrupts their social network and sense of belongingness. During the post-migration stage, migrants and refugees may encounter **cultural and religious differences in the host community**, making it difficult for them to adapt to their new settings. When people struggle to adapt to the culture of the host community, their mental health and psychosocial well-being can be compromised. This may often show up as diminished mood and anxiety, as well as a difficulty to socially engage [19].
Being religious or spiritual can have a healing effect on people on the move by allowing them to retain **a sense of connection** with their social and cultural practices. **The ability to practice one's religion is connected to positive mental health and well-being** and equips people with the skills needed to cope with the stress that often surrounds displacement [20,21]. Religion also offers migrants and refugees a like-minded community that

they can practice or connect with, which increases their access to emotional and social support, and protects against mental illness [22].

- **Social inclusion and social isolation**

Social isolation is a public health concern and has been shown to disproportionately affect migrants and refugees. Studies on the relationship between migration and loneliness generally show that **migrants and refugees of all ages report higher levels of loneliness** compared to the local population [23]. Migrants and refugees are at greater risk of experiencing social isolation in a host community due to lack of access to their previous social networks and challenges in understanding how the new social context operates. In turn, feelings of loneliness may be mediated by factors such as education, satisfaction with social relationships, and the feeling of belonging or fitting into one's environment [24]. Social inclusion for migrants and refugees can take many forms, ranging from participating in community festivities and events, to taking language classes, having access to health services and education opportunities, etc. **Having a larger local network**, which includes more of their own relatives and friends, **along with more frequent interactions with local friends, helps reduce feelings of loneliness and isolation** [25].

- **Prejudice, racism, and discrimination**

Migrants and refugees are at increased risk of experiencing prejudice, racism, and structural discrimination. This can be at any stage of the migration cycle. Many individuals and communities are forced to flee their home country on account of racism and discrimination, such as the Rohingya people. Once they manage to flee and seek asylum in another country, they may also encounter harsh and restrictive national policies, which criminalize them and view them as a 'threat' to the national security. This may take the form of denying or creating unnecessary hurdles in attaining refugee status, which may in turn affect their psychosocial well-being [26]. When they are granted refugee status, discrimination and racism in the resettlement country may prevent them from successfully integrating [27]. Although significant knowledge gaps exist regarding the impact of discrimination on mental health, a meta-analysis found consistent links between the two [28]. Additionally, another study demonstrated that **discrimination results in more limited access to social support** for migrants and refugees, which in turn makes them more physically and mentally vulnerable [29].

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Unit: 1.3 Risk, Protective, and Promotive/Resilience Factors

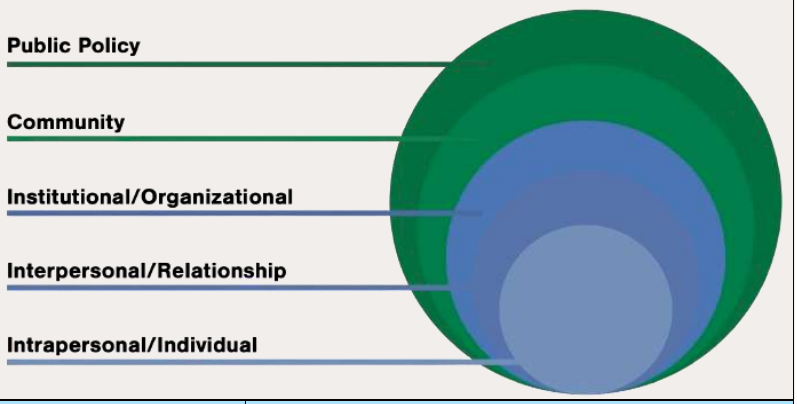
Table 1.3.1-R. *"Risk and Protective Factors to Promote Resilience"*

The Five Levels of the Social-Ecological Framework

Understanding the influence of risk and protective factors can have significant positive impacts in promoting good mental health and resilience for individuals, families, groups, and communities.

Definition of risk factors
Risk factors are aspects, characteristics, or exposures that increase the risk of developing a difficult mental health outcome.

Definition of protective factors
Protective factors are aspects, characteristics, or exposures that reduce risk factors, or independently act to increase positive outcomes.



Level	Risk Factors	Protective Factors
Individual *The individual characteristics that influence behavior, such as knowledge, attitudes, beliefs, skills, physical characteristics, and personality traits.*	• Genetic or familial predisposition • Gender and age • Childhood neglect • History of discrimination • Minority status (e.g., gender identity/ sexual orientation, marginalized racial/ethnic group) • Disability or chronic health condition • Low socio-economic status • Exposure to trauma (witnessing or experiencing), including involvement in armed groups • Experience of physical or sexual abuse	• Self-esteem • Coping styles • Civic engagement • Individual agency • Religious beliefs and practices • Access to livelihoods (including household-level) • Access to supportive and inclusive learning pathways (schools, training centers, etc.) • Access to care and support services
Relationships *Formal and informal social networks and social support systems, including family, friends, peers, neighbors, teachers, co-workers, service providers.*	• Loss of parent/caregiver or family member • A history of mental health conditions within the family, including depression, suicide, and self-harm • Alcohol and substance use within household • Intimate partner violence (witnessing or experiencing) • Household-level economic stress • Abuse and neglect within the family • Experiences of racism, sexism, ableism, and gender-based violence	• Parental support and parental monitoring • Secure attachment • Positive family functioning • Positive mental health of parent/caregiver • Quality of home environment • Emotional support • Peer social support • Participation and engagement in supportive relationships

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Organizations *Rules, regulations, policies, and informal structures of organizations and institutions (such as schools, workplaces, agencies, businesses, healthcare services, etc.) that may constrain or promote recommended behaviors.*	• Destruction of schools, workplaces, hospitals and/or lack of access to inclusive opportunities • Violence experienced at school, work, healthcare, and other agencies – by peers, teachers, supervisors, service providers • Lack of connectedness and a sense of belonging, including through teasing, discrimination, stigma • Lack of capacity of service providers • Lack of accessible physical environment and resources	• School retention/ level of schooling achieved • Work retention • Social support • Social cohesion programs • Counselling/peer-to-peer support • Mental and physical health promotion in school and work settings and in educational and employment planning • Meaningful participation in work, leisure, or community groups • Referral systems to connect people to appropriate services
Community *Social networks and norms, or standards, which exist among individuals, groups, and organizations/ institutions within defined boundaries.*	• Disruption of social networks • Changes in gender or religious dynamics • Cultural norms or concepts (i.e., hiding distress, using violence to resolve conflict) • Community-level violence • Stigma and discrimination • Prevailing perceptions of mental health/illness and acceptable coping strategies within communities	• Cultural norms, practices, or concepts (i.e., adherence to ideology, connection to land) • Community acceptance and cohesion • Inclusive services • Accessible spaces for living, working, and recreation • Adequate preparedness measures to mitigate risks from natural hazards
Public Policy *Local, state, and federal policies and laws that regulate or support healthy actions and practices.*	• Housing/settlement options (i.e., temporary vs. permanent) • Modes of delivery of support • Limited access to services and economic opportunities in historically excluded communities • Systemic marginalization and discrimination • Policies that serve to discriminate against members of specific communities • Absence of accountability mechanisms • Poor governance	• Peace and security • Supportive policies and legal frameworks • Trust in national system and government • Specific mental health policies for vulnerable groups, including children and adolescents • On the move support for migrants • Equitable development, with inclusive services and assistance at all levels

Note: Graphic sourced by McClay et al. (2023); Table re-produced by the EU-MiCare team based on information provided by the WHO (2023), UNICEF, (n.d.), McLeroy et al. (1988), and McClay et al. (2023).

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Table 1.3.2-R. *"Additional Risk and Protective Factors for Migrants and Refugees"*

Level	Risk Factors	Protective Factors
Before travel	• Exposed to and/or witnessing potentially traumatic and violent events • Economic hardship and social deprivation • History of mental health problems before migration	• Good financial conditions • A higher level of education in the home country
During travel	• Violent events and abuse and/or exploitation during the journey • Unsafe travel routes • Separation from loved ones • Witnessing the death of others (e.g., shipwreck, border violence)	• Travelling through less dangerous or more direct routes • Having the support of family members or trusted friends during the travel
Settlement in a host country	• Food insecurity • Lack of (suitable) accommodation or dissatisfaction with accommodation • Lack of access to information • Delays in residency/asylum-seeking process	• Having better conditions of settlement • Access to health care • Prompter and/or smoother process for obtaining a residence status
Integration in a host country	• Social isolation • Unemployment • Discrimination and victimization • Challenges related to cultural identity and acculturation issues • Descending social mobility • Length of resettlement (long-term resettled refugees and migrants vs. those at first resettlement)	• Social networks, including people from different ethnic groups • Sense of belonging in the host country
Immigration status challenged or revoked	• Threats of deportation • Detention in immigration centres • Losing jobs and/or accommodation	• Sense of being safe in the home country • Presence of a family or a social network there • Maintaining a strong sense of belonging

Note: Table re-produced by the EU-MiCare team based on information provided by the WHO (2023) and IOM (n.d.)

[World Health Organization (2023). *Mental health of refugees and migrants: risk and protective factors and access to care*; IOM (n.d.). *The Determinants of Migrant Vulnerability*.]

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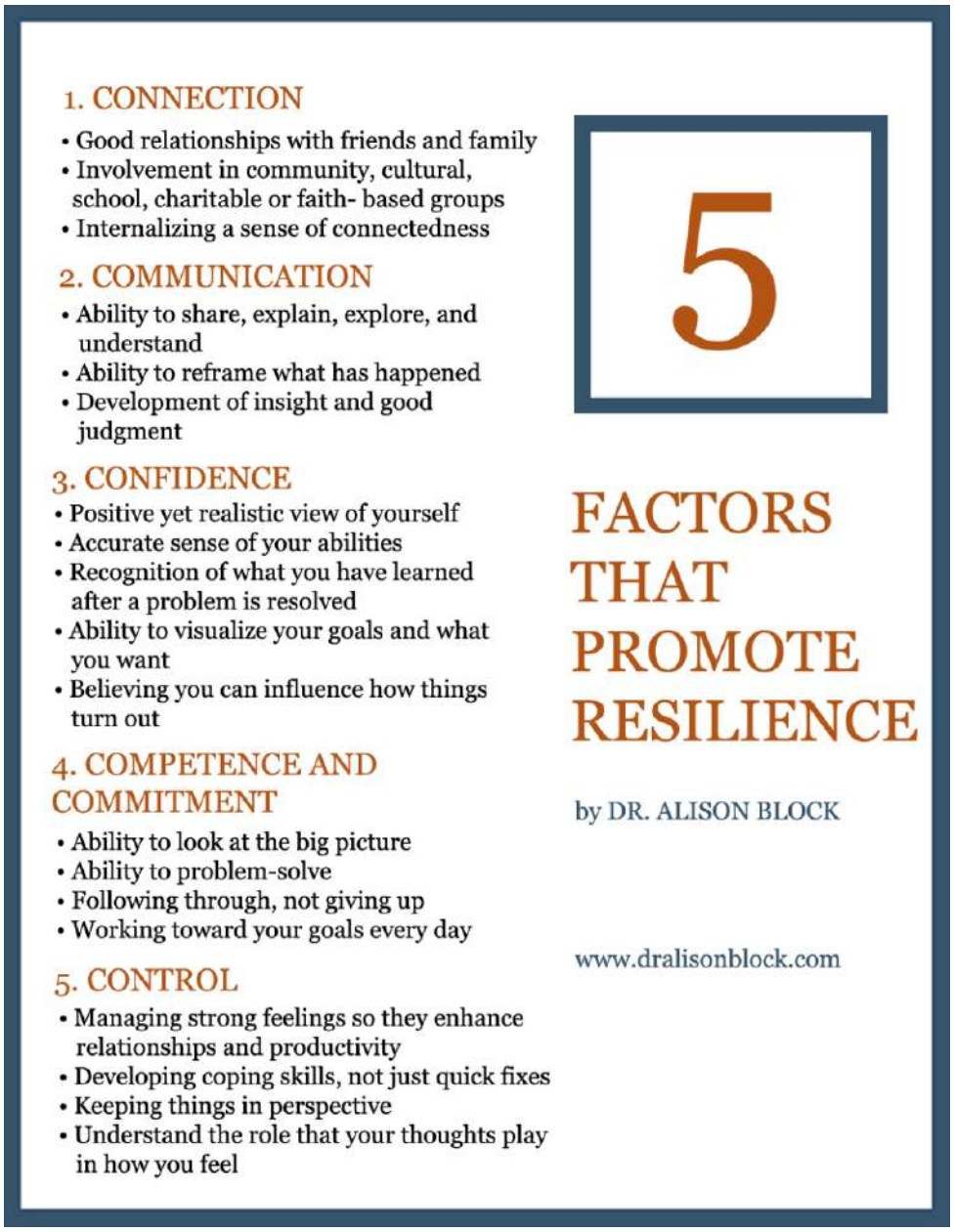
Figure 1.3.1-R. *"Five Factors that Promote Resilience"*

The graphic below illustrates five factors that promote resilience across individuals and communities. Note that resilience is not a trait that a person simply possesses or lacks; it is a dynamic process influenced by various interacting elements.



Note: Graphic sourced from the Dr. Alison Block and the Anti-Poverty Service – Learning Resources, 2021, "5 Factors that Promote Resilience"

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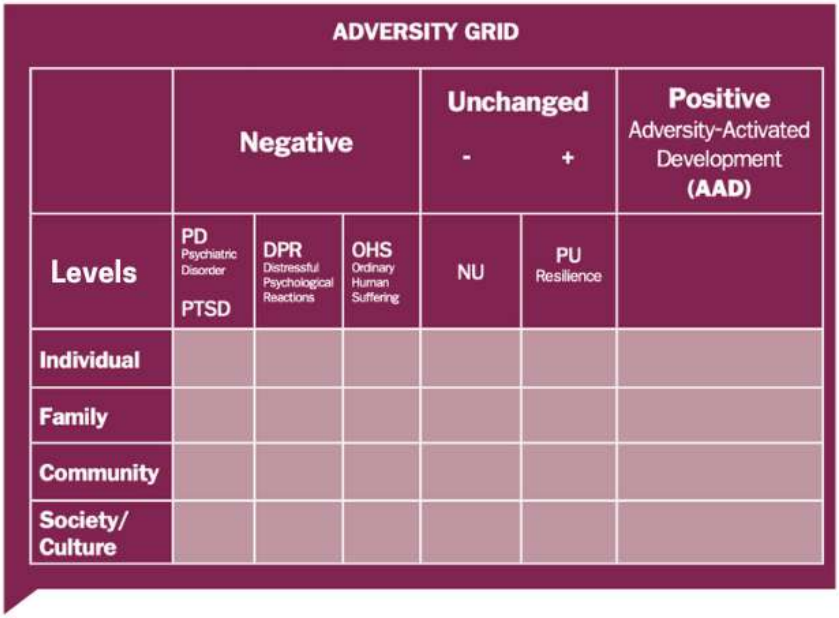
Handout 1: *"Adversity Grid in Detail"*

Developed by Prof. Renos Papadopoulos, the *Adversity Grid* (see Figure 1.3.4) is a **conceptual framework** designed to help workers and survivors of adversity **distinguish the diverse range of responses to highly challenging events**. It allows for the **crucial differentiation between distress and disorder**, and **facilitates the processing of adverse events** by making it easier to understand the complex impacts of adversity. This approach counters the common simplifications, polarizations, and generalizations that often arise in the field of migrant and refugee care and prevents the development of a victim identity among people who have survived adversities.

By providing a holistic and nuanced view of the refugee experience, **it avoids dehumanization and recognizes people's complexity, uniqueness, and totality.** The Grid also acknowledges that adversity affects not just individuals but also families, communities, and societies. While it is not a test or quantifiable assessment tool, it captures how adversity impacts these larger units, reflecting their collective experiences and perceptions.

Figure 1.3.2-R. *"Adversity/'Trauma' Grid: Range of Responses to Adversity"*



Note: Graphic sourced by Babel Day Centre, 2019, Manual on the "Psychosocial Dimensions of the Refugee Condition – Synergic Approach", ed. Renos Papadopoulos

How to utilize the Adversity Grid

The Adversity Grid is a **versatile framework** that can be used to understand the impacts of adversity on individuals, families, communities, and societies, whether for assessment or therapeutic purposes. It provides

a comprehensive view by considering positive and negative impacts as well as unchanged states across various levels of human groups.

Negative responses to adversity are categorized into three levels:

- **Psychiatric disorders (PD):** Severe and diagnosable conditions, such as PTSD, that meet criteria set by the DSM-5 or ICD-11 (see Unit 1.5 for more details). These are the most severe and intense responses that often require clinical intervention.
- **Distressful psychological reactions (DPR):** Symptoms that don't meet the full criteria for a psychiatric disorder but still affect individuals' mental health. Examples include occasional intrusive thoughts or mood changes that do not escalate to clinical levels.
- **Ordinary human suffering (OHS):** Common negative effects that result from adversity but do not fit the criteria for psychiatric or psychological disorders. This category recognizes that many people experience significant distress without developing clinical conditions.

Unchanged responses to adversity refer to personal qualities, relationships, and behaviors that remain constant, or unchanged, despite the adversities faced. This category highlights that not all aspects of a person's life change in response to adversity.

Positive responses to adversity involve recognizing that adversity can lead to personal growth and new strengths. This concept, known as Adversity-Activated Development (AAD), refers to the development of new, positive traits or capabilities that arise specifically due to the experience of adversity. Unlike pre-existing strengths that individuals maintain, AAD represents new, transformative aspects of development triggered by the adversity itself. This approach emphasizes that overcoming adversity can lead to meaningful and constructive changes in a person's life.

Applications of the Grid

The Grid can be utilized by various population groups:

- Field workers can start a collaborative conversation about the Grid with the individuals they are working with, and then provide them with a copy (either in print or digital format) for self-reflection. Afterward, individuals can return for a discussion of their insights. Writing responses can be done on separate sheets or digital documents, as the Grid's spaces are too small for detailed notes. The Grid can be completed over multiple sessions or in a single meeting, depending on priorities. It can also be used informally for exploration without writing, or solely for the worker's orientation without involving service users. Typically, the Grid is used by two people together but can also be adapted for couples, families, or groups, such as in refugee camps, for collective exploration.

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- Individuals/service users can use the Grid in a self-administered way to reflect on their own experiences beyond the obvious impacts, enhancing self-awareness. When used periodically over time, the Grid helps individuals observe changes in their responses and understand the actions and circumstances that led to these changes. This approach empowers individuals by allowing them to gain insights from their own experiences, rather than relying solely on external experts.
- Field workers, particularly those employed or volunteering in distressing environments where burnout or vicarious trauma are common concerns, can find the Grid useful for themselves. By applying the Grid to their own experiences, professionals and volunteers can gain a holistic view of their own responses to adversity. This self-awareness helps them understand the full range of their reactions and better manage the complexities of their work, counteracting the negative effects often associated with working in challenging settings.

The Grid is flexible and can be adapted to fit different contexts by modifying the levels and categories used. For instance, if family or community levels are not relevant, they can be replaced with alternatives, such as work teams or specific organizations. The number of levels can also be adjusted based on the focus of the assessment. Additionally, the three categories of negative effects can be tailored to fit specific situations. If the focus is not on mental health, you can replace psychiatric and psychological categories with simpler severity gradations (e.g., 'Most Severe,' 'Moderately Severe,' 'Least Severe') or other relevant degrees of negative impact. Similarly, the Grid can be adjusted to include different degrees of positive development in Adversity-Activated Development (AAD) based on the needs of the situation. Lastly, it can incorporate the dimension of time by adding layers that represent different chronological phases. This can be visualized as a three-dimensional cube, with each layer representing a distinct time period or phase. For example, when working with individuals who have been involuntarily displaced, you may use four different Grids to capture responses during each phase: Anticipation, Devastating Events, Survival, and Adjustment (see Unit 1.4 for more details on the phases of involuntary dislocation).

Content developed by the EU-MiCare team based on information in:

Papadopoulos, R. K. (2021). *Involuntary Dislocation: Home, Trauma, Resilience and Adversity-Activated Development.* Routledge.

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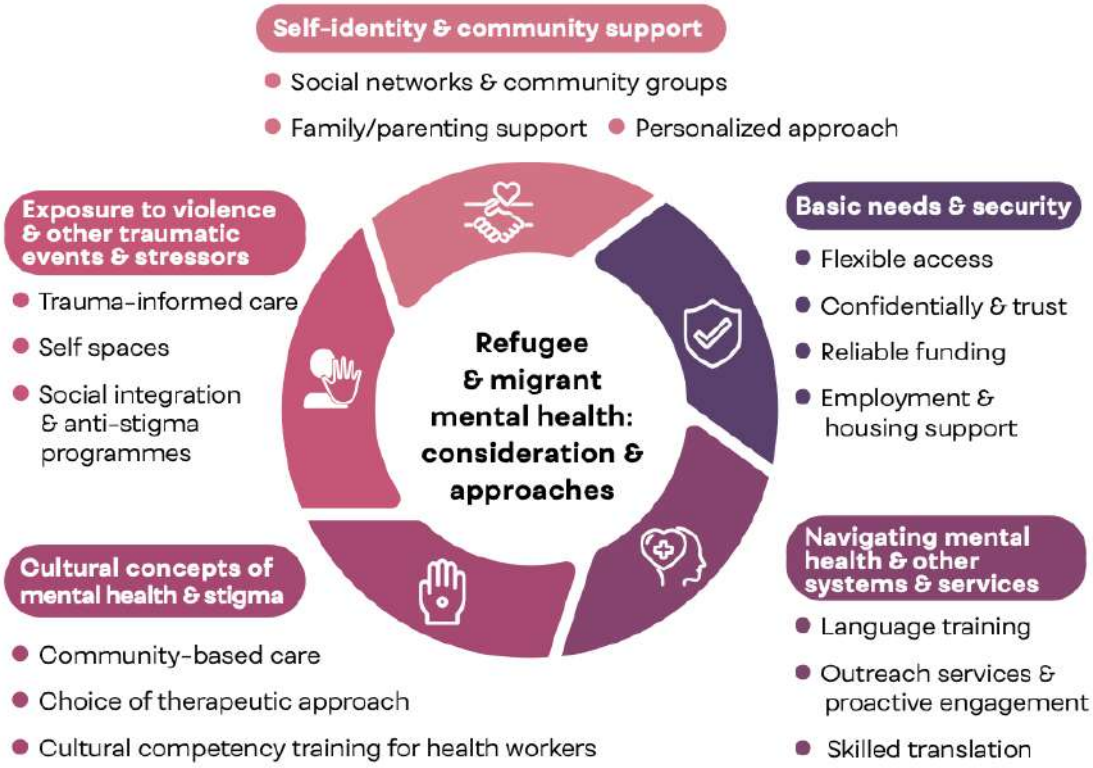
Handout 2: *"Challenges and Protective Influences Unique to Specific Sub-Populations"*

Evidence shows that risk and protective factors, as well as barriers and facilitators to care, vary among different migrant groups. In a recent report on the mental health needs of migrants and refugees, the World Health Organization has identified five key themes that apply across different groups and stages of migration: self-identity and community support; basic needs and security; cultural concepts of mental health and stigma; exposure to trauma; and navigating health systems. These themes are interconnected and can guide effective interventions for improving mental health care for migrants and refugees (see Figure 1.3.5).

Figure 1.3.3-R. *"Considerations and approaches for refugee and migrant mental health"*



Note: Graphic sourced by the WHO, 2023,
"Mental health of refugees and migrants: risk and protective factors and access to care"

A more comprehensive review on specific risk and protective factors faced by different sub-groups (such as women, people with experiences of torture, and LGBTQI+ individuals) is provided below.

- **Women**

Data indicates that migrant and refugee women and girls represent nearly half of international migrants worldwide. Despite this, there is limited research on the intersection of gender and migration, particularly as it

relates to experiences of sexual assault and intimate partner violence [1]. Young refugee women are particularly vulnerable to gender-based violence (including female genital mutilation/FGM) throughout their journey and often require reproductive health care after settling into a new country. A study in California revealed that one in three refugee women reported having survived traumatic events prior to migration, including physical assault, captivity, sexual assault, and weapon assault [2]. Refugee women in Western countries face a tenfold risk of developing symptoms of post-traumatic stress disorder (PTSD) compared to non-refugee women [3].

Compounding the migration-related challenges for women are difficulties related to resettlement. Migrant and refugee women face barriers such as separation from family, language difficulties, and unfamiliarity with their new environment. They often experience increased hardship and reduced social support as they transition from collectivist cultures to more individualistic ones. Additionally, they may be reluctant to seek help outside their family due to cultural differences and past experiences. Refugee women also struggle with the loss of resources, renegotiation of new roles, and institutional racism in the host communities [3].

Conversely, a growing body of research emphasizes the importance of faith, religious practice, and community engagement in the psychosocial well-being of migrant and refugee women. In a study exploring the experiences of refugee women in regional locations in Australia [4], a factor that was identified as crucial for coping was establishing connections with communities, whether from their country of origin or the host country. For those who were resettled without male partners, particularly important was the development of social supports within the local community due to being ostracized by their community of origin. Volunteers played an important role in filling support gaps in rural areas where services were lacking. Additionally, gaining employment was highlighted as contributing significantly to women's sense of belonging, providing not only extra income but also purpose, routine, and social support.

- **People with experiences of torture**

Experiences of torture have consistently been shown to be a strong predictor of various long-lasting physical and psychological challenges. Research indicates a significant association between torture severity and mental health symptoms, including depression, anxiety, and PTSD [5]. For refugee torture survivors, particularly those suffering from a pre-existing mental health condition, language barriers in the host society pose a significant risk factor by hindering access, utilization, and effectiveness of mental health services [5]. Moreover, immigration status plays a crucial role in mental health outcomes, with studies indicating that fear of detention and deportation exacerbate symptoms of PTSD [6].

Nonetheless, it is not possible to pinpoint the exact prevalence of psychological conditions among torture survivors due to the heterogenous samples and measures used across studies. This means that the lived realities of migrants and refugees with experiences of torture are not being adequately represented. As a case in point, researchers have reported that some individuals manifest extraordinary resilience and growth in the aftermath of torture, as seen in Ugandan former child soldiers [7] and Iraqi refugees [8]. As with migrant and refugee

women, community engagement plays a vital role in fostering resilience in people who have experienced torture. Refugee communities hold high values on collectivism and social cohesion, and evidence suggests that torture survivors who engage with community resources show higher levels of resilience. Language fluency and employment serve as additional resilience-promoting factors, with improved psychological outcomes observed among those proficient in English and employed [9].

- **LGBTQI+ individuals**

Lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI+) migrants and refugees encounter unique and specific risks throughout the migration process. Their experiences differ from those of other migrants due to the compounded and intersecting discrimination they may face, particularly related to their diverse sexual orientations, gender identities and expressions, and sex characteristics (SOGIESC). LGBTQI+ migrants and refugees have been found to exhibit significantly high prevalence rates of mental health challenges, including depression, anxiety, PTSD, suicidality, and substance use. These rates are markedly elevated compared to non-LGBTQI+ migrants as well as LGBTQI+ individuals without a migration background [10], suggesting that the intersectionality of multiple marginalized identities amplifies the vulnerability to poor mental health outcomes.

Risk factors for LGBTQI+ migrants and refugees include experiences of discrimination and violence in their countries of origin, often perpetrated by community members and state actors. Upon migration, they often continue to face risks of discrimination and violence, even in countries that are perceived as more accepting. Structural violence during the asylum-seeking process exacerbates these challenges, as they frequently encounter restricted access to healthcare, social services, and employment rights. Additionally, the necessity to continually verify their SOGIESC identity to secure asylum can be re-traumatizing, especially for those accustomed to concealing their identities due to criminalization or victimization in their home countries [11].

Protective and promotive factors for migrants and refugees with diverse SOGIESC include social support, the ability to accept and process emotions, and maintaining hope and optimism about the future. Studies indicate that support from the LGBTQI+ community, access to legal and community services, and the ability to remain hopeful, significantly contribute to positive mental health outcomes [12]. Despite enduring symptoms of depression, anxiety, and PTSD, many LGBTQI+ migrants and refugees demonstrate remarkable adaptability, underscoring that resilience and vulnerability are not mutually exclusive and can coexist. This is often facilitated by the newfound freedom to express their identities, which highlights the complex interplay between mental health and the capacity for positive adaptation.

- **Older adults**

Older migrants and refugees (i.e., those 65 and above) are perceived to be more vulnerable than their younger counterparts. Migration and forced displacement are considered to be significant risk factors for the development of mental health conditions in older adults, particularly anxiety, depression, and PTSD [13]. Older adults are also particularly vulnerable to poor mental health outcomes due to the cumulative effect of the life-

threatening events they may have been exposed to after fleeing their counties of origin [14]. Moreover, they may arrive in host countries with other underlying physical and mental health conditions – the experience of migration and forced displacement gets compounded by age-specific conditions such as neurodegenerative disorders, chronic physical illness, etc. [13] Adding to these challenges are the difficulties in adapting to new languages and customs, and struggling with isolation from family members during the transition [15].

Social support is a crucial protective factor for the well-being of older migrants and refugees. As seen above, health issues in later life, combined with past adversities, can lead to poor outcomes. However, strong social support can mitigate these effects by improving overall well-being and reducing early mortality [16]. Emotional support, particularly from family and community, buffers against the negative impacts of past adversities, enhancing life satisfaction and meaning. Older migrants and refugees who harbor a sense of purpose (such as in their roles as contributing and productive family members) have been found to have a higher quality of life [17]. Other protective factors include access to basic services, adherence to cultural and spiritual practices, and participation in ethnic communities and religious networks. Personal factors such as language acquisition, cognitive reappraisal, and optimism also play an important role [16].

- **Persons living with disabilities**

According to Article 1 of the United Nations Convention on the Rights of Persons with Disabilities [18], *"persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others"*. Migrants and refugees living with disabilities are considered to be an 'invisible' population, as they are systematically neglected and excluded from the discourse [19]. The intersection of migration and disability is critical as migrants and refugees with chronic physical and mental health conditions are especially vulnerable to exposure to adversity and often lack necessary care during the asylum-seeking process [20].

In their home countries, migrants and refugees living with disabilities may face persecution or stigma on the basis of their political views, religious beliefs, or disability (being actively discriminated against on grounds of impairment). Delays in social and healthcare services can worsen disabling conditions, serving as a significant risk factor for well-being [20]. They may also face challenges with their psychosocial well-being, including stigmatization and discrimination, lack of access to specialized educational programming, communication barriers, etc. [19-21]. Additional risk factors including the lack of suitable housing and employment that accommodates their specific needs, and a difficulty in accessing treatment due to structural barriers, such as limited capacity, long waiting times, a focus on short-term rather than long-term support, and inadequate allowances which may result in an over-reliance on charities for assistance [20,21].

Protective factors for migrants and refugees with disabilities include social inclusion in host countries, suitable housing, access to tailored and accommodating educational and vocational opportunities, and adequate healthcare services [22]. Community support and social networks are also critical in helping to trace and actively screen individuals with non-communicable conditions, as is often the case with neurodevelopmental disabilities.

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Unit: 1.4 Psychosocial Dimensions of the Migration Process

Handout 1: *"Psychological Phases of Displacement"*

In line with the general model of migration by Sluzki and Machleidt discussed in Unit 1.4, the following table presents a conceptualization of the psychological phases of displacement [1,2].

It is important to recognize that these models are not definitive and do not suggest a strictly linear progression; rather, they aim to enhance our understanding of the complex and nuanced dimensions of human experience. Each migratory journey is unique.

Table 1.3.1-R. *"Psychological Phases of Displacement"*

Pre-Migration *Period previous to displacement. It may include experiences of persecution, violence or living in a state of fear and uncertainty.*	Fear of persecution, trauma from past experiences, loss of security, and uncertainty about the future.
Migration or Flight *Actual process of displacement. This process can take months, until the displaced person or family arrive to their destination.*	Fleeing from danger, crossing borders, and seeking refuge in other countries. Possible experience of traumatic events during the migration journey. Loss of home and community. Uncertainty about the future.
Arrival (Feelings of Security – Insecure Residence Permit) *Period immediately following arrival in the host country, often characterized by relief at escaping immediate danger and uncertainty.*	*Culture shock*, language barriers, loss of social support networks, and uncertainty about legal status and rights. Asylum application processes (or the lack of options to obtain regularized residency permits and, consequently, feel secure and able to start building up stability) constitute a major stressor during this phase.
Secure Residence Permit (Rest Phase) *Period after ensuring security and stability (in many cases due to a secure residence permit) where the person typically enters in a "rest phase".*	**Distressful memories may resurface, leading to significant psychological distress**. Emotional decompensation can occur when individuals, already vulnerable due to past life-threatening experiences, become less able to manage their emotional responses. If these issues remain unattended and the individual lacks access to coping resources, decompensation can worsen, potentially resulting in more severe mental health issues, such as depression or anxiety disorders.
Long-Term Adaptation Phase (Balance – Multiculturality & Hybrid Identity) *Finding balance and rediscovering the identity of oneself. Ongoing process of adaptation to the new context and new life situation, which may take years.*	The regular acculturation process and the development of multicultural identities might start to take place. Acculturative stress, experiences of discrimination, barriers and opportunities to accessing education, employment, and healthcare can make a difference on how the functional adaptation to the new environment and psychological well-being might develop.

Note: Table adapted by the EU-MiCare team based on information by Kizilhan (2012; n.d.)

[Kizilhan, J.I. (2012). *Kultursensible Psychotherapie.* (p. 19-20). Berlin: VWB; and, Kizilhan, J.I. (n.d.). *Psychologische Phasen der Migration* [Video]. MiMi Gewaltprevention. Accessed September 18, 2024.]

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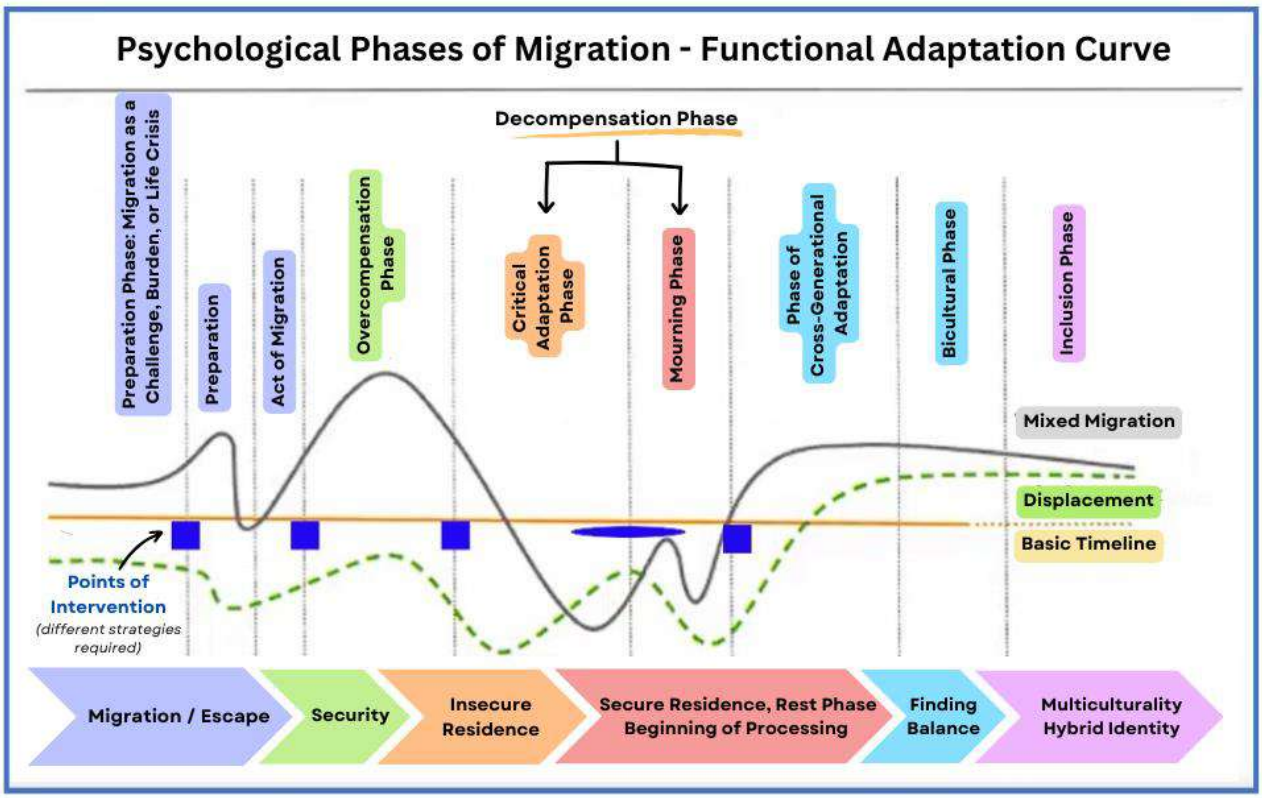
The processes surrounding mixed migration and displacement are visually integrated in the graphic below, highlighting both differences and commonalities for easier understanding and comparison.

Figure 1.4.1-R "*Migratory Processes in Mixed Migration and Displacement*"



Note: Adapted from Kizilhan, J.I. (2012). *Kultursensible Psychotherapie.* (p. 20). Berlin: VWB; Sluzki, C.E. (2010). Psychologische Phasen der Migration und ihrer Auswirkungen. In T. Hegemann & R. Salman (Hrsg.), *Handbuch Transkulturelle Psychiatrie* (p. 110). Berlin: Psychiatrie Verlag.

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Handout 2: *"Migratory Mourning"*

Achotegui's theory offers field workers a framework to better understand the emotional complexities migrants and refugees may face when leaving their home countries. It acknowledges the profound sense of loss many experience, which includes not only tangible losses like homes and communities but also symbolic ones such as identity, social status, and cultural belonging. Field workers can assess these areas by considering:

- **Vulnerability:** Assess the individual's history for prior difficulties that may affect their ability to adapt in specific areas (e.g., someone with pre-existing social anxiety may struggle to form new relationships). Vulnerable indicators might include:
  - *Physical Vulnerability*
  - *Psychological Vulnerability*
  - *Personal History*
  - *Age*

- **Stressor:** Identify the number and severity of post-migration obstacles in each area and determine if the person or family has sufficient resources to overcome them (e.g., a person accustomed to rural life might find urban living stressful due to limited access to nature). These might include:
  - *Personal Stressors*
  - *Environmental and Social Stressors*

Each area can be evaluated to understand the degree of stress and vulnerability a migrant experiences, depending on the resources they bring and the challenges or opportunities in the host community. Each vulnerability factor or stressor, which also determines the type of migratory mourning, can be assessed as "simple" (i.e., the mourning can be processed adequately), "complex" (i.e., with difficulties that can be overcome through the coping skills of the person or family), or "intense" (i.e., when difficulties are severe and may lead to a deeper crisis). Additionally, the level of support or discrimination in the host environment can significantly impact migrants' mental well-being.

Understanding these factors helps field workers identify areas where migrants are most vulnerable. It also highlights potential sources of resilience within the new environment. By recognizing their specific challenges and strengths, migrants can better navigate their journey, and professionals and volunteers can provide realistic, effective support tailored to their unique experiences.

The following section of this handout contains a reproduction of the "Ulysses Scale", originally developed in Spanish by Dr. Joseba Achotegui from the University of Barcelona, in collaboration with the Health Initiative of the Americas (HIA) at the School of Public Health, University of California, Berkeley. The scale was created to assist in assessing migratory grief and Ulysses Syndrome. The original material is available from the Centre de Documentació en Atenció a les Persones (Documentation Center for People Services), part of the Diputació de Barcelona (Barcelona Provincial Council) in Catalonia, Spain.

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The concept of Ulysses Syndrome falls within mental health, positioned on the boundary between common mental health challenges and diagnosable disorders.

	Vulnerability		Stressors	
Grief for the family	Simple		Simple	
	Complex		Complex	
	Extreme		Extreme	
Grief for the language	Simple		Simple	
	Complex		Complex	
	Extreme		Extreme	
Grief for the culture	Simple		Simple	
	Complex		Complex	
	Extreme		Extreme	
Grief for the land	Simple		Simple	
	Complex		Complex	
	Complex		Complex	
Grief for the social status	Simple		Simple	
	Complex		Complex	
	Extreme		Extreme	
Grief for the group of belonging	Simple		Simple	
	Complex		Complex	
	Extreme		Extreme	
Grief for physical risks	Simple		Simple	
	Complex		Complex	
	Extreme		Extreme	

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Recount	Simple	Complex
Vulnerability		
Stressor		
Mourning		

Other Observations	
Protective Factors	
Cultural Factors	
Risk Factors	
Subjective Factors	
Other Factors	
General Comments	

→ **VIDEO:** *The Ulysses Syndrome: Mental Health in a Minute*

Recommendations on how to apply the Ulysses scale based on a case study (Juan):

- **Background:** Juan is a 28-year-old man who arrived in Oakland, California, two years ago from Mexico. He was a healthy, strong, positive individual, actively involved in his community. He comes from a family that had good relationships.
- **Symptoms:** They include sadness, crying, anxiety, recurring thoughts about his problems, severe headaches, insomnia. He does not experience apathy or thoughts of death.
- **Personal Situation:** He left behind two children, ages 6 and 4, in Mexico and regrets that he does not know when he will see them again. He works in construction, installing roofs on houses; a risky and dangerous job, and he has fallen twice. He has had to move several times because his limited income, along with what he sends to his family, often does not cover rent. Additionally, he has a large debt from the journey to the U.S. He sees no way out of his situation.
- **Legal Status and Safety Concerns:** He is undocumented and fears deportation every day. If he returns without the money he owes, he fears for his life.
- **Language Barrier:** He does not speak English.

Grief for the family • **Vulnerability:** No physical or mental limitations prior to migration • **Stressors:** Forced separation from young children	Simple	X	Simple	
	Complex		Complex	
	Extreme		Extreme	X
Grief for the language • **Vulnerability:** No physical or mental limitations prior to migration • **Stressors:** Does not speak English	Simple	X	Simple	
	Complex		Complex	
	Extreme		Extreme	X
Grief for the culture • **Vulnerability:** No physical or mental limitations prior to migration • **Stressors:** Cannot connect with native culture	Simple	X	Simple	
	Complex		Complex	
	Extreme		Extreme	X
Grief for the land • **Vulnerability:** No physical or mental limitations prior to migration • **Stressors:** Oakland's climate is mild	Simple	X	Simple	X
	Complex		Complex	
	Complex		Complex	
Grief for the social status • **Vulnerability:** No physical or mental limitations prior to migration • **Stressors:** Hard work, undocumented status, severe housing issues	Simple	X	Simple	
	Complex		Complex	
	Extreme		Extreme	X
Grief for the group of belonging • **Vulnerability:** No physical or mental limitations prior to migration • **Stressors:** Has not experienced racism directly but believes there are certain prejudices toward immigrants	Simple	X	Simple	X
	Complex		Complex	
	Extreme		Extreme	
Grief for physical risks • **Vulnerability:** No physical or mental limitations prior to migration • **Stressors:** Fear of detention, works in dangerous conditions, threat of death if he returns	Simple	X	Simple	
	Complex		Complex	
	Extreme		Extreme	X

Content developed by the EU-MiCare team based on information in:

Achotegui, J. (2024). Migratory grief, as partial, recurrent, and multiple grief. *International Journal of Family & Community Medicine, 8*(2), 44–47. https://doi.org/10.15406/ijfcm.2024.08.00348

Achotegui, J. (2022). Immigrants living extreme migratory grief: The Ulysses syndrome. *International Journal of Family & Community Medicine, 6*, 303–305. https://doi.org/10.15406/ijfcm.2022.06.00295

Achotegui, J., Solanas, A., Fajardo, Y., Espinosa, M., Bonilla, I., & Espeso, D. (2017). Concordancia entre evaluadores en la detección de factores de riesgo en la salud mental de la inmigración: Escala Ulises. *Norte de Salud Mental, 15*(57), 13–23.

Handout 3: *"Berry's Acculturation Theory"*

1. Acculturation, acculturative strategies, and acculturative stress

Prof. John W. Berry defines acculturation as "the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members. At the group level, it involves changes in social structures and institutions and in cultural practices. At the individual level, it involves changes in a person's behavioural repertoire" [3].

Berry's model of acculturation provides a comprehensive framework for explaining how individuals and groups adapt to a new cultural environment using different strategies. It considers both the migrants' experiences (individual perspective) and the reactions and policies of the host society (societal perspective).

Individual Perspective

From the individual's point of view, there are four acculturation strategies based on two key dimensions: the degree to which individuals maintain their original culture and the degree to which they integrate new values and seek interaction with the host society.

- **Assimilation:** Individuals adopt mostly the host culture and separate from their original culture. They seek to become indistinguishable from the host society regarding behaviours, traditions and values. This strategy can lead to higher social acceptance but may involve significant personal and cultural loss.
- **Separation**: Individuals maintain their original culture and avoid interaction with the host society. They live within their cultural enclaves and limit their exposure to the broader host culture. While this strategy preserves their cultural identity, it can lead to social isolation and limited opportunities.
- **Integration:** Individuals maintain their original culture while also engaging with the host culture. They become bicultural, navigating and blending elements from both cultures. This strategy often leads to positive outcomes, such as increased social support and better mental health, as it allows individuals to retain their cultural identity while gaining the benefits of the new culture.
- **Marginalization:** Individuals neither maintain their original culture nor adopt the host culture. They feel disconnected from both their heritage and the new society, which can lead to significant psychological stress and social alienation.

Host Society Perspective

From the host society's point of view, Berry's model examines how the broader societal context influences the acculturation process. This includes the attitudes, policies, and practices that shape the experiences of migrants.

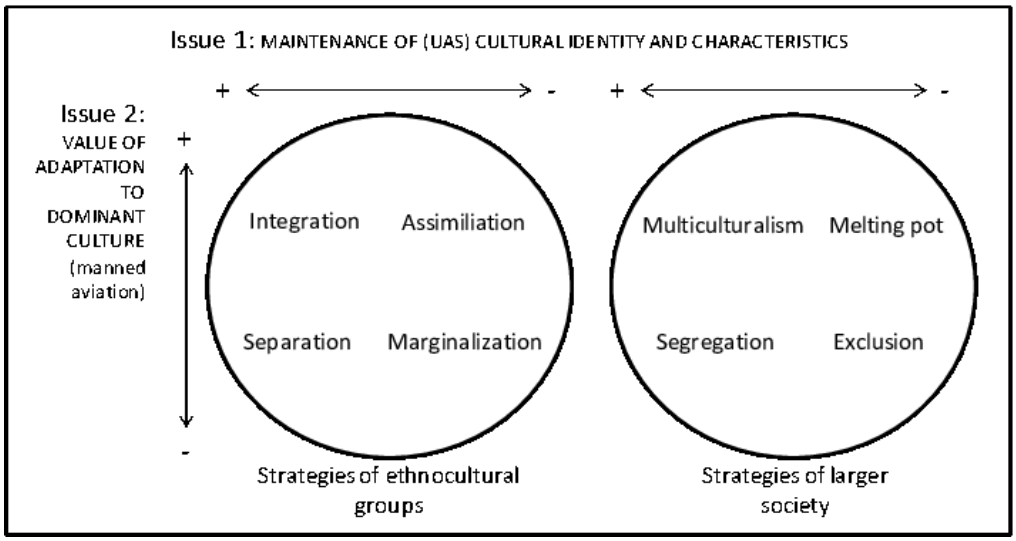
- **Multiculturalism:** The host society encourages the maintenance of original cultural identities and supports cultural diversity. This approach promotes integration by providing resources and opportunities for migrants to engage with both their culture of origin and the new culture. It leads to

positive outcomes for both the host society and the migrants, fostering social cohesion and mutual respect.

- **Melting Pot:** The host society expects immigrants to assimilate and adopt the dominant culture, often at the expense of their original cultural identities. This approach can pressure migrants to abandon their heritage, leading to potential loss of cultural diversity and identity conflict for individuals.
- **Segregation:** The host society supports the maintenance of original cultures but restricts interaction with the dominant culture. This can lead to the development of cultural enclaves and limited social integration. While it preserves cultural identities, it may hinder social cohesion and create parallel societies.
- **Exclusion:** The host society neither supports the maintenance of original cultures nor encourages interaction with the dominant culture. This approach marginalises migrants, leading to significant social and economic disadvantages. It fosters discrimination and social exclusion, negatively impacting the well-being of migrants and the overall harmony of society.

Berry's model emphasises that the interaction between individual strategies and societal attitudes significantly influences the acculturation process. For example, an individual's integration strategy is more likely to be successful in a multicultural society that values diversity. Conversely, an individual seeking to integrate in a society with exclusionary attitudes may face significant challenges and stress.

Figure 1.4.2-R. *"Model of acculturation strategies"*



Note: Berry, J. W. (2005). Acculturation: Living successfully in two cultures. *International Journal of Intercultural Relations*, 29(6), 697–712. https://doi.org/10.1016/j.ijintrel.2005.07.013

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[3] Berry, J. W. (2005). Acculturation: Living successfully in two cultures. *International Journal of Intercultural Relations*, 29(6), 697–712. https://doi.org/10.1016/j.ijintrel.2005.07.013

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Ethno-Medizinisches Zentrum e.V. PROLEPSIS INSTITUTE Cyprus University of Technology ZODIG POLIBIENESTAR Universitat de València teirnos BABEL

Module 2.

Improving Skills in Recognizing and Assessing Migrants' Mental Health Needs

Physicians, Psychologists, Psychotherapists and Nurses

Content drafted by ***Ethno-Medical Center/EMZ*** *(Ethno-Medizinisches Zentrum e.V. – Germany),*
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Module:	Improving Skills in Recognizing & Assessing Migrants' Mental Health Needs
Version:	Physicians, Psychologists, Psychotherapists and Nurses
Responsible Partners:	EMZ, Polibienestar, CUT, Syn-Eirmos/Babel Day Centre

Module Overview

This module is targeted to professionals working in clinical capacities and addresses the topic of identification and assessment of mental health needs of migrants and refugees. Unit 2.1 aims to support practitioners working in transcultural contexts in understanding and managing the influence of culture in the assessment of mental health needs. Unit 2.2 examines the intersectional perspective on migration and mental health, drawing from the rationale that the application of the intersectionality theory can do more justice to the complexity of the experience of migrants and refugees. An intersectional perspective can also help professionals and volunteers expand their views, identify further elements relevant to their practice, and reflect on their positions and how this affects their encounters with the people they work with. Unit 2.3 offers insights on the assessment of mental health needs of migrants and refugees. It highlights the limitations of ethnocentric diagnostic tools and introduces strategies for transcultural mental health assessment, including screening and referral networks. It also explores suicide risk assessment, considering cultural influences and vulnerabilities in migrants and refugees. Lastly, Unit 2.4 aims to improve participants' knowledge and skills to recognize and assess crises and implement Psychological First Aid (PFA) in the context of their work. By understanding the definition of PFA along with its basic framework and practices, participants will be better equipped to create a safe environment, ready to face the challenges of quick response to the mental health needs of migrant populations in different situations.

Module Learning Outcomes:

Upon completion of this Module, participants should be able to:

- Examine how cultural factors can influence various aspects of mental health
- Identify the four culture traps in transcultural interactions
- Discover frameworks for assessing and understanding mental health concerns of culturally and linguistically diverse populations
- Use self-reflection to uncover personal cultural biases, assumptions, and stereotypes
- Reflect on the intersections of power, privilege, and identity and their impact on mental health
- Review key factors for selecting culturally appropriate mental health screening tools
- Identify barriers to assessing mental health conditions among migrants and refugees
- Analyze effective approaches to suicide risk assessment
- Clarify intervention frameworks for mental health practitioners
- Demonstrate effective ways to discuss suicide with individuals in distress
- Describe the definitions of Psychological First Aid (PFA) and crisis intervention
- Explain what PFA is and what it is not
- List the three core action principles of PFA

Units in this Module:

Module 2. **Improving Skills in Recognizing & Assessing Migrants' Mental Health Needs**
Unit 2.1: Understanding the Influence of Culture on Mental Health
Unit 2.2: Intersectional Perspectives on Migration and Mental Health
Unit 2.3: Mental Health Screening Approaches for Migrants and Refugees
Unit 2.4: Psychological First Aid (PFA)

Unit 2.1: Understanding the Influence of Culture on Mental Health

Unit Overview
This training unit aims to support professionals working with migrant and refugee populations in understanding the influence of culture in the assessment of mental health needs. It addresses a variety of cultural factors that impact the way service providers and service users approach mental health, including the potential stigma associated with seeking help. The unit also offers a range of considerations and practical self-reflection tools designed to assist field workers in bridging cultural gaps and overcoming challenges in their interactions with migrants and refugees.

Unit Sections:

1. Introduction

As seen in Unit 1.1, culture influences the way we talk about mental health and, in turn, the way we talk about mental health influences culture. **When we encounter a word, whether spoken or written, we attach a meaning to it influenced by our cultural and societal perspectives**. Our life experiences shape how we interpret and understand that word. For example, the words '*mental health*' and '*mental illness*' may have **varied interpretations and explanations across different racial, ethnic, or cultural groups** [1].

In the context of healthcare, in which people from culturally and linguistically diverse backgrounds come together, **culture shapes nearly every part of the interaction**. Culture influences **how people communicate their symptoms** and **which symptoms they choose to share**. It affects **whether individuals seek help at all, the kind of help they look for, how they cope, the social supports they rely on**, and the **stigma they may**

associate with mental health issues. It also **shapes the meaning they attach to their experience.** Some people may view mental health problems as physical conditions, while others may see them as signs of misfortune. **If a health system fails to account for these diverse perspectives, individuals may not receive the help they need** [1-4].

To provide effective mental health services, it is important to create **an environment where there is a shared understanding – not just in terms of language, but also in terms of aligning expectations, perspectives, and interpretations between the service provider and the person accessing care** [4]. The development of a shared understanding, or *common language*, means a common recognition that forms a basis of mutual trust and communication among individuals who come from different viewpoints. This is not a skill that can simply be learned once and applied uniformly. Instead, **it is an active, ongoing process that evolves through ongoing interaction and collaboration with the people we work with.**

◎ Key Point: ***Intercultural, Multicultural, Cross-Cultural or Transcultural Contexts? A Note on Language***

In discussions about cultural differences and diverse contexts, the terms *multicultural, intercultural, cross-cultural, and transcultural* each carry distinct meanings [5,12]:

- *Multiculturality* describes **the parallel existence of diverse cultural groups within a society**; a mosaic of separate, relatively stable cultural identities. Multicultural environments often lack deep interaction between cultures, as they focus on tolerance and representation rather than active exchange or integration. Multiculturalism tends to maintain cultural boundaries, allowing groups to coexist without necessarily influencing one another's practices or perspectives.
- *Interculturality* focuses on the **interactions and relationships between distinct cultural groups**. It promotes dialogue and mutual understanding while acknowledging cultural differences, often in settings with historical or structural tensions between dominant and minority groups.

Intercultural frameworks are particularly relevant in educational and community contexts where bridging understanding between different cultural groups is prioritized.

- *Cross-culturalism* focuses on **comparing and analyzing behaviors, values, belief systems, morals, habits and social norms across different cultural groups**; its primary aim is to understand cultural nuances that influence human interaction. It is a systematic approach in research that focuses on identifying commonalities and differences between cultures. Although it does not imply integration or blending, it allows researchers and practitioners to develop frameworks that can facilitate communication and address potential misunderstandings in diverse settings.

- *Transculturality* derives from theoretical perspectives of cultures as relational, dynamic, fluid, and constantly evolving. In this view, **cultures are neither static nor isolated; they are actively shaped through continuous interactions and mutual influence**. This perspective is especially pertinent in migration contexts, as it highlights the shared, interconnected experiences across cultural divides. By challenging the notion of cultures as separate 'islands', transculturality encourages a mindset of social cohesion, **making it a critical framework for understanding the complexities of identity and belonging in an increasingly globalized world**.

In this course, we adopt a transcultural lens that transcends a unidimensional, linear understanding of migration. To truly understand the complexities of migrants' and refugees' lived experiences, we recognize that individuals continually engage with (and adapt to) diverse elements, accessing broader networks of cultural knowledge. As practitioners and service providers, we, too, are called to shift and evolve – leaving behind familiar perspectives to genuinely meet people on their path to creating a new home. This reciprocal transformation allows both parties to bridge cultural divides, fostering a mutual journey of resilience, adaptation, and understanding.

2. The Relationship between Culture and Mental Health

The phenomenology of mental health refers **to how individuals experience and make sense of their mental well-being.** It emphasizes the subjective meanings and interpretations that people attach to their psychological experiences within a broader cultural framework of beliefs, values, and practices [1].

However, culture significantly shapes not only the subjective experiences of individuals but also **the dynamics of their relationships with healthcare providers** [6,7]. As discussed in Unit 1.5, when social and cultural factors are overlooked in the assessment process, misdiagnosis and perpetuation of clinical stereotypes based on race, ethnicity, and gender – among other factors – may occur. Furthermore, a growing body of evidence underscores that existing **healthcare systems may not be adequately prepared to meet the needs of minority and migrant populations in transcultural contexts** [3]. In the following section, we reference a series of cultural factors that may influence various aspects of mental health.

Self-Identity

Culture significantly **shapes not only how individuals define and approach problems** but **also their assumptions about selfhood and relationships**. This diversity in worldviews means that fundamental beliefs about reality and the self vary across the world. Depression, for example, often manifests **through somatic and relational complaints in non-Western cultures, a reflection of the socio-centric** (or collective) **construct of identity in these settings** [1,3,4]. Here, the sense of selfhood is embedded in (and continually shaped by) relationships and social contexts. By contrast, Western cultures frequently frame depression through **feelings of worthlessness and despair**. These are intrapsychic states that mirror an individualistic notion of the self, which is seen as an autonomous, inner entity responsible for personal agency [4].

In non-Western settings, where self-identity is more relational, **concepts such as honor, duty, and virtue play an important role**, whereas **Western societies prioritize self-actualization and authenticity**. The difference in self-conception also impacts the kinds of emotional experiences people report: **guilt is more prevalent in individualistic cultures**, stemming from inner self-criticism, while **shame tends to be more pronounced in collectivist cultures**, tied to social judgment. These contrasting views of selfhood may pose challenges for providers, especially those trained in Western models that focus on individual change [4].

Coping Styles and Treatment-Seeking

Culture also informs coping styles and treatment-seeking behaviors [3,4], meaning that an individual's cultural background can dictate **whether they seek help from conventional mental health services or**

traditional healers. In cultures where psychological distress is perceived as being caused by spiritual forces (such as curses or the evil eye), individuals are more likely to turn to community practitioners for support rather than psychiatric care [1,3,4].Treatment-seeking may also be influenced by socio-cultural learning experiences surrounding mental health. Some cultures promote emotional openness, while others encourage restraint. In cultures where **mental health issues carry connotations of shame or weakness, individuals may internalize these beliefs**, resulting in reluctance to access mental health services.

Stigma

Defined by a 'cluster of negative attitudes and beliefs' [8], ***stigma*** **motivates societal fear, avoidance, and discrimination against people facing mental health challenges**. Stigma related to mental health issues and help-seeking can be understood through five distinct but interconnected domains [9]: (1) **self-stigma**, (2) **help-seeking stigma**, (3) **associative stigma**, (4) **public stigma**, and (5) **anticipated stigma**. Stigma is particularly pervasive among certain cultural groups, who may experience intensified shame and isolation due to cultural norms. Studies show that, for example, Asian American communities in the U.S. seek help at reduced rates, partly due to **extreme stigma associating mental illness with family dishonor** [10]. Meanwhile, cross-cultural research highlights how public attitudes towards mental illness vary [1,10,11]: Hispanic and Asian Americans often view individuals with mental health challenges as more dangerous than do other groups, potentially reinforcing barriers to treatment.

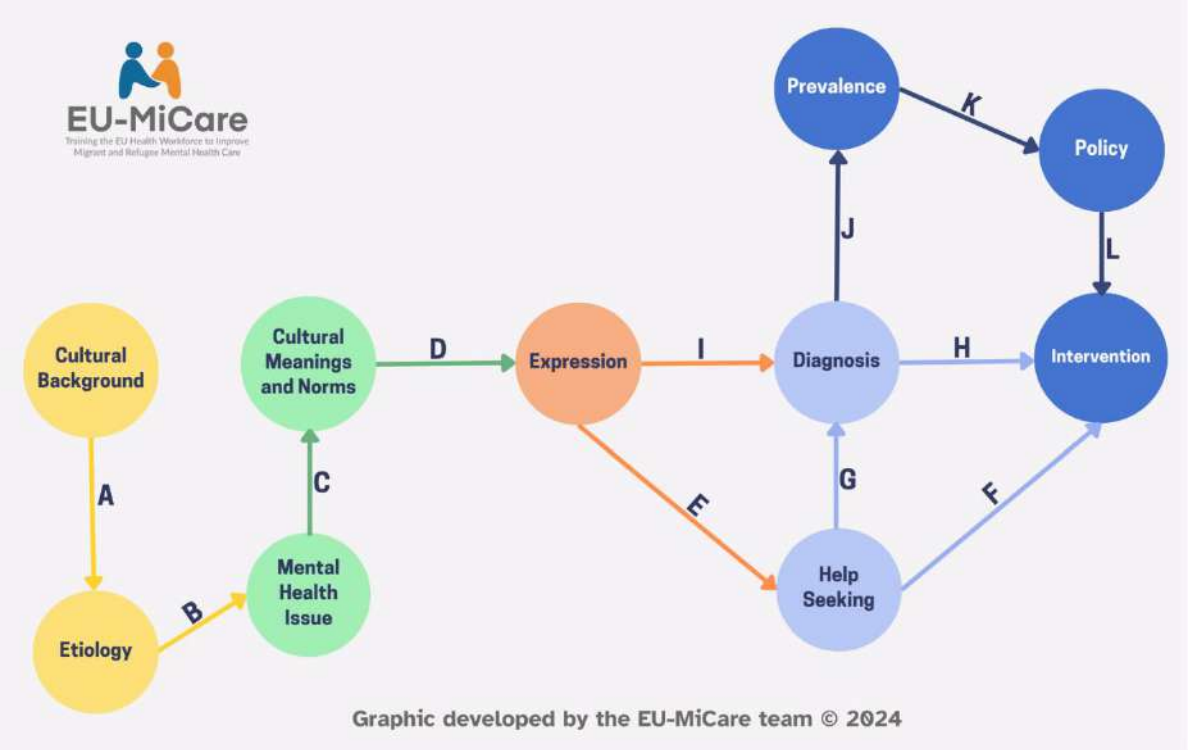
Relationships within Healthcare Systems

When service users and providers do not share cultural backgrounds, **the potential for misalignment in values, assumptions, and expectations about treatment may grow**, with professionals possibly dismissing symptoms or perspectives that the person finds critical. **Power dynamics, institutional biases, and historical injustices permeating healthcare systems** can also form substantial barriers to effective care provision [2,7]. For instance, marginalized populations often face systemic discrimination, which can foster **feelings of mistrust toward healthcare institutions that have historically failed to serve them equitably**.

Healthcare professionals, like any other group, have a distinct professional culture – one marked by a focus on **biomedical frameworks that conceptualize mental health issues as arising from chemical imbalances in the brain**. In turn, this may lead to a strong emphasis on 'objective diagnoses' and pharmacological treatments as a primary intervention method [4]. Such an approach risks **prioritizing universal solutions** and **may unintentionally create distance from service users by overlooking the culturally embedded perceptions that shape individual mental health experiences**.

While there is a growing acknowledgment among professionals that culture significantly affects mental health, many providers still struggle to articulate how these cultural factors translate into clinical practice. The Cultural Influences on Mental Health (CIMH) model (see Figure 2.1.1 below and table on the next page) [3] was developed specifically to fill this gap by providing **a structured approach to understanding how culture intersects with mental health**.

Figure 2.1.1. "*The Cultural Influences on Mental Health (CIMH) Model*"



Note: Graphic re-adapted by the EU-MiCare team based on information by Hwang et al. (2008)

Components of the CIMH Model	
Pathways A and B:	Cultural background and characteristics of individuals (A) are factors that influence the onset of mental health issues (B). For example, refugees who have been displaced may encounter unique stressors and barriers to mental healthcare, leading to an increased risk of adverse mental health outcomes.
Pathways C and D:	Cultural meanings and norms (C) shape how mental health issues are expressed (D).
Pathways E and I:	The way mental health issues are expressed affects whether and how the person seeks help (E) as well as the assumptions related to their diagnosis (I).
Pathways G, H, and F:	Professionals from different fields such as primary care, mental health services, and indigenous medicine/traditional healing practices may offer different interpretations of the mental health presentation (G), leading to diverse treatments and outcomes (H & F).
Pathways J, K, and L:	The diagnosis impacts the reported prevalence of mental health issues within specific population groups, such as migrants (J). This prevalence data can shape policy decisions (K), which in turn influences the types of treatments available, including culturally sensitive interventions and mental health resources in native languages (L).

Note: Re-produced by the EU-MiCare team based on information by Hwang et al. (2008)

◎ Key Point: ***A culturally sensitive approach to counselling in a case of traumatic bereavement***

To illustrate these cultural considerations, Prof. John McLeod [4] provides the following case study:

> *In the winter of 1984, about 12,000 Falashas (Jews of Ethiopia) were driven out of their villages in northern Ethiopia by a combination of hunger, fear of war and a desire to emigrate to Israel. On their long march through the desert and in refugee camps about 3,000 died. Eventually, the Israeli government managed to airlift the survivors to safety, but only after enormous trauma and disruption to family groups.*
>
> *Some two years later, M, a 31-year-old Ethiopian woman, married with four children, and who spoke only Amharic, was referred to a psychiatric unit in Jerusalem. Although it was difficult to obtain adequate translation facilities, it emerged that she had wandered for many weeks in the desert, during which time her baby had died. She continued to carry the dead body for several days, until she arrived in Israel, when the strong-smelling corpse was taken from her and buried. For the previous two years she had been repeatedly hospitalized following 'asthmatic attacks'. Now she was agitated, fearful and*

depressed, and complained of 'having a snake in her leg'. She was diagnosed as suffering from an acute psychotic episode. The staff in the psychiatric unit were able to find an anthropologist familiar with M's culture and language, and it emerged that she experienced herself as 'impure' because she had never been able to undergo the purification ritual required by her religious sect for all those who have come into contact with a human corpse. Her mother-in-law had not allowed her to talk about her feelings surrounding her bereavement: 'snake in the leg' turned out to be a Falasha idiom for referring to disagreement with a mother-in-law. M received counselling that encouraged her to talk about the death of her baby, and a purification ritual was arranged. At 30-month follow-up, she was doing well and had a new baby, although admitting to still mourning her dead child.

The case of M, and the issues it raises, are described more fully in Schreiber (1995). It is a case that demonstrates the strengths of a multicultural approach. Although the person in need presented with physical, somatic symptoms that could in principle be treated by medication and conventional Western psychiatry, the therapists involved in the case took the trouble to explore the meaning of these symptoms, and then to construct a form of help that brought together indigenous and psychotherapeutic interventions in a way that was appropriate for this individual person.

3. The Four Culture Traps in Interactions with Migrants and Refugees

As previously discussed, to promote psychosocial well-being in the context of transcultural interactions, **field workers must overcome challenges related to their own biases and attitudes.** Addressing these challenges involves self-reflection and awareness of the four culture traps that might mitigate the effectiveness of communication with people from different cultural and linguistic backgrounds [12,13].

The Four Culture Traps in Transcultural Interactions	
1. Power Asymmetries	Differences in social status, legal standing, or institutional roles can create imbalances in the interaction between field workers and migrants and refugees, affecting communication and collaboration.
EXAMPLE: *Mariela, an indigenous woman from a rural area in El Salvador, might feel intimidated by her German social worker due to her legal status and unfamiliarity with the German healthcare system. This power imbalance could lead to Mariela*	

hesitating to speak openly about her mental health issues out of fear of being stigmatized, impacting her overall health and adaptation process.	
2. Collective Experiences	Both clients/service users and professionals bring their collective cultural experiences and historical tensions into therapy, which can influence their perceptions and interactions.
EXAMPLE (cont'd): *If Mariela's social worker has preconceived notions about indigenous Salvadorans being resistant to modern medicine based on historical stereotypes, this could affect how they perceive Mariela's reluctance to certain treatments.*	
3. Foreign Images	Media portraits influence prejudices and stereotypes, shaping perceptions of different cultural groups.
EXAMPLE (cont'd): *Media often depicts Salvadoran migrants in a negative light, which might lead Mariela's social worker to unconsciously view her through a lens of stereotypes, such as seeing her as a victim or solely defined by her migrant status. Recognizing and challenging these stereotypes helps the social worker provide more personalized and meaningful care.*	
4. Different Cultural Patterns	Differences in cultural norms can lead to misunderstandings in the relationship between the person seeking help and the professional.
EXAMPLE (cont'd): *Mariela's social worker might expect to start counseling sessions with a direct focus on psychosocial issues, which contrasts with Mariela's practice of building trust through informal conversation first. Mariela may find the direct approach abrupt or impersonal. The social worker should recognize this cultural difference and allow time for relationship-building to improve communication and therapy effectiveness.*	

Note: Re-produced by the EU-MiCare team based on information by von Lersner & Kizilhan (2017)

4. Incorporating Diverse Perspectives in Mental Health Assessment

The following section introduces practical models and tools designed to help identify and address points of stagnation in the professional-client relationship, particularly in the context of migrant and refugee care. A summary of diagnostic categories and related cultural considerations can be found in Module 1, Unit 1.5: Most Common Mental Health Conditions among Migrants and Refugees.

Explanatory Models in Clinical Practice

An essential aspect of working in transcultural contexts involves **understanding how people make sense of their experience**. The DSM-5 defines ***cultural concepts of distress*** as the ways cultural groups

"experience, understand, and communicate suffering, behavioral problems, or troubling thoughts and emotions" [14]. These "understandings" or "explanations" – which may differ from scientifically based frameworks – reflect people's explanatory models of illness. When utilizing an ***explanatory model*** (EM), clinicians can ask the questions ***What, Why, How*, and *Who*** to develop a common language with the people they work with toward the goal of a shared outcome: healing [15,16]. By incorporating EMs into assessment processes, providers can gain valuable insights into a person's beliefs, expectations, and cultural background, thereby enhancing the effectiveness of interventions [15].

> **Reflection Break:** ***Engage in self-reflection (or group reflection with your peers) by thinking about a challenging moment***
>
> Reflect on a challenging or distressing experience you have encountered in a different cultural context – one where you felt frustrated, confused, embarrassed, or deeply bothered. Consider how your cultural background may have influenced your reaction to this situation. Can you identify any cultural factors that might explain your response? How might local individuals from that culture have reacted in a similar or different way, and what might their explanatory model of distress or illness have been in that situation? Why do you think there are differences in reactions, if any?
>
> *Sourced from Culture Matters: The Peace Corps Cross-Cultural Workbook*
> *and adapted by the EU-MiCare team for the purposes of this course.*
> The adaptation of this graphic for the purpose of this exercise does not imply endorsement by Peace Corps.

The ***Cultural Formulation Interview*** (CFI) [17] is the first tool in the DSM system designed to integrate the explanatory model approach into the exploration of mental health issues. The CFI will be explained in detail in Unit 2.3. However, the table on the next page provides a simple guide that can serve as **an icebreaker to initiate discussions about mental health**. It helps practitioners **understand the person's perspective** and **start building bridges toward developing adapted explanatory models** [12].

→ **VIDEO:** *Using the Cultural Formulation Interview* 💻

How would you define your problem?
1. What are the consequences of the problem?
2. What are the causes of the problem?
3. How long has the problem lasted?
4. What explanations does your family or social environment have for the problem?
5. What concerns do you have about the problem?
6. How do you think it can be treated?
7. Who could help you?

Note: Re-produced by the EU-MiCare team based on information by von Lersner & Kizilhan (2017)

Cultural Expressions of Deep Sadness ('Idioms of Distress')

While depression is recognized as a cross-cultural concept [12], culturally specific approaches to distress are shaped by individual explanatory models and cultural norms around mental health. People from diverse cultural backgrounds may therefore describe distress differently. These culturally unique expressions, **which may not align directly with specific symptoms or syndromes but rather embody a shared understanding of distress within a community**, are referred to as ***idioms of distress*** [18].

> ***Example:*** *In Turkey, two idioms of deep sadness are "my head has a cold" and "my liver is cold". The expressed emotions do not fit the usual Western diagnostic schemes and should be understood figuratively. They provide information about inner states in a culturally accepted way* [12].

Why is it important to consider idioms of distress? These expressions can serve as a vital bridge for mental health clinicians, enabling them to gain a deeper understanding of the issues and challenges that migrants and refugees articulate in relation to their well-being. Moreover, for professionals outside of this field, idioms of distress may indicate that an individual is at a juncture where it is appropriate to initiate specialized care and refer them to a mental health expert. While it may not be necessary to memorize every

idiom, phrase or concept due to their varying relevance (or lack thereof) across different communities, professionals must maintain an open, inquisitive stance toward exploring the diverse forms of communication shaped by factors such as generation, history, geographical region, and gender identity.

The DSM-5 offers a list of "cultural concepts of distress" to guide mental health providers in incorporating these nuances into clinical practice [14], emphasizing the significance of understanding both the intensity and the underlying meaning of these culturally specific expressions of discomfort. More information is provided in the 🕮 Repository (see 2.1 – Handout 1. "List of Idioms of Distress").

Cultural Competence and Cultural Sensitivity

The development of cultural competence necessitates a multifaceted approach which involves a deep understanding of diverse cultural norms, values, beliefs, and communication styles. It also requires the **cultivation of empathy, curiosity, humility, and openness toward cultural differences** [2,7]. Cultural sensitivity goes beyond mere awareness of cultural diversity; it involves **the capacity to adapt one's behavior, communication, and interventions to meet the needs and preferences of individuals from various cultural backgrounds**. This includes practices such as active listening, suspending judgment, and being attuned to cultural nuances in both verbal and non-verbal communication [7].

Engaging in proper reflection and developing these competencies can significantly aid in addressing challenges encountered in scenarios such as those illustrated above. Further exploration of these competencies and concepts will be provided in Module 3, Unit 3.1: Effective Communication and Unit 3.2: Cultural Awareness.

🕘 **Reflection Break:** ***Reflect on the iceberg analogy of culture***

Culture has been aptly compared to an iceberg. Just as an iceberg has a visible section above the waterline, and a larger, invisible section below the water line, so culture has some aspects that are observable and others that can only be suspected, imagined, or intuited.

(cont'd on next page)

Also like an iceberg, that part of culture that is visible (observable behavior) is only a small part of a much bigger whole. The idea of the cultural iceberg comes from Edward T. Hall's (1976) Beyond Culture.

Take a moment to reflect on the numbered features listed below. Think about which of these aspects are observable in your day-to-day interactions with migrants and refugees and which might be less visible or hidden beneath the surface. Consider how these invisible cultural elements might influence the behaviors and experiences that are visible to you as a professional or volunteer. In your reflection, ask yourself:

- Which aspects of culture can you see, and which remain hidden from view?
- How do the invisible aspects of culture shape or influence the visible behaviors?
- How might these factors be influencing their mental health or coping strategies?
- How might understanding these hidden factors change the way you approach the people you work with?

1. facial expressions
2. religious beliefs
3. religious rituals
4. importance of time
5. paintings
6. values
7. literature
8. child raising beliefs
9. concept of leadership
10. gestures
11. holiday customs
12. concept of fairness
13. nature of friendship
14. notions of modesty
15. foods
16. eating habits
17. understanding of the natural world
18. concept of self
19. work ethic
20. concept of beauty
21. music
22. styles of dress
23. general world view
24. concept of personal space
25. rules of social etiquette

Sourced from Culture Matters: The Peace Corps Cross-Cultural Workbook

and adapted by the EU-MiCare team for the purposes of this course.

The adaptation of this graphic for the purpose of this exercise does not imply endorsement by Peace Corps.

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Unit 2.2: Intersectional Perspectives on Migration and Mental Health

Unit Overview
This training unit aims to help professionals and volunteers working with migrants and refugees move beyond simplistic approaches in their practice. It addresses the risks of cultural essentialism, which reduces individuals to a single identity marker, neglecting the complexities of their experiences. The unit adopts an intersectional perspective and emphasizes the need for a multidimensional understanding of identity that incorporates factors such as race, gender, age, and legal status, alongside culture. It also provides tools and frameworks to better recognize the interplay of these factors, offering a more nuanced approach to supporting the mental health and psychosocial well-being of migrants and refugees.

Unit Sections:

1. Introduction: Beyond Culture

As seen in previous units, culture is a central element shaping individual identities and experiences, including perceptions of mental health and well-being. Yet, **the risk of *cultural essentialism* looms** – a narrowing lens that positions culture as the single determinant that shapes actions and outcomes, particularly among migrants and refugees. This tendency, paralleled by the ***oversimplification*** of migrant identities, flattens the complexity of people's lives into singular narratives defined solely by origin, appearance, or language. What is common between essentialism and oversimplification is that **individuals are reduced to (and categorized through) only one characteristic** – in this case, culture – **while all other dimensions of their identity are blended out or, even worse, erased.** This ultimately reinforces stereotypes while perpetuating divisions between 'Us' and 'Them'.

When defining ourselves, few of us would rely solely on the categories of 'German', 'Italian', 'Spanish', or 'Greek' without including other facets of identity (e.g., our gender, our profession, our age). Culture can by no means serve as a single explanation for all human behavior. Even within the same cultural group, understandings and practices of culture can vary widely, influenced by factors such as age, social class, education, gender, sexual orientation, or geographic context.

To move beyond this limiting lens, we must embrace a more nuanced understanding of culture. Culture must be seen not as a monolith but as **a dynamic interaction of discourses and practices, deeply influenced by broader systems of power**. Within this framework, intersectionality emerges as an indispensable tool, offering a means to unravel simplistic binaries and illuminate the structural forces that influence the lived realities of people on the move. While culture undeniably influences mental health, **it cannot be isolated from the ways migration intersects with other dimensions of identity**, such as race, class, and gender.

Understanding the experiences of those we seek to support demands **a multidimensional lens that respects their complex identities and positionalities**. For field workers, this means acknowledging **the diverse elements that shape migrants' and refugees' lives** – in their countries of origin, during their journeys, and in their new environments. Such awareness is essential to addressing their unique needs, concerns, and resources, particularly when it comes to supporting their mental health and psychosocial well-being. This unit will explore the intersectional perspective as a guiding framework to move beyond singular explanations based on culture, focusing instead on **a broader analysis of power and the way it shapes who migrants and refugees are and what challenges and contradictions they confront**.

2. Exploring Socio-Political Dimensions of Identity in the Work with Migrants and Refugees

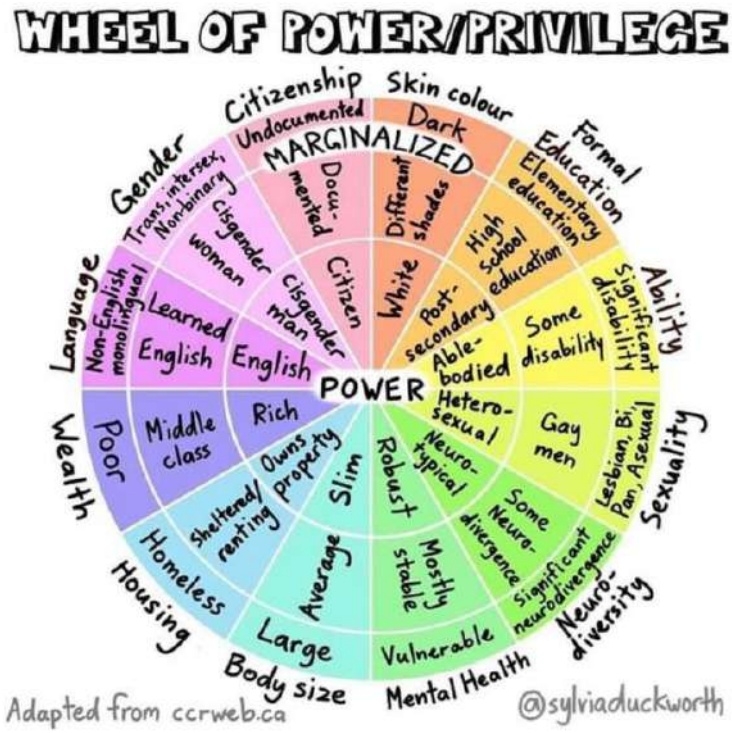
There is no definitive list of significant elements (also known as identity markers, social categories, or dimensions), just as there is no list of identities. In academic literature and research, the most extensively discussed are gender, race/ethnicity[1], and class, depending also on the context of the research. However,

[1] In the US context, the terms 'race' and 'ethnicity' are common categories used in research, media, and census classifications. In the European context, due to its historical connotations and the potential for reinforcing racial stereotypes, the term 'race' is mostly avoided. Instead, alternative concepts such as 'ethnicity', 'ethnic origin' or 'migrant background' are typically used.

for some individuals, further dimensions such as age, sexuality, disability, religion, or legal status can play a crucial role. Ultimately, **which dimensions are decisive varies from individual to individual and depends on their life situation as well as the context**.

Figure 2.2.1 illustrates the varying degrees to which individuals, based on specific characteristics, may experience marginalization or have power within society. **Positions closer to the center represent power** and **indicate that the person can enjoy greater privilege in that dimension** (e.g., being a citizen, being white, or being wealthy). Conversely, **positions farther from the center signify increased marginalization and potential discrimination** (e.g., having a significant disability or lacking housing).

Figure 2.2.1. *"The Wheel of Power/Privilege"*



Note: Graphic produced by @sylviaduckworth based on the Canadian Council of Refugees.

If you position yourself on the wheel along the different categories, you will likely notice that your position is closer to the center in some cases, while in others you may find yourself more on the outside of the wheel. The same happens to migrants and refugees you may encounter in a professional setting. While this

version of the wheel includes many important characteristics, **it should not be considered definitive.** Additional categories can be added, or some included may play a minor role for certain individuals or within specific contexts[2]. **There are numerous dimensions influencing the lived experiences of migrants and refugees, both positively and negatively**. A tentative, non-exhaustive list can be found in the 🕮 Repository (see 2.2 – Handout 1. "A Non-Exhaustive List of Characteristics").

Mental health is included as a category in the wheel of power and privilege, which highlights its dual association with privileged and marginalized positions. Individuals with stable mental health often possess greater capacity to navigate systems of power compared to those with mental health vulnerabilities. This dynamic, however, is deeply interwoven with other identity dimensions, varying in intensity and impact:

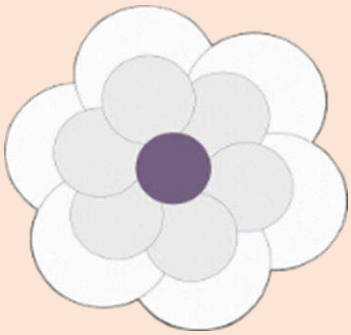
- **Citizenship/Legal Status**: Prolonged insecurity in legal status significantly exacerbates mental health challenges among refugees, asylum seekers, and undocumented migrants. As already seen in Unit 1.2, factors such as detention, restricted mobility, and precarious housing conditions contribute to poor mental health [1,2,3].
- **Appearance/Skin Color**: Visible markers of difference, such as skin color or cultural attire, significantly increase exposure to discrimination and racist violence, both of which are strongly correlated with psychological distress. These experiences are **not equally shared among migrants and refugees but vary along racial and ethnic lines**. Individuals easily identified as 'foreigners' or 'Others' on the basis of their appearance (e.g., darker skin tones or wearing cultural attire like headscarves) face heightened risks of discrimination and violence. Those who can blend into predominantly white, European societies are less likely to encounter such treatment [4,5,6]. These disparities highlight the disproportionate mental health burden borne by visibly marginalized groups.
- **Gender**: In mental health, patterns often align with traditional conceptions of femininity and masculinity, as well as gendered expectations. Women are generally more likely to experience internalizing disorders, such as anxiety and depression, which often involve self-blame and self-reproach [7]. In contrast, men are more prone to externalizing disorders, such as harmful substance use

[2] The category 'language', for example, demonstrates that this version of the wheel has been developed in an English-speaking context, and could be adapted into a more neutral 'country language'.

or dependence, which frequently manifest as aggressive or confrontational behavior [8,9]. However, recent developments in mental health research underline **the need to capture situations emerging at the crossroads of gender and other factors, such as race and class**.

Reflection Break: ***Engage in self-reflection using the Power Flower***

Draw a large flower on a piece of paper following the example below. Label 6–7 petals with identity categories relevant to your context, such as sex, race, class, religion, family type, education, ability/disability, or geographic origin. The flower's center represents nationality (e.g., Spanish), the inner petals reflect your specific characteristics (e.g., gender: female; religion: Muslim), and the outer petals represent dominant identities in society (i.e. identities that historically had and currently have more resources and influence; e.g., gender: male; religion: Catholic).



After filling in your own characteristics on the petals, reflect on the following questions:

- How many of your personal characteristics differ from the dominant identity?
- Which of your characteristics are fixed or unchangeable?
- What insights does this provide about your own power or potential for exercising power?
- How might this understanding shape your role as a professional or volunteer working with migrants and refugees?

3. Intersectionality: A Framework for Understanding Complexity

As discussed earlier, **individuals simultaneously occupy multiple positions across various identity dimensions.** However, understanding these positions requires more than simply listing and summing them up. A shift toward analyzing these categories collectively and examining how they interact and influence each other is essential. This integrative approach reveals the interconnected nature of identity dimensions and their cumulative impact. The concept of intersectionality provides valuable insights into this interplay.

Intersectionality has its origin in the social struggles and the civil rights movement of the 1970s in the United States, which were directed against multi-layered forms of discrimination. At the time, the focus was on **the specific oppression suffered by Black women, who were simultaneously affected by sexism and racism**. For a long time, the concept has remained restricted within feminist circles and the academia. However, in recent years, the intersectional perspective has been increasingly adopted in a broader context, e.g., in the analysis of health disparities.

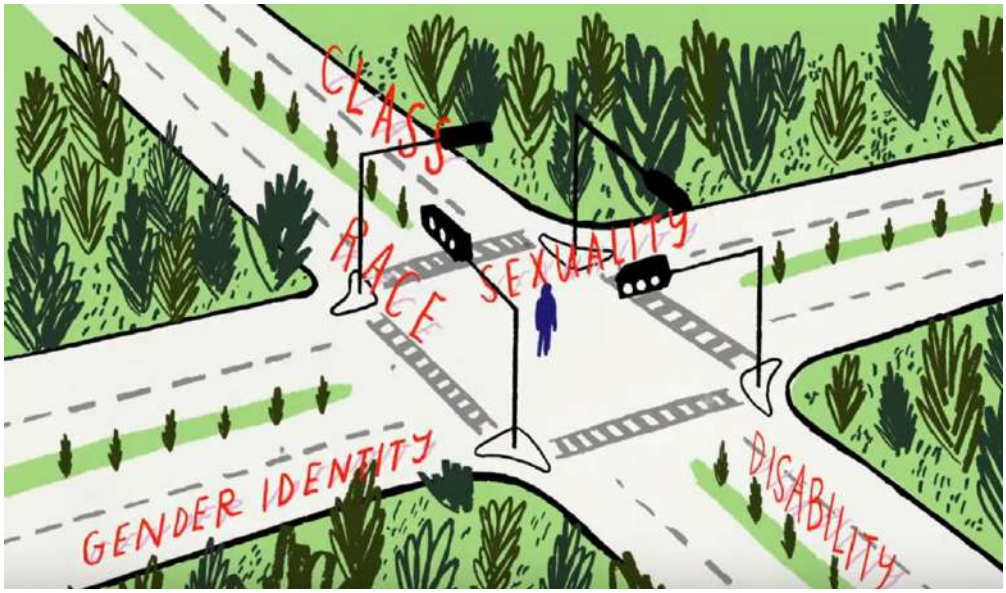
→ **VIDEO:** *What is Intersectionality?* 💻

The conceptualization of the term was introduced in the late '80s by Black lawyer and sociologist Kimberlé Crenshaw [10,11]. In her legal scholarship, she used **the metaphor of a street intersection (crossroad) to illustrate the complex interactions between identity markers/social and different forms of discrimination and oppression**, as depicted in Figure 2.2.2 on the next page. The concept has since become a foundational tool in social theory, offering insights into how different social categories intersect to produce unique experiences of inequality and injustice.

What was innovative in the intersectionality approach is that **it focuses on the simultaneous, overlapping, and mutually influencing effects of different socio-political categories**. In this view, it is not enough to simply recognize multiple dimensions of identity and add them together; it is necessary to understand the interdependence between them. At the intersections of these identities, **individuals may simultaneously experience both privilege and discrimination as a result of their membership in different social groups**.

For example, a person can be discriminated against because of their gender identity, but at the same time experience privileges on account of their class status.

Figure 2.2.1. *"Intersectionality as a Crossroads"*



Note. Screenshot taken from the National Museum of African American History and Culture (NMAAHC) (2017): #APeoplesJourney: African American Women and the Struggle for Equality; YouTube [28.03.2024].

→ **VIDEO:** *Intersectionality and Health* 💻

→ **VIDEO:** *Intersectionality and Mental Health* 💻

In the case of migrants and refugees, an intersectional perspective can guide field workers to recognize how processes of discrimination and exclusion originate, and how access to resources and barriers to participation are defined by the interplay of different social markers of differences. The following case exemplifies how an intersectional perspective can enhance the understanding of real-life scenarios:

(…) a young Roma woman is discriminated against in the labor market because (i) she is Roma and is perceived to be 'dangerous', (ii) she is a woman, and is therefore 'bound to have children soon', and (iii) she is young, and therefore 'inexperienced'. These circumstances or overlapping factors create a compounded form of discrimination that cannot be understood by simply adding each individual criterion. In being considered inexperienced and incompetent, the woman

shares certain experiences of discrimination with young people; in being assumed to fit into a traditional role, she shares experiences with other women; and in being perceived as dangerous, she shares experiences with all Roma, including men. However, it is the intersection of all these elements that makes her experience unique [12].

Although the intersectional perspective has often been used for analyzing specific forms of oppression or discrimination – as in the example above – **it can also help identify specific resources and opportunities that originate from the interplay of different dimensions**. Professionals and volunteers working with migrants and refugees are called to grasp the complexity of the life situations of the people they work with, marked by the **simultaneous presence of privileges, discriminations, and resources**. Intersectionality can help them not only focus on the factors making their lives difficult (e.g., hardships and adversities on the basis of their gender or sexual orientation, experiences of exclusion and downward social mobility on account of their ethnicity, etc.) but also on **those elements which, if properly developed, can represent a resource and open future perspectives for them** (e.g., experiences of belonging to a social or religious community, the development of personal skills and knowledge, social and family ties).

◎ Key Point: ***Putting the Ideas of Intersectionality into Practice***

How can the rather abstract concepts of this unit be operationalized by professionals and volunteers working on the ground? How can we initiate a change of attitudes and perspectives in daily practice? Here are some suggestions:

- Think of culture as only one dimension shaping the personal identities and positions of migrants and refugees. Remember, we are much more than the culture we grew up in, and so are those you work with.
- Focus on the uniqueness of each person and avoid stereotyping individuals as representatives of a particular culture. If you want to understand the role of culture for a specific person, simply ask them about it.
- Recognize that everyone, including yourself, is influenced by cultural aspects that shape how we think, act, and perceive the world. Reflect on how your own cultural background (along with other factors) may affect your perceptions and evaluations of situations or behaviors.

- Move beyond cultural competence as the singular framework of providing support. While knowledge of a culture is helpful, focusing on shared experiences and common elements will foster stronger bonds with those you serve.
- Use an intersectional perspective to understand the complex life circumstances of those you support. Consider the interplay of various social dimensions (such as gender, age, legal status) and explore how these factors can generate resources to help individuals navigate challenges.
- Be reflective! Your social positioning and experiences affect your encounters with your counterparts. Tools such as the Wheel of Power/Privilege and the Power Flower can increase your awareness of how these factors impact your work.

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Unit 2.3: Mental Health Screening Approaches for Migrants and Refugees

Unit Overview
This unit offers insights for mental health professionals on assessing the mental health needs of migrants and refugees. It highlights the limitations of current diagnostic tools and introduces strategies for mental health assessment through a transcultural lens, focusing on effective screening and referral networks. A brief version of the Cultural Formulation Interview (CFI) from DSM-5 is provided to help build a shared understanding between the person seeking help and the professional. The unit also provides an in-depth exploration of suicide risk assessment in the context of migrant and refugee care.

Unit Sections:

1. Introduction

As seen in previous units, **mental health assessment in settings characterized by diversity presents a significant challenge**. Traditional assessment tools – which have been primarily developed in Western contexts – often struggle to accurately depict and understand mental health issues in individuals from diverse cultural and linguistic backgrounds. This gap highlights the pressing need for culturally sensitive and adaptable tools that account for the varied experiences of migrant and refugee populations.

This unit will offer an overview of recommendations that will help field workers approach the assessment of mental health needs in migrants and refugees from a place of cultural humility.

2. A Foundational Framework for Assessing Mental Health in Diverse Contexts

Psychosocial interventions with migrants and refugees often involve multiple stages, each requiring tailored approaches and specialized tools to effectively address the diverse needs of this population. Interdisciplinary collaboration is vital in these contexts, particularly where challenges are complex and resources are limited. In practice, this involves integrating expertise from health, education, legal, protection, and psychosocial domains to establish a coordinated, layered system of care. The delineation of roles and thoughtful integration of expertise across disciplines fosters a cohesive approach to ensuring appropriate actions are taken at every stage of the intervention. In this direction, the following framework highlights three foundational and interconnected steps in mental health assessment [1]:

1) **Screening & Assessment**, for which it is necessary to have **adequate instruments and frameworks** to help evaluate the following two steps. → *Assessment Tools and Frameworks*

This phase necessitates **culturally sensitive and appropriate assessment tools and frameworks to evaluate the specific needs and concerns of the individual**. Initial screenings and assessments are critical in determining whether the scope of the professional's expertise or the capabilities of a volunteer can adequately address these needs. **Assessment instruments should comprehensively cover domains such as physical and mental health, socio-economic stability, and access to legal and educational resources** [2].

2) **Intervention**, provided within **the framework of one's expertise** and **using confident intervention strategies.** → *Confident Professional Intervention Strategies*

Tailoring interventions to address the specific needs and concerns of the individual is crucial for facilitating adaptation to a new context and reducing migratory stress. This requires multidisciplinary approaches, including psychosocial counseling, employment and educational/integration programs, and legal assistance. **Intervention strategies should be relevant to the current challenges the individual is facing.** It is also important to recognize both our professional and personal limits.

3) **Referral**, **when supportive resources need to be mobilized** and **the intervention of other professionals is required.** → *Mobilization of Resources and Use of Referral Networks*

A well-informed professional or volunteer, working within an expansive network of resources, is better equipped to approach interventions with greater confidence, mitigating the isolation often encountered in complex real-life scenarios. **Service mapping must be conducted prior to screening and assessment to ensure the availability of effective referral pathways** [3]. Collaboration with civil society organizations, municipalities, and local authorities is essential to optimize support efforts. Establishing ongoing relationships with focal points across various agencies facilitates seamless referrals. Referral networks should include critical services such as **medical care, psychosocial support, legal advice, social counseling, cultural mediation, and employment assistance,** all of which are vital for the psychosocial well-being of migrants and refugees.

3. Implications for Diagnosis and Assessment

As discussed in Module 1, migrants and refugees are particularly vulnerable to mental health issues due to factors such as acculturation stress, language barriers, socio-economic difficulties, and experiences of adversity or discrimination. Distress can manifest differently across cultures, making it crucial for mental health professionals **to use assessment tools that are both culturally relevant and empirically validated**. To address these challenges, integrating cultural humility into the diagnostic process is essential. This involves **understanding cultural concepts of distress, ensuring linguistic accuracy, and considering cultural beliefs about mental health**. Additionally, **ongoing training for professionals** is necessary to recognize and mitigate biases, ensuring effective communication with individuals from diverse backgrounds. The following table outlines some recommended factors for selecting mental health screening tools in cross-cultural contexts [1,4].

Selecting Mental Health Screening Tools in Cross-Cultural Contexts	
Validity	Ensuring the tool measures what it intends to measure within the specific cultural context.
Reliability	Ensuring consistent and stable results across different administrations and cultural groups.
Linguistic Relevance	Ensuring that the language used in the tool is appropriate and understandable for the target population.
Cultural Sensitivity	Ensuring that the tool considers cultural differences and respects cultural norms and values.

Cross-Cultural Equivalence	Equivalence (i.e. the extent to which the tool accurately measures the same construct across different cultural groups) is a central criterion for comparing test results across different cultural groups and is aligned with the tests' reliability. To ensure this reliability when translating evaluation tests, full equivalence is necessary. This allows us to conclude that differences between populations reflect fundamental differences. • **Linguistic Equivalence** (i.e. through accurate translation) • **Cultural Equivalence** (i.e. same interpretation of the meaning of the items in a questionnaire or test despite of cultural and linguistic differences)

Note: Adapted from Galesmer, Brähler, & von Lersner, 2012, as cited in von Lersner & Kizilhan, 2017

Recognizing the ongoing limitations in the development of validated, reliable, multilingual, and culturally sensitive instruments, a list of recommended tests is provided in the 🕮 Repository (see 2.3 – Handout 1. "List of Recommended Tests"). These are included because they meet key criteria: they are proven to be relevant to the constructs they measure, and/or they are available in multiple languages. However, this is not an exhaustive or definitive list, as research and the development of effective tools remain an ongoing process.

◎ Key Point: ***A Note on Diagnosis and Clinical Assessment***

The clinical assessment of mental health conditions among migrants and refugees is fraught with significant **barriers that complicate accurate diagnosis and treatment**. These obstacles arise from a combination of factors. The following points outline key challenges in effectively assessing and addressing the mental health concerns of migrants and refugees [4]:

- **The absence of culturally responsive, reliable tools** for identifying common disorders across diverse migrant and refugee populations.
- **Inadequate screening processes,** including the use instruments not developed or validated in migrants and refugees.
- **Insufficient understanding of the prevalence, persistence, and costs of mental disorders among migrants and newly arrived refugees**, as well as **the cost-effectiveness of screening and treatment**.

- People's help-seeking behaviors may be influenced **by cultural or conceptual differences in health perceptions**.
- Existing disparities in mental health care in host countries are exacerbated for migrant and refugee populations due to **language barriers, stigma, a lack of culturally responsive providers, and challenges in service delivery**.
- **Difficulty in distinguishing between pre-existing psychiatric conditions and psychological issues arising from adversity**, leading to potential **misdiagnosis**.
- **Over-diagnosis resulting from cultural irrelevance**; certain behaviors perceived as severe psychopathology by Western practitioners (e.g., psychosis) may be better understood within the context of cultural, religious, or spiritual beliefs.

Migrants and refugees represent heterogeneous groups **who collectively experience many distressing psychological and somatic symptoms**. Theoretically, a screening instrument should include symptoms that optimally predict common disorders in multiple refugee groups with high efficiency. In practice, this is impossible given the complexities of these groups and the many factors in place affecting their experience.

4. Mental Health Assessment: The Cultural Formulation Interview (CFI)

As seen in Unit 2.1, depending on the explanatory model that an individual may have regarding certain challenges, combined with the potential stigma surrounding the expression of mental health issues, they may be more or less comfortable discussing intimate topics with healthcare professionals.

The Cultural Formulation Interview (CFI) was developed by the American Psychiatric Association as part of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) **to build communication bridges between the field worker and the person seeking help** [5]. The CFI is based on the work of Arthur Kleinman, a prominent psychiatrist and anthropologist. Kleinman's cultural formulation model emphasizes **the importance of understanding the cultural context in which mental health symptoms occur**, considering factors such as cultural identity, social context, and the meaning of illness within different cultural frameworks.

The CFI addresses the limitations of traditional, ethnocentric diagnostic tools that often fail to account for cultural variations in the expression and understanding of mental health issues. In response to the barriers mentioned in Unit 2.1 and earlier in this unit, which could hinder mental health professionals working in cross-cultural and transcultural contexts, the CFI offers several benefits:

- ***Enhanced Intercultural Competence:*** It equips professionals with a tool to understand and respect cultural differences, which may in turn lead to more accurate and empathetic assessments.
- ***Improved Patient-Clinician Relationship:*** It fosters trust and rapport by acknowledging and integrating cultural factors.
- ***Comprehensive Assessments:*** It ensures that cultural influences on mental health are systematically explored, providing a more holistic and nuanced understanding of the person's risks, protective, and promotive/resilience factors.
- ***Guidance for Tailored Interventions:*** Insights gained from the CFI can inform culturally appropriate intervention plans, increasing the likelihood of successful outcomes.

Below is a brief exploration adapted from the DSM-5's CFI. The full version can be found in the 🕮 Repository (see 2.3 – Handout 2. "Complete CFI in English").

Short Exploration adapted from DSM-5's Cultural Formulation Interview (CFI)	
Explanation	**Suggested Formulation**
Cultural Definition of the Problem *(Understand cultural definitions of the problem)*	
Elicit the individual's view of core problems and key concerns. Focus on the individual's own way of understanding the problem. Use the term, expression, or brief description elicited in the question on the side to identify the problem in subsequent questions (e.g., "your conflict with your son").	***What brings you here today?*** *People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would you describe your problem?*
Culturally Specific Perceptions of Possible Cause, Context, and Support Available to the Person Seeking Help *(Identify cultural perceptions of the cause, context, and support systems)*	

This question indicates the significance of the problem for the person, which could be relevant for clinical treatment. Note that individuals may identify multiple causes, depending on the aspect of the problem the individual is considering.	*Why do you think this has happened to you? What do you think are the causes of the problem?*
Focus on the views of the members of the person's social network. These may be different and may differ from those of the person.	*What do others in your family, your friends or other people in your environment think about the causes of your problem?*
Culturally Specific Factors that Affect Coping Strategies and Previous Requests for Help *(Explore factors affecting self-coping and past help-seeking behaviors)*	
Ask about different types of support options (e.g., medical treatment, psychiatric care, support groups, work-based counseling, folk medicine, religious or spiritual counseling, and other forms of traditional or alternative treatment).	*People often seek different types of help, including different doctors, helpers or healers. What types of treatment, help, counseling or healing have you sought in the past for your condition?*
Clarify the person's experience and evaluation regarding the help they received.	*Which types of help or treatment were the most helpful? Which were not?*
Culturally Specific Factors that Influence the Current Request for Help *(Recognize the impact of cultural factors on the relationship between the person and the professional)*	
Clarify the person's current perceived needs and expectations for help without limitations. Focus on the views of their social network regarding their help-seeking behavior.	*What types of help do you believe would be most helpful for your problem at this time?*
Explore any concerns related to the treatment facility or the doctor-patient relationship, including perceived racism, language barriers, or cultural differences that might affect their willingness to seek help, communication, or the quality of care.	*Have you ever been concerned about this, and is there anything we can do to ensure you receive the treatment you need?*

Note: Adapted from APA and Falkai et al., 2015, as cited in Lersner & Kizilhan, 2017

5. Suicide Risk Assessment: Key Aspects

As healthcare professionals, evaluating suicide risk among those displaced from their homelands is imperative. Systematic reviews and meta-analyses reveal that these populations experience significantly

higher rates of suicide and suicidal behaviors (such as attempts and ideation) than the general public. **Experiences of adversity and social isolation profoundly contribute to this heightened risk**. As seen in Module 1, **the vulnerability of these individuals is compounded by the intricate web of socioeconomic, cultural, and psychological challenges they face** [6,7,8]. A list of specific risk factors for suicide is provided in the 🕮 Repository (see 2.3 – Handout 3. "Risk Factors Associated with Suicide").

Yet, beyond a crisis-driven lens, it is vital to understand that **when individuals feel trapped in their circumstances, their distress often manifests in emotionally charged statements**, including expressions of suicidal intent. **These declarations are less about finality and more about communicating the depth of their pain and a desperate plea for recognition.** For professionals and volunteers alike, it is crucial to approach such moments with empathy, recognizing the gravity of the person's feelings [9,10].

The Role of Collective Responsibility in Suicide Prevention

In addressing suicide risk among migrants and refugees, it is important to recognize that **while healthcare professionals play a pivotal role, they are not alone in managing these complex situations**. Suicide prevention should not fall solely on the shoulders of individual practitioners; **it is a collective responsibility shared by organizations, communities, and networks of support**. The responsibility of safeguarding individuals at risk is embedded in structural frameworks that ensure resources and accountability are in place. Research emphasizes that healthcare systems must take proactive steps to identify and address suicide risk across various care settings. Unfortunately, many organizations fail to provide adequate support, leaving professionals to navigate these risks in isolation.

Suicide prevention should be considered part of **a broader, coordinated strategy that involves clear organizational responsibility, regular risk assessments, comprehensive care and aftercare protocols, and thorough follow-up**. The latter should also include appropriate referrals and rehabilitation services for the persons at risk, as well as support for those providing care. Professionals should be equipped with not only the skills but also **the institutional backing to effectively intervene**. Incorporating these elements ensures that no one professional bears the emotional and logistical burden of managing these scenarios alone.

Core Principles of Responding to Expressions of Suicidal Intent

In essence, when someone voices suicidal thoughts, they may be saying, *"The pain is so overwhelming, I cannot see a future"*. **Validating this pain** (acknowledging the individual's sense of being trapped) **can offer a sense of being seen and heard**. Statements such as, *"It sounds like this situation feels so overwhelming that alternatives are hard to see right now"*, reflect both empathy and acceptance of their experience. Additional recommendations for responding to expressions of suicidal intent are provided below [9].

When engaging with individuals who express suicidal thoughts, it is important to challenge damaging misconceptions. Suicidal expressions should never be dismissed as manipulative or theatrical. Framing such expressions as attention-seeking risks invalidating the individual's pain and deepening their isolation. Another common fallacy is the belief that discussing suicide increases the likelihood of action. On the contrary, evidence consistently demonstrates that **open conversations about suicide reduce stigma, alleviate anxiety, and encourage individuals to seek help** [9-12].

- **Maintain an open attitude.** Keep an open attitude towards culturally sensitive exploration to assess the individual's current risk, considering both taboos and protective factors, such as cultural or religious beliefs and attitudes regarding suicide. Ask the person if they are having thoughts about death in general. If suicide is because of religious or cultural reasons, a taboo for the client, it will be very difficult for the person to verbalize it since these thoughts will come together with guilt. Keep an open, empathic, and friendly conversation, avoiding judgments and at the same time showing understanding for the conflict that the person might feel [10].
- **Validate emotions.** Show understanding of these thoughts in the current life context. Demonstrating respect and comprehension towards these thoughts can strengthen the therapeutic relationship and promote trust.
- **Take the person seriously.** It is possible that in the context of a deportation threat, the individual may express a desire to die rather than return to their place of origin. Although these expressions may sometimes be perceived as attention-seeking or instrumentalization to stop the deportation,

it is important to remember that, in your role as a professional, you must take these expressions seriously and act within your scope of intervention: assess, intervene, refer.

- **Normalize.** Remember that thoughts related to death are part of the symptomatology of some clinical conditions, such as depression or PTSD. Nevertheless, it is not necessary to have a clinical diagnosis to experience suicidal thoughts. Convey to the person that they are not alone with these thoughts. Others in similar situations experience them, too. It is not a symptom of "madness" but an expression of despair in a difficult situation.
- **Reinforce and alleviate.** Praise your client for seeking help and finding the confidence to open up and talk about these thoughts. This is the first step in finding alternatives to suicide. They have done the right thing; reinforce this idea.
- **Use culturally sensitive assessment tools.** Evaluate possible underlying mental health issues to provide treatment and/or refer accordingly.
- **You are not alone; connect with and/or refer to other professionals.** If necessary, activate resources by referring the client to a more protective environment if the suicide risk is high and your intervention capacities have reached their limits. This could range from referring to a colleague with more experience and training to evaluate these aspects, to a health professional, a clinic, or emergency services depending on the risk and urgency to act.
- **Activate medium-term resources.** Once resources have been assessed, activate formal, informal or institutional resources by referring the individual to other professionals who can address aspects such as legal (e.g., related to immigration status), social (e.g., activating support groups), socioeconomic (e.g., employment or housing) or familial (e.g., resolving family conflicts) issues.

Considerations When Assessing Immediate Suicide Risk

Below are three fundamental questions to guide your assessment in cases of immediate suicide risk. These questions are not intended as a rigid checklist or a script for an interview but rather as **a framework to anchor your approach with sensitivity and discernment**. When possible, incorporate insights from the person's medical history or their caregivers, adapting your engagement to the unique contours of their experience. Trust and support are built through thoughtful adherence to the recommendations outlined above, which prioritize empathy and understanding [10].

Three Questions to Ask Yourself When Assessing Immediate Suicide Risk
Assessment Question #1: **Has the person recently attempted suicide or self-harm?**
• Intoxication or poisoning through alcohol, drugs, medication, or any other substance • Signs requiring urgent medical treatment (bleeding from a self-inflicted wound, loss of consciousness, extreme lethargy, etc.)
Assessment Question #2**: Is there an imminent risk of suicide or self-harm?**
Ask the person and/or carers about: • Thoughts or plans to suicide (current or in the past month) • Self-harm in the past • Access to means of suicide (e.g., pesticides, rope, weapons, knives, prescribed medications and drugs) **Detect alarm signs for acute suicide risk:** • Severely emotional distress or hopelessness • Violent behavior or extreme agitation • Withdrawal or unwillingness to communicate **Apply the 4-P's Modell** [12]: • **Past** suicide attempts • Suicide **plan** • **Probability** of completing suicide • **Protective factors**
Assessment Question #3: **Are there concurrent conditions associated with suicide or self-harm?**
Assess and manage possible concurrent conditions: • Chronic pain or disability (e.g. due to recent injuries incurred during the humanitarian emergency) • **Presence of key symptoms or diagnosed severe mental health issues** (e.g. moderate-severe depressive disorder, Psychosis, Harmful alcohol or drug use, post-traumatic stress disorder, *or acute* emotional distress *such as grief, acute stress, or other severe health conditions).*

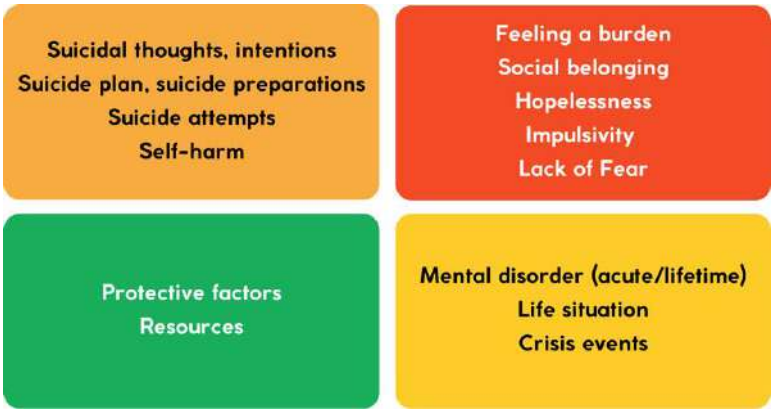
Note: Adapted from the WHO's mhGAP-HIG (2015)

Recognizing the Urgency of Intervention

Figure 2.2.3 on the following page uses a traffic light system to illustrate suicide risk levels. Each color corresponds to factors influencing risk: as more risk factors accumulate, the level of concern increases, guiding the urgency of intervention. It is important to note that risk and protective factors are correlated and cumulative. This means individuals with some risk factors are more likely to experience additional risks and may have fewer protective factors. This framework is intended for reference purposes only, to help

streamline the suicide risk assessment process. However, it is always essential to not make any decisions in isolation and discuss specific cases within the context of your team when unsure.

Figure 2.2.3. *"Protective and Risk Factors for Suicide Behavior"*



Green: represents protective factors, indicating low risk.

Yellow: signifies moderate risk from mental health issues or life crises.

Orange: highlights high-risk indicators like suicidal thoughts or behaviors.

Red: denotes severe risk linked to psychological and social factors.

Note. Adapted by the EU-MiCare team from general principles in Suicide Risk Assessment

Initiating the Conversation About Suicide

Talking about suicide and self-harm is never easy. Below are some suggested questions that can help break the ice and approach this delicate topic [12]. Again, the goal of these questions is not for them to be asked in a literal or interview-like manner. Instead, **it is recommended to create an empathic and respectful environment where the person feels safe to open up about their struggles**.

How to Talk About Suicide or Self-Harm
1. **Create a safe and private atmosphere for the person to share thoughts. Do not judge the person for being suicidal. Offer to talk with the person alone or with other people of their choice.**
2. **Use a series of questions where any answer naturally leads to another question. For example:** • Start with the present: *How do you feel?* • Acknowledge the person's feelings: *You look sad/upset. I want to ask you a few questions about it.* • *How do you see your future? What are your hopes for the future?* • *Sometimes people feel that life is not worth living. Can you tell me how you feel about your own life?* • *What are some of the aspects of your life that make it worth living?* • *What are some of the aspects of your life that may make you feel or think that your life is not worth living?* • *Do you find yourself wishing for a permanent escape from life?*

- *How would that happen for you? What might you do to achieve that?*
- *Do you think about your own death or about dying?*
- *Have you ever thought of harming yourself or trying to take your own life?*

3. If the person has expressed suicidal ideas, you may ask:

- *Do you think about hurting yourself?*
- *When did you begin to experience these thoughts and feelings?*
- *What happened before you had them?*
- *Have you made any plans to end your life?*
- *Have you considered when to do it? Have you ever attempted suicide?*
- *Can you stop yourself from having them by distracting yourself with an activity or other more positive thoughts?*
- *Have you ever acted upon these thoughts?*
- *If you have not acted upon them, how close do you feel you came to acting?*
- *What stopped you from acting on them?*
- *Do you think you might act on these thoughts of self-harm or suicide in the future?*
- *Do you have a plan to harm yourself or take your own life? Can you tell more about it?*
- *Do you have those methods available to you to take your life, such as over the counter pills, prescription pills, knives or proximity to a balcony, bridge or subway?*
- *If you did take your own life, what do you imagine would happen after you die to those people who are important to you?*

4. Assess protective factors by asking:

- *How do you feel about your own future?*
- *What would help you to feel or think more positively, optimistically or hopefully about your future?*
- *What would make it more (or less) likely that you would try to take your own life?*
- *What happens in your life to make you wish to die or to escape from life?*
- *What happens in your life to help you to want to live?*
- *If you began to have thoughts of harming or killing yourself again, what would you do to prevent them?*

Note: Adapted from the WHO's mhGAP-HIG (2015) [10] and the Registered Nurses' Association of Ontario (n.d.)

For a more comprehensive evaluation, the Columbia-Suicide Severity Rating Scale (C-SSRS), listed in the table of recommended assessment tools available in the 🕮 Repository (see 2.3 – Handout 1. "List of Recommended Tests"), provides a structured approach to assessing these four aspects of suicide risk. This tool is available in multiple languages, making it accessible for use across diverse populations. The C-SSRS is widely recognized for its clarity and effectiveness in evaluating suicidal ideation and behavior, offering a reliable framework to

Establishing a Verbal Agreement and Developing a Collaborative Safety Plan

When the suicide risk is moderate to high, establishing a verbal agreement and developing a collaborative plan can be an effective way to support the safety of a person experiencing suicidal thoughts or behaviors. **A plan aims to ensure safety and provide a proactive guide through moments of crisis, when emotional or psychological turmoil might impede clear thinking**. Typically, it captures coping strategies and specific steps to seek help when suicidal thoughts intensify. Whatever the format, this plan is co-created with the individual, emphasizing their autonomy and input in identifying what strategies resonate most with them when navigating distressing emotions [10].

At the core of this process is the option to introduce **a verbal agreement**. The agreement signifies **the person's commitment to remaining safe until the next meeting, with an understanding of the role available resources play in supporting their safety**. However, as outlined above, a verbal agreement does not place the responsibility solely on the individual. Instead, it recognizes that **safety is also the responsibility of a broader network – the healthcare system, mental health services, and the person's support structures all play their part**. This commitment to stay safe should be rooted in **the collective accountability of these systems**.

When a verbal agreement is made, it should be understood as a mutual, structural commitment between the person, their community, and the professionals involved, rather than an isolated promise from one individual. As part of this process, the following steps provide structure and clarity [9]:

1) **Introducing a Verbal Agreement**

The option of making a verbal agreement and a safety plan is presented, ensuring the person is in a state to commit to it (e.g., not under the influence of alcohol or other substances that could impair their judgment). Suggested wording: *"Some people experiencing similar difficulties find it helpful to make a verbal agreement. Would you like us to agree now, to ensure that you can stay safe until our next meeting?"*.

2) **Verbal Commitment to Safety**

The individual agrees to remain alive, safe, and unharmed until their next appointment, specifying the date and time. This agreement includes a verbal acknowledgment that they will not intentionally or unintentionally endanger their life and a commitment to use every available resource at their disposal to maintain their safety.

→ *This verbal agreement on behalf of the client should complement the development of a comprehensive safety plan, which is supported by the actions of providers. On their part, professionals must also commit to ensuring that mechanisms for safety and ongoing support are in place. These mechanisms include, and sometimes presuppose, several key components: mapping available services (including specific details such as the operating hours of emergency clinics or food banks, especially for individuals in precarious conditions), facilitating information-sharing across the organizational context while upholding strict confidentiality, mobilizing resources, and actively engaging the individual's carers or broader support network [10].*

3) Emergency Contact Plan

An emergency plan is collaboratively developed, identifying who the person will contact if their condition worsens. This list may include up to three trusted individuals (family members, friends, or support persons) and/or a mental health professional or institution. The person should have easy access to their emergency contacts, such as keeping a written note with names and phone numbers in their wallet or phone.

4) Agreement Confirmation

Both the field worker and the individual verbally confirm their understanding and acceptance of the agreement, ensuring clarity about their respective roles in the crisis plan.

5) Follow-Up

The individual is made aware of the time and location of their next appointment, with encouragement to utilize the agreed-upon emergency contacts or crisis resources if needed before the meeting.

The verbal commitment is just one element within the broader collaborative safety planning process, yet a crucial one to establish a sense of safety and shared responsibility. It may prove especially effective when language barriers or educational differences make written documents difficult to understand. Safety planning may also include identifying a range of strategies tailored to the person's unique needs and concerns, such as soothing techniques for distressing emotions, self-care practices, maintaining a

nutritious diet, setting healthy boundaries, and creating consistent sleep routines. These elements collectively form **a "toolbox" that the person can access when facing heightened and difficult emotions**.

No two safety plans are the same; they must remain flexible and responsive, evolving alongside the individual's shifting circumstances. In this view, **safety plans are not bound by rigid or predetermined templates but are instead dynamic, living documents that adapt to the complexities and evolving circumstances of each person's journey**.

Regular check-ins are crucial to maintaining trust and adjusting the plan as needed. Providers should encourage revisiting the safety plan during follow-up sessions to ensure it remains relevant and effective. Equally important is approaching this process with cultural sensitivity. If the individual struggles with the term 'suicide' due to cultural taboos or personal discomfort, reframing the plan as a resource "to keep them safe" or "to navigate moments of crisis" can make it more accessible and supportive [12].

To enhance the utility of a safety plan, it is important to offer formats that align with the individual's preferences and access needs. For some, a tangible paper copy may serve as a reliable resource, while others might benefit more from electronic or application-based tools, or a simple photo stored on their phone for easy reference. Whatever the format, the provider should maintain a documented copy, ensuring seamless transitions of care. Standardized protocols for storing, reviewing, and updating safety plans should be established within organizational structures **to prevent redundancy and reduce the emotional toll of recounting distressing experiences repeatedly, which individuals often face** [10].

When a person experiences suicidal thoughts but is not in immediate danger and possesses sufficient coping resources, emergency interventions or hospitalization may not be necessary. In these cases, collaboratively developing a safety plan can be invaluable. Such plans guide both the professional and the individual in navigating moments of acute distress. However, **it is crucial to ensure that a safety or 'crisis' plan is only implemented for individuals who do not have a concrete suicide plan, intent, or impulsive behaviors**. If the individual cannot guarantee adherence to the plan, the situation necessitates activating additional support systems, such as emergency services or hospitalization, depending on the resources available in your country.

The following table provides a structure to help individuals identify their coping strategies and establish clear steps for seeking support based on their capacity to manage distressing thoughts.

Steps for a Crisis Plan to Cope with Acute Suicidal Thoughts
1. Identification of warning signs of a suicidal crisis. *How will you notice that it's time to use/activate the emergency plan?*
2. Coping strategies that can be used independently. *What actions can you take on your own to manage these thoughts and avoid acting on them?*
3. People and social situations that distract you from these thoughts. *Are there individuals or social settings that can help redirect your thoughts? Are there places where you feel safe and secure?*
4. Supportive individuals you can reach out for help. *Who can you reach out to for emotional support or to share your difficulties?*
5. Contacts to professional help centers

Note: Adapted from Stanley, B., & Brown, G. K. (2012)

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Unit 2.4: Psychological First Aid (PFA)

Unit Overview
This unit is designed to enhance the ability of participants to recognize and assess crises and effectively implement Psychological First Aid (PFA) within the context of migration. The primary goal is to promote and safeguard the mental health and psychosocial well-being of migrants and refugees. Through discussion of the core principles, key practices, and various modes of application of PFA, participants will be better equipped to create an inclusive and supportive environment for the individuals they work with. This will enable them to respond effectively and empathetically to the diverse mental health needs that may arise in this population.

Unit Sections:

1. Introduction

When distressing events occur – such as natural disasters, accidents, fires, or incidents of interpersonal violence (e.g., sexual violence) – individuals, families, and entire communities can be profoundly affected [1,2]. Individual reactions to these events vary substantially, as each person processes these events differently. While some may feel overwhelmed, confused, or uncertain about what is happening, others may experience fear, anxiety, numbness, or emotional detachment. Reactions can range from mild to severe, depending on the individual and the circumstances. And while people are innately resourceful and capable of coping with life's challenges, some individuals may be particularly vulnerable during a crisis and require additional support [1]. The primary purpose of Psychological First Aid (PFA), that will be explored further in this unit, is to assist those in distress through the provision of emotional and practical support in

the immediate aftermath of a traumatic event [2]. In such situations, anyone may find themselves in a position to offer this critical help.

Psychological First Aid (PFA) is designed to help people feel calmer, safer, and more secure. It is a compassionate and supportive approach that focuses on addressing both emotional and practical needs. PFA is grounded in the understanding that, in times of crisis, people may experience overwhelming emotions that diminish their ability to cope [1,2]. Through active listening and steady communication with the person in distress, the helper works to identify their immediate needs and support them to regain a sense of control [2].

2. Definition of Psychological First Aid (PFA): Purpose and Components

Definition of PFA

Psychological First Aid (PFA) **involves a humane, supportive response to individuals who are suffering and in need of assistance**. It encompasses the following practices and principles [1,2]:

- Providing practical care and support without being intrusive
- Assessing needs and concerns to determine appropriate help
- Addressing basic needs, such as access to food and water
- Listening to people without pressuring them to talk
- Comforting people and helping them to feel calm
- Connecting people to information, services, and social support networks
- Protecting individuals from further harm and distress

It is also important to clarify what PFA is <u>NOT</u>:

- It is not an approach reserved only for professionals
- It is not professional counseling or therapy
- It does not entail asking someone to discuss or analyze the distressing event
- It does not involve pressing individuals for details about what happened

- It does not entail a detailed discussion of the distressing event
- It does not mean pressuring people to share their feelings and reactions to the event.

PFA: Who, When, and Where?

WHO can provide PFA?	*Anyone in the field can provide PFA* – volunteers, first responders, members of the public. It is not limited to mental health specialists or those with specific expertise.
WHO is PFA for?	*PFA is for people who are experiencing distress following exposure to a crisis*. It can be provided to both children and adults. However, not everyone will need or want PFA. **Do not force** help on people who do not want it, but ensure that you are easily accessible to those who may seek support.
WHEN is PFA provided?	PFA is aimed at helping people *who have been very recently affected by a distressing event,* and is usually provided *during or immediately after the event*. However, it may sometimes be required days or even weeks later, depending on the duration of the event, its severity, and the individual's response.
WHERE is PFA provided?	PFA is provided in *settings where it is safe enough for both you and the people you are working with*. This may include community spaces such as the site of an accident, health centers, shelters, camps, schools, or distribution points for food and other aid. PFA should also be offered *in settings where there is privacy to talk to the individual receiving support*. For people who have been exposed to certain types of crisis events, such as sexual violence, privacy is essential to maintain confidentiality and preserve the person's dignity.

Note: Reproduced by the EU-MiCare team based on information by the World Health Organization (2011, 2013) and the IFRC Reference Centre for Psychosocial Support (2018)

3. Guidelines of PFA in Different Crises: "Look, Listen, Link"

Definition of Crisis and Crisis Events

Crisis is defined as: *"An unstable condition involving an impending abrupt or significant change that requires urgent attention and action to protect life, assets, property or the environment"* [4]. PFA can be beneficial in a wide range of situations where individuals are experiencing suffering or distress. In each of these contexts, PFA can be applied with a tailored approach, using specific guidelines to address the unique needs of those affected. Crises are categorized into the following types [2]:

Personal Crises	Most people will face a crisis at some point, whether that entails being in a car accident, losing a job, or experiencing the death of a loved one. Personal crises can produce a wide variety of responses, depending on the circumstances and their impact on the individual.
Social Challenges	Staff and volunteers support individuals and groups of people who are marginalized and experience social isolation.
Health Challenges	National Societies in most countries around the world are involved in health-related activities, including conducting trainings, providing PFA, and supporting people living with physical and mental disabilities.
Natural Disasters	Disasters such as earthquakes, floods and fires often affect large numbers of people at once. These events can cause widespread environmental damage and result in significant loss of lives and homes.
Man-Made Disasters	Many disasters are the result of human behavior, including fires, explosions in factories or mines, massive accidents involving transport vehicles, or panic situations at festivals when stages collapse.
Violence	Many people witness or experience violence, in domestic conflicts, sexual and gender-based violence, criminal violence, gang-related violence, hate crimes, and stigma-based violence, etc.
Displacement	More people are migrating around the world than ever before, and the reasons for global migration are highly varied.

Note: Reproduced by the EU-MiCare team from IFRC Reference Centre for Psychosocial Support (2018)

"Look, Listen, Link"

The three basic action principles of PFA are look, listen, and link. These action principles will help guide you to safely enter a crisis, approach affected people and understand their needs, and link them with practical support and information [1-3,5]:

"LOOK"

- Assess what has happened or is happening.
- Determine who needs help and evaluate safety and security risks.
- Check for physical injuries and identify immediate, practical needs.
- Assess emotional reactions.

"LISTEN"

- Be attentive and listen actively, accept the emotions of the person in distress.
- Try to create an environment of calm for them.
- Inquire about the person's immediate needs and concerns to address the most pressing sources of distress.

"LINK"

- Help the person who is in distress to access key information.
- Connect them with loved ones and individuals who can help them tackle practical problems.
- Put them in touch with social support services.

Do's and Don'ts of Effective Communication

To foster a safe environment and ensure effective communication, some strategies can be applied [1,7].

THINGS TO SAY AND DO ✓	THINGS NOT TO SAY AND DO X
• Try to find a quiet place to talk, and minimize outside distractions. • Respect privacy and keep the person's story confidential, if this is appropriate. • Stay near the person but keep an appropriate distance depending on their age, gender, and culture. • Let them know you are listening: for example, nod your head or say "hmmmm…" • Be patient and calm. • Provide factual information, if you have it. Be honest about what you know and don't know. "I don't know, but I will try to find out about that for you." • Give information in a way the person can understand – keep it simple. • Acknowledge how they are feeling and any losses or important events they tell you about, such as loss of their home or death of a loved one. "I'm sorry. I can imagine this is very sad for you." • Acknowledge the person's strengths and how they have helped themselves. • Allow for silence.	• Don't pressure someone to tell their story. • Don't interrupt or rush someone's story (for example, don't look at your watch or speak too rapidly). • Don't touch the person if you're not sure it is appropriate to do so. • Don't judge what they have or haven't done, or how they are feeling. Don't say: "you shouldn't feel that way", or "you should feel lucky you survived". • Don't make up things you don't know. • Don't use terms that are too technical. • Don't tell them someone else's story. • Don't talk about your own troubles. • Don't give false promises or false reassurances. • Don't think and act as if you must solve all the person's problems for them. • Don't take away the person's strength and sense of being able to care for themselves. • Don't talk about people in negative terms (for example, don't call them "crazy" or "mad").

Note: Adapted by the EU-MiCare team from the World Health Organization (2011). *Psychological first aid: Guide for field workers.*

→ **VIDEO:** *What is PFA?* 💻

Special Considerations in PFA Delivery

In order for PFA to be compassionate but also contextually relevant and impactful, it is important to recognize the distinct challenges faced by specific groups [1]. Children and adolescents, for instance, are especially vulnerable due to their ongoing emotional and psychological development. Their needs extend beyond immediate safety and comfort, requiring interventions that nurture long-term resilience and stability. Likewise, individuals living with health conditions or disabilities encounter compounded hardships, as the upheaval of displacement often disrupts access to essential care and support. Those at heightened risk of discrimination or violence form another group requiring particular care. As seen in Unit 2.2, experiences of marginalization, whether based on ethnicity, gender, or other factors, can significantly intensify the psychological toll of displacement. For these individuals, PFA must integrate physical and psychological considerations, as well as efforts at the societal level (i.e., mediation and advocacy) that address the underlying inequities and vulnerabilities that shape their experiences.

Often, the implementation of PFA is complicated by the diversity of available frameworks. While the WHO's guidelines serve as a foundational reference, numerous adaptations have emerged, each designed to meet the unique needs of specific populations or contexts [6]. This has led to a rich heterogeneity of approaches, reflecting the complexity of human experiences in crises. This diversity, though challenging, is also one of PFA's greatest strengths. It allows practitioners to select models that align closely with the cultural, social, and individual characteristics of the people they serve. Ultimately, the effectiveness of PFA lies in its adaptability and responsiveness, acknowledging that while suffering may be a shared human experience, the pathways to healing are deeply personal and varied.

4. A Case Scenario of PFA for Reflective Practice

"Refugees arrive at a new location, transported in trucks, and are informed that this will now be their home. They have been relocated due to the conflict that drove them from their previous communities. As they step off the trucks, a range of emotions is evident – some are crying and visibly fearful, others appear disoriented, while a few sigh with relief. For most, fear and uncertainty dominate; they are unsure of where they will sleep, eat, or access healthcare. The sharp sound

of any loud noise startles some, evoking fears of gunfire. You are a volunteer with an agency that distributes food items and have been asked to help at distribution sites."

As you prepare to help, **consider what you would like to know** about this situation. Ask yourself:

- Who are the people I will be helping?
- What is their cultural background?
- Are there any rules of conduct or customs I need to follow? For example, is it more appropriate for women helpers to speak with women refugees?
- How far have they traveled?
- What do I know about the conflict they have experienced?
- What services are being provided in the place where the refugees are being received?
- If I am working on a team, how will we organize ourselves to help in this situation? What tasks will each person take on? How will we coordinate with each other and with other groups of helpers who may be there?

Upon **encountering** a group of refugees, what should you **LOOK** for?

- What will most of the refugees need?
- Will they be hungry, thirsty, or tired? Is anyone injured or ill?
- Are there families or people from the same village within the refugee group? Are there any unaccompanied children or adolescents?
- Who else may need special help? Individuals in the refugee group seem to be having different types of reactions to the crisis. What kinds of emotional responses do you see?

As you **approach** people in the refugee group, how can you best **LISTEN** to their concerns?

- How should I introduce myself before offering support?
- People who have experienced or witnessed violence may be very frightened and feel unsafe. How can I support them and help them feel calm?
- How can I identify the needs and concerns of people who may need special help, such as women?
- How will I approach and help unaccompanied children and adolescents?

What can you do to **LINK** people with **information and practical support**?

- What basic needs may people have?
- What support services are available that may be useful?
- How can people access them?
- When and where can people find more information about what is causing this event?
- How can I help to protect vulnerable people, such as women or unaccompanied children, from further harm?
- How can I help link vulnerable people with loved ones and services?
- What special needs might people have, including those who have been exposed to violence? What can I do to connect people with their loved ones or services?

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Repository

Module 2. Improving Skills on Recognizing & Assessing Migrants' Mental Health Needs

The information provided hereafter is supplementary and not part of the core material of this Module.

However, learners seeking a more thorough understanding of the subject matter are strongly advised to review this document in addition to the main curriculum.

Unit: 2.1 Understanding the Influence of Culture on Mental Health and Mental Health Promotion

Handout 1: *"List of Idioms of Distress"*

With the introduction of the DSM-IV in 1994, culture-bound syndromes were officially recognized in psychiatric classification for the first time. The DSM-5 (2013) revised and expanded this section, shifting from viewing culture as region-based to understanding it as a dynamic, broader concept [1,2].
The DSM-5 defines three types of cultural concepts of distress:

1. *Cultural syndromes* - Symptom patterns commonly found in specific cultural contexts, recognized locally as meaningful illness experiences.
2. *Cultural idioms of distress* - Shared ways of expressing suffering that may not align with specific diagnoses, reflecting how individuals talk about personal or social distress.
3. *Cultural explanations or perceived causes* - Culturally shaped beliefs about the origin or meaning of symptoms or illness.

An appendix in the DSM-5 [2] includes a glossary of well-documented cultural concepts of distress, highlighting their clinical relevance and the relationships between syndromes, idioms, and cultural explanations. This glossary is reproduced in Table 2.1.1.-R: "Glossary of Cultural Concepts of Distress" below.

We recommend field workers to view this glossary not as a fixed or universal reference, but as a set of examples to guide awareness and inquiry. Culture and language are constantly evolving; idioms may vary across generations, social groups, or regions, and their meanings may shift over time. Field workers should remain open and curious, especially when encountering unfamiliar expressions or forms of distress. Engaging with individuals to co-create a shared understanding of their experience-rather than relying solely on predefined terms-helps ensure more respectful and accurate support. Ultimately, the glossary is a starting point, not a substitute for culturally sensitive, person-centered engagement.

Table 2.1.1.-R: "Glossary of Cultural Concepts of Distress"

Idiom/Syndrom	Description
Ataque de nervios ***Related conditions in other cultural contexts:*** *Indisposition* in Haiti, blacking out in the Southern United States, and *falling out* in the West Indies. ***Related conditions in DSM-5:*** Panic attack, panic disorder, other specified or unspecified dissociative disorder, conversion (functional neurologic symptom) disorder, intermittent explosive disorder, other specified or unspecified anxiety disorder, other specified or unspecified trauma and stressor-related disorder.	*Ataque de nervios* ("attack of nerves") is a syndrome among individuals of **Latino descent**, characterized by symptoms of intense emotional upset, including acute anxiety, anger, or grief; screaming and shouting uncontrollably; attach of crying; trembling; heat in the chest rising into the head; and becoming verbally and physically aggressive. Dissociative experiences (e.g., depersonalization, derealization, amnesia), seizure-like or fainting episodes, and suicidal gestures are prominent in some *ataques* but absent in others. A general feature of an *ataque de nervios* is a sense of being out of control. Attacks frequently occur as a direct result of a stressful event relating to the family, such as news of the death of a close relative, conflicts with a spouse or children, or witnessing an accident involving a family member. For a minority of individuals, no particular social event triggers their *ataques*; instead, their vulnerability to losing control comes from the accumulated experience of suffering. No one-to-one relationship has been found between *ataque* and any specific psychiatric disorder, although several disorders, including panic disorder, other specified or unspecified dissociative disorder, and conversion disorder, have symptomatic overlap with *ataque*. In community samples, *ataque* is associated with suicidal ideation, disability, and outpatient psychiatric utilization, after adjustment for psychiatric diagnoses, traumatic exposure, and other covariates. However, some *ataques* represent normative expressions of acute distress (e.g., at a funeral) without clinical sequelae. The term *ataque de nervios* may also refer to an idiom of distress that includes any "fit"-like paroxysm of emotionality (e.g., hysterical laughing) and may be used to indicate an episode of loss of control in response to an intense stressor.

Dhat sydnrome ***Related conditions in other cultural contexts:*** *koro* in Southeast Asia, particularly Singapore and *shen-k'uei* ("kidney deficiency") in China. ***Related conditions in DSM-5:*** Major depressive disorder, persistent depressive disorder (dysthymia), generalized anxiety disorder, somatic symptom disorder, illness anxiety disorder, erectile disorder, early (premature) ejaculation, other specified or unspecified sexual dysfunction, academic problem.	*Dhat syndrome* is a term that was coined in **South Asia** little more than half a century ago to account for common clinical presentations of young male patients who attributed their various symptoms to semen loss. Despite the name, it is not a discrete syndrome but rather a cultural explanation of distress for patients who refer to diverse symptoms, such as anxiety, fatigue, weakness, weight loss, impotence, other multiple somatic complaints, and depressive mood. The cardinal feature is anxiety and distress about the loss of *dhat* in the absence of any identifiable physiological dysfunction. *Dhat* was identified by patients as a white discharge that was noted on defecation or urination. Ideas about this substance are related to the concept of *dhatu* (semen) described in the Hindu system of medicine, Ayurveda, as one of seven essential bodily fluids whose balance is necessary to maintain health. Although *dhat syndrome* was formulated as a cultural guide to local clinical practice, related ideas about the harmful effects of semen loss have been shown to be widespread in the general population, suggesting a cultural disposition for explaining health problems and symptoms with reference to *dhat syndrome*. Research in health care settings has yielded diverse estimates of the syndrome's prevalence (e.g., 64% of men attending psychiatric clinics in India for sexual complaints; 30% of men attending general medical clinics in Pakistan). Although *dhat syndrome* is most commonly identified with young men from lower socioeconomic backgrounds, middle-aged men may also be affected. Comparable concerns about white vaginal discharge (leu-korrhea) have been associated with a variant of the concept for women.
Khyal cap ***Related conditions in other cultural contexts:*** Laos (*pen lom*), Tibet (*srog rlunggi nad*), Sri Lanka (*vata*), and Korea (*hwa byung*).	"Khyal attacks" (*khyâl cap*), or "wind attacks," is a syndrome found among **Cambodians in the United States and Cambodia**. Common symptoms include those of panic attacks, such as dizziness, palpitations, shortness of breath, and cold extremities, as well as other symptoms of anxiety and autonomic arousal (e.g., tinnitus and neck soreness). Khyâl attacks include catastrophic cognitions centered on the concern that *khyâl* (a windlike substance) may rise in the body—along with blood—

Related conditions in DSM-5: Panic attack, panic disorder, generalized anxiety disorder, agoraphobia, posttraumatic stress disorder, illness anxiety disorder.	and cause a range of serious effects (e.g., compressing the lungs to cause shortness of breath and asphyxia; entering the cranium to cause tinnitus, dizziness, blurry vision, and a fatal syncope). Khyâl attacks may occur without warning, but are frequently brought about by triggers such as worrisome thoughts, standing up (i.e., orthostasis), specific odors with negative associations, and agoraphobic-type cues like going to crowded spaces or riding in a car. Khyâl attacks usually meet panic attack criteria and may shape the experience of other anxiety and trauma- and stressor-related disorders. *Khyâl* attacks may be associated with considerable disability.
Kufungisisa ***Related conditions in other cultural contexts:*** "'Thinking too much" is a common idiom of distress and cultural explanation across many countries and ethnic groups. It has been described in Africa, the Caribbean and Latin America, and among East Asian and Native American groups. ***Related conditions in DSM-5:*** Major depressive disorder, persistent depressive disorder (dysthymia), generalized anxiety disorder, posttraumatic stress disorder, obsessive-compulsive disorder, persistent complex bereavement disorder.	*Kufungisisa* ("thinking too much" in Shona) is an idiom of distress and a cultural explanation among the **Shona of Zimbabwe.** As an explanation, it is considered to be causative of anxiety, depression, and somatic problems (e.g., "my heart is painful because I think too much"). As an idiom of psychosocial distress, it is indicative of interpersonal and social difficulties (e.g., marital problems, having no money to take care of children). *Kufungisisa* involves ruminating on upsetting thoughts, particularly worries. *Kufungisisa* is associated with a range of psychopathology, including anxiety symptoms, excessive worry, panic attacks, depressive symptoms, and irritability. In a study of a random community sample, two-thirds of the cases identified by a general psychopathology measure were of this complaint. In many cultures, "thinking too much" is considered to be damaging to the mind and body and to cause specific symptoms like headache and dizziness. "Thinking too much" may also be a key component of cultural syndromes such as "brain fag" in Nigeria. In the case of brain fag, "thinking too much" is primarily attributed to excessive study, which is considered to damage the brain in particular, with symptoms including feelings of heat or crawling sensations in the head.

Maladi moun ***Related conditions in other cultural contexts:*** Concerns about illness (typically, physical illness) caused by envy or social conflict are common across cultures and often expressed in the form of "evil eye" (e.g. in Spanish, *mal de ojo*, in Italian, *mal'occhiu*). ***Related conditions in DSM-5:*** Delusional disorder, persecutory type; schizophrenia with paranoid features.	*Maladi moun* (literally "humanly caused illness," also referred to as "sent sickness") is a cultural explanation in Haitian communities for diverse medical and psychiatric disorders. In this explanatory model, interpersonal envy and malice cause people to harm their enemies by sending illnesses such as psychosis, depression, social or academic failure, and inability to perform activities of daily living. The etiological model assumes that illness may be caused by others' envy and hatred, provoked by the victim's economic success as evidenced by a new job or expensive purchase. One person's gain is assumed to produce another person's loss, so visible success makes one vulnerable to attack. Assigning the label of sent sickness depends on mode of onset and social status more than presenting symptoms. The acute onset of new symptoms or an abrupt behavioral change raises suspicions of a spiritual attack. Someone who is attractive, intelligent, or wealthy is perceived as especially vulnerable, and even young healthy children are at risk.
Nervios ***Related conditions in other cultural contexts:*** *Nevra* among Greeks in North America, *nierbi* among Sicilians in North America, and *nerves* among whites in Appalachia and Newfoundland. ***Related conditions in DSM-5:*** Major depressive disorder, persistent depressive disorder (dysthymia), generalized anxiety disorder, social anxiety disorder, other specified or unspecified dissociative disorder, somatic symptom disorder, schizophrenia.	*Nervios* ("nerves") is a common idiom of distress among Latinos in the United States and Latin America. Refers both to a general state of vulnerability to stress and to a syndrome evoked by difficult life circumstances. *Nervios* includes a wide range of symptoms of emotional distress, somatic disturbance, and inability to function. Common symptoms include headaches and "brain aches," irritability, stomach disturbances, sleep difficulties, nervousness, tearfulness, inability to concentrate, trembling, tingling sensations, and *mareos* (dizziness with occasional vertigo-like exacerbations). *Nervios* tends to be an ongoing problem, although it is variable in the degree of disability manifested. *Nervios* is a broad syndrome that ranges from cases free of a mental disorder to presentations resembling adjustment, anxiety, depressive, dissociative, somatoform, or psychotic disorders. Differential diagnosis depends on the constellation of symptoms, the kind of social events associated with onset and progress, and the level of disability experienced.

Shenjing shuairuo ***Related conditions in other cultural contexts:*** Neurasthenia-spectrum idioms and syndromes are present in India *(ashaktapanna)* and Japan *(shinkei-suijaku)*, among other settings. Other conditions, such as brain fag syndrome, burnout syndrome, and chronic fatigue syndrome, are also closely related. ***Related conditions in DSM-5:*** Major depressive disorder, persistent depressive disorder (dysthymia), generalized anxiety disorder, somatic symptom disorder, social anxiety disorder, specific phobia, posttraumatic stress disorder.	*Shenjing shuairuo* ("Weakness of the nervous system" in **Mandarin Chinese**) is a cultural syndrome that integrates conceptual categories of traditional Chinese medicine with the Western diagnosis of neurasthenia. In the second, revised edition of the Chinese Classification of Mental Disorders (CCMD-2-R), *shenjing shuairuo* is defined as a syndrome composed of three out of five nonhierarchical symptom clusters: weakness (e.g., mental fatigue), emotions (e.g., feeling vexed), excitement (e.g., increased recollections), nervous pain (e.g., headache), and sleep (e.g., insomnia). *Fan nao* (feeling vexed) is a form of irritability mixed with worry and distress over conflicting thoughts and unfulfilled desires. The third edition of the CCMD retains *shenjing shuairuo* as a somatoform diagnosis of exclusion. Salient précipitants of *shenjing shuairuo* include work- or family-related stressors, loss of face (*mianzi, lianzi*), and an acute sense of failure (e.g., in academic performance). *Shenjing shuairuo* is related to traditional concepts of weakness (*xu*) and health imbalances related to deficiencies of a vital essence (e.g., the depletion of *qi* [vital energy] following overstraining or stagnation of qi due to excessive worry). In the traditional interpretation, *shenjing shuairuo* results when bodily channels (*jing*) conveying vital forces (*shen*) become dysregulated as a result of various social and interpersonal stressors, such as the inability to change a chronically frustrating and distressing situation. Various psychiatric disorders are associated with *shenjing shuairuo*, notably mood, anxiety, and somatic symptom disorders. In medical clinics in China, however, up to 45% of patients with *shenjing shuairuo* do not meet criteria for any DSM-IV disorder.
Susto ***Related conditions in other cultural contexts:*** Similar etiological concepts and symptom configurations are found globally. In the Andean region, *susto* is referred to as *espanto*.	*Susto* ("fright") is a cultural explanation for distress and misfortune prevalent among some **Latinos** in the United States and among people in **Mexico, Central America, and South America**. It is not recognized as an illness category among Latinos from the Caribbean. *Susto* is an illness attributed to a frightening event that causes the soul to leave the body and results in unhappiness and sickness, as well as difficulties functioning in key social roles. Symptoms may appear any time from days to years after the fright is experienced. In extreme cases, *susto* may result in death. There are no

Related conditions in DSM-5: Major depressive disorder, posttraumatic stress disorder, other specified or unspecified trauma and stressor-related disorder, somatic symptom disorders.	specific defining symptoms for *susto*; however, symptoms that are often reported by people with *susto* include appetite disturbances, inadequate or excessive sleep, troubled sleep or dreams, feelings of sadness, low self-worth or dirtiness, interpersonal sensitivity, and lack of motivation to do anything. Somatic symptoms accompanying *susto* may include muscle aches and pains, cold in the extremities, pallor, headache, stomachache, and diarrhea. Precipitating events are diverse, and include natural phenomena, animals, interpersonal situations, and supernatural agents, among others. Three syndromic types of *susto* (referred to as cibih in the local Zapotec language) have been identified, each having different relationships with psychiatric diagnoses. An interpersonal *susto* characterized by feelings of loss, abandonment, and not being loved by family, with accompanying symptoms of sadness, poor self-image, and suicidal ideation, seemed to be closely related to major depressive disorder. When *susto* resulted from a traumatic event that played a major role in shaping symptoms and in emotional processing of the experience, the diagnosis of posttraumatic stress disorder appeared more appropriate. *Susto* characterized by various recurrent somatic symptoms—for which the person sought health care from several practitioners—was thought to resemble a somatic symptom disorder.
Taijin kyofusho ***Related conditions in other cultural contexts:*** *Taein kong* po in Korea. ***Related conditions in DSM-5:*** Social anxiety disorder, body dysmorphic disorder, delusional disorder, obsessive-compulsiveisorder, olfactory reference	Taijin kyofusho ("interpersonal fear disorder" in **Japanese**) is a cultural syndrome characterized by anxiety about and avoidance of interpersonal situations due to the thought, feeling, or conviction that one's appearance and actions in social interactions are inadequate or offensive to others. In the United States, the variant involves having an offensive body odor and is termed olfactory reference syndrome. Individuals with *taijin kyofusho* tend to focus on the impact of their symptoms and behaviors on others. Variants include major concerns about facial blushing (erythrophobia), having an offensive body odor (olfactory reference syndrome), inappropriate

syndrome (a type of other specified obsessive-compulsive and related disorder). Olfactory reference syndrome is related specifically to the *jikoshu-kyofu* variant *of taijin kyofusho*, whose core symptom is the concern that the person emits an offensive body odor. This presentation is seen in various cultures outside Japan.	gaze (too much or too little eye contact), stiff or awkward facial expression or bodily movements (e.g., stiffening, trembling), or body deformity. *Taijin kyofusho* is a broader construct than social anxiety disorder in DSM-5. In addition to performance anxiety, *taijin kyofusho* includes two culture-related forms: a "sensitive type," with extreme social sensitivity and anxiety about interpersonal interactions, and an "offensive type," in which the major concern is offending others. As a category, *taijin kyofusho* thus includes syndromes with features of body dysmorphic disorder as well as delusional disorder. Concerns may have a delusional quality, responding poorly to simple reassurance or counterexample. The distinctive symptoms of *taijin kyofusho* occur in specific cultural contexts and, to some extent, with more severe social anxiety across cultures. Similar syndromes are found in Korea and other societies that place a strong emphasis on the self-conscious maintenance of appropriate social behavior in hierarchical interpersonal relationships. *Taijin kyofusho*-like symptoms have also been described in other cultural contexts, including the United States, Australia, and New Zealand.

Note: American Psychiatric Association. (2013). Glossary of cultural concepts of distress. In *Diagnostic and statistical manual of mental disorders* (5th ed., pp. 833–837). American Psychiatric Publishing. https://doi.org/10.1176/appi.books.9780890425596

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Unit: 2.2 Intersectionality

Handout 1: *"A Non-Exhaustive List of Characteristics"*

Based on relevant research [1-7] below you will find a tentative, non-exhaustive list of dimensions that can be especially relevant for refugees and migrants and how they can play a positive/negative role for them.

- **Gender:** generally speaking, the life experiences of individuals are always gendered and this is true for any setting. Concerning refugees and migrants in particular, gender can be e.g. relevant in shaping experiences in the country of origin (e.g. specific oppression and lack of freedom for women in some countries of origin) and during the flight/migration process (e.g. women are generally more exposed to gender-based violence). On the other hand, life in the destination country can coincide with a re-negotiation of gender roles within the family and with new opportunities for all genders.
- **Race/Ethnicity:** these elements are especially relevant regarding exposure to discrimination and racism. Among refugees and migrants, those who are easily labeled as foreigners (e.g. because of their skin color or appearance) are more exposed to discrimination, racist violence etc. These elements, in turn, can have a great impact on how the person feels in the migration country, his/her willingness and ability of participation in the migration society. Race/ethnicity may play a role also in the country of origin, e.g. in case of an ethnic minority.
- **Class**: class is central for the experiences of refugees and migrants in their countries of origin, as class belonging influences education, access to resources, economic situation etc. These factors, in turn, enable some people to leave their country more easily or comfortably than others, or to leave at all when those belonging to the poorest social class might not have this option. Although the flight/migration experience and arrival in a new country often levels the class differences in some ways (e.g. because all asylum seekers/refugees are accommodated in the same facilities and undergo the same legal processes), these persist concerning the immaterial aspects (e.g. knowledge of foreign languages, education, contacts).
- **Age:** age determines the "bodily" experience of flight/migration, the possibilities and perspectives in the country of migration (e.g. in learning the language, finding a job) but is also relevant from a legal point of view. Minors enjoy different rights than adults regarding their asylum process and chances of legal status, and special regulations apply to unaccompanied minors. In this regard, young asylum seekers and migrants might also enjoy some advantages due to their age.
- **Sexuality:** discrimination and oppression based on sexual orientation are a common ground for flight and migration from repressive countries of origin. Furthermore, sexuality plays a role in the country of arrival, as further discrimination experiences due to this reason cannot be excluded. However, it also informs the chances of a successful asylum-seeking procedure, as special rights are recognized to people from sexual minorities coming from countries where e.g. homosexuality is banned and repressed. The shared belonging to a sexual minority can, in some cases, facilitate the contact and the bounding with organized communities in the countries of arrival. This, in turn, can enhance the feeling

of being part of a community and enjoying a safe-space, elements that can become very important for the quality of life and mental health of refugees and migrants.

- **(Dis)ability:** while representing doubtless an additional hurdle in the asylum/migration process, like age and sexuality, disability can provide to the affected person additional possibilities concerning legal status and benefits in the country of migration.
- **Legal status:** this element is of crucial importance for refugees and migrants, as it defines the whole array of possibilities and future perspectives they dispose of (e.g. access to a legal employment, to health care, to education, to social benefits, right to apply for a private accommodation, possibility of travelling, possibility of applying for family reunification etc.). Those with a secure legal status (as recognized refugees or as migrants with legal residency) enjoy much better life conditions than those with an insecure status (e.g. because the asylum process is not completed yet). At the very bottom are the undocumented migrants and those whose asylum application has been rejected, who are *de facto* condemned to an existence in the shadow, with illegal employment, no access to social benefits and an utterly insecure future perspective.
- **Religion:** religion-based persecution can often be a ground for seeking refuge in another country, and members of some religious minorities have chances to a successful asylum application. Furthermore, religion can be for many people an important form of resilience, providing comfort in especially challenging times, but also enabling access to specific communities in the country of migration due to a shared religious belonging.
- **Family ties:** fleeing or migrating with family members instead of alone can be an important resource during the process. However, dependent family members such as young children or the elderly can also represent an additional source of concern, limit participation possibilities for the care-taking person (e.g. the participation to a language course when the children do not attend Kindergarten). Refugees and migrants who have left their countries by themselves can, on the other hand, experience great worries about their families left behind, feeling of shame or responsibility towards them etc.

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Unit: 2.3 Mental Health and Suicide Risk Assessment

Table 1: *"List of Recommended Tests"*

Construct measured	Test	
Life Quality and Health	**RHS-15** (Refugee Health Screener-15; Hollifield et al., 2013) [1] RHS-15 PDF – Pathways to Wellness	Brief screening tool specifically designed to assess emotional distress in refugees and other displaced migrants. Developed to address the unique mental health needs of refugees, the RHS-15 helps identify individuals who may be experiencing significant psychological distress, including symptoms of depression, anxiety, and PTSD (Post-Traumatic Stress Disorder).
	WHOQOL-100 (WHO Quality of Life-100; Angermeyer, Kilian and Matschinger, 2000) [2] WHOQOL-100 – World Health Organization	The WHOQOL-100 assesses quality of life across physical, psychological, social, and environmental domains. It is well-suited for transcultural use due to its strong cross-cultural validity, extensive field-testing in diverse countries, and availability in multiple languages.
	WHOQOL-BREF (Short version of WHOQOL-100; Angermeyer, Kilian and Matschinger, 2000) WHOQOL-BREF – World Health Organization	Fewer items than WHOQOL-100. Quicker to administer.
	SWLS (Satisfaction with life scale; Diener et al. 1985) [3] SWLS – Ed Diener's Lab, University of Illinois	A brief 5-item measure of global life satisfaction, assessing individuals' judgments about their goals, achievements, and overall contentment with life. It is widely used across cultures due to its strong psychometric properties, simple wording, and availability in many languages. Its demonstrated cross-cultural reliability makes it a valuable tool in transcultural and international research on well-being.
	PSS (Perceived Stress Scale; Cohen, Kamarck, & Mermelstein, 1983) [4] PSS – Mapi Research Trust	A widely used 10-item questionnaire that measures individuals' perception of stress, focusing on feelings of unpredictability, lack of control, and overload. It is especially relevant in transcultural contexts due to its availability in numerous languages and its demonstrated validity across diverse cultural groups, making it a reliable tool for assessing perceived stress in international and multicultural research settings.

	IADQ (Adjustment Disorder Questionnaire; Shevlin et al., 2019) [5] IADQ – Trauma Measures Global	The IADQ is a brief self-report tool developed to assess Adjustment Disorder (AjD) as defined by the ICD-11, focusing on core symptoms like stressor exposure, preoccupation, and failure to adapt. Designed for international applicability, it has been validated across diverse cultural contexts and is available in multiple languages, including English, German, Hebrew, and Chinese, making it a reliable instrument for cross-cultural research and screening.
Explanatory Models for Mental Health Issues	**IPQ-R** (Illness Perception Questionnaire-Revised; Moss-Morris et al., 2002) [6] IPQ-R PDF – Royal Holloway University of London	Helps to understand how individuals perceive their illness. It covers various dimensions such as identity (symptoms associated with the illness), cause (beliefs about the cause of the illness), timeline (perceived duration), consequences (expected impact), and control/cure (beliefs about the manageability and treatment of the illness). It is particularly relevant in transcultural contexts due to its strong psychometric properties, availability in multiple languages, and validation across diverse cultural settings, making it a valuable instrument for cross-cultural research and clinical practice.
	MINI (McGill Illness Narrative Interview, Groleau, Young and Kirmayer, 2006) [7] MINI – McGill University	A semi-structured qualitative interview designed to elicit detailed personal narratives about illness experiences. It comprises three main sections: (1) a temporal narrative of symptom and illness experience, (2) prototype narratives based on previous experiences or those of others, and (3) explanatory models encompassing labels, causal attributions, and expectations for treatment and outcomes. Supplementary sections explore help-seeking behaviors, treatment experiences, and the impact of illness on identity and relationships. The MINI has been translated into multiple languages and validated across diverse cultural contexts, making it a valuable tool for cross-cultural research and clinical practice.
Suicide Assessment	C-SSRS (Columbia-Suicide Severity Rating Scale; Posner et al., 2011) [8] C-SSRS – Columbia University	A structured tool designed to assess the severity and immediacy of suicidal ideation and behaviors. It evaluates aspects such as the presence of suicidal thoughts, the intensity and frequency of these thoughts, the presence of a plan, intent to act, and any preparatory behaviors or actual attempts. The C-SSRS is particularly relevant in transcultural contexts due to its availability in over 150 country-specific languages, many of which have undergone linguistic validation. This extensive linguistic adaptation ensures that the tool maintains its reliability and validity across diverse cultural settings, making it a valuable instrument for global suicide risk assessment.

	CARS (The Cultural Assessment of Risk for Suicide; Chu, J., Floyd, R., Diep, H., Pardo, S., Goldblum, P., & Bongar, B., 2013) [9] (A direct, freely available version of the full CARS questionnaire is not accessible online. For access to the full CARS instrument, including its manual and normative data, might require contacting the authors directly or obtaining them through academic or clinical channels).	A 39-item self-report measure developed to evaluate culturally specific suicide risk factors. It assesses dimensions such as cultural sanctions related to suicide, idioms of distress, minority stress, and social discord, which may influence suicidal thoughts and behaviors. The CARS has demonstrated good internal consistency and convergent validity with established suicide-related measures, making it a valuable tool for culturally competent suicide risk assessment.
	Suicide Risk Assessment Toolkit by Mental Health Commission of Canada (MHCC) in partnership with the Canadian Patient Safety Institute (CPSI) [10] Suicide Risk Assessment Toolkit – MHCC	This toolkit helps healthcare professionals choose and use suicide risk assessment tools effectively. It emphasizes that tools should support, not replace, clinical judgment. The toolkit reviews various tools, focusing on their reliability and cultural sensitivity, ensuring they are appropriate for diverse populations including Indigenous peoples, LGBTQ+ communities, and racialized groups. It offers practical guidance to integrate assessments into holistic care.
Depression	**PHQ-9** (Patient Health Questionnaire-9; Kroenke, Spitzer & Williams, 2001) [11] Official PHQ Screeners Website	The PHQ-9 is a brief self-administered tool that assesses the severity of depression based on nine DSM-IV criteria. It asks respondents to rate the frequency of symptoms over the past two weeks. Widely used across cultures, it is available in multiple languages and has been validated internationally, making it suitable for transcultural research and clinical use.
	HAM-D (Test Hamilton - Depression scale; Hamilton 1959) [12] HAM-D PDF (University of Florida) HAM-D Online Calculator (QxMD)	The HAM-D is a clinician-administered scale used to assess the severity of depression symptoms, including mood, guilt, insomnia, anxiety, and somatic complaints. It is widely used in clinical and research settings and has been translated and validated in multiple languages, making it suitable for use in diverse cultural contexts.
	HSCL-25, second part (Hopkings Symptom Checklist, second part, depression; Petermann and Brähler, 2013) [13] HSCL-25 – HPRT Cambridge	The HSCL-25 is a self-report questionnaire assessing symptoms of anxiety and depression. Part 2 focuses on depression, evaluating mood, energy, sleep, and self-worth. It has been validated across various populations and translated into multiple languages, making it suitable for transcultural research and clinical use.
Anxiety Disorders	**HAM-A** (Test Hamilton – Anxiety scala; Hamilton, 1959) [12] HAM-A – MDCalc	The HAM-A is a clinician-administered scale that assesses the severity of anxiety through 14 items covering both psychological and somatic symptoms. It evaluates aspects like anxious mood, tension, and physical complaints. Widely translated and validated, it is a valuable tool for assessing anxiety in diverse cultural and clinical contexts.

	HSCL-25, first part (Hopkings Symptom Checkist, first part) [13] HSCL-25 – HPRT Cambridge	The first part of the HSCL-25 focuses specifically on anxiety symptoms. It assesses a range of symptoms associated with anxiety, such as nervousness, fearfulness, and physical symptoms like dizziness. Due to its availability in multiple languages and strong cross-cultural validation, it is especially relevant in transcultural mental health assessments.
PTSD	**CAPS-5** (Clinical Administered PTSD Scale for DSM-5; Weathers et al., 2013) [14] CAPS-5 – ISTSS	The CAPS-5 is a structured clinical interview used to diagnose PTSD and assess symptom severity based on DSM-5 criteria. It is highly valued in transcultural contexts because clinicians can adapt questions and clarify meanings, allowing culturally sensitive assessment. It has been validated across diverse populations and is available in multiple languages.
	HTQ (Harvard Trauma Questionnaire; Mollica et al. 1992) [15] HTQ – HPRT Cambridge	Self-report tool assessing trauma exposure and PTSD symptoms, especially in refugee and war-affected populations. Includes culturally specific items and has been translated and validated widely.
	ITQ (International Trauma Questionnaire; Cloitre et al., 2018) [16] ITQ – Trauma Measures Global	Brief self-report tool for PTSD and Complex PTSD based on ICD-11. Designed to be culturally neutral and validated in many countries, with versions in over 30 languages.
	IES-R (The Impact of Event Scale – Revised; Weiß and Marmar, 1997) [17] IES-R – Trauma Measures Global	Measures distress related to traumatic events, focusing on intrusion, avoidance, and hyperarousal. Broadly used and translated; suitable for transcultural contexts despite not being culture-specific.
	ITEM (International Exposure Trauma Measure; Hyland et al. 2021) [18] ITEM – Trauma Measures Global	Self-report tool that assesses exposure to a wide range of potentially traumatic events. Developed explicitly for cross-cultural use, avoiding culturally biased assumptions. Validated internationally and available in multiple languages.
	PCL-5 (PTSD Checklist for DSM-5; Weathers et al. 2013) [19] PCL-5 – LA County DMH	A self-report questionnaire for screening and monitoring PTSD symptoms. Widely used, translated into many languages, and adaptable to diverse populations.
Somatisation Disorder	**PHQ-15** (Health questionnaire for patients - Somatisation; Kränke, Spitzer and Qillias, 2002) [20] Official PHQ Screeners Website	Self-report questionnaire assessing the severity of somatic symptoms over the past four weeks. It covers 15 common physical complaints, such as pain, gastrointestinal issues, and fatigue. In transcultural contexts, its straightforward language and broad symptom coverage make it adaptable across diverse populations. The PHQ-15 has been translated into multiple languages and validated internationally, enhancing its utility in various cultural settings.

	SOMS-2 (Screening for somatoform symptoms - 2; Rief and Hiller, 2008) [21] (A direct, freely available version of the full SOMS-2 questionnaire is not accessible online. For access to the full SOMS-2 instrument, including its manual and normative data, might require contacting the authors directly or obtaining them through academic or clinical channels).	A comprehensive self-report tool designed to identify somatoform symptoms by listing numerous physical complaints without identifiable medical causes. Its broad symptom coverage supports detailed evaluation across cultural contexts, accommodating varying symptom expressions.
Migratory Stress, Acculturative Strategies, Migratory Mourning	**BISS** (Barcelona Immigration Stress Scale; Tomás-Sábado, Qureshi, Montserrat, & Collazos, 2007; Eiroa-Orosa, Evangelidou, Qureshi, & Collazos, 2023) [22, 23] (A direct, freely available version of the full BISS questionnaire is not accessible online. For access to the full BISS instrument, including its manual and normative data, might require contacting the authors directly or obtaining them through academic or clinical channels).	A 42-item self-report questionnaire developed to assess acculturative stress among immigrants, particularly in European contexts. It evaluates various stressors associated with the migration experience, such as homesickness, perceived discrimination, cultural adaptation challenges, and general psychosocial stress. Designed with cultural sensitivity in mind, the BISS has been validated across diverse immigrant populations, demonstrating its applicability in transcultural settings. Its comprehensive approach allows for a nuanced understanding of the psychological impact of immigration across different cultural groups.
	FRACC (Frankfurt Acculturation Scale; Bongard, Etzler and Frankenberg, 2020) [24] (A direct, freely available version of the full FRACC questionnaire is not accessible online. For access to the full FRACC instrument, including its manual and normative data, might require contacting the authors directly or obtaining them through academic or clinical channels).	Is a 20-item self-report tool that measures how migrants balance their heritage and host cultures, based on Berry's acculturation model. It identifies four strategies: integration, assimilation, separation, and marginalization.

Handout 2: *"Complete CFI in English"*

Cultural Formulation Interview (CFI)

Supplementary modules used to expand each CFI subtopic are noted in parentheses.

GUIDE TO INTERVIEWER	INSTRUCTIONS TO THE INTERVIEWER ARE ***ITALICIZED.***
The following questions aim to clarify key aspects of the presenting clinical problem from the point of view of the individual and other members of the individual's social network (i.e., family, friends, or others involved in current problem). This includes the problem's meaning, potential sources of help, and expectations for services.	*INTRODUCTION FOR THE INDIVIDUAL:* I would like to understand the problems that bring you here so that I can help you more effectively. I want to know about ***your*** experience and ideas. I will ask some questions about what is going on and how you are dealing with it. Please remember there are no right or wrong answers.
CULTURAL DEFINITION OF THE PROBLEM	
CULTURAL DEFINITION OF THE PROBLEM (Explanatory Model, Level of Functioning)	
Elicit the individual's view of core problems and key concerns. *Focus on the individual's own way of understanding the problem.* *Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g., "your conflict with your son").*	1. What brings you here today? *IF INDIVIDUAL GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE:* People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would *you* describe your problem?
Ask how individual frames the problem for members of the social network.	2. Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them?
Focus on the aspects of the problem that matter most to the individual.	3. What troubles you most about your problem?
CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT	
CAUSES (Explanatory Model, Social Network, Older Adults)	
This question indicates the meaning of the condition for the individual, which may be relevant for clinical care. *Note that individuals may identify multiple causes, depending on the facet of the problem they are considering.*	4. Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]? *PROMPT FURTHER IF REQUIRED:* Some people may explain their problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes.
Focus on the views of members of the individual's social network. These may be diverse and vary from the individual's.	5. What do others in your family, your friends, or others in your community think is causing your [PROBLEM]?

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STRESSORS AND SUPPORTS (Social Network, Caregivers, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Cultural Identity, Older Adults, Coping and Help Seeking)	
Elicit information on the individual's life context, focusing on resources, social supports, and resilience. May also probe other supports (e.g., from co-workers, from participation in religion or spirituality).	6. Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others?
Focus on stressful aspects of the individual's environment. Can also probe, e.g., relationship problems, difficulties at work or school, or discrimination.	7. Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems?
ROLE OF CULTURAL IDENTITY (Cultural Identity, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Older Adults, Children and Adolescents)	
	Sometimes, aspects of people's background or identity can make their [PROBLEM] better or worse. By ***background*** or ***identity,*** I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, or your faith or religion.
Ask the individual to reflect on the most salient elements of his or her cultural identity. Use this information to tailor questions 9–10 as needed.	8. For you, what are the most important aspects of your background or identity?
Elicit aspects of identity that make the problem better or worse. *Probe as needed (e.g., clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation).*	9. Are there any aspects of your background or identity that make a difference to your [PROBLEM]?
Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles).	10. Are there any aspects of your background or identity that are causing other concerns or difficulties for you?
CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING	
SELF-COPING (Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors)	
Clarify self-coping for the problem.	11. Sometimes people have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]?

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Cultural Formulation Interview (CFI)

PAST HELP SEEKING (Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship)	
Elicit various sources of help (e.g., medical care, mental health treatment, support groups, work-based counseling, folk healing, religious or spiritual counseling, other forms of traditional or alternative healing). *Probe as needed (e.g., "What other sources of help have you used?").* *Clarify the individual's experience and regard for previous help.*	12. Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your [PROBLEM]? *PROBE IF DOES NOT DESCRIBE USEFULNESS OF HELP RECEIVED:* What types of help or treatment were most useful? Not useful?
BARRIERS (Coping and Help Seeking, Religion and Spirituality, Older Adults, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship)	
Clarify the role of social barriers to help seeking, access to care, and problems engaging in previous treatment. *Probe details as needed (e.g., "What got in the way?").*	13. Has anything prevented you from getting the help you need? *PROBE AS NEEDED:* For example, money, work or family commitments, stigma or discrimination, or lack of services that understand your language or background?
CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING	
PREFERENCES (Social Network, Caregivers, Religion and Spirituality, Older Adults, Coping and Help Seeking)	
Clarify individual's current perceived needs and expectations of help, broadly defined. *Probe if individual lists only one source of help (e.g., "What other kinds of help would be useful to you at this time?").*	Now let's talk some more about the help you need. 14. What kinds of help do you think would be most useful to you at this time for your [PROBLEM]?
Focus on the views of the social network regarding help seeking.	15. Are there other kinds of help that your family, friends, or other people have suggested would be helpful for you now?
CLINICIAN-PATIENT RELATIONSHIP (Clinician-Patient Relationship, Older Adults)	
Elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers, or cultural differences that may undermine goodwill, communication, or care delivery. *Probe details as needed (e.g., "In what way?").* *Address possible barriers to care or concerns about the clinic and the clinician-patient relationship raised previously.*	Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations. 16. Have you been concerned about this and is there anything that we can do to provide you with the care you need?

Page 3 of 3

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Note: American Psychiatric Association. (2013). *Cultural Formulation Interview (CFI)*.
https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM5_Cultural-Formulation-Interview.pdf

Handout 3: "Risk Factors Associated with Suicide"

- **Acculturation stress and identity conflict:** the intense pressure to adapt to a new culture can lead to significant stress and identity conflict. As discussed in the unit 1.4. the struggle to balance the values and norms of their culture of origin with those of the host culture can result in feelings of confusion, isolation, and distress. These feelings can increase the risk of suicidal ideation and behaviour [26, 28].
- **Social isolation and lack of support networks:** separation from family and familiar social networks is common among migrants. This isolation can be exacerbated by language barriers and difficulties in establishing new social connections in the host country. The resulting loneliness and lack of social support are potent risk factors for suicide [26, 27].
- **Family conflicts:** Tensions and conflicts within the family, especially due to intergenerational cultural gaps or differing adaptation speeds, increase psychological distress and suicide risk among migrants [26, 27, 29].
- **Experiences of discrimination and xenophobia:** experiences of discrimination and xenophobia can lead to chronic stress, a sense of helplessness, and a diminished sense of belonging, all of which contribute to an increased risk of suicide. It might lead to re-traumatisation or new traumatic experiences, especially when physical and emotional violence takes part. Discrimination can also exacerbate the previous risk factors since the person feels isolated and has much fewer opportunities to establish and cover all basic needs [26, 27].
- **Trauma exposure pre- and post-migration:** consider the history of trauma of the client. These can be histories of trauma related to war, persecution, or violence in their home countries, as well as traumatic experiences during the migration process and can lead to (complex) post-traumatic stress disorder (C-PTSD) and other trauma-related mental health conditions that heighten the risk of suicide [26,28].
- **Legal status and fear of deportation**: uncertainty about legal status and the fear of deportation are significant existential stressors for many migrants. This fear can contribute to anxiety, depression, and feelings of hopelessness, all of which are associated with an increased risk of suicide [27, 28].
- **Substance abuse as coping mechanism:** studies show that alcohol abuse, in combination with other risk factors explained above, can lead to suicide behaviour and, therefore, a higher risk of suicide. This can be explained by the lack of sustainable resources to cope with emotional, psychological or social problems [27, 29].
- **Gender-specific vulnerabilities:** Immigrant women may face compounded risks due to gender roles, violence, and cultural pressures that increase their risk of suicidal behavior [26].

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Unit: 2.4 Psychological First Aid

Handout 1: *"Special Situation of Children"*

How children react to the hardships of a crisis depends on their **age** and **developmental** stage. It also depends on the ways their caregivers and other adults interact with them (if they exist). For example, young children may not fully understand what is happening around them and are especially in need of support from caregivers. **In general, children cope better when they have a stable, calm adult around them.** [1,2]

THINGS TO SAY AND DO FOR CHILDREN

Keep together with loved ones	» Keep them together with their caregivers and family whenever possible. Try not to let them get separated. » When unaccompanied, link them with a trustworthy child protection network or agency. Don't leave the child unattended. » If no child protection agency is available, take steps yourself to find their caregivers or to contact other family who can care for them.
Keep safe	» Protect them from being exposed to any gruesome scenes, like injured people or terrible destruction. » Protect them from hearing upsetting stories about the event. » Protect them from the media or from people who want to interview them who are not part of the emergency response.
Listen, talk and play	» Be calm, talk softly and be kind. » Listen to children's views on their situation. » Try to talk with them on their eye level, and use words and explanations they can understand. » Introduce yourself by name and let them know you are there to help. » Find out their name, where they are from, and any information you can in order to help find their caregivers and other family members. » When they are with their caregivers, support the caregivers in taking care of their own children. » If passing time with children, try to involve them in play activities or simple conversation about their interests, according to their age.

Note: Graphic from World Health Organization. (2011). *Psychological first aid: Guide for field workers*. https://www.who.int/publications/i/item/9789241548205

Remember that children also have their own resources for coping. Learn what these are and support positive coping strategies, while helping them to avoid negative coping strategies. Older children and adolescents can often help in crisis situations. Finding safe ways for them to contribute to the situation may help them to feel more in control.

The three principles "Look, Listen, Link" of PFA for children: [1,2]

"LOOK" FOR:

- ✓ information on what has happened
- ✓ safety and security risks
- ✓ who the child is with or whether the child is alone
- ✓ physical injuries
- ✓ immediate basic, practical and protection needs emotional reactions.
- ✓ Assess emotional reactions

"LINK"

- ✓ assess the child's needs, with the child, if possible
- ✓ help the child access protection and services for basic needs
- ✓ give age-appropriate information
- ✓ connect the child with loved ones and, if needed, social services

"LISTEN"

- ✓ approach the child and introduce yourself
- ✓ calm the child
- ✓ pay attention and listen actively
- ✓ accept and validate the child's reactions and feelings
- ✓ ask about needs and concerns with age-appropriate questions
- ✓ help the child find solutions to their immediate needs and problem

Note: Adapted from *A guide to psychological first aid for Red Cross and Red Crescent societies* (pp. 58–61), by International Federation of Red Cross and Red Crescent Societies, 2018, IFRC Reference Centre for Psychosocial Support.

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Module 3.

Improving Skills in Managing Migrants' Mental Health Needs

Physicians, Psychologists, Psychotherapists, Nurses, Social Workers, Counselors, Caregivers of Unaccompanied Minors and Volunteers

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EU-MiCare
Training the EU Health Workforce to Improve Migrant and Refugee Mental Health Care

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Module:	Improving Skills in Managing Migrants' Mental Health Needs
Version:	Psysicians, Psychologists, Psychotherapists, Nurses, Social Workers, Counselors, Caregivers of Unaccompanied Minors and Volunteers
Responsible Partners:	Prolepsis Institute, Zadig, CUT

Module Overview

This module equips professionals and volunteers who are not working as interpreters or cultural mediators in the respective contexts (e.g., those in medical, counseling, social care, or community work roles) with the necessary skills and strategies to manage the mental health needs of migrants and refugees. It emphasizes effective communication, cultural awareness, collaboration with interpreters and cultural mediators, and interdisciplinary teamwork. A supplementary unit at the end of the module provides focused attention to the unique circumstances of migrant children and youth, including unaccompanied minors. Unit 3.1 focuses on effective communication, providing tools to build empathy, trust, and rapport with migrants and refugees while addressing language and cultural barriers through techniques such as Non-Violent Communication (NVC) and reflective practice. Unit 3.2 emphasizes cultural awareness, encouraging self-reflection on biases and promoting culturally sensitive approaches to care, with an introduction to structural competency to address systemic inequities. Unit 3.3 delves into collaborating for effective interpretation and cultural mediation, highlighting the role of interpreters and cultural mediators in bridging linguistic and cultural gaps, and offering guidelines for teamwork in triadic communication settings. Unit 3.4 explores interdisciplinary collaboration in mental health and psychosocial support, promoting integrated care approaches across diverse professional roles. Finally, Unit 3.5 examines the special situation of children, addressing the unique mental health and psychosocial needs of migrant and refugee children with tailored strategies to ensure safety, trust, and engagement.

Module Learning Outcomes:

Upon completion of this Module, participants should be able to:

- Demonstrate effective communication skills to build trust, empathy, and rapport with migrants and refugees
- Identify and address nonverbal communication cues, understanding their significance and using them effectively to establish rapport
- Implement effective communication strategies, including the use of NVC and reflective practice
- Apply cultural awareness and structural competency to tailor psychosocial support
- Collaborate efficiently with interpreters and cultural mediators and understand their roles
- Implement best practices for triadic communication to bridge linguistic and cultural gaps
- Facilitate interdisciplinary collaboration, integrating the roles of various professionals to provide mental health and psychosocial support for migrant and refugee populations
- Review the risk and protective factors as well as diverse needs and responses to stress related to displaced children
- Respond to the unique needs of migrant and refugee children, employing age-appropriate approaches to ensure safety, trust, and engagement

Units in this Module:

Module 3. **Improve Skills in Managing Migrants' Mental Health Needs**
Unit 3.1: Effective Communication
Unit 3.2: Cultural Awareness
Unit 3.3: Collaborating for Effective Interpretation and Cultural Mediation
Unit 3.4: Interdisciplinary Collaboration in Mental Health and Psychosocial Support
Unit 3.5: Special Situation of Children

Unit 3.1: Effective Communication

Unit Overview
This unit covers key themes in effective communication for supporting migrants and refugees in mental health and psychosocial support settings. It begins with strategies for building empathy, trust, and rapport, followed by the role of interpreters and cultural mediators in overcoming language and cultural barriers. Nonverbal communication is explored, with practical examples of using gestures, tone, and body language to enhance understanding. Reflective practice is introduced to help field workers develop self-awareness and improve their communication approaches. Finally, the principles of Non-Violent Communication (NVC) – observations, feelings, needs, and requests – are presented as tools for fostering clear and collaborative interactions.

Unit Sections:

1. Introduction

Effective communication is crucial in mental health settings involving migrants and refugees due to their unique challenges and experiences [1,2]. Communicating in a clear, empathetic, and culturally sensitive manner allows field workers to accurately assess needs, build trust, and provide tailored support. This ensures the people we work with feel heard and understood, which in turn promotes their active participation in the treatment process and improves mental health outcomes.

Moreover, effective communication is essential for overcoming barriers to care [3]. It necessitates multilingual resources and a deep understanding of the cultural contexts influencing mental health perceptions and practices (see also Units 2.1 & 2.3). Recognizing and addressing the unique challenges posed by language barriers through collaboration with interpreters and cultural mediators enhances trust

and ensures more accurate and supportive interactions [4]. Respectful and open dialogue helps professionals and volunteers identify and address obstacles such as fear of deportation, stigma surrounding mental health issues, and practical problems like employment and housing [5].

This unit will explore key elements of effective communication such as the role of empathy, building trust and rapport, nonverbal communication, and reflective thinking [6-8]. Practical strategies for each element will be discussed to enhance professionals' communication with migrants and refugees. Lastly, the principles of Non-Violent Communication (NVC) will be discussed.

2. Key Elements of Effective Communication

Understanding the Role of Empathy, Trust, and Building Rapport

Empathy involves understanding and sharing the feelings of another individual. Having empathy is imperative for building trust, which for the purposes of this training refers to establishing a rapport based on truth and reliability, developing a good rapport, and establishing a genuine connection and relationship between the professional and the person accessing care [9,10]. Having empathy is imperative for overcoming barriers; it supports individuals in sharing difficult experiences, alleviates fears of authority, and establishes a strong relationship [9-12].

Empathy plays a central role in the professional-client relationship. Empathy is defined as being capable of understanding another individual's lived experiences and needs, communicating and confirming this understanding with the individual, and acting upon this understanding in a supportive and helpful way [11]. It is the foundation of all activities surrounding mental health and psychosocial well-being [9-11].

Although there is a breadth of literature highlighting the importance of empathy, healthcare and other relevant professionals, who work towards improving the mental health and psychosocial well-being of migrants and refugees, do not always respond from a place of empathy to the needs of a person [13]. Moreover, language barriers are a significant risk factor that could impact the quality of care provided. Unit 3.3 will highlight the vital role of interpreters and cultural mediators in migrant and refugee mental

healthcare, and understand the positive opportunities their presence may provide in a transcultural interaction [14].

The effectiveness of empathy in mental health care is not solely about understanding an individual's experiences but also about how this understanding is communicated and acted upon. For professionals and volunteers, mastering the skills to convey empathy through both verbal and nonverbal communication is crucial. This involves validating and respecting the individual's feelings while integrating different perspectives [9]. Given the transactional nature of empathy, where both the professional and the individual influence each other, effective communication becomes a dynamic and interactive process.

The Empathic Communication Coding System (ECCS)

The ***Empathic Communication Coding System (ECCS)*** is a validated instrument that measures empathic communication in professional-client encounters. The table below can be used as a framework for professionals to gain clarity on how they respond to different situations [15]. Responses that have been marked in red are undesirable reactions whereas those marked in green are preferable.

Empathic Communication Coding System	
Denial/Disconfirmation	Professional ignores the empathic opportunity to connect with the person or makes a discomforting statement.
Perfunctory Recognition	Professional gives a scripted-like, robotic response, with little empathic opportunity and minimal recognition.
Implicit Recognition	Professional does not recognize the core problem in the empathic opportunity but focuses on a peripheral part of what was disclosed and proceeds to change the topic of discussion.
Acknowledgment	Professional recognizes the core problem in the empathic opportunity but focuses on a peripheral part of what was disclosed and proceeds to change the topic of discussion.
Pursuit	Professional has acknowledged the core issue described during the empathic opportunity and pursues it further by asking the migrant/refugee questions, providing support or advice, or elaborating further on what the patient disclosed.
Confirmation	Professional conveys to the migrant/refugee the emotion or challenge disclosed is valid and legitimate.
Shared Feeling or Experience	Professional discloses that they share the person's emotion or have been through a similar experience or challenge.

Note: Content adapted by the EU-MiCare team based on information from Bylund (2005).

Building Trust and Rapport

◎ **Key Point:** ***The Importance of Building Trust and Rapport***

Building trust is essential due to several critical reasons:

- Migrants and refugees often come from diverse cultural backgrounds and may not speak the local language fluently. These differences can create significant barriers to care. By building trust, field workers can bridge these gaps, ensuring that migrants and refugees feel heard and understood [16].

- Many migrants and refugees have experienced significant adversities, including war, persecution, economic hardship, or dangerous journeys in their pursuit for safety. These experiences can lead to a heightened sense of vulnerability and mistrust. Trust is crucial in helping them feel safe and supported enough to share their experiences and feelings. Without trust, they may be reluctant to open up, hindering the therapeutic process and their ability to heal and recover [9-12].

- Migrants and refugees may have a mistrust of authorities due to previous negative experiences in their home countries or during their migration journey. This mistrust can extend to the professionals and volunteers they might be working with, making it challenging for them to seek and engage in mental health services. Establishing rapport helps alleviate these fears, making migrants and refugees more likely to engage with and benefit from the support available to them. This can be particularly important in encouraging them to participate in ongoing therapy and adhere to treatment plans [17].

- A strong rapport enhances the effectiveness of psychosocial interventions, as it fosters collaboration, mutual respect, and a shared commitment to the treatment goals. When individuals feel that professionals genuinely care about their well-being and are invested in their recovery, they are more likely to be motivated and active participants in their mental health care.

Practical Strategies and Techniques to Establish Trust with Migrants and Refugees

Trust: in the context of working with migrants and refugees refers to the belief that the service provider (e.g., social worker, healthcare professional, or aid worker) is reliable, honest, and genuinely committed to the well-being of the individuals they serve. It involves creating a safe and supportive environment where migrants and refugees feel confident that their needs and concerns will be addressed with respect and confidentiality [18].

Practical Example: To build trust, a social worker might consistently follow through on promises, such as providing resources or information within the agreed time frame. They might also show empathy by actively listening to a refugee's story, demonstrating that they value and respect their experiences and emotions.

Rapport: refers to the positive relationship and mutual understanding developed between the service provider and the person. It involves creating a connection that fosters open communication and a sense of collaboration, making the individual feel heard, understood, and respected [19].

Practical Example: A healthcare worker might build rapport by using culturally sensitive communication, asking about the individual's comfort levels, and showing genuine interest in their cultural background and personal experiences. This can help the migrant or refugee feel more comfortable sharing important health-related information.

As will be further discussed in Unit 3.3, interpreters and cultural mediators are essential in bridging language and cultural barriers, as they facilitate accurate and nuanced communication between migrants or refugees and service providers [20]. They not only translate words but also convey cultural contexts that are critical for understanding. They are crucial in building both trust and rapport by ensuring that the person feels understood and respected in their own language, which is vital for effective service delivery.

The Importance of Nonverbal Communication

***Nonverbal Communication*:** refers to the transmission of messages or information without using words. This can include facial expressions, gestures, posture, eye contact, tone of voice, and other body language cues [21, 22]. Nonverbal communication is especially significant in mental health settings, where migrants and refugees may be dealing with difficult emotions, including stress or anxiety. These individuals might

not always have the words to express their feelings, or they might be hesitant to speak openly due to cultural norms or fear of stigma [3, 19, 21-23].

◎ Key Point: ***Practical Examples of Nonverbal Communication***

- **Facial Expressions**: A field worker can use a calm and empathetic facial expression to reassure a person who is sharing a difficult experience. A gentle smile or a nod can communicate understanding and support without needing to say anything.
- **Body Language**: Open and relaxed body language, such as sitting facing the client with uncrossed arms, can make the person feel more comfortable and at ease. It signals that the provider is approachable and fully present.
- **Eye Contact:** Maintaining appropriate eye contact (considering cultural sensitivities) shows that the provider is paying attention and values what the client is saying. However, it is important to be aware that in some cultures, direct eye contact might be perceived as disrespectful or intimidating.
- **Tone of Voice:** A soothing and calm tone of voice can help in de-escalating a situation where a person might be feeling overwhelmed or distressed. Even when language is a barrier, the tone can convey care and concern.
- **Gestures:** Simple gestures like offering a tissue, gently patting someone's hand (if culturally appropriate), or using hand signals to guide a conversation can communicate support and understanding when words are difficult.

Nonverbal cues can help bridge the gap between the professional and the individual, making the migrant or refugee feel safer and more understood, even when they are unable to fully articulate their feelings or experiences [24,25].

Understanding and being sensitive to cultural variations in nonverbal communication is also key. What might be a comforting gesture in one culture could be misinterpreted in another, so field workers need to be culturally aware and responsive in their use of nonverbal cues (e.g., handshake). The interaction

between a field worker and a migrant or refugee is significantly influenced by nonverbal behaviors and cues [21, 22, 25].

Attentiveness	Refers to the professional's ability to focus on the present interaction. If the refugee/migrant perceives that the professional is distracted or uninterested, the rapport is compromised. To convey interest, the professional must give their full attention to the individual, maintain eye contact, and nod to encourage further meaningful dialogue.
Positivity-Negativity	Refers to the emotional tone of the interaction and how the professional and refugee or migrant are responding to each other. It is whether the professional and refugee/migrant are enjoying their interactions. This will be displayed with nonverbal behaviors, including leaning forward, and open postures. Negative indicators of the interaction will show indifference and create a barrier to effective mental healthcare.
Coordination	Refers to mirroring each other's nonverbal cues, whether it is eye contact, reciprocal smiles, or matching body language, which strengthens rapport and promotes engagement of the professional and refugee or migrant.
Observation	Refers to the professional's ability to discern and evaluate the migrant or refugee's risk of harming themselves or others

Note: Content adapted by the EU-MiCare team based on information from Folie & Gentile (2010)

Nonverbal behaviors are essential to observe as a field worker, as they can help the professional discern and evaluate the individual's risk of harming themselves or others. For example, a migrant who denies having a history of self-harm but has scars on their forearms would be considered at a higher risk for future self-harm or accidental suicide. On the other hand, an individual who is upset about being involuntarily admitted to a hospital may present their anger through nonverbal behavior, including raising their voice, tightening their fists, etc. The professional or volunteer will observe nonverbal behaviors and take preventive measures to ensure the individual's distressed feelings don't escalate.

It is important that the professional carefully observes the individual and changes in their mental status to delve deeper and ascertain the root causes of any behavioral shifts from the person's norm. Any shift from the person's typical demeanor and behavior warrants attention and further exploration. This is especially significant, as nonverbal cues, being largely unconscious, tend to provide more authentic insight into the individual's true emotional state. Changes in nonverbal expressions during therapy sessions serve as indicators to the health professional that the individual may not yet be ready to address certain issues. Unit

2.3 can be helpful in integrating different screening and assessment approaches with nonverbal communication.

Reflective Practice

Reflective practice is a vital component of effective communication between field workers and migrants or refugees. It enables professionals and volunteers to engage in self-awareness, reduce biases, and continuously improve their skills and approaches. Reflective practice is based on the distinction between one's world and that of the person. If this awareness is lacking, the provider runs the risk of comparing and overlapping their perspective with that the migrant or refugee, of becoming sympathetic rather than empathetic, thus leaving the professional or volunteer role [26].

When someone sympathizes, they imagine themselves in another person's situation and think about how they would feel in that position. In contrast, when someone *empathizes*, they focus on understanding what it's like to actually *be* the other person, experiencing their feelings and perspective – without simply feeling sorry for them [27]. The emphasis given by the field worker on the expression of empathy facilitates better communication and promotes necessary emotional support for those who may have been accustomed to unequal treatment [28].

Reflective practice involves the continuous process of self-examination and evaluation of the professional's own experiences, thoughts, and actions to improve personal and professional growth. In the context of refugee and migrant mental health, reflective practice is especially important for several reasons. It means an individual or team can manage their feelings and emotions and stay in charge, rather than be overwhelmed by them. Knowledge of how certain situations can make us feel affords us the opportunity to plan and prepare.

Reflective practice is an ongoing process that is never complete. Therefore, self-evaluation needs to be undertaken at regular intervals. This evaluation process helps us to see how far we have come, identify what we still need to learn and plan how we are going to get there [29]. This will be further explored in Module 4. Self-Care and Staff Well-Being.

◎ Key Point: ***Why is reflective practice so important?***

- Reflective practice helps field workers become more aware of their own biases, assumptions, and cultural perspectives, which can significantly impact their interactions with migrants and refugees. By regularly reflecting on their thoughts, words, and behaviors, providers can identify and mitigate any unconscious biases or cultural misunderstandings that may hinder effective communication.
- Reflective practice enhances the quality of support provided to migrants and refugees by promoting continuous learning and improvement among providers. It encourages them to critically assess their methods and outcomes, seek feedback, and adapt their strategies to better meet the needs of this population. In the dynamic and often challenging field of refugee and migrant mental health, this adaptability and commitment to ongoing professional development are crucial for delivering effective and responsive care.

3. Principles of Non-Violent Communication

→ **VIDEO:** *Non-Violent Communication by Marshal Rosenberg: Animated Book Summary* 💻

Non-Violent Communication (NVC), developed by Marshall Rosenberg, is a communication framework that emphasizes empathy, understanding, and compassionate connection [30]. It involves four key components: observations, feelings, needs, and requests. NVC aims to facilitate more effective and harmonious interactions by focusing on these elements, reducing misunderstandings and conflicts [31, 32]. Below, we delve deeper into each component, incorporating concrete actions and examples.

1. **Observations**: identifying and articulating specific, factual actions or events that impact our well-being. These observations should be free of judgment or interpretation, focusing solely on what can be seen or heard.

Application: For instance, a field worker might observe, "I noticed that during our last session, you mentioned having trouble sleeping and feeling constantly on edge". By clearly stating what has been observed without imposing any judgments, the professional sets the stage for an open and non-threatening conversation.

2. **Feelings**: the emotional responses we have in relation to our observations. Expressing these feelings helps to connect with the emotional reality of the situation.

Application: After observing, it's important for the field worker to reflect on how this affects their own feelings and the possible feelings of the migrant or refugee. For example, "When I hear that you're having trouble sleeping, I feel concerned because I understand how important rest is for your overall well-being". Acknowledging and naming feelings validates the emotional experience of people. When providers openly share their own feelings of concern, it humanizes the interaction and fosters a deeper emotional connection.

3. **Needs**: the underlying needs, values, or desires that drive our feelings. Recognizing these needs helps in understanding why we feel a certain way and what might be necessary to address those feelings.

Application: For example, the practitioner might say, "I believe your difficulty sleeping might be linked to a need for safety and stability, which is understandably challenging in your current living situation". By connecting feelings to unmet needs, professionals demonstrate a deeper understanding of the challenges faced by the person. This not only helps in addressing the root causes of distress (see also Units 1.2 and 1.3) but also shows that the provider is attuned to the individual's broader life context.

4. **Requests**: are specific, actionable, and respectful requests made to meet the identified needs. These requests are framed in a way that allows for collaboration and respects the autonomy of the other person.

Application: After identifying the needs, the professional can make a specific request that aims to address them. For instance, *"Would you be willing to explore some relaxation techniques or grounding exercises that might help improve your sleep?"* Making clear, actionable requests empowers migrants and refugees by involving them in their own care. It shows respect for their autonomy and acknowledges their capacity to take steps towards improving their well-being. This collaborative approach not only addresses immediate concerns but also strengthens the overall relationship by reinforcing the idea that the provider is there to support, not dictate.

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Unit 3.2: Cultural Awareness

Unit Overview
This unit explores the concept of cultural awareness in the context of mental health and psychosocial support for migrants and refugees. It emphasizes the importance of self-reflection and understanding one's own cultural identity while being sensitive to the cultural experiences and needs of others. The unit challenges field workers to move beyond cultural competence and adopt a flexible, empathetic approach, tailoring care to respect the diverse values, beliefs, and behaviors of those they serve. Structural competence will also be discussed as a framework that goes beyond cultural awareness in addressing how power dynamics, discrimination, and social structures impact mental health outcomes. This approach promotes interdisciplinary perspectives, structural interventions, and humility in recognizing the limits of field workers' expertise in addressing systemic inequalities.

Unit Sections:

1. Introduction

In the context of mental health and psychosocial support, ***cultural competence*** and ***cultural awareness*** are key concepts, but they represent different approaches. Cultural competence involves acquiring specific knowledge about diverse cultures, developing skills to communicate effectively across cultural boundaries, and demonstrating respectful attitudes toward cultural differences [1]. While professionals acknowledge the importance of culture, they often struggle with practical implementation, lacking clear guidelines and operational clarity. Additionally, cultural competence approaches have been criticized for overemphasizing cultural traits, conflating culture with ethnicity, nationality, or language, and reducing

complex human behaviors to stereotypes. The term 'competence' is increasingly being rejected because it implies a technical endpoint or solution rather than an ongoing process and commitment. Many cultural competency curricula have reduced culture to a list of traits, leading to stereotyping [2].

When working with migrants and refugees, cultural awareness is increasingly preferred. This is because it allows professionals to adapt their approach dynamically, responding to each individual's unique experiences and needs rather than relying on a fixed set of cultural competencies. This dynamic and reflective approach often leads to more effective and respectful psychosocial support for migrants and refugees. The complex interplay between culture and mental health has been discussed in Unit 2.1; here, we provide practical ways for field workers to tailor their work and everyday behavior from a culturally aware approach.

2. Cultural Awareness

Cultural awareness focuses on the individual's understanding of their own cultural identity and how it influences interactions with others. It involves self-reflection to recognize personal biases and how they impact perceptions of migrants and refugees from different backgrounds [3]. Cultural awareness emphasizes openness and sensitivity to cultural differences without necessarily having extensive knowledge about other cultures. With regards to responding to mental health and psychosocial needs, cultural awareness focuses on the ability of professionals and volunteers to deliver care that respects the diverse values, beliefs, and behaviors of migrants and refugees, while tailoring the service to meet their social, cultural, and linguistic needs. This encourages professionals to remain flexible, empathetic and engaging with migrants and refugees on a more personal level.

Practitioners working with people from diverse cultural and linguistic backgrounds must be aware of their own cultural assumptions and biases, possess cultural skills and knowledge, and remain open to different cultural perspectives on mental health problems [4]. This includes recognizing differing values, avoiding stereotypes, and selecting treatments appropriate to the person's cultural background [5].

Effective interventions use culturally appropriate methods to engage with individuals, honoring cultural systems and values in ways that foster recovery from mental illness [6].

◎ **Key Point:** ***Practical Tips for Cultural Awareness***

Commitment to Reflective Practice and Respect for Diversity

- Critically reflect on your own culture, beliefs, biases, and values, and consider how this influences your attitudes, behaviors, and interactions with migrants and refugees. You might explore tools like the Intercultural Sensitivity Scale or the Harvard University Implicit Bias Test. Assess how your culture, race, ethnicity, gender, and class relate to those of the individual you are supporting and recognize existing power imbalances.
- Respect and value cultural differences. Avoid a one-size-fits-all approach (i.e., treating everyone the same) or making assumptions, generalizations, stereotypes, or judgments about other cultures.
- Remember culture is fluid, not rigid! It is complex, dynamic, and not homogeneous across a population.
- Acknowledge your limitations: understand when and where to seek expert guidance or refer migrants and refugees to more suitable services.
- Request relevant upskilling and capacity building training and education, including through regular supervision
- Advocate for improvement of services through systematic evaluations and feedback.
- We are not observers; we play an active role in the quality of service provided within the organization.

Build knowledge of diverse cultures, histories, and experiences

- Use migrants' and refugees' skills, strengths, resources, capacities, and talents.
- Learn about migrants' and refugees' cultures and home countries, including various ethnic groups, languages, religions, gender norms, and widespread cultural practices

- Learn about refugees' or migrants' journey and experience, including stressors throughout the journey.
- Gain knowledge about the historical and sociopolitical context, conflict, and systems in migrants' and refugees' countries of origin.
- Understand systemic factors impacting migrants' and refugees' daily lives, including racism, social exclusion, financial exclusion, etc.

Engage Respectfully with Migrants and Refugees

- Actively seek feedback on your communication from migrants and refugees and persons facilitating the interaction with them, such as interpreters and cultural mediators, to improve your practice.
- Be human first! Approach the person with empathy, humility, an open mind, and with motivation to tackle any issue that may arise.
- Create an environment that fosters trust and a sense of safety.
- Maintain continuity of professionals interacting with the individual, whenever possible.
- Avoid using stigmatizing or stereotyping language and address any real or perceived threats in the physical environment, such as adjusting lighting and seating arrangements.
- Discuss the migrant's or refugee's expectations and clearly outline the purpose and role of the services provided.
- Clarify professional roles, including those of interpreters and various professionals, explain the rules and limits of confidentiality, and other relevant ethical guidelines.
- Ensure migrants and refugees understand how their information will be used, shared, and protected, and how national systems (e.g., health system) operate and relate to or differ from the immigration system.
- Be flexible and responsive: Adapt to the migrant's/refugee's needs both through your own services and by making appropriate referrals. Ask questions such as, "What is most important to you regarding your experience of illness, treatment, or our work together?" and "I know little about your home country – what would you like me to understand to better assist you?"
- Develop the ability to discuss sensitive topics, such as experiences of adversity and torture, and to address harmful or illegal behaviors like gender-based violence with care.

- Avoid asking refugees to repeat traumatic stories: make thorough case notes and, with the client's consent, inform referral services of their background so the client does not have to repeat their stories to each service or worker
- Remain cognizant of what information is essential for you to effectively do your job to prevent re-traumatization. For example, it is unnecessary for a psychologist to know the specific details of a GBV case; however, a nurse performing an assessment requires further details.
- Consider learning from experienced colleagues and exploring training resources such as the e-learning course Fundamentals of Providing Services to Survivors of Torture, which covers cultural competence and working with interpreters, as well as the University of Minnesota's Introduction to Immigrant and Refugee Health course, which includes a module on effective communication across language and culture.

Reflection Break: ***Reflect on the iceberg analogy of culture***

Think of a time when you had to adapt your communication style when working with a particular individual. How did you meet them where they were at to ensure effective understanding? What strategies did you use to build trust and rapport? And most importantly, how can you incorporate these suggestions to your work and life in general?

Practicing cultural curiosity with migrant and refugee children

Due and Currie's (2021) review of the literature identified six key competencies for practitioners working with children from migrant and refugee backgrounds:

1. Knowledge of the complex needs of these populations.
2. Use of holistic/strengths-based approaches.
3. Ability to work in coordination with others in the network.
4. Ability to build trust and therapeutic relationships.
5. Seeking feedback from the individual.

6. Cultural competency, ensuring practitioners understand a person's cultural background and differences.

Practicing ***cultural curiosity*** when engaging with children and families further enhances the adoption of 'culturally competent' and 'culturally curious' approaches. While the evidence for the effectiveness of such approaches is still emerging and most have not yet been rigorously evaluated for use with refugee and asylum-seeking children and families, these competencies offer a valuable framework for practice [5].

Know the Landscape but Ask the Individual

Cultural differences between field workers and migrants can be a barrier to effective communication, leading to poorer health outcomes, poor adherence to medical instructions, and overall dissatisfaction [7]. As seen in Units 2.1 and 2.3, cultural differences between professional and patient become stark, with tangible consequences when discussing mental health, as different cultures approach mental health differently. Thus, field workers who are culturally aware can recognize and reconcile sociocultural differences to work towards a patient-centered approach to care.

An illustrative example of how service providers can tailor care to the individual's life circumstances, personal values, cultural values, and religious affiliations, adapted from the guide *"Walking Together: A Mental Health Therapist's Guide to Working with Refugees"* is provided below [7].

Awa is a 38-year-old woman from Somalia who has been experiencing nightmares, intrusive thoughts, poor sleep, and panic attacks for the last several years. The symptoms have gotten worse over the last four months and have been so debilitating of late that Awa has quit work and is only sleeping two hours a night. The case worker believes that Awa's problem is post-traumatic stress disorder caused by witnessing extreme violence in Somalia and being raped multiple times in the refugee camp. The therapist believes that Awa would benefit from trauma-focused therapy and medication. However, when the case worker asks Awa what she thinks is causing the problem Awa says "jin," or an evil spirit, and that only an imam or religious leader at a mosque could help.

Intervention	Outcome
Western-Only Intervention	Awa attends a few more counseling sessions but struggles to understand why the therapist wants to discuss her past. She also refuses to take the prescribed medication, believing it is unnecessary for what she perceives as a spiritual issue.
Traditional-Only Intervention	Awa feels better after visiting an Imam and undergoing an exorcism, but the relief is only temporary. When the symptoms return, Awa seeks the Imam's help again.
Western and Traditional Intervention *(combination)*	Awa agrees to take medication and attend therapy while also seeking an exorcism from an Imam. She feels better after the exorcism and begins to sleep better. With improved sleep, she has more energy and asks the Imam about volunteering weekly at the mosque, to which he agrees. Her visits to the mosque help her meet people and make new friends. Through one of these friends, she connects with and secures a job at a restaurant. Although Awa refuses trauma-focused therapy, she continues to attend weekly counseling sessions and appreciates the support and encouragement from her therapist.

3. Structural Competence with Migrants and Refugees

In addition to cultural awareness, alternative concepts have emerged, including structural competence, which emphasizes power dynamics, institutional discrimination, and issues of colonialism and paternalism in healthcare [3].

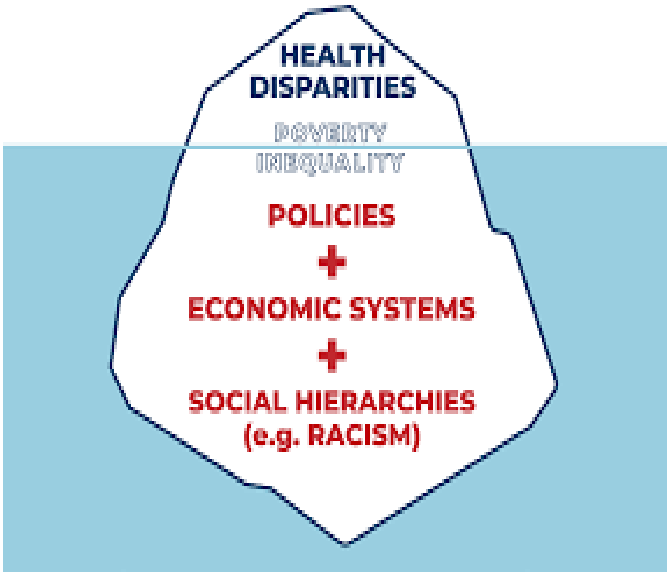
Structural competence builds upon existing efforts in social determinants of health, cultural competency, and cultural humility. Unlike many frameworks focused on social determinants of health, discussed in detail in Unit 1.2, that describe health disparities without addressing their historical and political contexts with which they've come into fruition, structural competency places these determinants within a broader structural context [8,9]. For example, instead of merely describing the epidemiology of racial health disparities, structural competency examines the structures that create and sustain racial inequity, such as structural racism. It shifts attention from individual interactions to the broader forces influencing health outcomes (see also Figure 3.2.1 on the next page).

In simple words, structural competency is defined as a framework for addressing health-related social justice issues by emphasizing the recognition of economic and political conditions that produce and

racialize health inequalities [10]. It serves as an emerging paradigm for training professionals within healthcare and social care system and creating a common language to address the structural processes that determine health inequalities and their normalization. There are five pillars [9]:

1. Identifying the structures that influence interactions
2. Developing a language that addresses structural factors beyond the current environment (for example, a clinical setting)
3. Reframing cultural concepts with regards to structural influences
4. Envisioning and identifying structural interventions
5. Cultivating structural humility

Figure 3.2.1. "*Structural Competency: Examining the Iceberg of Health Disparities*"

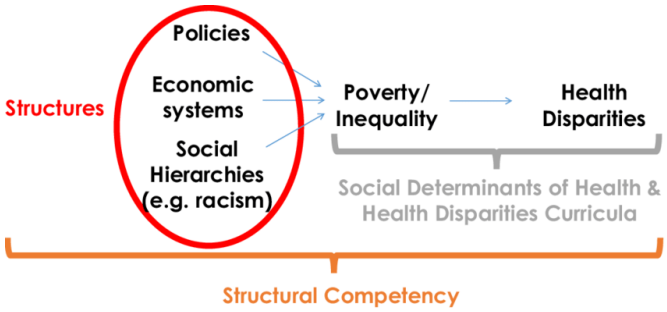


Note: Graphic sourced from the Structural Competency Working Group

We do not see structural competency as a completely new creation but as a paradigm that condenses pre-existing elements from various disciplinary and national traditions, including social medicine, social epidemiology, intercultural health, global health, and critical theories such as anti-racist, feminist, social justice, and decolonizing theories [9, 11].

Structural competency shares many aims with these sources, such as holistic analysis, a relational approach, a focus on social worlds of suffering, emphasis on social inequalities and structural vulnerabilities in health, unraveling the naturalization of inequities, and recognizing knowledge creation as an interdependent and collaborative activity between expert and lay knowledge [12,13].

Figure 3.2.2. "*Structural Determinants of the Social Determinants of Health*"



"Structural determinants of the social determinants of health"

Note: Graphic sourced from the article *Structural Competency in Conflict Zones: Challenging Depoliticization in Israel*

Domain 1: Cultural awareness and reflexivity	*Domain 2:* Cultural and Linguistic Validation	*Domain 3:* Sensitivity to Cultural Diversity and Structural Vulnerabilities	*Domain 4:* Representativeness of Minority Groups and Excluded Populations
Defined as the research team's capacity to critically analyze how their cultural, ethnic, social, and expert backgrounds interact with those of the participants, affecting research questions, design, recruitment, data collection, data analysis, and dissemination activities. A core aspect of reflexivity is cultural humility and the ability to	This refers to the process of adapting instruments, tools, informed consent forms, participant information sheets, questionnaires, researcher-participant interactions, and dissemination outputs to be linguistically and culturally appropriate for participants. It involves not just translating materials into participants' languages, but also	This refers to the integration of variables and relevant information concerning cultural diversity and structural vulnerabilities of the studied groups throughout all phases of epidemiological research. This comprehensive approach encompasses team training in intercultural and structural competency,	This refers to the ability to enhance the representativeness of marginalized and excluded populations throughout all phases of the study, including the composition of the research team, sample selection, and dissemination activities. It involves identifying and addressing social and cultural barriers to their participation and

recognize the diverse knowledge of others, whether lay knowledge or experience based. Reflexivity, an intangible domain related to attitudes and predispositions, influences the quality of research. For example, being reflexive about cultural and social gaps between the research team and the study populations can offer new insights for reducing bias.	ensuring that the discourse is clear and understandable to them. This adaptation helps avoid biases that arise from using questionnaires that participants do not comprehend and addresses potential exclusion related to immigration status, low education levels, disability, or a combination of these factors.	understanding the cultural and social contexts of the populations under study, and knowledge of the medical history and research legacy pertaining to ethnic minorities and marginalized communities in the research setting. It also involves incorporating social determinants of health and structural vulnerability issues into the study design.	promoting their involvement in the dissemination process to, for example, strengthen their agency [17].

Note: Adapted by the EU Mi-Care Team from Martinez-Hernaez & Bekele (2022)

For those interested in the ways working with individuals through a structural competency framework looks like in practice, relevant case studies and strategies have been included in the 🕮 Repository (see 3.2 – Handout 1. "Cultural Competence – Case Studies and Best Practices").

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Unit 3.3: Collaborating for Effective Interpretation and Cultural Mediation

Unit Overview
This unit focuses on how to work effectively with interpreters and cultural mediators to facilitate communication between field workers and migrants and refugees. After making a critical distinction of the roles of interpreters, translators, and cultural mediators, the unit emphasizes the necessity of working with trained professionals in legal, medical, and psychosocial contexts while avoiding reliance on ad hoc interpreters, such as community members or children. The unit concludes by addressing best practices for planning and conducting triadic meetings in order to foster a climate of mutual respect and collaboration.

Unit Sections:

1. Introduction

Most migrants and refugees in Europe arrive with limited or no knowledge of the local language and find themselves in a place where host communities are very unfamiliar with their native tongue [1]. ***Language barriers*** make it difficult for migrants and refugees to express their stories, address their needs, and access their rights, including access to legal and health (including mental health) services. For professionals and volunteers working with these populations, this translates to not being able to provide sufficient support or facilitation to services, as language barriers make it difficult to convey information, but also to understand the individual's experience and to build a trusting relationship.

This is why the presence of an ***interpreter*** or ***cultural mediator***, whose role is facilitating cross cultural-communication and understanding, is crucial. Therefore, it is the responsibility of field worker to learn how

to successfully cooperate with cultural mediators and interpreters, in order to ensure a fruitful and meaningful exchange of dialogue and information in a culturally appropriate way between professional and the individual.

A general guideline is that a cultural mediator should be present when a migrant or refugee can only grasp a little more than basic greetings and phrases. That being said, even if the individual is in a position to hold dialogue in the host language, they may feel unable to express themselves regarding more complex issues such as emotional or physical distress. As a rough rule of thumb, an interpreter or cultural mediator should be present in interactions between professionals and migrants or refugees, particularly when they have only resided in the host country for two years or less [2]. Interpreters or cultural mediators act as cultural brokers, not just translating but providing a point of association with one's culture. Their ability to convey nuances of language, tone, and emotion ensures that the message is accurately and empathetically conveyed, fostering trust and rapport between the professional and the person of concern.

In addition to supporting with communication in day-to-day needs, an interpreter or cultural mediator provides linguistic and cultural mediation support prior to and during:

- *Medical examinations and psychological sessions* – accompanying individuals to services; assisting them with reception and admissions procedures, as well as health and social services orientation activities; supporting health care education where necessary; bridging communication and understanding gaps that may arise during interviews on health and mental health needs, due to language difficulties but also to the different meanings that certain concepts have in different cultures, as seen in previous units [3];
- *Social or legal interviews*, helping to navigate the complexity and jargon of the legal system; advocating for linguistic equity; empowering individuals to participate fully in legal proceedings, accessing their full rights; preparing with migrants and refugees for asylum interviews, and with all administrative and bureaucratic processes [1].

The interpreter or cultural mediator should therefore be recognized as a professional ally, who helps providers relate to the person and navigate the complexities of cross-cultural communication.

2. Interpreter, Translator, Cultural Mediator

The first step to build an effective teamwork is to know what other professionals *can* and what they *cannot* do. So far, we have referred to interpreters and cultural mediators, as both professions, in fact, support two-way oral communication, conveying information between one language (source language) to another language (target language), as accurately as possible, acting as a bridge between cultures, remaining impartial and culturally sensitive [4].

The definitions of 'cultural mediator', 'interpreter', and '***translator***', which are often used interchangeably in the setting of cross-cultural care, are provided below [5, 6].

Key Definitions	
Interpreter	Interpreters verbally translate from one language to another language.
Translator	Person specially trained to convert written text from one language to another.
Cultural Mediator	Person who facilitates mutual understanding between a person or a group of people, the migrant/refugee population for example, and a caregiver, a doctor for example, by interpreting and taking into consideration cultural elements. They can give advice to both parties regarding appropriate cultural behaviors.

Note: Adapted from Self-Study Module 3: Interpreting in a Refugee Context (2009) and Field Guide to Humanitarian Interpreting & Cultural Mediation (2017)

Indeed, interpreter and cultural mediator are different roles with different skill sets. Below is a list of **activities that may be typically required of a cultural mediator but are not necessary the responsibility of an interpreter**. However, the lines can often be blurry. Meanwhile, remember that **not all interpreters and cultural mediators in these settings will have both professional interpreting skills and language high proficiency** [6].

- Convey only main messages;
- Provide cultural advice and context if and when asked (interpreter does it only if absolutely necessary for comprehension);
- Possible liaise with communities, collect information and feedback to relevant parties;
- Provide additional support besides conveying information.

Both cultural mediators and interpreters do not provide written translation; that is, a translator's work.

While highlighting the distinctions between different professions, it is important to emphasize that it is not recommended to work with an untrained interpreter or mediator (i.e., someone without formal professional training, whether through their academic studies or organization/individual agency), and certainly not ad hoc interpreters meaning random by passer byers, where the ability to clarify roles and expectations is not secured.

In medical and social care settings, particularly in emergency services, professionals working with linguistically and culturally diverse populations often face a lack of immediate access to trained interpreters or cultural mediators. As a result, they may rely on family members, friends, or even random bystanders to act as ad hoc interpreters. However, research highlights significant challenges in relying on untrained interpreters [7]. Untrained interpreters (particularly family members) often act independently during interactions, actively participating rather than neutrally conveying messages. This can lead to omissions, misinterpretations, or the inclusion of personal opinions [8]. Another concerning practice is asking children to translate for their parents, especially when the children have a better command of the host country's language. As discussed in Unit 1.4, which examines the psychosocial dimensions of migration, this poses serious risks. Children under 18 should never be tasked with translation, as doing so exposes them to potential secondary traumatization, especially when interpreting sensitive topics like parental experiences of violence. The emotional and cognitive burden, along with the responsibility of ensuring accurate translation, is far too great for a child [9].

3. Needs and Challenges of Facilitating Communication for Different Professionals

The work of various professionals and volunteers working in migrant and refugee care includes principles such as social justice, de-stigmatization, and inclusion [9]. As seen previously in this course, these principles are based on an acknowledgement that power in society is not equally dispersed, and it is the job of the field worker to look for resources and empower recipients of social care to take an integrated place in society. Professionals and volunteers must be mindful to use non-exclusionary language and words with negative connotations that work to disempower recipients of social welfare. This requires them to engage with interpreters or cultural mediators in order to negotiate roles within the triad.

The presence of a third person (interpreter or cultural mediator) in the exchange between the individual and the professional, may pose challenges in the construction of the relationship between the two and in the professional's perception of the effectiveness of his or her intervention. Different professions are characterized by different communication and therefore mediation objectives. We will look here at the main ones, followed by general good practices for effective teamwork.

Mental Health Professionals

Understanding nonverbal information can be difficult because of the delay between the time the person spoke and the interpretation, making it challenging to link nonverbal expressions with the person's words. Similarly, it can be complex to understand how the tone changes with respect to the topic. Moreover, some gestures and mimics of the consultations are not immediately understandable for all members of the triad and require some form of intervention by the interpreter/cultural mediator. They interpret these gestures or mimics with verbal means or they replace them with gestures or mimics that are understandable for the recipients.

In addition, limitations may emerge during the interpretation process during sessions. In particular, a mental health clinician can be deprived of important diagnostic material, when:

- Interpreters verbalize their personal inferences of meaning, when the speech of some person treated for mental health conditions can be hard to understand and consequently difficult to render in a different language.
- Interpreters reduce or omit emotional or subjective elements and make the discourse more factual.

- Interpreters omit or mitigate elements creating or reinforcing relational tensions within the triad, when the emotions and subjective perceptions are not central aspects of the discussion.
- On several occasions, conclusive comments added at the end of a question-answer sequence are not reproduced in renderings, even though they appear important for clinical and relational dynamics.
- When other members of the triad (whether the person or the provider) interrupt interpreters while they are delivering a prolonged message, this often results in significant changes of the structure of the original speech, for example, reduction, simplification, and/or clarification [10].

Social Workers

Social workers engage with case work in many different settings, sometimes acting as social service providers, counsellors or as a part of the healthcare system. Often, they are required to give and receive information that is vital for the legal rights of beneficiaries to be upheld. This could be a reason why social workers in the field prefer direct translation and prefer interpreters to remain neutral in social work interviews.

Medical Practitioners

In medical encounters, difficulties may arise due to the need to describe technical terms and explanations and the need to translate cultural differences around certain concepts in a careful manner (see Unit 3.2). Moreover, in order to accomplish their task of performing the medical interview within a given time frame, doctors must work throughout the encounter to provide a structure. Within this encounter, it is the role of the doctor to set the agenda, on the basis of the patient's needs as perceived by the patient and the doctor. Time management can be an issue, as the familiar structure of the medical interview is broken, physicians have less control over what is being said, and following a question-answer structure can be more challenging.

Two difficulties are mentioned in gathering information via interpreters or cultural mediators. Delays might occur, disturbing the physician's train of thought or their ability to test hypotheses. Physicians may feel it

is difficult to negotiate a treatment plan because they had little control over how their message was transmitted, as nonverbal aspects are often lost.

4. Communicating and Relating in a Triad

Before the Meeting

In the context of migrant and refugee care, achieving a successful relationship between an interpreter/cultural mediator and volunteers or professionals involves several steps that ought to be taken.

- ***Choosing the appropriate interpreter/cultural mediator***

To choose the most appropriate interpreter/culture mediator, a first aspect that needs to be considered is, of course, language. Ideally, the person facilitating the linguistic and/or cultural exchange with a migrant or refugee must speak the same language AND dialect with them. It should not be assumed that someone who speaks a language can speak/understand it in all dialects. However, it is common that an interpreter/cultural mediator and a migrant or refugee may be speaking a different language (an Afghani-born individual might speak Farsi but might also speak Pashtu) or a vastly different dialect. For appointments with families, the very least would be to ensure that the language is understood by all the members [2].

Nationality, religious beliefs, educational level, as well as the migration history and the political landscape of a migrant or refugee's homeland ought to be considered seriously. These aspects can facilitate or compromise the relationship, trust, and comprehension dynamics, and even render such a relationship completely unattainable [3]. If an interpreter/cultural mediator finds out that they personally know the individual (e.g., they are a relative, friend or acquaintance), they should report immediately so that another interpreter/cultural mediator is notified to take over. It is widely recognized as good practice to maintain the same interpreter when undertaking therapeutic work.

- ***Briefing the interpreter/cultural mediator***

A briefing between professionals and interpreter/cultural mediator is necessary to let the person facilitating the interaction prepare at the best possible and to express any worries they may have before the meeting and not during it. In particular, during this preparatory meeting, field workers should [2, 3]:

- Provide information about the migrant or refugee: gender, age, nationality, language, type of support requested, possible behavioral challenges (intense aggressiveness, dyslexia, etc.), as well as about anyone else that might be participating in the meeting.
- Discuss with the cultural mediator/interpreter the purpose and the expectations before the meeting, what questions will be asked and what sort of information must be gathered, and acquaint the interpreter/cultural mediator with any written form that may be used during the meeting, so they are familiarized with it before having to translate it [3].
- Agree a 'STOP sign' in case the interpreter/cultural mediator wants to interrupt the treatment/consultation (e.g., because of their own concern, etc.).
- Ask the cultural mediator about relevant cultural background information, a minimum of culture-specific knowledge might be essential for effective counseling-therapeutic work.
- Make considerations in advance and clarify the organization of the meeting: the seating order (see section later in this unit), the person who will be responsible for the introductions, etc.
- Clarify the type of interpreting they should follow (simultaneous or consecutive) and specific desiderata in translating professional jargon (medical or legal terms) (see Table below).

Forms of Interpreting	
Simultaneous Interpreting	Performed generally from an interpreting booth in a conference environment.
Consecutive Interpreting	Speaker leaves pauses for the interpreter to relay the speech one section at a time.
Bilateral Interpreting	Interpreter relays both (or all) sides of a conversation between speakers of different languages, working both into and out of their main language.
The professional should define the form of interpreting required and the translation needed. Please note that sometimes word-to-word translation deprives us of meaning or, in some cases, even appropriateness. To the extent that an interpreters'/cultural mediators' ability allows, they must try and correctly convey the meaning of what is said. The fact that some words or phrases cannot be translated does not necessarily constitute a problem.	

Note: Adapted from Field Guide to Humanitarian Interpreting & Cultural Mediation [6]

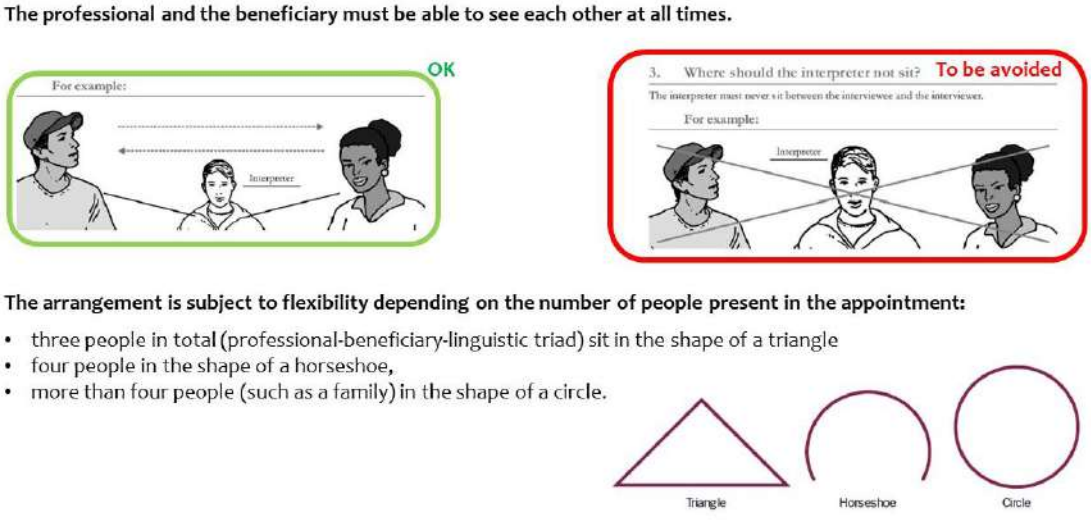
→ **VIDEO:** *Working with Interpreters* 💻

- ***Planning the setting appropriately***

Meeting in a triad also entails specific organizational needs. It is important for the practitioner to consider carefully [2,3,5]:

- Longer duration of the conversation, since the pre- and post-conversation with the interpreter/cultural mediator as well as the interpreting process in the main phase require additional time.
- Consider time and place of the meeting, avoiding the interpreter/cultural mediator to wait in the same room/space as the person accessing support, to avoid the possibility of them starting a discussion regarding the individual's personal matters or them asking for help and advice.
- Find an appropriate seating arrangement that should be discussed in advance. The way in which chairs are positioned plays an important role in enabling or compromising communication between the migrant/refugee and professionals. Figure 3.3.1. shows the arrangements suggested in the triad.

Figure 3.3.1. "*Seating Arrangement in the Meeting Room*"



Note: Adapted from DIPS (2009). Interpreting in a Refugee Context [5] and Papadopoulos, R. K. (2019). Psychosocial Dimensions of the Refugee Condition [2]

During the Meeting

During the first meeting, professionals should introduce themselves and the interpreter, then explain:

- Who they are and what their and interpreter/cultural mediator's role entails.
- That the interpreter/cultural mediator is bound by an ethical code in their profession and will ensure full confidentiality with regards to everything that will be said during the meeting, and is in no position to discuss anything with people outside of that meeting.
- The purpose of the meeting and the exact interpretation and mediation facilitation process.
- Point out that the contact between the client and the interpreter/cultural mediator after the session should be avoided.

In general, it is good practice to have a meeting format in which attention is paid to each phase with an introduction/welcome phase, session agenda, and greetings. Both the interpreter/cultural mediator and the professional should recognize their specific roles, tasks, and competencies. At the same time, it should be clear that the professional is responsible for the management of the session or service.

During the welcome and introduction phase, professionals should:

- Welcome the participants and perform a brief introduction of their and the interpreters'/cultural mediators' role. The greeting should be translated immediately.
- Assign seats to the participants.
- Explain the confidentiality principles to the participants.
- Explain the type of interpreting and the rules.
- Explain also the meaning of the "STOP" sign to the person.

During the intervention/counselling phase, professionals should:

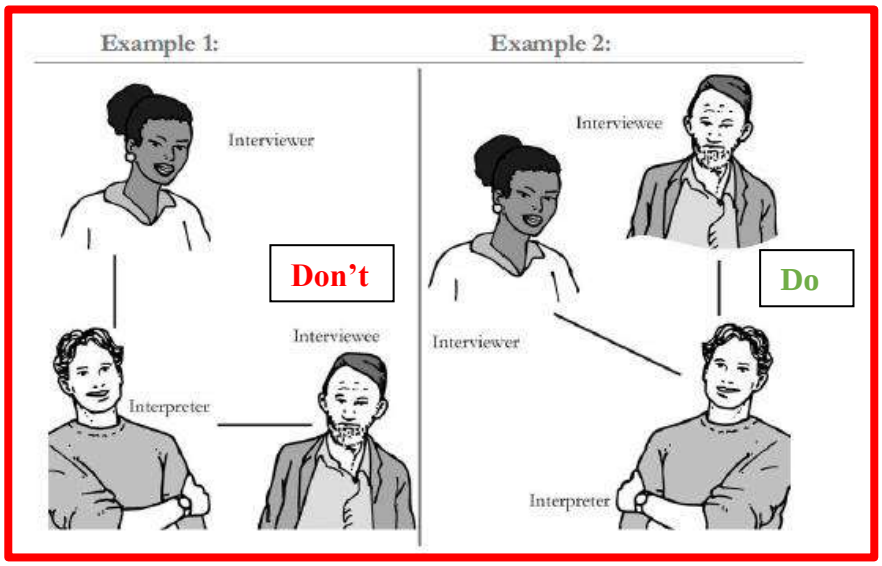
- Make sure to keep their sentences and questions short, and to pause frequently in between so that the interpreter/cultural mediator has the time to translate. Pause after 2-3 short sentences to give an interpreter/cultural mediator an opportunity to translate accurately.
- Speak directly to the migrant or refugee in the first person, using the first and second person "I" and "you" (see Figure 3.3.2).
- Maintain eye contact with the person, even when the cultural mediator/interpreter is speaking, and observe signs in the body language of both the interpreter and the person (see Figure 3.3.2)
- Avoid specialized terms or colloquial language and explain potentially difficult terms or concepts to the interpreter/cultural mediator.
- Recognize that there will be occasions where the interpreter/cultural mediator might have to take a bit more time to explain what was said to better clarify it.
- Avoid sarcasm, cynicism, and jokes, as these are usually difficult to translate.
- Avoid discussing with the interpreter without translating the content of their chat.

In the last phase of the meeting:

- Professionals should provide the person/client with an opportunity to ask questions or express anything else they may need.
- If necessary, especially if painful and difficult issues have been discussed, a follow-up appointment should be arranged with the person and the interpreter/cultural mediator at the end of the session.
- The person/client should leave the room first. As a rule, the interpreter/cultural mediator leaves the counseling room alone.

→ **VIDEO:** *Collaborating for Effective Collaboration - DOs* 💻

Figure 3.3.2. "*Triad Relation During the Meeting*"



Note: Adapted from DIPS (2009). Interpreting in a Refugee Context

After the Meeting

After the session concludes and the person/client has left the room, the frontline worker and the interpreter or cultural mediator should take time to reflect on the meeting. The frontline worker should:

- Discuss with the interpreter or cultural mediator if their involvement is causing difficulties rather than facilitating communication. If the issue cannot be resolved collaboratively, notify a supervisor to identify a mutually agreed solution.
- Ask the interpreter or cultural mediator for advice on culturally specific nuances that may enhance understanding of the interaction.
- Provide space for the interpreter or cultural mediator to raise concerns about interpretation challenges, such as dialectal differences or the flow of speech.
- Suggest reflecting together on the treatment or counseling, if you feel it would make a positive impact on future sessions.

- Inquire if the interpreter or cultural mediator has been emotionally affected by the session, particularly if it involved distressing topics (e.g., trauma, death, torture). If so, dedicate time to process these feelings.
- Complete any necessary forms, such as confirmation documents with billing details, date, duration, and signatures, if applicable.

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Unit 3.4: Interdisciplinary Collaboration in Mental Health and Psychosocial Support

Unit Overview
This unit covers the importance of interdisciplinary collaboration in addressing the mental health and psychosocial needs of migrants and refugees. It emphasizes the roles of various professionals, including mental health specialists, social workers, healthcare providers, interpreters, and volunteers, each contributing to a coordinated approach to care. The unit discusses multi-sectoral approaches to psychosocial interventions, focusing on strategies that enhance resilience and social cohesion. The IASC Guidelines and the MHPSS Intervention Pyramid are introduced as frameworks for structured support, emphasizing the integration of services along a complex continuum of care.

Unit Sections:

1. Introduction

Collaboration involves the joint efforts of multiple entities working together to reach a shared objective [1]. Working together in healthcare is crucial, not just for regular service provision but also for solving larger-scale challenges such as health issues and social inequalities. By joining forces, field workers can address these complex problems more effectively. Teamwork helps ensure everyone gets the care they need, especially those facing difficult circumstances.

As we have seen so far, mental health is not the sole domain of mental health professionals; rather, it is shaped by a constellation of interconnected factors. The collaboration of healthcare and other specialists can transform care outcomes by cultivating an environment rich in communication, mutual respect, and collaboration [1]. This is especially crucial when addressing the complex needs of migrant and refugee

populations. Here, interdisciplinary partnerships – bridging diverse fields and uniting various stakeholders and organizations – become indispensable [2]. Such collaborations create a tapestry of collective effort that can significantly enhance the mental health outcomes for migrants. Beyond immediate care, this united approach ensures culturally sensitive service delivery, equitable resource allocation, and a deeper resonance with the multifaceted needs of migrant communities [2].

2. Clarifying Roles and Scope of Action

Perhaps one of the most critical aspects of this ***interdisciplinary collaboration*** is understanding the unique roles and contributions of each professional involved. It is essential to recognize **who you are** in this network and **who the people you are working with are**. Understanding these roles not only clarifies the responsibilities but also facilitates better coordination among professionals. In this framework, each stakeholder holds a distinctive yet interwoven role in supporting the mental health journey of people on the move [3-7]:

Mental Health Professionals	Play a critical role in the diagnosis and treatment of severe mental health conditions given their specialized training and expertise. They may utilize a combination of evidence-based interventions (such as cognitive-behavioral therapy/CBT, trauma-focused therapy, and interpersonal psychotherapy/IPT) and transcultural approaches (see also Unit 2.3). Their work often includes (but is not limited to) conducting comprehensive mental health assessments, facilitating group therapy sessions, and addressing complex issues such as grief, loss, and adjustment challenges.
Social Workers	Complement the work of mental health professionals by addressing the social determinants of health that significantly impact psychosocial well-being (see also Unit 1.2). They provide direct psychosocial support through crisis intervention, case management, and advocacy. Social workers connect migrants to essential services, such as housing, employment, education, and legal aid, helping to reduce barriers to stability and integration. They also advocate for systemic changes to improve policies and programs that affect migrant populations. By coordinating community resources and fostering partnerships, social workers contribute to a holistic approach that addresses both the social and clinical dimensions of migrant mental health.
Healthcare Providers	Serve as frontline responders, delivering a wide range of medical services, from diagnosing and treating acute and chronic conditions to administering vaccinations and managing communicable diseases. In addition to providing care in clinical settings, they engage in public health initiatives such as health screenings, prenatal care, and

	immunization campaigns. They also focus on health promotion, disease prevention, and patient education. Uniquely, their role encompasses managing physical health concerns and coordinating care for complex medical conditions, setting them apart from psychologists and social workers, whose focus lies on mental health and social determinants of health, respectively.
Skilled Interpreters	Are essential in medical settings, ensuring accurate and culturally appropriate communication between healthcare providers and migrants. They play a critical role in obtaining informed consent, accurately conveying medical and psychosocial histories, and facilitating discussions about diagnoses and treatment plans. Unlike untrained interpreters or family members, skilled interpreters adhere to strict ethical standards, maintaining confidentiality and neutrality, thereby preventing miscommunication that could lead to medical errors or misunderstandings.
Volunteers	Offer practical support by assisting migrants and refugees with navigating healthcare systems, completing necessary paperwork, and attending appointments. They help reduce social isolation by connecting people with community resources and organizing support groups or integration activities. Volunteers also enhance the support network by identifying unmet needs and acting as liaisons between migrants/refugees and service providers, ensuring that resources and services are both accessible and welcoming.

◎ **Key Point:** ***Core Principles and Actions Recommended by UNHCR, IOM, and the WHO***

Here is a list of the core principles and actions recommended by UNHCR, IOM, and the WHO [11], for supporting the psychosocial needs of people on the move in the context of interdisciplinary teams.

Respect and Empowerment	Humane Support in Distress
Information Access	Psychoeducation
Child Protection	Family Support
Cultural Relevance and Interpretation	Identify Vulnerable Individuals
Severe Mental Conditions	Limit Psychotherapeutic Treatments
Staff & Volunteer Well-being	Coordination and Cooperation
Understand Roles and Responsibilities	Effective Communication
Holistic Approach to Care	Community Engagement
Advocacy and Policy	

3. Multi-Sectoral Approaches in Psychosocial Interventions

Psychosocial interventions are defined as "*interpersonal or informational activities, techniques, or strategies that target biological, behavioral, cognitive, emotional, interpersonal, social, or environmental factors with the aim of improving health functioning and well-being*" [8]. These interventions are crucial for migrants and refugees, as they address both individual and collective well-being, enhancing resilience, social cohesion, and integration. Effective psychosocial support, therefore, not only aims to alleviate distress but also fosters community ties, promoting mental health and well-being amidst the challenges of migration.

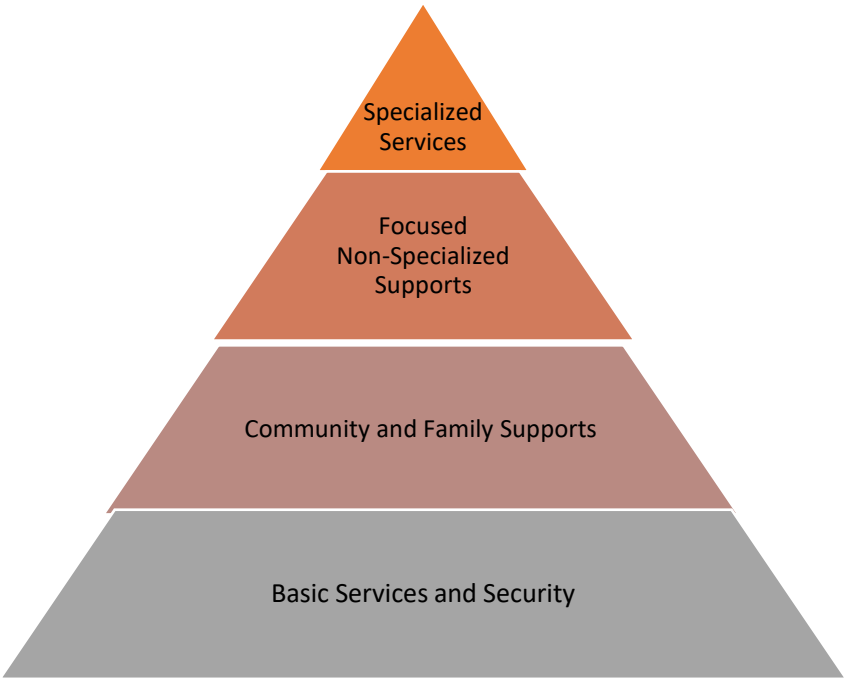
The 'do no harm' principle is fundamental in this context, as it helps ensure that interventions do not inadvertently worsen the vulnerabilities of affected populations. Migrants and refugees often encounter stressful and potentially harmful environments, including hostile reception, undignified conditions, and insecurity, which can further undermine their mental health. Psychosocial support must be provided in a way that respects the autonomy and dignity of individuals, ensuring that support is tailored to their specific needs and capacities.

The Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings [9], which were developed in 2007 by a coalition of over 35 humanitarian organizations, offer a comprehensive framework for implementing these interventions. They emphasize the importance of integrating mental health and psychosocial support into all aspects of humanitarian response, advocating for a holistic approach that encompasses community-based strategies, protection, and human rights standards. While they were initially developed for emergency settings, they are equally pertinent to everyday practice. In routine healthcare and social services, adopting these guidelines ensures that interventions are comprehensive, culturally sensitive, and rights-based, thereby enhancing the quality and effectiveness of support provided to migrants and refugees.

A critical concept in the IASC guidelines is the ***IASC MHPSS Intervention Pyramid***, which emerged as a result of a growing recognition of the need for a structured and comprehensive approach to mental health and psychosocial support. Prior to its development, there was a lack of clarity around how to address the

diverse psychosocial needs of affected populations, especially in crisis situations where resources were limited, and many different organizations were involved. Figure 3.4.1 provides an illustration of the IASC Intervention Pyramid. The pyramid consists of four layers, each addressing different levels of need:

Figure 3.4.1. *"IASC MHPSS Intervention Pyramid"*



Note: Graphic sourced from the IASC Guidelines on Mental Health and Psychosocial support in Emergency settings, 2007, pp. 12-13

Level	Description	Key Actions
Basic Services and Security	Focuses on ensuring safety and basic needs (food, shelter, water, healthcare) are met, promoting overall well-being through essential services.	Advocate for basic services, document impact on mental health, influence delivery to promote mental health, ensure services are participatory and socially appropriate.
Community and Family Supports	Targets people who need help accessing family and community supports, especially during disruptions such as displacement or separation.	Support family tracing, assist mourning, conduct communal healing, promote constructive coping, organize social networks (e.g., women's groups, youth clubs).
Focused, Non-Specialized Supports	Provides focused interventions for individuals requiring more specific support from trained but non-specialized workers, such as survivors of gender-based violence.	Offer emotional and livelihood support, Psychological First Aid (PFA), and basic mental health care by primary healthcare workers.

Level	Description	Key Actions
Specialized Services	For a small percentage of the population with severe mental health needs who require specialized psychological or psychiatric support.	Provide referrals to specialized services, initiate training for primary health care providers, offer long-term support for those with severe mental disorders.

IMPORTANT: Treating mental health conditions is typically a specialized service that comes at the upper level of this pyramid. However, in everyday practice, it is essential to ensure that needs at other levels are attended to. This is where interdisciplinary collaboration becomes crucial.

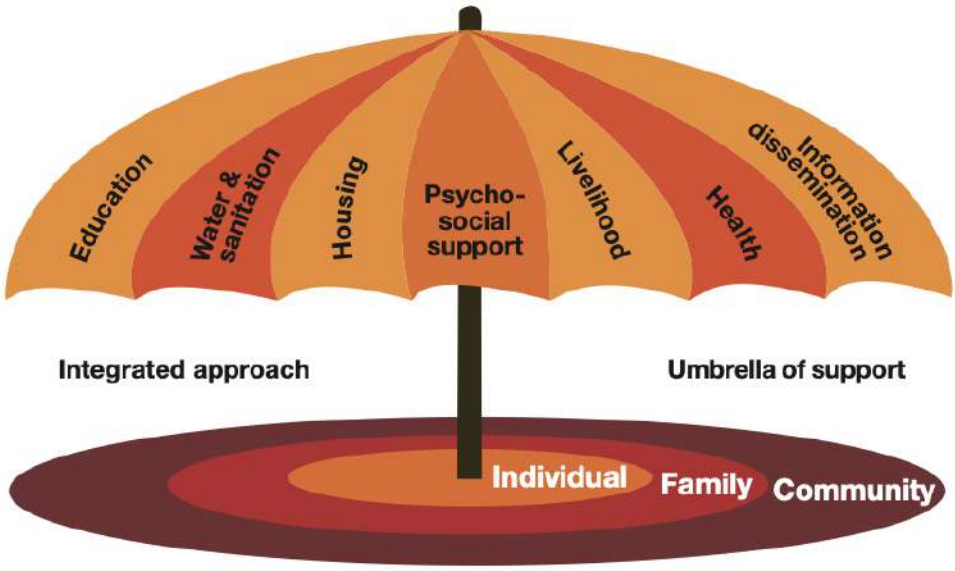
The work of a psychologist, for instance, goes beyond providing therapy; it involves collaboration with other professionals to address a range of needs. Before therapy can begin, a psychologist must first ensure that basic survival needs (such as food, shelter, and healthcare) are met. Without these, any psychological intervention would be ineffective. In this context, social workers can ensure that individuals have access to these basic services. At the same time, educators may provide educational support, offering both intellectual and emotional stability during uncertain times. As individuals start receiving the care they need, therapy can begin, but it is always shaped by the broader context. Psychologists may encourage people to join community support groups, where shared experiences help rebuild social connections. Alongside individual therapy, psychologists may work with healthcare providers to ensure that health concerns are addressed within general healthcare settings. For more complex mental health needs, psychologists may refer individuals for psychiatric support, ensuring a continuous, supportive care network.

This holistic approach highlights the importance of integrating basic services, community support, and specialized care. Each layer of the pyramid supports the others, helping to create a comprehensive, adaptable response to the mental health and psychosocial needs of affected populations.

Building upon the layers outlined in the IASC MHPSS Intervention Pyramid, the 'umbrella of support' model, illustrated in Figure 3.4.2 on the next page, enhances this framework by providing a structured, yet flexible, response to the complex needs of individuals, families, and communities. While the pyramid emphasizes the importance of basic services, community support, focused interventions, and specialized care, the umbrella of support model serves as a platform for integrating these various responses. It ensures

that psychosocial support is the central entry point, guiding the identification of needs across multiple sectors and fostering coordinated efforts [10].

Figure 3.4.2. *"Umbrella of Support to the Individual, Family, and Community"*



Source: Dr. Subhasis, American Red Cross and Indian Red Cross Society

Note: Graphic sourced from Thierry, M. (2019). Desk study: Official development assistance to child and family-focused mental health and psychosocial support (MHPSS), April-June 2019, p. 6

Given that psychosocial needs are constantly evolving, it is essential to ensure that interventions remain relevant and responsive to these changing needs.

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Unit 3.5: Responding to the Special Situation of Children

Unit Overview
This unit examines the distinct challenges faced by migrant and refugee children, including unaccompanied minors, and offers practical strategies for supporting their mental health and psychosocial well-being. It underscores the importance of understanding the varying mental health needs of this population, which differ by age and stage of migration. The unit also emphasizes the need for a coordinated, multi-agency approach to provide holistic care. Practical strategies for engagement (such as building trust, addressing basic needs first, and offering culturally sensitive support) are provided to equip field workers with the tools necessary to help children navigate their complex circumstances.

Unit Sections:

1. Introduction

The need for this unit is quite important, as ***displaced minors*** and ***unaccompanied and separated children (UASC)*** constitute a special category of people on the move. According to the literature, children are disproportionately impacted by forced displacement; they form 30% of the world's population but constitute 41% of all forcibly displaced people [1]. The data is clear: children of all ages are impacted by displacement. Specifically, based on the latest report by UNHCR, the estimation is that 29% of displaced children are aged 0–4 years, 42% are aged 5–11, and 29% are aged 12–17 [1], many of which are unaccompanied minors, with distinct vulnerabilities and needs, due to separation from, and loss of, their families [2]. Unaccompanied minors are also particularly vulnerable to psychosocial challenges, given that

they do not have support from parents to help mitigate migration-related stressors [1,2]. Girls are especially vulnerable in the context of being unaccompanied, with an estimated 10% being pregnant or mothers [1,2].

Therefore, a call for greater child-sensitive evidence and recognition about the mental health of these vulnerable groups is vital. Exposure to severe and chronic stressors in childhood (particularly in early childhood, when developmental systems are still maturing) may result in prolonged activation of stress response systems, which can lead to damaged, weakened bodily systems and brain architecture or toxic stress [1,3,4]. Displaced children and youth have an elevated risk of clinically significant mental health problems due to exposure to prolonged and cumulative adverse experiences that can have long-term impacts across childhood and into adulthood [1,3].

2. Children in Conflict, Adversity, and Displacement

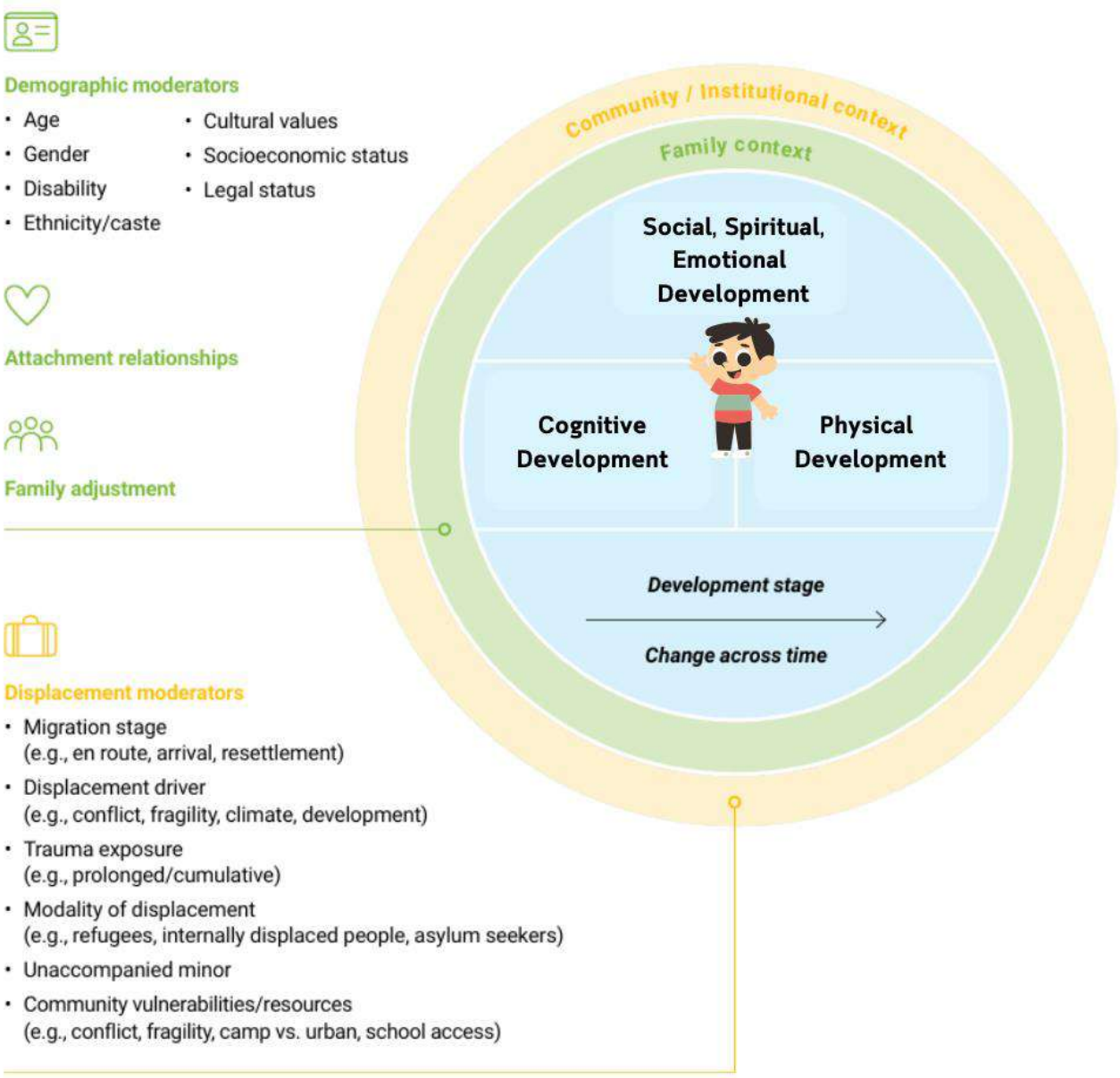
Children and Young People on the Move

According to the UN Convention on the Rights of the Child, ***children*** are defined as *"every human being below the age of 18 years, unless under the law applicable to the child, majority is attained earlier"* [4]. Refugee children represent a particularly vulnerable population, distinct from other refugee groups [7], due to their unique experiences during a highly sensitive developmental stage. Their exposure to adversity, loss, and upheaval during critical periods of physical, emotional, and cognitive development can have long-lasting effects on their mental health and overall well-being.

The mental health challenges faced by children and young people of the move are complex, arising from a confluence of factors that span pre-migration, peri-migration, and post-migration stages [7]. Children are inherently more vulnerable to the adverse effects of displacement because they are still in the process of developing the cognitive and emotional tools to cope with stress. Furthermore, migrant and refugee children are at risk of experiencing disrupted attachment bonds and difficulties with identity formation, which can contribute to mental health challenges. Research on the mental health of young migrants and refugees highlights the importance of understanding these challenges within the context of each migration phase, considering the risk and protective factors that may emerge at each stage [8]. Unit 1.2

and Unit 1.3 addressed the risk factors faced by adult migrant and refugees. An enhanced model of factors impacting the mental health and psychosocial well-being of children is provided below.

Figure 3.5.1. "*Conceptual Model of the Mental Health of Displaced Children*"



Note: Graphic re-produced by the EU-MiCare team based on information by UNICEF, 2023, Mental Health in Displaced Child and Youth Populations: A developmental and Family Systems Lens (p. 22).

Unaccompanied Minors

A special and vulnerable group of displaced children are unaccompanied minors. Not only is this group exposed to the same adversities as other displaced children, but they must also cope without the support of a caregiver since they lack the existence of a family. In addition, many minors deal with grief and loss due to separation from, or the death of, their parents [1,2]. Lacking this critical protective source increases the risk of being exposed to additional adverse experiences, abuse, and exploitation. Most unaccompanied minors are adolescent males aged 14 to 17 years, although the proportion of younger and unaccompanied minor girls is increasing [2].

Stages of Childhood and Adolescence

Moreover, the impact of displacement is different at various stages of childhood and adolescence. The following Table explains the different needs and reaction to stress in each age interval.

Age Intervals	Specific Needs	Reaction to Stress
0-5 years old	• Care • Protection • Responsiveness to their immediate physical and emotional needs	• Feeling overwhelmed, dissociation, or passivity • High levels of anxiety • Poor confidence, lack of self-agency • Difficulty to reach trust relationships and hard to engage
5-12 years old	• Education • Negotiating peer relationships and friendships • Becoming proficient in practical skills, while maintaining a safe base within the family	• Excessive sense of responsibility • Constant sense of failure due to their developmental inadequacy for what is asked
12-18 years old	Developmental tasks including: • acquiring personal independence • occupational skills • a sense of role and responsibility outside the family circle	• Deep sense of abandonment and loneliness • Sense of social disconnection accompanied by feelings of being discriminated → consequent disaffection

Note: Adapted from Maloney, C., Nelki, J., & Summers, A. (Eds.). (2022). *Seeking asylum and mental health: A practical guide for professionals*. Cambridge University Press.

Between the ages of 0–5 years old, displacement primarily affects physical growth and brain development. It may also affect emotional development [10]. Regarding middle childhood (5–12 years old), the

development of independence and autonomy, in relationship to parents, peers, and other adults. The child learns behavioral codes, begins to assimilate cultural values and rituals, including religious practices, and develops an understanding of moral frameworks [10]. For adolescents, the neurodevelopmental processes underpin these behavioral changes, including molding and maturation of neuronal circuits for social cognition and self-regulation [10]. Lastly, it is reported that higher rates of mental health problems exist in older children compared to younger ones, such as higher rates of trauma and challenges to emotional self-control (e.g., emotional dysregulation), PTSD, depression, and anxiety [1,8].

More information on the risk and protective factors faced by migrant and refugee children is provided in the 🕮 Repository (see 3.5 – *"Useful Resources"*).

3. Practical Strategies for Working with Children on the Move

To develop effective strategies for supporting migrant and refugee children, it is crucial to build the capacity of key stakeholders, including parents, guardians, educators, and other caregivers, to provide mental health and psychosocial support. This requires equipping them with the knowledge and tools to understand the complex needs of children and to create environments that promote healing and resilience. Specifically, it is essential for caregivers to understand:

1. How ensuring access to safe and nurturing environments will have a positive impact on the mental health and psychosocial well-being of children and adolescents.
2. How their mental health and well-being affect that of the child in their care.
3. What the direct link is between children's and adolescents' mental health and psychosocial well-being and the quality of their relationships [1,9].

The questions outlined in the following page provide a useful framework for engagement and exploration during appointments with children and young people [10]. Remember to foster an open, non-judgmental atmosphere by showing curiosity about cultural beliefs, and ask open-ended questions to see how these may influence the child's experiences. Allow children and youth some agency in the process, respecting their boundaries by giving them control over what to share and when to share it.

Question	Reasoning
Do you want to talk or play or draw? You don't have to talk if you don't want to.	Sometimes children and young people prefer to play, draw, or even just to listen to start with.
What would you like to get help with?	A child may be missing things like a phone, bike, a toy or a pet, and want to talk about these first. Sometimes a solution-focused approach may lead to relatively fast gains and may help in developing trust and engagement. Discussion of important day-to-day upsets, such as loneliness or shyness, may gradually lead to other important issues like shame and guilt. Visual aids may help, such as drawing a map of the areas that need addressing.
What do we need to know to understand you?	Ask questions in an interested, non-judgmental way about their background, e.g., about where they grew up or the games they used to play. What are their hopes and dreams? These questions can help the child feel someone genuinely wants to know who they are.
How is life here? What is best? What is hard? What is missing?	Children, especially unaccompanied minors, often primarily want to get on with their lives in the host country, and a conversation around their life here may be more likely to engage them initially. It may also allow them to express their disappointment and feelings like homesickness and missing loved ones.
Who decided you had to leave, and why?	This begins a conversation about what has happened to them.
What helped you to cope? What are you good at? What do you enjoy? Who helped you to cope?	Asking first about achievements, exploring good experiences, resources, and coping skills focuses on strengths rather than problems. This may also help identify other significant adults (and peers). It may be used to ask the child to imagine what these people would have said about the current situation.
Who did you help along the way?	Remind the child of having agency, competence, and concern for others.
What support do you have now?	Maybe draw a 'map' of the relationships around the child, and what makes each special. This may include parents, extended family, family in the home country, foster parents, support workers, social services, school, doctors, lawyers, charities, and volunteers. This map may enhance the sense of support and connectedness and can be referred back to later. Support that has been lost might also be included, as a way of thinking about how it might be recovered. The social network supports recovery and growth, and its strengths and weaknesses need to be borne in mind when planning any intervention.
What happened?	When the child is ready to talk about the past, use prompts for both positive and negative memories. What else was going on in their life when things went wrong? Be mindful of the developmental impact of positive and negative events. How do they understand things now if they look back? Were there things they did, or were made to do, that they feel bad about? Are there things they feel proud of? What are they?

Note: Adapted from Maloney, C., Nelki, J., & Summers, A. (Eds.). (2022). *Seeking asylum and mental health: A practical guide for professionals*. Cambridge University Press.

In developing a comprehensive assessment for a child or young person, it is essential to take into account several factors that influence their well-being.

- Consider the developmental stage of the child, both in terms of their current emotional and psychological state and how past events may have shaped their development.
- Pay special attention to the disruption of early attachments, as adverse events leading to migration may have caused separations from primary caregivers or disrupted established bonds.
- Acknowledge the shift in family roles during migration, which can place additional burdens on children without them recognizing these new responsibilities, potentially affecting their emotional and psychological health.
- Assess the child's experience at school, including their social and academic coping, and whether their performance has changed compared to before migration.
- Obtain third-party information from family members, teachers, or social services to gain a fuller understanding of the child's experience.

Working with migrant and refugee children and youth requires a coordinated approach that involves collaboration among a wide range of agencies and organizations (see also Unit 3.4). This includes schools, community groups, primary care services, local authorities, and third-sector organizations [1,8,9]. Children and young people in these situations have complex, multifaceted needs, dealing simultaneously with loss, adversity, and new experiences. They often have limited access to services prior to their arrival in a host country, so field workers may need to take on advocacy roles, assisting with basic needs such as accommodation, schooling, and connecting them to appropriate support systems. Building a strong network is crucial to providing holistic care and ensuring that the child's psychosocial well-being is supported within a broader context.

Engagement with migrant and refugee children can be challenging, as many may view adults with suspicion due to past experiences, cultural differences, or concerns about the field worker's connection to immigration authorities. To overcome these barriers, it is important to frame the worker's role in terms

that resonate with the child's cultural background. For example, asking who they would have spoken to back home when confused or upset can help the child understand your role.

Additionally, peer support is critical, as peers often bridge the gap between old and new cultures, facilitating acceptance of mental health support. Engaging children in less formal settings, such as through sports or group activities, can also make them more comfortable with other interventions. For unaccompanied migrant youth transitioning to adulthood, who might be at risk of losing the required professional support upon reaching the age of 18, peer support groups can offer a valuable network that remains available beyond this age [1,2]. Ideally, these young people will have access to an interdisciplinary team to manage their case, ensuring ongoing support during this critical transition [2,9].

Before diving into mental health interventions, it is essential to attend to the basics, such as ensuring the child's safety and social connectedness. For unaccompanied minors, this may involve liaising with social services to prevent exploitation or gang involvement. Creating a safe environment and helping children build social networks are priorities in the early stages of engagement. Children in temporary accommodation may benefit from connecting to local support groups, and families may need assistance in re-establishing family roles. Schools can be a vital resource, but they may also present challenges such as bullying or academic pressure, so it is important to work with schools to ensure they understand the specific needs of migrant and refugee children.

Psychosocial interventions should be tailored to the unique experiences of each child, adopting a gradual and developmentally appropriate approach. For some children, particularly those who have faced extreme adversity, more specialized interventions may be required. However, it is important that these interventions are introduced only when the child is stable enough to engage. In the early stages, simpler interventions, such as normalizing intrusive thoughts or providing relaxation techniques, can help alleviate distress. Creative therapies, including art, music, or play-based therapies, are often effective for children who have difficulty verbalizing their experiences. The table on the next page summarizes some approaches to supporting unaccompanied young people, which may also benefit children in other situations, including those in family contexts [10].

Enhance the network	Young people are highly sensitive to social exclusion and loneliness, but strongly receptive to peer advice and influence. It is important to foster connections with peers both in similar situations, and who have been in the UK longer and who can act as 'bridge builders.' Also consider enhancing connections with family members back home or elsewhere, and cultural activities relating to both their own and to UK culture.
Relate to hopes and dreams first	Unaccompanied young people have often set out (or been sent out) with great hopes for the future and want to keep moving forwards. Kohli (Digital Notebooks For Social Work — Apprentis d'Auteuil, no date) suggests that relating to the future first, and then dealing with present challenges before addressing the past may align the therapist with the young person's perceived trajectory and support engagement.
Manage distress	Self-management of overarousal is likely to be needed in order to establish and maintain new social connections and open up opportunities for new learning. In group programmes, games can not only promote light-hearted connectedness but also facilitate discovery about activities that help reduce stress. For example, participants may be asked after the game what they think helped them to feel better (e.g. 'doing something together,' being active, distraction), and brainstorm how this could be done outside the session.
Break the silence	Facilitating some sharing of experiences amongst peers has also been highlighted as promoting recovery (Majumder, 2016). This can help young people feel validated and that their responses are normal, as well as drawing some meaning out of their journeys.
Support self-agency and independence	Recognising and addressing needs for independence and self-agency alongside their needs for support connects with their developmental needs at this stage. It is also necessary preparation for service withdrawal when they reach 18.

Note: Adapted from Maloney, C., Nelki, J., & Summers, A. (Eds.). (2022). *Seeking asylum and mental health: A practical guide for professionals*. Cambridge University Press.

The transition of displaced children, particularly unaccompanied minors, to adulthood is:

- Time-consuming,
- An interdisciplinary process that demands clear communication within and between institutions,
- Dependent on transparency and consultation with the young people to effectively prepare and support them during this period of significant change.

Various factors influencing the success of the path to autonomy must be considered to provide each young person with the appropriate and necessary support [1,2,8,9].

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Repository

Module 3. Improving Skills in Managing Migrants' Mental Health Needs

The information provided hereafter is supplementary and not part of the core material of this Module.

However, learners seeking a more thorough understanding of the subject matter are strongly advised to review this document in addition to the main curriculum.

Unit: 3.2 Cultural Awareness

Handout 1: *"Cultural Competence – Case Studies and Best Practices"*

Is Poverty Making Me Sick? An Example of the Impact of Medical-Legal Partnership on Keeping Children Healthy

Introduction

Physicians who serve vulnerable patient populations often struggle to identify and address risks related to the social determinants of health (SDH). These often complex structural issues and institutional barriers affect patients' health and include risks related to substandard housing and lack of access to basic supports like health insurance and food assistance. Many of these barriers to health have significant legal underpinnings – e.g., enforcement of housing safety ordinances and erroneous delays and denials of eligibility for Medicaid and programs like the Supplemental Nutrition Assistance Program (SNAP). Still, it can be overwhelming and discouraging for physicians as they try to tackle such complex nonclinical issues on their own. Physicians need partners, both inside the clinic and in the community, to effectively address the needs of their patients. The following case study explores the value of the medical-legal partnership (MLP) approach in addressing risks related to the SDH. MLPs embed legal professionals and law students alongside healthcare professionals to address social and structural barriers to patient and population health through training and education, consultation, referral, and collaborative upstream problem-solving [1].

Below, we introduce a clinical case in order to illustrate the ways that MLPs can provide an evidence-based approach to identifying and managing health-relevant social and environmental risks. The case is one that is not uncommon in pediatrics; although similar issues could come up in other practice areas, including family medicine and obstetrics. Specifically, through the case below, we illustrate the value of a systematic approach to SDH screening, referral of appropriate cases to an MLP's legal advocates, and ongoing analysis of population-level patterns that emerge from individual patient cases reviewed by MLPs. We highlight how such strategies

ultimately empower clinicians to affect structural changes in ways that can improve the health of their individual patients and their patient panels more broadly.

Section 1: A Common Medical Case

It is a hot day in early summer. You cannot believe it is more than 90° in May. You are thankful for air conditioning, to say the least! You are a 2nd year pediatric resident with a busy schedule, and your first patient just arrived. You look down at your docket for the day only to see the appointment is a "twofer," a brother and sister coming to see you together. The brother is a 7-year-old boy named Chris. He is being seen for a follow-up visit as he was discharged from the hospital 2 days ago. His sister, Brianna, is being seen for a weight check; she is 2 months old with a chief complaint of "poor weight gain." You try to spend your last minute before knocking on their door preparing yourself for the visit. How will you assess their medical risks? Are there other concerns or triggers likely to be raised? How will you respond? Will this be a quick in-and-out visit, or are you poised to start your day behind? Finally ready, you knock on the door.

You start with Chris. Between your review of the electronic health record and your discussion with him and his mother, Ms. Williams, you uncover the following. Just days ago, Chris was hospitalized for roughly 48 h due to an acute asthma exacerbation. He is a known asthmatic, and this is his third lifetime admission; his second was in the last 6 months. He has also visited the emergency department multiple times for asthma in the last year. During his recent inpatient stay, he was placed on the evidence-based protocol for asthma management and left the hospital feeling better than when he was admitted. He is on two daily controller medications, and Chris and Ms. Williams report that he takes them both "most of the time." On your physical examination, Chris seems to be breathing comfortably. He is not actively wheezing. You are pleased that he seems to have improved from his acute asthma attack.

You move on to his younger sister, Brianna. Prior to entering the room, you had noticed some concerning aspects of her growth curve. She has not been growing at the velocity that you would have liked to have seen. This is also not a new complaint or concern – Brianna was recently seen by a colleague of yours who had been tracking her weight closely. The dietician saw her at the last visit as well. Ms. Williams says that Brianna continues to exclusively breastfeed and does not have any emesis. Ms. Williams is fairly certain she has adequate milk supply; the child latches well and is feeding every 3 h, even at night. Brianna has had the requisite number of wet and dirty diapers. Her physical examination is normal and does not point to any specific organic causes of her poor weight gain.

You leave the room to discuss both of these children with your preceptor. To summarize, you have a 7-year-old boy who has gotten over the worst of an acute asthma exacerbation and a 2-month-old girl who, you are worried, is failing to thrive. For Chris, you are tempted to ensure that he has adequate supply of his acute and chronic asthma medications and plan to see him back in 2–3 months. For Brianna, you are contemplating asking Ms. Williams to fill out a detailed feeding diary to more effectively identify how much Brianna is truly eating.

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You are then considering a follow-up visit with both in 1 month. Are these plans adequate? Would other, as yet unasked, questions lead you down different paths, ones that could more effectively identify and address common root causes? Can we look at these same cases using a different lens?

Section 2: Shifting Perspective

We frequently fall into heuristics that prompt us to see clinical cases narrowly. As physicians, we may become accustomed to treating certain ailments in certain ways such that we may miss clues that would appropriately take us off that standard path. For example, asthma is generally treated using evidence-based protocols. These protocols help us to effectively manage acute exacerbations or attacks. They may not, however, provide us with the tools to identify triggers of that attack. Such protocols can at times create blinders, streamlining, and/or oversimplifying our approach to problems or issues that may be inherently complex [2]. How can we break free from a mindset that might be limiting our ability to see the forest for the trees (without, of course, ignoring the trees themselves)?

Health inequities in childhood are widespread and are often exacerbated by risks related to the SDH. For example, much is now known about the higher incidence and severity of asthma among children who live in substandard housing [3,4,5]. Although children living in low-income households are somewhat more likely to be diagnosed with asthma, they are far more likely to suffer the worst outcomes due in large part to adverse environmental exposures [2, 5,6,7] – they are far more likely to experience the attacks endured by our previously referenced 7-year-old patient, Chris. Indeed, exposures to water damage, mold and mildew, pests like cockroaches and rodents, tobacco smoke, and pollutants are all known to make asthma worse [8,9,10,11]. As another example, we know that hunger and food insecurity are exceedingly common in this country. Roughly one in four children lives in food-insecure households, where a food-secure household is defined by the US Department of Agriculture (USDA) as "access by all people at all times to enough food for an active, healthy life" [12, 13]. The rate of food insecurity is likely to be even higher within at-risk, under-resourced populations served by many academic primary care centers [14, 15]. As such, identifying these types of triggers and risks, such as adverse housing and food insecurity, as part of routine screening is gaining favor as a key component of preventive, outpatient care and is also starting to be implemented in some inpatient settings [16,17,18].

Of course, identifying risks is one thing, but overcoming those risks is the ultimate goal. However, physicians and those working within clinical settings may not have the requisite expertise to act appropriately. Community partners, organizations, and agencies with needed, complementary expertise may be critical adjuvants to the services clinicians and medical professionals can provide.

An MLP is an interdisciplinary collaboration between a medical entity such as a clinic or hospital and a legal entity such as an attorney, legal aid office, or law school. MLP partners approach improving health for their target population by addressing risks related to the SDH. By helping medical partners to identify and address legal barriers that may cause or exacerbate health problems, legal professionals can be key members of the

healthcare team [19, 20]. Since addressing these legal barriers, which are frequently synonymous with risks related to the SDH, often requires a multidisciplinary team approach, MLP is an important component of medical education in structural competence. Training medical students and residents in the MLP approach is an opportunity to impart to the next generation of physicians the knowledge, skills, and attitudes to recognize and address barriers to health on the patient, clinic/institution, and population levels [21, 22].

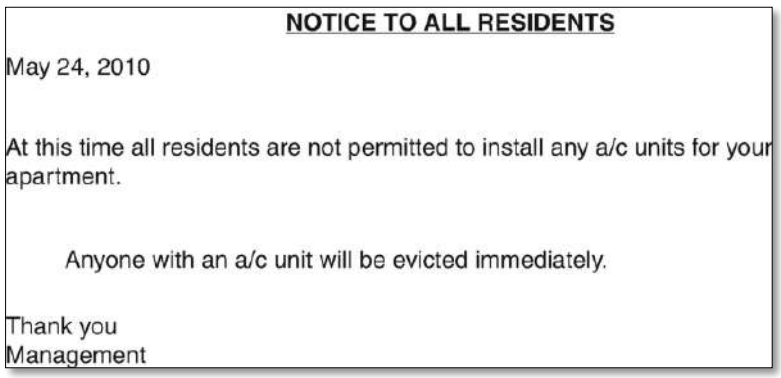
To illustrate this point, let us return to our case, this time, imagining that there was a legal advocate just down the hall for the resident to consult, and she offered to join the resident in their visit.

Section 3: Revisiting This Common Medical Case with Added Perspective

After you, the pediatric resident, left the room the last time, you realized you needed help. Yes, Chris' asthma symptoms were better, but you were really worried that he was at high risk of being rehospitalized in the future. Yes, Brianna's failing to thrive did not appear to have an organic cause, but you just could not understand why she was not growing. As you discussed these concerns with your preceptor, she suggested you go back to the room to obtain more history. She recommended posing questions to the family about their in-home exposures, their experience with their public benefits, and their ability to keep food on the table. She handed you a form with validated social history questions relevant to these and other SDH. She also showed you where, within the electronic health record, these same questions were referenced and could be documented [16, 17, 23, 24]. Armed with this guidance, you return to the patients' room.

Once again, you start with Chris. You ask him and his mother if they have thoughts about what might have triggered his asthma attack. Although Ms. Williams is unsure, she says Chris seems to be really sensitive to temperature swings. He has not been doing so well with the recent heat wave that has been hitting the city, especially considering that those occupying apartment units at her building have been told that they are not allowed to have window air conditioning units. She pulls out a paper she has in her purse, one that had been posted on her front door just days before (see Figure 3.2.1-R).

Figure 3.2.1-R



NOTICE TO ALL RESIDENTS

May 24, 2010

At this time all residents are not permitted to install any a/c units for your apartment.

Anyone with an a/c unit will be evicted immediately.

Thank you
Management

She also mentions that her apartment unit "is riddled with cockroaches, the ceiling is falling in, and [her] landlord isn't responsive to [her] concerns." She takes out her phone and shows you some pictures (Figure 3.2.2-R).

Figure 3.2.2-R

You are horrified and do not know quite what to say. You thank her for her honesty and express your uncertainty at how to respond. You tell the mother that you would like to discuss this new information with your preceptor. First, however, you had a few more questions about Brianna. You ask Ms. Williams about whether she is currently receiving public benefits for herself, the family, or the infant. The mother notes that she has the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) [25] and has applied for SNAP (i.e., food stamps) [26], but she has not yet received her SNAP benefits and cannot determine the status of her application. You feel similarly confused, at a loss for how to continue. You excuse yourself from the room and return to your preceptor.

You tell your preceptor this new information, about how you think that, perhaps, the problems experienced by both Chris and Brianna may have their origins in these newly uncovered factors. Listening intently, your preceptor recommends that you speak with the legal advocate down the hall, who is a member of your clinic's MLP. This advocate has expertise in the legal rights of people with low income. You knock on their door curious about how they will add to your assessment and about whether they will be able to devise care plans that add value to your own. With the legal advocate, you review both of the cases and contemplate additional questions you might pose to the family, questions that may direct the legal care plan in more specific ways. You then go back to the room, explain to Ms. Williams that there are legal professionals right there in the clinic with expertise in some of the problems she is facing, and ask her if it would be okay to bring the advocate in to meet her. After she says yes, you return once again to the room, this time with the advocate by your side.

After introducing your partner from the MLP, the legal advocate jumps in with a clear awareness of some potentially important questions that build upon your assessment. She asks the mother, "What is your address? Who is the landlord? Has the local health or building department inspected your apartment for code violations?" Ms. Williams was initially surprised to learn she might get housing help at her children's doctor visit, but she is glad to speak with anyone who may be able to assist. She states that they live in a multiunit apartment building in a neighborhood just blocks from the hospital, one characterized by high rates of poverty and crime. No one has inspected their apartment for code violations. The legal advocate knows the area well and knows the landlord by reputation. You think to yourself that you would have never asked these questions, questions that already have led you down a far different path than where you were mere moments before.

With this new perspective, you are now curious about how the legal advocate will approach Brianna. She asks some quick follow-up questions relevant to the infant's case, focusing first on the family's benefits: "When did you apply? Have you turned in all the documentation on your household size and income that the public benefits office needs? What have they told you?" The mother replies that her application went in the same week Brianna was born and she has done everything the public benefits office asked. She has been bounced around from one caseworker to another whenever she has tried to follow up. As a result, the household is struggling to put food on the table. She is pleased that she has been able to continue breastfeeding Brianna, but she has been forced to feed Chris "Hamburger Helper" without the meat. As for herself, she is eating only oatmeal once or twice a day.

You step out of the room to let the legal advocate continue to obtain history from Ms. Williams and formulate her plan. You feel increasingly like albuterol alone will not help Chris and that a feeding diary for Brianna may be wholly insufficient. You relay what you just heard to your preceptor and the other residents and medical students in the office's workroom. You contemplate the breadth of what you just heard, the questions the advocate asked that you would not have considered. You had never thought of asking about the neighborhood, about the landlord, and about certain aspects of public benefits. You had never considered how to expand your social history to reach those social and environmental factors clearly at the core of your patients' experienced morbidity. How could that be changed? You find that even in the short time, you were with the legal advocate and you learned quite a bit. You make a mental note of key questions that you might pose to future patients to help you identify legal and structural barriers and consider making other MLP referrals.

Section 4: Co-developed Educational Curricula on the Social Determinants of Health

The questions that the resident started grappling with as described within the section above were posed at the primary care centers of Cincinnati Children's Hospital Medical Center (CCHMC) several years ago. What could and should families be screened for? Evidence suggests the majority of low-income families receiving care at urban pediatric clinics report at least one unmet basic need related to underlying poverty; many report several such needs [24, 27]. A recent survey at CCHMC highlighted that 28% of primary care families had their gas or electricity shut off in the previous year; 23% had doubled up (lived with others to pay the rent) or moved to a

cheaper residence; 14% of mothers diluted their formula to make it last longer; and 33% had run out of food without money to buy more [14, 15].

Based on the information from these and other local surveys, risks related to the SDH have emerged as significant issues to be addressed consistently with families in the Pediatric Primary Care Center (PPCC) at CCHMC. The recognition of their importance grew alongside CCHMC's MLP, the Cincinnati Child Health-Law Partnership (Child HeLP), a partnership between the hospital's primary care centers and the nonprofit Legal Aid Society of Greater Cincinnati (Legal Aid) [28]. Child HeLP launched in 2008 to assist medical providers and social workers with helping patient-families resolve social and legal problems by adding legal advocates (i.e., attorneys and paralegals) from Legal Aid to the healthcare team [19]. SDH screening processes were initiated through the electronic health record and now routinely occur in over 90% of primary care encounters [16, 24]. Screening questions address housing conditions, food insecurity, public benefits denials and delays, mental health concerns, intimate partner violence, barriers to education, and availability of transportation. Questions were selected after a review of existing evidence and discussions with our key community partners, including legal advocates from the MLP. Questions were also tested for feedback from those that mattered most, patients and their families. The enhanced social screening processes enable clinicians and social workers to more effectively identify patients to refer to the MLP.

As the expanded social history was deployed and as Child HeLP developed and grew, curricula were put into place to train pediatric residents on the relevance and importance of the SDH. A series of didactic and experiential learning sessions were co-developed with medical and legal staff. The facilitated didactic sessions focus on legal rights (e.g., landlord-tenant laws, public benefits eligibility) and are delivered by an interdisciplinary team of pediatricians and legal advocates. Immersion experiences take learners out of the clinic and into the local public benefits office, a large food bank, and a neighborhood that is home to many PPCC patients. Within this neighborhood, learners meet local leaders (e.g., elementary school principal, community center manager) who paint a picture of what life is like within that community. To improve how SDH were discussed with patients, the team also has put into place a "video curriculum" that provides realistic examples of how to discuss social risks and resources with families. Videos include scenarios where interactions and interventions are solely medically based compared to those that also address underlying social issues. Videos include first-hand testimony from families as to how they experienced discussions of risks and ensuing actions (i.e., their experience with Child HeLP). Early evidence suggests that these educational pursuits have led to increased comfort by residents in addressing the SDH as well as more referrals to our available resources [16, 29,30,31,32,33]. These available resources, most notably Child HeLP, have led to key positive outcomes at both the patient and population levels [19, 34].

Section 5: Moving from Patient to Population Health Together

The legal advocate returns from her office to discuss next steps related to Chris and Brianna. After confirming that Ms. Williams has authorized her to discuss this information with you, she starts with Chris. She tells you that she immediately knew this complaint sounded familiar to her. A legal colleague had mentioned in passing

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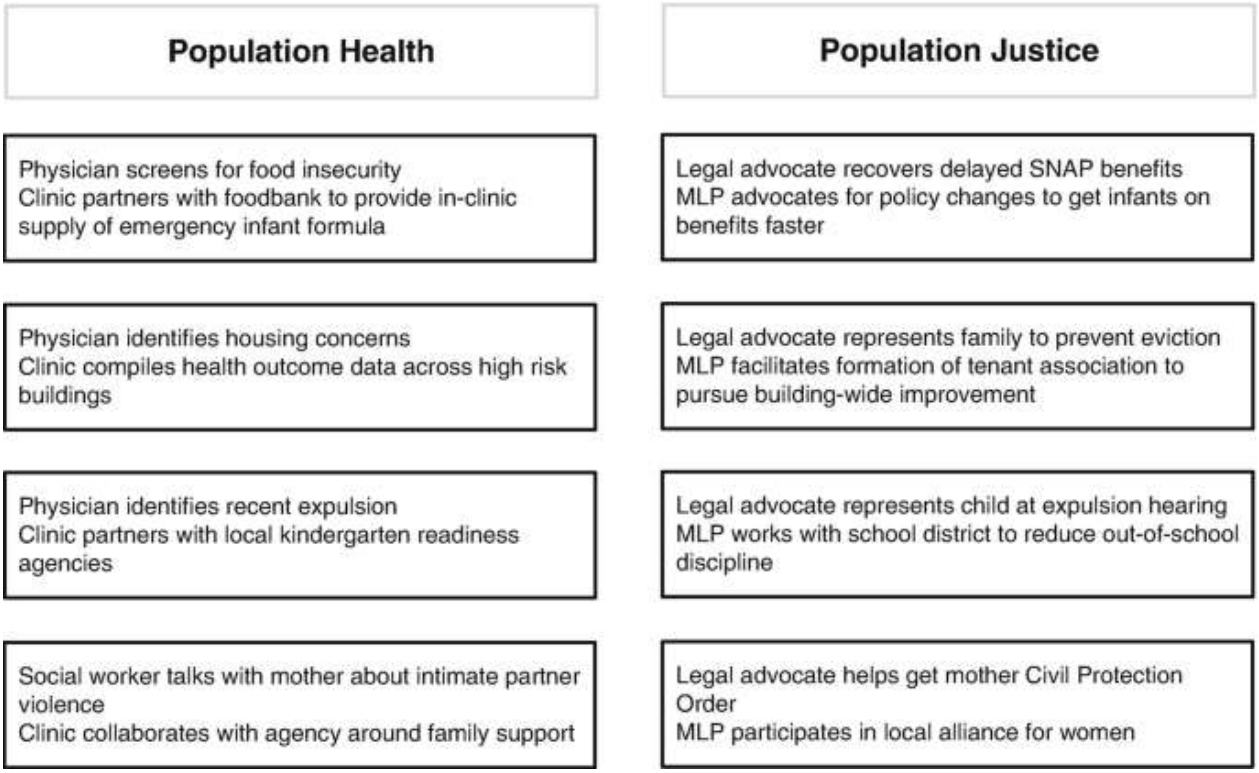
just days earlier that one of her clients had reported that her landlord threatened eviction over putting in a window air conditioning unit. When the legal advocate went back to substantiate this in the Legal Aid case management database, to ensure that her memory served her well, she identified that this was not just a coincidence. It was an "outbreak" of substandard housing amenable to collective action. In the preceding weeks, there had been more than 15 referrals to Child HeLP from buildings managed by the same out-of-state landlord. Publically available city data suggested that each of the 19 complexes managed by this landlord had outstanding violations of city housing ordinances [34]. This "outbreak" called for action in the short and long terms. It also called for action for Chris and his family, as well as his neighbors and fellow tenants. In this sense, individual cases collectively highlighted a structural issue amenable to a structural intervention. This occurred because multiple cases were brought to the same partners, a key aspect of MLP enabling both individualized and population-wide action.

What about Chris' sister Brianna? What about the food insecurity that was also plaguing this family? The legal advocate had news there, too. After advocacy with the local public benefits office, she secured SNAP benefits for the family by the end of the day. Benefits were issued retroactively to the months since Ms. Williams's application was filed because of the county's failure to meet its legal duty to provide benefits in a timely manner. Ms. Williams received nearly $500.00 in food assistance that week and the confidence that she would be able to feed herself and her children moving forward.

Over time, Child HeLP's assistance continued for the Williams family had expanded to benefit other similarly situated families. For example, a Legal Aid attorney was connected to Ms. Williams and educated her on her legal rights to healthy housing and the process for filing an escrow case in court to legally withhold her rent payments until the landlord made legally required repairs. The attorney also filed complaints with the local health and building departments that enforce health and safety ordinances. This strategy was a clear example of "population justice" occurring in the confines of the primary care clinic. It was also a clear example of how patient health was quickly ratcheted up, becoming an indicator of population health; again a unique reality made possible by the MLP. Indeed, one child in one housing unit quickly expanded to include the other 15 units the MLP had identified, placing them within a larger cadre of nearly 700 low-income housing units that were at potential risk [34].

It is in this space that population health can be quickly linked to population justice (Figure 3.2.3-R).

Figure 3.2.3-R



Collaborative work by the MLP led to this identification of a large cluster, an "outbreak," of substandard, poor-quality housing conditions. This collaborative response improved the housing situation for individual patients and families, and it also created linkages between tenants leading to meaningful community-wide housing improvements. Indeed, organization and advocacy promoted by the MLP led to improvements for both the "sick child" (Chris and other tenants with asthma who were patients of CCHMC) and the portfolio of more than 19 "sick buildings" (those managed by the out-of-state landlord). Here, asthma was a common health issue among the children identified by the MLP, but many other health problems are known to be associated with stress and with substandard housing in particular [10, 34].

Limiting or removing asthma triggers in housing units with high-risk children makes a difference. Over the months that followed, the MLP led building- and complex-wide activities devoted to improving home environmental conditions for referred children and families as well as the broader tenant population. A team of Legal Aid attorneys and advocates helped to organize a tenant association and utilized litigation and other legal strategies to obtain substantial improvements. Of the 19 buildings in the out-of-state landlord's portfolio, 11 received significant systemic repairs (e.g., a new roof, new windows). This particular portfolio of buildings, which the absentee out-of-state landlord ultimately allowed to go into foreclosure, was subsequently purchased by a nonprofit developer. This new developer is now working with other community agencies, and

a large grant from the Department of Housing and Urban Development, to rejuvenate these buildings inside and out. Legal Aid continued to advocate for further improvements and maintenance to ensure that the buildings are affordable and healthy.

Williams' situation also provided a means through which the MLP could facilitate a jump from patient to population and from population health to population justice in the area of nutrition and food security. The legal advocate and her colleagues saw this case, among others, as indicative of an alarming trend toward increasingly lengthy application processing delays for SNAP. Indeed, a large percentage of eligible families were not getting their applications for their public benefits approved by the 30-day deadline required by law. This observation was found to be part of a broader, system-wide issue, identified through Legal Aid's active surveillance of publically available data on the timeliness of public benefit application processing (i.e., time from application to decision). Then, through negotiation with the local public benefits agency, Legal Aid attorneys secured systemic changes in application processing procedures that resulted in a 30% increase in timely food assistance application decisions in just 4 months. Continued advocacy has greatly increased the numbers of applications processed in a timely fashion and ensured that other children and families in the community get the help they need to reduce food insecurity.

Section 6: A Common Medical (-Legal) Case with a Happy Outcome

It is a brisk fall morning. You are excited because today you will be following up with two of your favorite patients for their well-child checks – a now 8-year-old Chris and his now 7-month-old sister Brianna. Outside the room, you reflect on how your practice has changed in the past few months. Not only have you become more adept at screening for and addressing risks related to the SDH, but the ongoing broader advocacy undertaken by Child HeLP has also given you increased structural competency. You have come to understand and appreciate how existing systems – within the four walls of the primary care center and within the broader community – have a strong influence over the health of your patients. You have also watched as improvements to those various systems have directly resulted from advocacy by Child HeLP. It has been inspiring for you to be a part of that interdisciplinary team.

You enter the room and start with Chris, asking all the questions you have now grown accustomed to asking, considering those interventions, both medical and social, that are now part of your armamentarium. Chris has had a wonderful summer and a happy start to the school year. He says he wants to be a scientist. He has been taking his daily asthma controller medications without any issues and has rarely required his rescue medication. His home is free of cockroaches and the ceiling and walls of his home have been fixed. Ms. Williams states that repairs across the building are ongoing. Chris has not been to the emergency department since last spring.

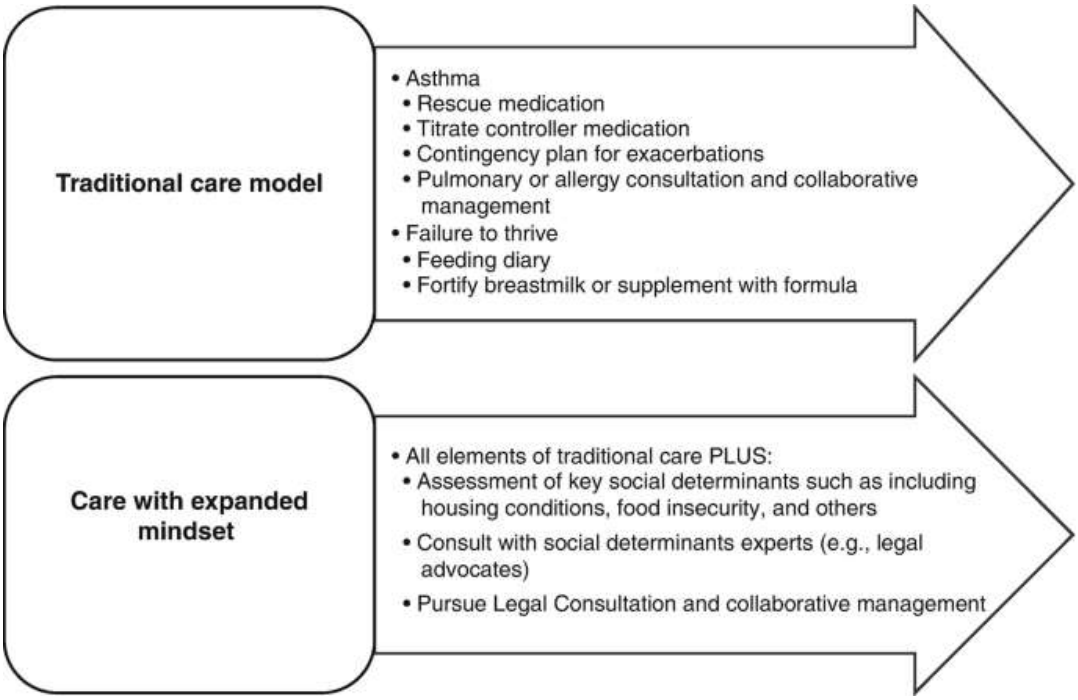
You turn to Brianna who looks like a different baby. She continues to breastfeed and has also started to receive solid foods. She is back on the growth curve such that you would never know, just by looking at her, that she had ever failed to thrive. Ms. Williams appears healthier and happier, too. She tells you the family no longer

goes without food – WIC and SNAP benefits are helping the family considerably. She and Chris are eating three meals a day; Ms. Williams only eats oatmeal when she wants to eat oatmeal. While you are talking, you smile as you hear Brianna babbling in the background. As you leave the room to place your orders, you walk by the Child HeLP office to express gratitude. You have come to understand that referrals to or consults of community experts are often just, if not more impactful, referrals to or consults of medical experts.

Conclusion

Clinical providers and legal advocates, as part of a broadly conceived healthcare team, can be an effective force for change. Indeed, attorneys and paralegals can help physicians and nurses understand social determinants. They can also partner with healthcare providers to use the law as a tool to address key risks, to intervene, and to advocate for patients and families through interventions not yet typical in the clinical setting. Although medical trainees generally accept the importance of social and environmental exposures on health outcomes, many still focus narrowly on medical treatments despite the undeniable influence of contextual social and environmental factors (Figure 3.2.4-R).

Figure 3.2.4-R



This case, and others like it [1], highlights how a broader mindset that considers both medical and social factors is critical to achieving desired outcomes and how bridging complementary areas of expertise (e.g., medicine and law) can support the health and well-being of patients and populations.

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Unit: 3.5 Responding to the Special Situation of Children

"Useful Resources"

Here you can find more information, in the following table, about the risk factors and the impact of war, conflict and displacement on children:

Table 1:Risk factors for the displacement children [10]

Box 11.1 The impact of war, conflict and displacement on children

1. The loss of basic resources

- Homelessness, hunger, starvation
- Loss of health care, education, and social support
- Loss of safety with unfamiliar, unpredictable and dangerous surroundings

2. Disruptions of family relationships

- Death or imprisonment of family members
- Parental anxiety and preoccupation
- Other separations from family
- Loss of wider social, cultural, and societal frameworks as support for parents and whole family, loss of peer relationships as part of supporting networks of children
- Pressure towards age-inappropriate roles, such as childcare responsibilities, earning money, emotional support for parents, or family advocacy (based on language skills)
- Strained sibling relationships, especially if older children carry childcare or boundary-setting responsibilities for younger ones.
- Children adopting new cultural norms at different rates than their parents
- Other ambivalence towards parents – especially if sent away for safety, and expected to fulfil the family's hopes and aspirations

3. Normalisation of violence

- Subjection to, or witnessing, significant violence
- Being enlisted in perpetrating violence, especially interpersonal
- Violence as a survival strategy – needed for self-defence, self-assertion, and social status

4. Post-flight discrimination and stigma

- Experiencing prejudice, stigma, and xenophobia
- Loss of cultural reference points
- 'Moral injury' due to actions and attitudes elicited en route – with consequent sense of guilt, shame, and self-stigmatisation

5. Pessimism and/or demoralisation

- Protracted asylum claims.
- Poverty, loss of status
- Loss, loneliness, disconnection, and disorientation (especially if unaccompanied)
- Challenge to religious and cultural beliefs

Note: Adapted from Maloney, C., Nelki, J., & Summers, A. (Eds.). (2022). *Seeking Asylum and Mental Health: A Practical Guide for Professionals*. Cambridge University Press.

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Module 4.

Self-Care and Staff Well-Being

Content drafted by ***Ethno-Medical Center/EMZ*** *(Ethno-Medizinisches Zentrum e.V. – Germany)*

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Module: Self-Care and Staff Well-Being

Responsible Partners: EMZ, Syn-Eirmos/Babel Day Centre

Module Overview

This module addresses the critical topic of managing stress and ensuring mental well-being for professionals and volunteers working with migrants and refugees. Unit 4.1 examines the numerous stressors inherent in this work, such as the emotional burden of supporting individuals who have experienced significant adversities, loss, and displacement. It also discusses the complexities of operating in challenging, and at times, hostile environments, where resources are limited, and structural and systemic barriers can hinder effective support. By identifying the different sources of stress (whether emotional, structural, or environmental) field workers can better manage their own mental health, which in turn enhances their ability to support migrants and refugees in a sustainable way. Unit 4.2 focuses on self-care as a professional competency. It introduces practical strategies that participants can incorporate into their daily routines. Lastly, Unit 4.3 emphasizes the duty of care on the part of employers while providing strategies for employees to advocate for a culture of care within their working environments. It discusses how organizations can create supportive structures through regular supervision, debriefing, and team support, among other things. It also offers practical ideas for reflective practice. Special attention is given to volunteers, who often lack formal support systems, highlighting the need for clear communication and boundaries to prevent occupational exhaustion. Recognizing the multifaceted nature of our work and understanding how stress may manifest in our day-to-day practice is crucial for maintaining well-being and ensuring meaningful service provision.

Module Learning Outcomes:

Upon completion of this Module, participants should be able to:

- Appreciate the complexity of their own emotional responses to their work with migrants and refugees
- Understand how both internal and external stressors may manifest in day-to-day responsibilities
- Recognize signs of stress and mental strain, and differentiate between various types of occupational stress (e.g. burnout, compassion fatigue, and vicarious trauma)
- Apply self-care strategies to enhance resilience in both personal and professional contexts
- Understand the importance of the employers' and their own responsibility in fostering a supportive work environment
- Promote team cohesion by recognizing the importance of peer support and social interaction
- Identify how to communicate and maintain clear boundaries, especially in volunteer roles
- Reflect on both the challenges and the meaningful, rewarding aspects of their work

Units in this Module:

Module 4. **Self-Care and Staff Well-Being**
Unit 4.1: Effects Among Professionals and Volunteers Working in the Context of Migration
Unit 4.2: Self-Care
Unit 4.3: Staff Care

Unit 4.1: Effects Among Professionals and Volunteers Working in the Context of Migration

Unit Overview
This unit introduces course participants to the topic of mental health among professionals and volunteers who work with migrants and refugees. It highlights how they are exposed to emotional stressors due to the nature of their work, which involves close contact with people who have survived adversities and/or are experiencing precarious and unjust conditions. The unit explains different types and scales of stress, introducing its origins as well as common signs for recognizing it. Lastly, the positive implications that helping professionals and volunteers may experience through their encounters with migrants and refugees are mentioned, with a focus on the concept of secondary/vicarious post-traumatic growth. The unit concludes with a critical exploration of the 'victim narrative' which can also contribute to the occupational exhaustion of field workers.

Unit Sections:

1. Challenges and Opportunities in Working with Migrants and Refugees

"If the migrant and refugee experience does not presuppose trauma, migrant and refugee support does not presuppose burnout" [1]. This statement is a powerful reminder that, **just as the people we work with exhibit a range of responses to adversity** (as seen in Module 1, these may include positive, negative, and neutral responses) **professionals and volunteers in this field can develop resilience and find strength through meaningful work**, rather than be consumed by it. While the pressures of supporting individuals who have lived through adversity and displacement are real, **they do not have to result in burnout**. The question lies in **how we approach and manage these pressures**.

The emotional and psychological weight of this work is undeniable. External stressors are inherent in working with migrant populations, as the work involves supporting people who have survived significant hardships and are often experiencing major disruptions to their personal security and livelihoods. At the same time, **migration deterrence policies, the absence of integration measures, as well as the lack of coordination and cooperation among stakeholders constitute a quite negative context in which migrants and field workers meet each other**. This means that professionals and volunteers are regularly exposed to overwhelming stories of trauma, loss, and displacement, while simultaneously dealing with all the above context-related features in addition to long working hours, job insecurity, and complex bureaucratic systems [1]. **These factors combined are detrimental to psychological and emotional well-being**, and can often increase the risk of developing mental health challenges. A more detailed overview of some of the occupational challenges you may face while working or volunteering in this field is provided below.

◎ Key Point: ***Most Common Occupational Challenges in the Work with Migrants and Refugees***

- **The high level of need among clients or service users** can create a sense that no matter what you do, it will never be enough (e.g. securing housing, accessing healthcare, arranging language classes, or obtaining legal aid, all while individuals or families may be grappling with significant emotional and financial stress). This can lead to an irrational sense of responsibility, where you overestimate what you 'should' be able to accomplish.
- **The frequent emergencies** (whether real or based on unrealistic expectations/insufficient resources) can lead to **blurred boundaries between work and personal time**, making it difficult to distinguish between when you are 'on duty' and when you are 'off duty'.
- **The tension between the close interpersonal engagement required to assess migrants and refugees' needs**, and **the need to maintain an appropriate professional distance** by openly communicating personal and structural limitations. This delicate balancing act can result in field workers **over-investing emotionally**.
- **Hearing accounts of horrific traumatic experiences**, especially if you have had similar experiences yourself (which is more likely, for example, for people with lived experiences of migration and displacement), can have **a profound emotional impact** and create **a sense of helplessness**.

- **The lack of a supportive workplace culture and clear organizational structures can result in frustration and inefficiency.** When organizational structures are unclear, roles and responsibilities can become muddled, leading to staff members feeling **frustated and uncertain about their duties or how to effectively contribute**. Often, tasks may be duplicated or overlooked entirely.
- **A lack of positive feedback or recognition**, leaving professionals and volunteers feeling **undervalued and demotivated**, ultimately affecting their ability to provide quality services.
- **Job unpredictability, frequent salary cuts, layoffs, overwhelming workloads, and high turnover rates** create **a sense of discontinuity and insecurity** among field workers. The lack of job stability can undermine workers' mental health and diminish their capacity to provide consistent and reliable support to the populations they serve.
- **The combination of insufficient training, experience, and chronic lack of material and human resources** can leave you feeling overwhelmed when navigating complex systems, especially if you are new to this type of work.
- **The partiality and fragmentation of services provided to migrants and refugees** can make it difficult to coordinate comprehensive care. This disjointed approach can lead to service gaps, **causing frustration for both workers and the individuals they support**, as critical needs may go unmet.
- **Persistent systemic barriers**, resulting in a continuous need to navigate cultural differences, language barriers, and structural limitations, such as restricted access to local health care and social security systems.
- **Widespread policies of hostility and deterrence towards migrants and refugees create a pervasive climate of tension and distrust**. The hostility from external systems not only affects the migrants but also places additional stress on professionals, making it harder to build supportive relationships based on trust and transparency.

How this exposure to the human suffering of others affects your mental health, however, depends not only on the external *stressors* you encounter but also on **your ability to respond to and manage these stressors**. These include aspects of the working environment, e.g. your ability to act independently as a worker; relationships with management, co-workers, and service users; personal factors such as your

personal history of trauma and *coping skills*. 'Coping skills' refer to your ability to **respond to stressors in ways that preserve your emotional and mental health and overall well-being**.

Being aware of your emotions is crucial for maintaining your mental health and navigating your personal and profesisonal life with clarity and effectiveness. The challenge is to find balance – **caring for others while also taking care of yourself**.

2. Different Types and Scales of Stress

In our everyday lives, we often refer to '*stress*' or 'being stressed out', but how is stress defined? In the medical definition, **stress is the body's physiological response to any demand**. The stress response activates **hormones, the central nervous system, the muscles**, and also **the immune system**. When someone (including yourself) or something (a situation) requires you to act, your body and mind will develop the sort of tension needed for you **to process and respond to the demand**. You become alert and attentive, and your mind and muscles are primed to react more quickly than when they were at rest [2].

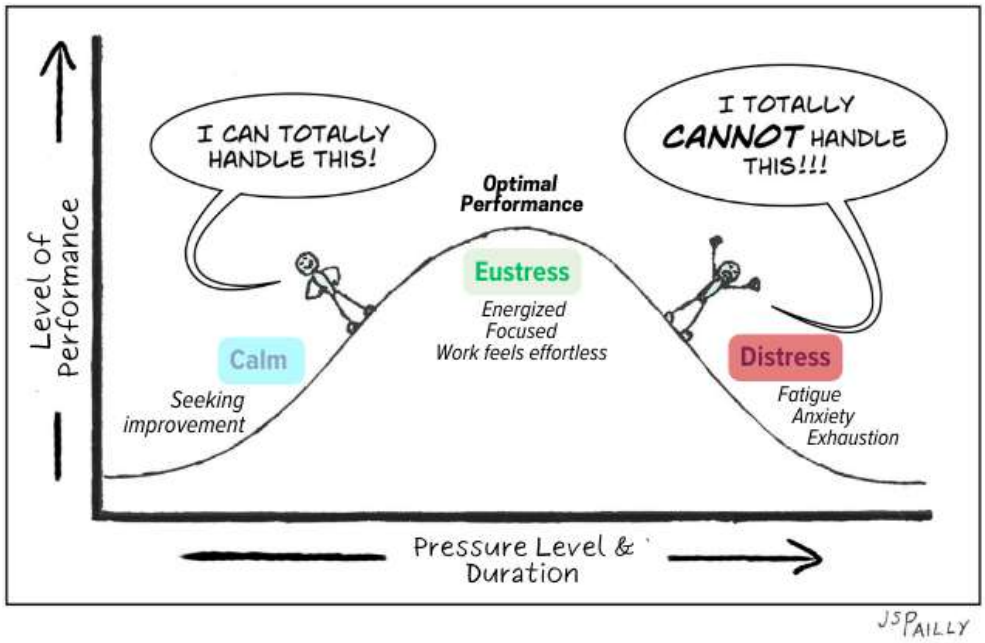
This type of stress **does not necessarily have a negative impact or long-term effect**. In fact, it is **a necessary process that enables you to perform the tasks and solve the problems that are part of life**, using your knowledge, skills, and experience. **This positive, natural stress response is also called *eustress*** (the prefix 'eu-' comes from Greek and denotes 'good'). Normally, after you have successfully completed your response to the demand or challenge – which, as seen above, is made possible through the physiological stress response – **your body and mind will return to a state of rest, leaving you content and with a pleasant feeling of accomplishment**.

Sometimes, however, the natural stress response is triggered in a way that makes it impossible to return to rest and contentment. This happens **when the demands of the situation are too great**, or **if you do not trust that you have the knowledge, skills, and experience to respond adequately**. It can also happen when the demands on you **are sustained or arrive in such short succession** that your body does not get the chance to return to rest. As a result, you may feel overwhelmed and find the demands insurmountable [3].

This negative version of stress is known as *distress*. While the physiological response is still the same as in eustress, how you perceive it and its effects on your well-being are very different.

As seen in Figure 4.1.1, while eustress provides a short-term boost to meet challenges, **excessive stress can affect your level of functioning**, making you feel mentally paralyzed and unable to think clearly. This can prevent you from accessing and applying your existing knowledge and skills, reinforcing feelings of being overwhelmed. **Over time, excessive stress can prevent your body from returning to a restful state, significantly impacting your mental health and psychosocial well-being.**

Figure 4.1.1. *"Eustress vs. Distress"*



Note: Graphic re-adapted by the EU-MiCare team based on information by J.S. Pailly and Integrative Cancer (Planet Pailly, 2019, Eustress vs. Distress; Integrative Cancer, (n.d.), Integrative Cancer Review: Multiplying the Power of Healing)

The reproduction of this graphic does not imply endorsement by its original author.

→ **VIDEO:** *How Stress Affects Your Brain* 💻

Stress not only affects individuals, it also affects groups and teams [1] because each team member relies on others to function properly. This is why we need not only to pay close attention to the effects of stress

on individuals working in challenging situations, but also consider the conditions under which the entire team operates.

The stress bucket (Figure 4.1.2) **is another simple way to understand how stress works** both on an individual level and within the context of a team [4]. **Imagine a bucket that collects all the stresses in your life.** In the field of migrant and refugee care, these stresses might include high emotional demands, long hours, inadequate resources, and navigating complex bureaucratic systems. Each time you (or your team) encounter stress, it feels like adding water to the bucket. **If these stressors accumulate without proper outlets** – such as support from colleagues, supervision, or self-care – **the bucket will eventually overflow**. When that happens, you (personally or collectively) may feel overwhelmed and unable to cope.

Figure 4.1.2. *"The Stress Bucket"*

Note: Graphic produced by Mental Health UK (2018) based on an idea by Brabban and Turkington (2002)

→ **VIDEO:** *The Stress Bucket* 💻

> **Reflection Break:** ***Engage in personal and/or group reflection***
>
> Take some time to reflect on the concepts of eustress and distress, along with the visual metaphor of the stress bucket. Then, consider: What helps you reduce stress? How can you keep those activities going when other pressures build up? You may also complete this useful handout together with your co-workers (also in 🕮 **Repository**, see 4.1 – Handout 1. "The Stress Bucket").
>
> *Sourced from mentalhealth-uk.org*

Burnout

It is widely accepted that burnout can be common among professionals and volunteers who work with people in need, particularly those who have survived extreme adversities. It is defined as **a mental state**[1] **of exhaustion stemming from persistent exposure to work-related stressors**, while **lacking sufficient resources to efficiently cope** with these stressors. It manifests through three key dimensions: an overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment [5].

Burnout develops gradually, slowly depleting your emotional, mental, and physical resources. When individuals experience burnout, **work that was once seen as creative and meaningful becomes increasingly unfulfilling and unsustainable over time.** People experiencing burnout may also cease to take care of themselves, use alcohol and nicotine, eat and sleep badly, and be often preoccupied with work even when they are not at work.

Signs of Burnout	
Physical depletion, chronic tiredness	Lack of sense of personal accomplishment
Emotional exhaustion	Negative attitudes toward work, life itself, other people

[1] While burnout is generally acknowledged by researchers, clinicians, and the public as a critical occupational problem, there is yet no agreement within the scientific community regarding its definition and the appropriateness of classifying burnout as a distinct mental health diagnosis.

Depersonalization (feeling 'beside yourself')	Reduced ability to cope with the environment
Sense of helplessness	Evidence of poor client care
Disillusionment	Evidence of neglect of clinical/administrative duties

Note: Content adapted by the EU-MiCare team based on information from Mor Barak et al. (2001), Laslach & Leiter (2016), and Stackelford (2006).

[Mor Barak, M. E., Nissly, J. A., & Levin, A. (2001). Antecedents to retention and turnover among child welfare, social work, and other human service employees: What can we learn from past research? A review and metanalysis. *Social service review*, *75*(4), 625-661. https://doi.org/10.1086/323166; Maslach, C., & Leiter, M. P. (2016). Understanding the burnout experience: Recent research and its implications for psychiatry. *World Psychiatry*, *15*(2), 103-111. https://doi.org/10.1002/wps.20311; Shackelford, K. (2006). Preparation of undergraduate social work students to cope with the effects of indirect trauma. (Unpublished doctoral dissertation). University of Mississippi Department of Social Work, University, MS.]

Personal factors can influence how susceptible you are to chronic stress and occupational burnout. These include characteristics based on your identiy and background, such as age, gender, education, coping styles, personal history of trauma, support from family and social circles, and financial situation. While the effects of these factors are difficult to modify, **your coping skills and resilience can be influenced through training as well as professional and personal development activities** [1]. We provide more information and examples of these in the coming units.

Compassion Fatigue

Compassion fatigue, also described as "the cost of caring", shares some characteristics with burnout, but refers to **a separate phenomenon**. It is **a profound chronic emotional and physical exhaustion closely related to caring work**, which is central to the care of people with traumatic experiences. Those affected by compassion fatigue become detached and cynical, to the detriment of the quality of care they are able to provide [6].

Signs of Compassion Fatigue	Specificities of Compassion Fatigue Compared to Burnout
Irritability	It focuses on the **exhaustion of empathy and healing capacity**.
Physical pain	It **prevents you from remaining compassionate and empathic**.
Detachment	In burnout, motivation and energy for your work are often lacking. In compassion fatigue, you are **likely to remain motivated**, but you are **unable to apply your usual empathy and compassion**.

Poor job satisfaction	The start of symptoms in compassion fatigue **can be mostly traced to a particular case or situation**.

Note: Content adapted by the EU-MiCare team based on information from Leris & Byrne (2003), and Stackelford (2012).

[Lerias, D., & Byrne, M. K. (2003). Vicarious traumatization: Symptoms and predictors. *Stress and Health: Journal of the International Society for the Investigation of Stress*, *19*(3), 129-138. https://doi.org/10.1002/smi.969; Shackelford, K. (2012). Occupational Hazards of Work in Child Welfare: Direct Trauma, Secondary Trauma and Burnout. In: CW360 a comprehensive look at a prevalent child welfare issue. Spring 2012. https://ovc.ojp.gov/sites/g/files/xyckuh226/files/media/document/os_sts_child_welfare_article_review.pdf]

Moral Injury

Moral injury refers to **the lasting emotional, psychological, social, behavioral, and spiritual impacts of actions that violate someone's core moral values and behavioral expectations of self or others**. It can be seen as "a damage to one's conscience or moral compass" [7] and it is caused by "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations" [8].

Only recently moral injury has been identified as a distinct phenomenon (e.g. in contrast to PTSD) and studied above all in the context of military employment [9]. However, recent research has been taking into consideration moral injury in occupational contexts other than the military, such as the medical field. Moral injury is often associated with strong moral emotions related to the event, including guilt, anger, and disgust, and **can lead to serious distress and psychological difficulties such as depression and suicidality**. It debilitates people on an individual level and can affect one's capacity to trust others.

3. Vicarious Trauma and Vicarious Post-Traumatic Growth

Vicarious Trauma (VT), sometimes also called Secondary Traumatization or Secondary Traumatic Stress (STS), **is considered to be common among practitioners who engage with trauma survivors or witness traumatic events**, especially on a repetitive basis (e.g. therapists, social workers, doctors and paramedics, police officers, firefighters). It originates from the exposure to the trauma of others – **be it in person or through listening to others** (clients or service users) **recount their traumatic experiences, reviewing case files, or hearing about or responding to violence and other traumatic events**. Vicarious trauma can affect one's perception and experience of the world, manifesting in physical, emotional, and behavioral signs.

→ **VIDEO:** *What is Vicarious Trauma?* 💻

Similarly to how stress is experienced differently on an indiviudal basis, vulnerability to vicarious trauma is influenced by several factors such as life stress, social support, age, gender, education, socioeconomic status, unresolved past personal trauma, and overly empathic responses. **Professional experience, education, as well as organizational support in the form of training, debriefing, supervision, and peer support can lower it** [10]. The likelihood of developing symptoms of vicarious trauma also depends on the characteristics of the trauma event you are exposed to and the extent to which they violate your worldview and belief system [11].

If you think you could be exposed to the risk of vicarious trauma, have a look at this exercise included in our 🕮 Repository (see 4.1 – Handout 2. "The ABC of Addressing Vicarious Trauma").

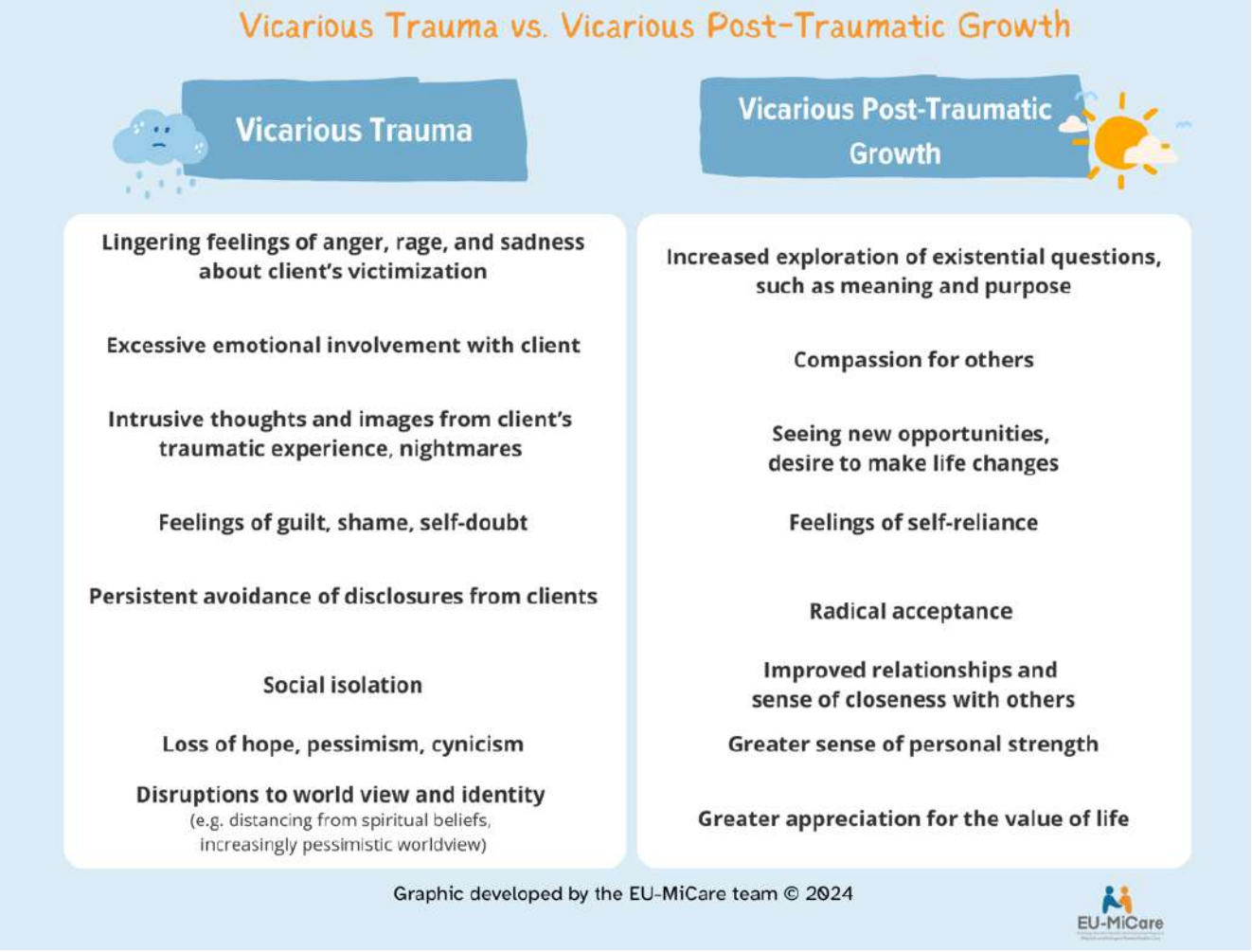
As discussed earlier in this unit, **working with people who have experienced trauma** and/or find themselves in difficult and precarious situations **does not necessarily have to be negative or distressing**. Alongside the potential risks you might be exposed to as a helping professional or volunteer, your encounters with migrants and refugees can also have **a positive impact on your life** and offer opportunities for personal and professional growth.

The concept of **Vicarious** (or Secondary) **Post-Traumatic Growth** (VPTG/SPTG) is used to refer to the **positive psychological changes** (in the form of personal growth and meaning-making) **that occur in individuals who help people who have survived adversities** [12]. Much like post-traumatic growth (PTG) [13], which is experienced by the individuals we assist who have survived significant adversities (see Unit 1.3 for more details), these positive changes also relate to self-perception, relationships with others, and philosophy of life. However, vicarious post-traumatic growth entails aspects related to professional identity, including **the awareness that one's work has value**, as well as **the development of professional competencies** [14]. Vicarious post-traumatic growth is more likely when professionals have **strong social support** (both personal and professional) as well as **effective coping strategies**. The next units in this module are dedicated to these crucial aspects.

→ **VIDEO:** *What is Vicarious Post-Traumatic Growth?* 💻

Figure 4.1.3 below offers a overview of the two concepts along with their defining characteristics, as outlined in the relevant literature.

Figure 4.1.3. "*Vicarious Trauma vs. Vicarious Post-Traumatic Growth*"



Note: Graphic created by the EU-MiCare team based on information from Baird & Jenkins (2003), Lerias & Byrne (2003), and Tedeschi & Calhoon (2004a, 2004b).

[Baird, S., & Jenkins, S. R. (2003). Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence and victims*, *18*(1), 71–86. https://doi.org/10.1891/vivi.2003.18.1.71; Lerias, D., & Byrne, M. K. (2003). Vicarious traumatization: symptoms and predictors. *Stress and Health: Journal of the International Society for the Investigation of Stress*, *19*(3), 129–138. https://doi.org/10.1002/smi.969; Tedeschi, R. G., & Calhoun, L. G. (2004a). Vicarious post-traumatic growth: Understanding resilience in trauma workers. *Trauma Psychology*, *10*(3), 319–328.; Tedeschi, R. G., & Calhoun, L. G. (2004b). TARGET ARTICLE: "Posttraumatic Growth: Conceptual Foundations and Empirical Evidence." *Psychological Inquiry*, *15*(1), 1–18. https://doi.org/10.1207/s15327965pli1501_01.]

4. Critically Examining the Victim Narrative

As discussed in earlier modules, **working with displaced individuals inevitably entails direct engagement with profound human suffering as well as with extraordinary resilience and adversity-activated development**.

As the people we work with navigate their complex emotional landscapes, their needs can fluctuate significantly – some may be still processing what happened to them, while others may have begun to envision their futures in a new context. A crucial part of learning to care for ourselves in this complex operating context is **recognizing how our preconceived notions may complicate our interactions with migrants and refugees**, and **how this in turn may contribute to occupational exhaustion**.

If we categorize people as mere victims who lack the ability to respond to adversity in complex ways, we risk perpetuating a dynamic that undermines their agency [1,15]. This one-dimensional narrative not only **positions us as rescuers and them as victims and passive recipients of help,** but also **contributes to increased stress within our work setting and limits the potential for meaningful, empowering support**.

◎ Key Point: ***The Emotional Experience of Practitioners Working with Displaced Individuals***

Papadopoulos [1] has conceptualized three distinct moments in the reactions of field workers who operate under the dichotomous framework of 'victims-rescuers'. This binary view has a direct implication to service provision and ultimately impacts both our well-being and that of the people we aim to assist.

- ***The period of over-productivity and enthusiasm:*** Field workers often start with high motivation and a desire to help, often taking the form of overactivity and eagerness to 'make a difference'. Deeply touched by the suffering they encounter, they may see their role as heroic, believing that they are omnipotent and that their work is profoundly impactful. In this stage, professionals and volunteers may work extended hours while focusing their energy entirely on helping others, often neglecting their own needs in the process.

- ***The period of defenses and suspicion:*** When progress seems to be slow or unrecognizable, even after putting in the utmost effort by field workers, frustrations may arise. Professionals and volunteers may feel inadequate, guilty, and helpless. These emotions may cause them to be defensive and attribute their struggles to external factors, such as colleagues or organizational shortcomings. At this stage, tension may prevail in teams with blame being cast outwardly, leading to cliques or scapegoating within the organization.

- ***The period of distancing oneself (and self-reflection):*** Professionals who experience this stage may react in one of two ways. The first scenario involves distancing themselves from their work, creating a sense of emotional safety but at the cost of meaning and engagement. This leads to feelings of boredom due to their work becoming routine and mechanical in nature. In the second scenario, field workers may use the challenges they face as opportunities for deeper self-understanding. This enriches their experience and helps them retain complexity in their thinking, allowing them to avoid falling into stereotypes or preconceived notions.

It should be emphasized that the above stages are not necessarily linear. The emotions that accompany these phases often come in circular or ambiguous ways. One may fluctuate from feelings of omnipotence and overinvestment to apathy and disconnection. These reactions are common among professional and volunteers; the trick is to bring them to conscious awareness. Doing so allows us to create more effective strategies for both self-care and the care of others [1].

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Unit 4.2: Self-Care

Unit Overview
In this unit, we present a range of tools and resources that can help you critically reflect on your professional life, working environment, and their impact on your mental health. We will provide a few measures to help you identify signs of stress and mental strain, along with a discussion on the concept of self-care as a competency. Additionally, you will explore self-care and stress-relief techniques that can be seamlessly integrated into your daily professional routine to enhance resilience and cope with stress, when it arises.

Unit Sections:

1. Recognizing Signs of Stress and Mental Strain

Several self-administered tests for the assessment of work-related stress and the professional quality of life have been developed in recent years. Their content effectively applies to professionals and volunteers working with migrants and refugees, and for this reason, we have included them in our 🕮 **Repository** (see 4.2 – Handout 1. "Professional Quality of Life Scale (ProQOL), Version 5" and Handout 2. "The Professional Wellbeing Self-Assessment Tool").

Nevertheless, we invite you to **be cautious with the self-administering of these tools**. They can offer insights into your mental health by helping you recognize signs of excessive stress. However, if you feel like you need help with dealing with the negative consequences of your profession or voluntary work on your well-being, **it is crucial to seek additional, multifaceted support**.

Regular supervision, peer/staff support groups, and interdisciplinary collaboration are better suited for identifying and addressing stress and mental strain in these environments. Additionally, while seeking

professional help is vital, as a professional or volunteer in migrant and refugee care, **you can take numerous steps in addition to therapy to maintain your well-being and prevent occupational exhaustion**.

Below are some statements/reflective prompts that can help you **critically reflect on your professional life, working environment, and their impact on your mental health**. These questions stem from different tests and studies [1-3] and are not meant to be used as a formal evaluation. Instead, you should see them as **the starting point of your 'self-care' journey.** You can therefore respond in a way that feels most comfortable (either through written reflection or just utilizing them as 'food for thought'), using formats such as yes/no answers or frequency ratings (i.e. never/rarely/sometimes/often/very often).

Reflection Break: ***Engage in personal reflection***

We invite you to take some time and reflect on your current professional situation and/or your engagement as a volunteer. Then, consider the following prompts:

- *I am happy.*
- *I am preoccupied with more than one person I [work with/support].*
- *I feel connected to others.*
- *I find it difficult to separate my personal life from my life as a [professional/support worker].*
- *Out of anger or frustration about situations I am experiencing, I tend to overestimate and/or overburden myself.*
- *I am not as productive at work because I am losing sleep over traumatic experiences of a person I [work with/support].*
- *I feel trapped by my job as a [professional/support worker].*
- *I am thinking about giving up on my activity because I cannot help or do as much as I would like.*
- *Because of my [helping work], I have felt 'on edge' about various things.*
- *I feel as though I am experiencing the trauma of someone I have [supported].*
- *I am worried that my own traumatic experiences may be triggered.*
- *I am worried about not being able to set boundaries sufficiently.*

(cont'd on next page)

- *I show empathy but can still keep my distance.*
- *I am worried about being "overrun" by too many requests and not being able to do justice to all of them.*
- *My work makes me feel satisfied.*
- *I have happy thoughts and feelings about those I [work with/support] and how I could help them.*
- *I feel overwhelmed because my case [work] load seems endless.*
- *I believe I can make a difference through my work.*
- *As a result of my [helping work], I have intrusive, frightening thoughts.*
- *I feel 'bogged down' by the system.*
- *I am happy that I chose to do this work.*
- *I am currently engaged in wellness, resilience, and self-care practices.*

Sourced and adapted from Therapie-Tools Psychotherapie für Menschen mit Migrations- und Fluchterfahrung
(Therapy Tools: Psychotherapy for People with Migration and Refugee Experience)

2. Self-Care as a Competency

As the title of this section suggests, **taking care of yourself is a competency that you can learn**. While it may feel like stress is either caused by external factors or is an inherent part of your personality, the truth is that there are many ways to enhance your natural ability to manage stress. **Self-care involves balancing the care you provide to others** – which is the core of your work as a professional or volunteer working with migrants and refugees – **with sufficient care for yourself** (see Figure 4.2.1 on the next page for details on how this might look like). Self-care is a prerequisite for taking care of others. It is no accident that the safety instructions before every flight repeat: "*Put your own oxygen mask on first before assisting others!*".

If you treat self-care as a competency that is necessary for you to perform your work – just like any other knowledge, skill, and experience that would typically be listed on your resume – it opens up all sorts of opportunities for learning and maintaining this skill. In doing this, you should bear in mind that stress-reinforcing thought patterns (i.e. "*I have to do everything perfectly, or I'll disappoint others*" and "*I can't*

show any weakness because that would make me look incompetent") can turn the friendly advice to eat, sleep, and exercise into yet another source of pressure to fulfill the expectation of constant self-improvement. It is therefore important to **find ways of incorporating these recommendations into your life, not as additional tasks on your to-do list, but as opportunities for rest and enjoyable, unstructured recreational activities**.

Figure 4.2.1. *"Self-Care Foundations for Professionals and Volunteers"*

Note: Graphic developed by the EU-MiCare team based on information by Gräßer et al. (2013)

[Gräßer, M., Iskenius, E.-L., & Hovermann, E., Jr. (2017). *Therapie-Tools Psychotherapie für Menschen mit Migrations- und Fluchterfahrung.* Weinheim: Beltz.]

3. Practical Strategies for Managing and Reducing Stress

Many tools, strategies, and exercises are available for managing and reducing stress. Some are as simple as taking real breaks during work hours, 'disconnecting' during lunch breaks by enjoying a short walk or

eating with your colleagues (in the shared commitment to not talk about work!), regularly opening the windows to let fresh air circulate in the room. **These small actions can contribute significantly to improving your overall well-being and creating a more balanced work environment.**

Understanding What You Do Daily

In the table below [3], you will find additional insights into practical activities you can incorporate into your daily routine.

Possible Interventions	I already do this!	I would like to pay more attention to it...
I monitor my own stress levels and take timely action to counteract them.		
I take my physical warning signals seriously.		
I have a clear time management with break regulation.		
I set clear priorities during my working hours.		
I know my limits and stick to them.		
I cultivate my social relationships and contacts.		
I use relaxation techniques or resource-oriented procedures.		
I am good at distancing myself and have my own distancing ritual.		
I undergo regular supervision.		
I regularly take part in training and strengthen my professional skills.		
I regularly do sport and exercise.		
I have a hobby.		
I have time for nice things, and they are a fixed part of my calendar.		
I have the opportunity to talk to co-workers promptly if something is bothering me, e.g. over a cup of coffee or on the phone.		
I feel free to address my own difficulties with my employer or supervisor.		

I do not make promises that I cannot keep.		
I delegate tasks that are not part of my area of responsibility or for which others are more specialized.		
I am good at saying 'no' and I do so.		
I have a clear job description and my tasks and responsibilities are clear to me.		

Improving Your Sleep

One of the pillars of self-care is to get enough and good sleep. Below you can find a list of tips [4] to promote healthy sleep habits.

Tips for Healthy Sleep	
1.	Take notice if you find yourself becoming frustrated at night about not being able to sleep. Such annoyance and worry can have a stimulating effect similar to caffeine. Try to avoid looking at the clock during the night.
2.	Use mindfulness exercises daily until they work well for you. Write any worries on a piece of paper next to your bed to put them out of your mind until the next day.
3.	Learn relaxation and meditation techniques, such as guided visualizations and Progressive Muscle Relaxation (PMR). Experiment with different methods to discover what helps you fall asleep more easily and improves the quality of your sleep.
4.	Exercise during the day (not in the evening) to reduce stress, achieve balance, and feel physically tired.
5.	Only go to bed once you are genuinely sleepy and feel ready for sleep. Use your bedroom and bed only for activities that have to do with sleeping (except sexual activity).
6.	Reduce the time you spend in bed. Calculate your actual sleeping time in relation to the time you spend lying in bed, for example 5 out of 7 hours. If you want to get up at 7am, go to bed at 2am. This may be tiring during the first week, but you will go to sleep more quickly and sleep through the night. When your body has got used to sleeping without waking for 5 hours, you can slowly increase the time you spend in bed again.
7.	Do not take naps during the day.
8.	Get up at the same time every day, no matter how much you have slept during the night or how rested you feel.
9.	Do not look at backlit screens (mobile phone, computer) for the last 2 hours before going to bed. The blue light they emit inhibits the melatonin release that makes you sleepy.
10.	Do not drink alcohol for the last 2 hours before going to bed. Do not drink caffeinated drinks (tea, coffee, cola, energy drinks) for at least 6 hours before going to bed. Avoid smoking during the last several hours before going to bed.

11.	Go to sleep on a positive thought (What was nice today? What am I grateful for?). Develop a regular going-to-bed ritual that signals to you that the time for sleep is approaching.
12.	When you go to bed, turn the light out with the intention of going to sleep. Some people find it helpful to go to another room if they can't fall asleep, occupy themselves with a pleasant, quiet activity until they feel sleepy, and then return to the bedroom.
13.	If you are used to it, eat a small snack before going to bed to prevent getting hungry during the night.
14.	If you are still having sleeping problems, talk to a doctor and/or psychologist/psychotherapist to consider therapy, medication and/or further investigation in a sleep laboratory.

Incorporating Mindfulness

Mindfulness can be another effective self-care practice by promoting greater awareness of the present moment. Mindfulness techniques can enhance **emotional regulation, improve focus, and foster a sense of calm**, ultimately contributing to overall well-being.

→ **VIDEO:** *Mindfulness: Working Towards Wellbeing* 💻

Fostering a Healthy and Safe Digital Environment

Smartphones are often essential tools for field workers (professionals and volunteers alike), but it is a real art to use them wisely. Many people identify their smartphone as a particular source of stress.

The feeling of being constantly available can result in a state of constant alertness, contributing to the overall stress-levels you are exposed to. Here you can find some useful tips for a healthier use of your phone [5].

Tips for Digital Mindfulness	
1.	Use flight mode or do-not-disturb mode during the day as well. You can still be shown certain alerts, e.g. appointment reminders.
2.	Set the phone to do-not-disturb for a regular period, e.g. from 9pm to 8am.
3.	Tell others the times of day during which you will be offline. This will avoid disappointment and serves as an additional incentive for you to stay offline.
4.	Deactivate push-messages.

5.	Use apps (e.g. 'Quality Time', 'Offtime', 'Forest') to analyze your usage patterns, and make decision based on these.
6.	Be brave: uninstall social media apps.
7.	Only answer messages and emails 1-3 times per day. In most cases it is sufficient to answer emails once in the morning.
8.	Try digital detox. Switch off your smartphone for an entire evening, an entire day, or even an entire week. Consider going on a multiple-day mindfulness/meditation retreat that includes digital detox.
9.	Use your ringtones and alerts as a trigger for breathing/mindfulness exercises: every time your smartphone rings or alerts you, you breathe in, breathe out, and smile before responding (or deciding to respond later!).
10.	Designate the toilet as a smartphone-free zone. Use it as a place for resting your mind.
11.	Shared time is smartphone-free time: ensure that your smartphone does not show messages and alerts while you are in live contact with other people.

Developing Your Own Self-Care Plan

Establishing a self-care plan is also a good idea. Try this questionnaire in order to build your own [6].

◎ Key Point: ***Reflective Prompts to Establish Your Own Self-Care Plan***

- **Structure:** *What do I want to pay attention to regarding the structure of my days and week? When do I knock off work? What do I do after work?*
- **Social Interaction & Social Competency:** *Who is important to me? How frequently do I want to see this person? What do I want to learn from being in contact with others?*
- **Sports & Exercise:** *When and how often do I want to play sport/exercise, and with whom?*
- **The Beautiful Things in Life:** *Which activities (art, music, creativity, sensual experiences, humor, silence, intimacy/sex, gardening, relaxation techniques, cuddles – including pets, planning holidays/adventures, entertainment, experiencing grace, cooking/eating, time in nature, etc.) do I want to keep or expand on? How?*
- **Sense of Purpose ('living your values'):** *What is important to me? What do I want to devote more time to (do someone a favor, teach someone, 'give oneself' to someone without sacrificing yourself, volunteering, spirituality/religion, interaction with like-minded people, etc.)?*
- **Sleep:** *What do I want to pay attention to?* (see 'Tips for Healthy Sleep' above)
- **Worries & Ruminations:** *How do I want to deal with worries, ruminating on problems, and the underlying feelings?*
- **Self-Discipline:** *How much do I want to get out of my comfort zone? For which reasons? How often?*

- **Self-Reflection:** *Strengths and weaknesses: what do I have to pay attention to in myself? How do I put pressure on myself? Which of my attitudes do I want to call into question? What are the 'red buttons' others tend to push in me? What can I do when I get triggered?*
- **Self-Compassion & Self-Acceptance:** *How do I become my own best friend? What are some of the old 'automatic messages' of feeling bad about myself that I want to give up? How do I put self-acceptance into practice? How do I show myself that I like myself? What inner resistance to this do I need to give up?*

What else is important to me?

A collection of tools and resources is available in the 🕮 Repository (see 4.2 – Handout 3. "Additional Tools and Resources for Self-Care"). From deep breathing exercises and meditation practices to comprehensive guides on vicarious trauma and mobile applications designed for mental health support, these resources serve as valuable first steps in enhancing your well-being.

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Unit 4.3: Staff Care

Unit Overview
This unit illustrates how employers and organizations can effectively fulfill their duty of care with respect to the mental health and well-being of their staff. It emphasizes the importance of creating favorable working conditions while offering stategies and ideas on what field workers can do to advocate for a culture of care within their organizations. This unit concudes with considerations regarding the unique circumstances faced by volunteers (whose work often takes place outside of a professional context), including specific suggestions on setting and communicating boundaries.

Unit Sections:

1. Implementing an Integrated Staff Care System

Ideally, **staff care is a multifaceted system of tools, workplace practices, and organizational structures that are integrated into the workplace**. The overall staff care implementation should aim to support field workers both personally and professionally, and both individually and within their teams. It is important to stress that **staff care is the employer's duty of care put into practice**. **It is not meant to be an ad-hoc or emergency response measure when things go wrong**, but rather **a continuous, proactive effort** to maintain the health and well-being of all employees and volunteers.

Below are some necessary components for preventing risks to staff well-being, and implementing an integrated staff care system [1]:

1. The organization must acknowledge staff care and its importance for its staff.
2. The organization must develop an operational framework of staff care within its systems.

3. The staff care operational framework that the organization develops must be sensitive to culture, context, and gender.
4. The organization must develop a written staff care policy.
5. The organization must promote a culture of staff care practices and an understanding that it will respond supportively to staff care needs.
6. The organization must regularly evaluate its staff care needs.
7. The organization must facilitate self-care practices among its staff.
8. The organization must integrate staff care into planning and budgeting procedures.

◎ Key Point: ***Foundations of an Integrated Staff Care System***

Several core elements of human resource management contribute to the foundation of an integrated staff care system [2]. These include:

- **Accurate and updated job descriptions.** These should ensure that workers are not asked to become involved in activities that contradict their ethical practice, including professional confidentiality (for example, surveillance of service users or informing immigration authorities).
- **Established contacts with external services to respond to critical incidents**.
- **Regular exchange of experiences and reflection within the team and with the management**, including documenting the results (quality improvement).
- **Appropriate staff to client/service user ratios.**
- **Time allocation for relevant study, planning, reflection, networking, and policy development.**
- **Appropriate professional development opportunities**, including financial support and time.
- **Time allocation for professional collaborations and collegiate exchange beyond the organization.**
- **Support through professional supervision** (including the necessary financial resources and time), especially in fields where workers frequently encounter stories/accounts of trauma.
- **Time for team-based reflection.**

2. Supportive Structures in the Workplace

Understanding the importance of workplace support is crucial for field workers, **as it directly impacts their mental health and job satisfaction**. Recognizing that **employers have a responsibility to create a supportive environment helps field workers advocate for their needs and contribute to a culture of well-being**. When staff are aware of their rights to support and resources, they are more likely to seek help when needed. But how does this look like in practice?

Advocating for a Culture of Care

Ensuring an employer's duty of care for both professionals and volunteers involves **creating conditions that actively reduce stress and prevent its long-term effects on mental health**. In practice, this is achieved through offering **timely, regular, and high-quality de-briefing, supervision, and team reflection**. A lack of supervisory support can result in field workers mentally detaching from their role and workplace. Regular and reliable meetings help staff develop trust while encouraging them to seek professional support and two-way feedback [3].

Social interactions complement formal debriefings, supervision, and reflective processes, helping professionals and volunteers feel more secure even in challenging situations. **These opportunities for connection, combined with formal support, contribute to a stronger sense of stability and team cohesion.** Examples of such interactions include:

- **Celebrate successes (even small ones) to appreciate everyone's contribution.**
- **Organize team-building activities that involve social interaction** (during, as well as outside of working hours). These should not dwell on case details or the negative aspects of the work, and may also include loved ones.
- **Hold confidential support group meetings to create a safe space where professionals can discuss difficult cases and the mental and emotional impact of their work.** Low-impact debriefing is one possible technique for facilitating this process (see activity on next page).

Reflection Break: ***Practice the low impact debriefing strategy with a co-worker***

Low-impact debriefing* is a supportive technique designed to facilitate discussions about difficult experiences, ensuring that the listener is both consenting and aware of the conversation. This method is designed to be less intense than traditional debriefing, and is particularly useful in high-stress professions such as healthcare, social work, or emergency response. It consists of four steps:

- **STEP 1. Increased Self Awareness:** Be mindful that exposure to difficult stories on a daily basis can lead to desensitization, making it easier to overlook the profound impact that specific experiences may have on those not involved in this line of work. For individuals outside of mental health and human services, these details can be quite impactful. At the same time, the details are not necessary to achieve the aims of debriefing.
- **STEP 2. Fair Warning:** When you are about to mention explicit details, let your counterpart know that what you are about to tell them could have a negative impact on them or even shock them (in other words, give them a 'trigger warning'). This way, they can mentally prepare themselves for what they are about to hear.
- **STEP 3. Consent:** *(Closely related to the previous point)* – After having given a trigger warning, ask your counterpart for their consent to be told the story. This gives the listener an opportunity to decline hearing about the details.
- **STEP 4. Limited Disclosure:** Try telling your story by beginning with a less explicit outline. If you still feel that you need to talk about the details in order to benefit from debriefing, you can continue subject to Steps 2 and 3 above. This gives you a chance to consider how much detail the story actually needs, and how much your counterpart can handle.

Sourced from tendtoolkit.com

*You may also review this useful handout (also in 🕮 Repository, see 4.3 – Handout 1. "Low Impact Debriefing").

Additional measures on your employer's part to mitigate the impact of stress may include **rotating complex caseloads in order to distribute the more severe cases evenly among available staff**. Offering

field workers some level of control and flexibility with regard to their own schedule (e.g. flexible hours, remote working options, etc.) also helps them **better balance work and personal life**.

Organizations can also promote a supportive organizational climate at the structural level. For example, **realistic recruitment**, **regular in-service training**, and other **professional development opportunities** – including on working with people who have survived adversities – can have a preventive effect on stress levels. **Realistic recruitment can help prevent high staff turnover and industrial disputes** [4]. It means **communicating job requirements clearly and transparently**, including being open about the difficult aspects of the job.

Supervision and Staff Support Teams

Supervision in professional settings (healthcare, education, social services, etc.) carries various meanings. In many cases, supervision is viewed as a managerial function focused on overseeing tasks, outcomes, and performance. However, within the context of mental health and psychosocial support, **supervision tends to embody a more supportive and collaborative relationship between the supervisor and supervisee(s).**Here, the emphasis is on creating a safe space that helps promote professional growth, technical competency, and personal well-being. This relationship enables practitioners to **reflect critically on their work, enhancing not only the quality of the services they deliver but also psychological resilience within their teams** [3,5].

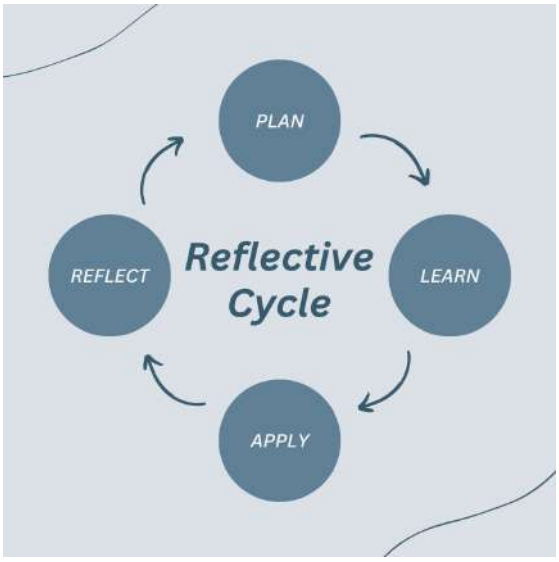
The contemporary model of supervision is **non-directional in nature**, **where the supervisor affirms the already existing resources, capacities, strengths, strategies, and pathways taken by the professional or volunteer rather than directing them** [6]. This is similar to the relationship practitioners are encouraged to maintain with the people they work with: **one built on respect for their autonomy and complexity**. Supervision teams try to restore some of this complexity through structured tools such as the 'Adversity Grid' (see Module 1, Unit 1.3 and 🕮 **Repository**, 1.3 – Handout 1. "Adversity Grid in Detail" for more details). Such frameworks can help us navigate the complex intricacies of our work and move beyond the limiting dichotomies discussed in Unit 4.1.

Staff support teams are facilitated by an external mental health provider and follow along a path similar to supervision, this time focusing on **the personal psychological welfare of the field workers**. Staff support teams may help practitioners challenge and deconstruct false dichotomies in their thought processes related to 'vicarious trauma'. Staff support teams can open up **a collaborative, dialogic space for genuine reflection** by helping professionals and volunteers appreciate the complexity of their experience [6].

Engaging in Reflective Practice

A further key strategy to improve your working conditions is to **engage in reflective practice regularly**. Although reflective practice has been mostly conceptualized for professionals in different fields (healthcare, education, social services, etc.), it can be of great help also for volunteers working with migrants and refugees. **Reflective practice is an ongoing process** [7] and should be seen as part of **a cycle involving further phases such as planning, learning, and applying insights from what you have reflected upon** [8] (see Figure 4.3.1). It can take place at both an individual level (self-reflective practice) and a team or organizational level.

Figure 4.3.1. "*The Reflective Cycle*"



Note: Graphic developed by the EU-MiCare team based on information by Schön (1992) and Bassot (2013)

[Schön, D. (1992). *The reflective practitioner: How professionals think in action*. Routledge. https://doi.org/10.4324/9781315237473; and Bassot, B. (2013). *The Reflective Journal.* Basingstoke: Palgrave]

Practicing reflection means **taking the time to bring hidden or subconscious thoughts and decision-making processes into the open for reassessment**. In the following exercise, you may find some useful guiding questions for self-reflecting on the involvement with individuals and communities who have survived adversity, loss, and displacement.

Reflection Break: ***Engage in personal reflection***

Take some time to reflect on your relationship to your work. Ask yourself questions like:

- What motivates me to do this kind of work?
- What are my expectations?
- What is expected of me?
- How am I responding to the challenges of the work?
- What effects (positive, negative, and/or neutral) does it have on me?

Adapted from the Reflection Toolkit – University of Edinburgh

Key Point: ***Insights on Reflective Practice from Donald Schön***

One of the most relevant conceptualizations of reflective practice was done by the philosopher Donald Schön [7], who stressed the role of reflection within the professional learning process. He identified two types of reflection:

1. **Reflection-*in*-action**, which refers to the **immediate thinking that occurs *while* you are doing something**; while you are performing an act. Reflection-*in*-action allows you to reshape the situation or activity on which you are working **in real time**. Schön suggests that, through 'reflecting-in-action', practitioners reflect on unexpected experiences and conduct 'experiments' which serve to **generate both a new understanding of the experience, and a change in the situation**. In the context of migrant and refugee care, this adaptability is crucial when addressing the diverse and immediate needs of the people we serve.

2. **Reflection-*on*-action**, which involves **reflecting on an experience, situation, or phenomenon *after* it has occurred.** This process entails **a critical examination of what happened in that particular situation, why you acted the way you did, whether you could have acted differently, and so on**. Reflection-*on*-action is often associated with **reflective writing** in which professionals reflect on their experiences and explore alternative ways to improve their practice [8]. For those working with migrants and refugees, reflection-on-action can lead to enhanced strategies for supporting others and better understanding the complexities of their experiences.

3. From Individual to Team and Organizational Resilience

As discussed in Module 1, resilience is commonly seen as an individual quality: the ability to resist, 'bounce back', or recover from difficulties or setbacks. More specifically, it is defined as **the ability to use the learning gained from negative experiences to adapt to different contextual and developmental circumstances** [9]. However, **individually-focused strategies alone will not be enough to support the well-being of staff as a whole**. Even the most resilient staff member cannot cope with challenging working conditions.

Reflection Break: ***Engage in group/team reflection***

Take a moment to reflect and write down your answer to the following questions:

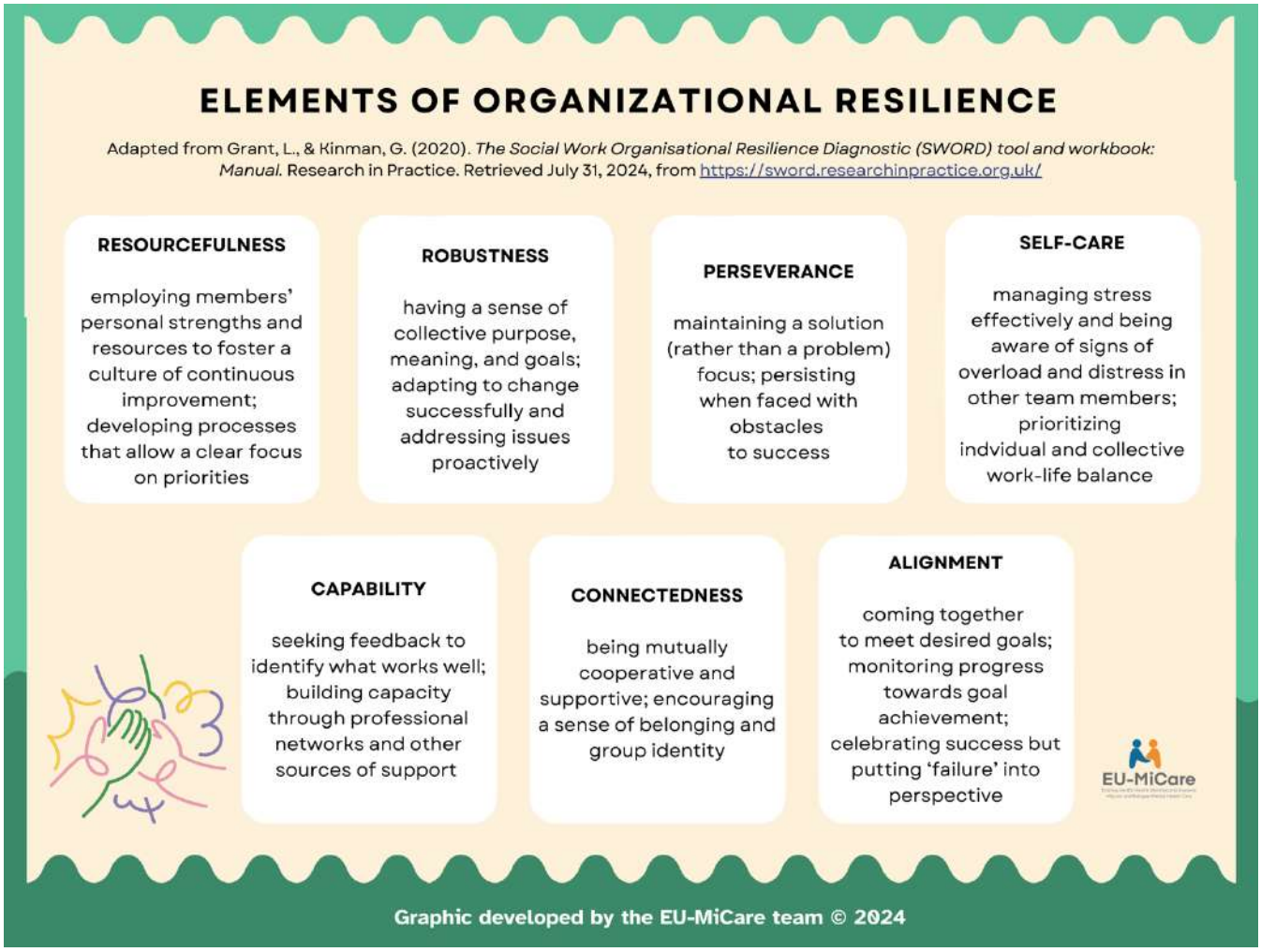
- What do I do to take care of myself?
- What does my team (colleagues, organization, etc.) do to take care of each other?
- What other means can I use for more appropriate care for myself to be able to care for others?

Sourced from *'Psychosocial Dimensions of the Refugee Condition' – Babel Day Centre*

A resilient team is one whose members **use their individual and collective resources to adapt positively to maintain well-being and performance, and to achieve common goals or purposes**. Team resilience protects team members from the potential negative effects of the external or internal disturbance factors that are likely to threaten team functioning (e.g. dramatic increase in referrals, changes in team or

organizational leadership, high turnover, or unexpected, high-impact events). **Multi-level, systemic interventions at the organizational level** (see Figure 4.3.2) are necessary to support the development of personal and collective resilience alike [9].

Figure 4.3.2. *"Elements of Organizational Resilience"*



The development of this graphic does not imply endorsement by SWORD.

4. Setting and Communicating Boundaries: Particularities of Volunteer Work

While setting boundaries is important for maintaining mental health and well-being in all aspects of life, it has particular significance in the context of working with migrants and refugees. **In situations where**

human needs – almost by definition – exceed the available support, setting boundaries ensures that the existing resources are not depleted further by occupational exhaustion.

Although volunteers should be treated the same way as paid professionals when it comes to staff care, their situation is different in several ways. **The voluntary nature of their commitment means they have more autonomy in shaping the extent and nature of their contribution** (and possibly limit or even end their commitment). At the same time, **many volunteers lack a formal support structure**, and **often feel alone and isolated in managing their relationship to the migrants and refugees they are supporting**.

The contact between volunteers and migrant populations – especially if prolonged over time – can rapidly evolve into **an intense, one-on-one relationship**, in which the volunteer **experiences great responsibility** and **can hardly set (self-care) boundaries**. A lack of clear boundaries can lead to stress, wasted time, conflict, as well as negative emotions such as resentment and anger. Setting healthy boundaries can help remind you of what is best for you, and can provide a solid basis for making decisions for yourself [1].

→ **VIDEO:** *Setting Boundaries as a Volunteer* 💻

Establishing clear boundaries is **essential for protecting both volunteers and the people they support**. By defining acceptable behaviors, volunteers can gain confidence in how to act in various situations, fostering high standards and consistency across different individuals. **This clarity helps manage expectations and prevent misunderstandings**, which can otherwise lead to confusion and conflict. Moreover, **it allows everyone involved to preserve their privacy and prioritize self-care**, ultimately ensuring healthy and sustainable relationships in the long run. Setting these boundaries not only benefits the individuals directly involved but also contributes to a more effective and harmonious support environment [10].

It is generally preferable for volunteers to work within a structured service provision framework rather than on a completely private basis. Within a structured context, volunteers should be enabled to find 'their place'. **Expectations, duties, tasks, and reporting relationships should be clearly defined and communicated.**

◎ Key Point: ***Key Tips for Boundary-Setting***

- Become aware of your boundaries through reflective practice.
- Communicate your boundaries clearly using 'I' statements, and do not be tempted to include long explanations or reasons. It is sufficient to say *"I cannot work on weekends, but I can be available weekday mornings between 10am and 1pm."* or *"I can't support individuals with issues related to sexual abuse, but I can help them deal with administrative processes and filling out forms."*.
- Respond immediately if your boundaries are disrespected or crossed, do not wait until you become resentful, and do not complain to others who are not involved (*"I noticed you have me scheduled for next Saturday morning. Please change it, as I am unavailable on weekends."*).
- Consider how you respond when others communicate their boundaries. While you may initially feel affronted or blamed, understanding their boundaries often improves the relationship and fosters closer connections.
- If you are not accustomed to asserting your boundaries, you may feel uncomfortable or anxious at first. However, many people report feeling relieved after successfully setting and maintaining their boundaries!

→ **VIDEO:** *Setting Boundaries with Clients: Role Play, Demo, Foundations* 💻

Because the roles of volunteers may be individualized, varied, and less clearly defined, volunteers often find themselves in situations where they have to communicate their own boundaries and limits clearly and repeatedly to both service users and other practitioners or co-workers [10]. Skills in boundary-setting are therefore especially important for protecting volunteers' health and well-being, as well as for retaining volunteers within the organization.

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Repository

Module 4. Self-Care and Staff Wellbeing

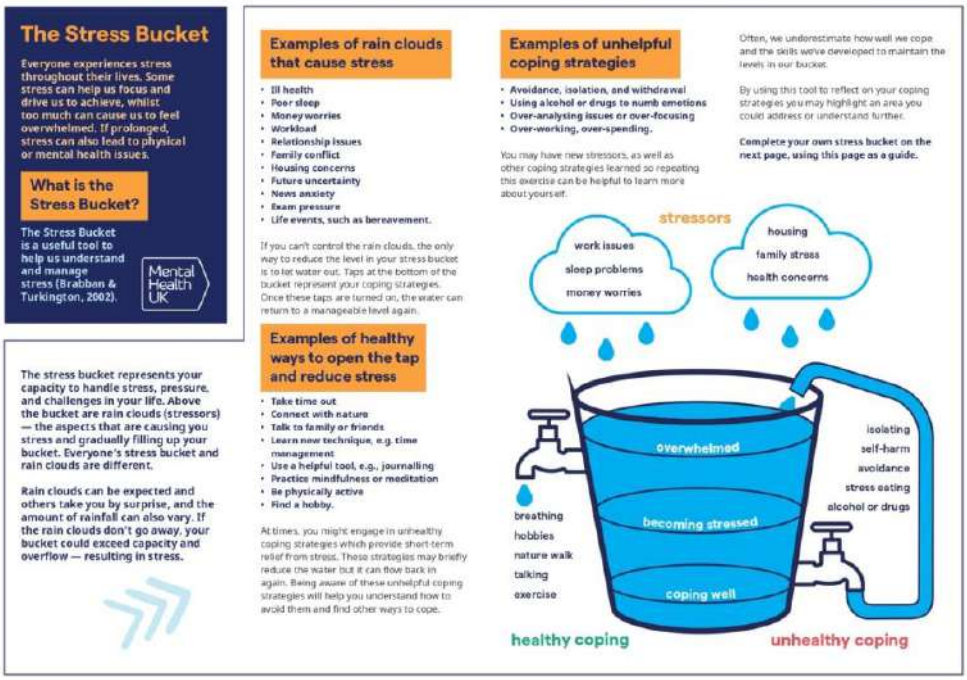
The information provided hereafter is supplementary and not part of the core material of this Module.

However, learners seeking a more thorough understanding of the subject matter are strongly advised to review this document in addition to the main curriculum.

Unit: 4.1 Effects Among Professionals and Volunteers Working in the Context of Migration

Handout 1. *"The Stress Bucket"*

The Stress Bucket is a visual tool that illustrates how various stressors (represented as rain clouds) accumulate in an individual's bucket. If these stressors aren't managed through healthy coping mechanisms (depicted as taps at the bottom of the bucket), the bucket can overflow, leading to emotional distress.



Note: Sourced from Mental Health UK. The full handout is available as a standalone .pdf resource in the Repository under the title **4_4.1 – Handout 1. "The Stress Bucket"**.

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Handout 2: *"The ABC of Addressing Vicarious Trauma"*

The ABC of Addressing Vicarious Trauma handout provides a practical framework for professionals and volunteers to recognize and mitigate the effects of vicarious trauma. It emphasizes three key strategies:

(i) Awareness of personal trauma histories,
(ii) Balance through self-care practices, and
(iii) Connection through supportive relationships.

Handout 6: ABCs of Addressing Compassion Fatigue

Directions. This activity has two parts. In the Part 1 you will engage in a self-assessment to determine how well you engage in the ABCs (Awareness, Balance, and Connection) of mitigating compassion fatigue. In the second part, you will identify one strategy focused to help you build awareness, balance and connection.

This document was adapted from Saakvitne, K. & Pearlman, L. (1996). *Transforming the Pain: A Workbook on Vicarious Traumatization for Helping Professionals who Work with Traumatized Clients*. New York, New York: W.W. Norton and Company. Retrieved from (https://4.files.edl.io/0d8f/06/25/18/182950-e99322a0-a293-4bab-9821-c2522b697049.pdf)

Part 1.

Take the Self-Assessment. Determine whether or not you engage in the following approaches for Awareness, Balance and Connection

Note: Sourced from Minnesota Department of Education. The full handout is available as a standalone .pdf resource in the Repository under the title **4_4.1 – Handout 2. "The ABC of Addressing Vicarious Trauma"**.

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Unit: 4.2 Self-Care

Handout 1. *"Professional Quality of Life Scale (ProQOL), Version 5"*

The Professional Quality of Life Scale (ProQOL), Version 5 is a comprehensive tool designed to measure the positive and negative emotional effects of working in helping professions, particularly those who support individuals affected by trauma. It consists of 30 items that assess three key components: Compassion Satisfaction, which refers to the pleasure and fulfillment derived from helping others; Burnout, which measures feelings of emotional exhaustion and the depletion of personal resources; and Secondary Traumatic Stress (STS), which reflects the emotional toll caused by exposure to others' trauma. The ProQOL is widely used by professionals in fields like counseling, healthcare, social work, and emergency response to assess their well-being and guide interventions to prevent or mitigate negative effects of their work.

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE
(PROQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often

1. I am happy.
2. I am preoccupied with more than one person I *[help]*.
3. I get satisfaction from being able to *[help]* people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I *[help]*.
7. I find it difficult to separate my personal life from my life as a *[helper]*.
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
9. I think that I might have been affected by the traumatic stress of those I *[help]*.
10. I feel trapped by my job as a *[helper]*.
11. Because of my *[helping]*, I have felt "on edge" about various things.
12. I like my work as a *[helper]*.
13. I feel depressed because of the traumatic experiences of the people I *[help]*.
14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. I feel worn out because of my work as a *[helper]*.
20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
21. I feel overwhelmed because my case [work] load seems endless.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
24. I am proud of what I can do to *[help]*.
25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
26. I feel "bogged down" by the system.
27. I have thoughts that I am a "success" as a *[helper]*.
28. I can't recall important parts of my work with trauma victims.
29. I am a very caring person.
30. I am happy that I chose to do this work.

Note: The Professional Quality of Life Scale (ProQOL), Version 5 is provided by B. Hudnall Stamm (2009-2012) and is available at ProQOL.org. The full handout and instructions for scoring are available as a standalone .pdf resource in the Repository under the title **4_4.2 – Handout 1. "Professional Quality of Life Scale (ProQOL), Version 5"**.

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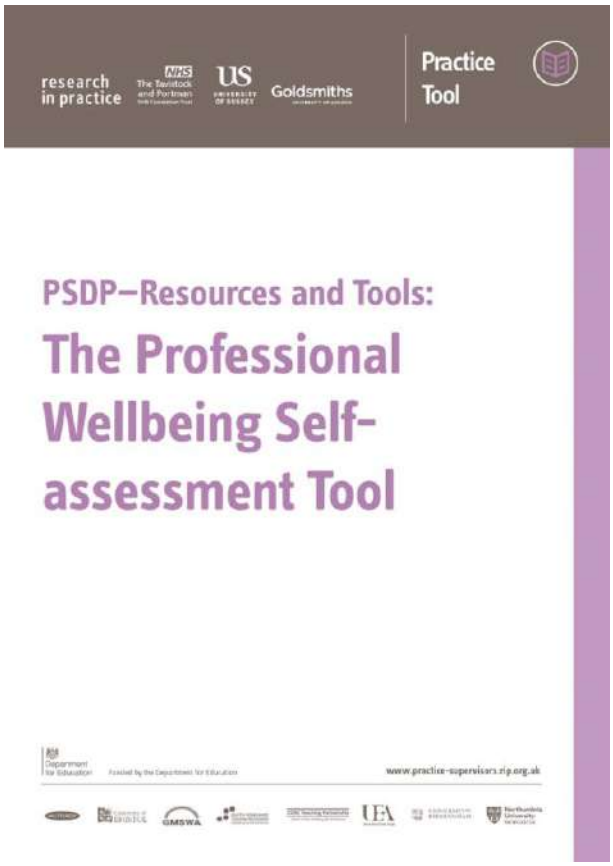
Handout 2. *"The Professional Wellbeing Self-Assessment Tool"*

The Professional Wellbeing Self-Assessment Tool is a reflective resource designed to help professionals evaluate their own wellbeing across seven key dimensions: Perspective, Self-management, Professional Development, Supports, Workload, Balance, and Values. Developed by Vicki Hirst and Rosemary Nash, experienced professional supervisors from Aotearoa New Zealand, the tool aims to identify areas of strength and those requiring attention to promote resilience and prevent burnout. It begins with a 35-question self-assessment, where individuals rate their satisfaction in each area on a scale from 1 to 5. The results are then plotted to create a visual 'professional wellbeing map', facilitating a comprehensive overview of one's current state. This map serves as a foundation for further reflection through guided questions, ultimately leading to the development of a personalized wellbeing plan with actionable goals and review timelines. The tool is particularly beneficial when used in supervision contexts, encouraging ongoing dialogue and support between supervisees and supervisors.



Note: Sourced from the Practice Supervisor Development Programme (PSDP), funded by the Department for Education (UK). The full handout is available as a standalone .pdf resource in the Repository under the title **4_4.2 – Handout 2. "The Professional Wellbeing Self-Assessment Tool"**.

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Handout 3. *"Additional Tools and Resources for Self-Care"*

Two self-tests based on the work of German psychologist, psychotherapist, and author, Gert Kaluza

The first self-test in this section allows you to check your current stress level by giving yourself a score on a range of physical, emotional, mental, and behavioral warning signals.

The second checklist shows you how many stress-reinforcing thoughts you have regularly. This test allows you to rate your responses on scales that indicate self-beliefs or internal messages that reinforce stress. You can then address these individually to reduce their stress-reinforcing effects.

- First self-test: How stressed are you? Write your scores in the right hand column.

Stress Warning Signals	Strong	Light	Little/Few	Your Score
Physical Warning Signals				
Heart palpitations / stabbing pains	2	1	0	
Constricted feeling in the chest	2	1	0	
Breathing problems	2	1	0	
Trouble falling asleep	2	1	0	
Trouble sleeping through the night	2	1	0	
Chronic tiredness	2	1	0	
Digestive problems	2	1	0	
Stomach ache	2	1	0	
Loss of appetite	2	1	0	
Sexual dysfunction	2	1	0	
Muscular tension	2	1	0	
Headache	2	1	0	
Backache	2	1	0	
Cold hands / feet	2	1	0	
Sweating profusely	2	1	0	
Emotional Warning Signals				
Nervousness, internal restlessness	2	1	0	
Irritability, feeling annoyed	2	1	0	
Anxiety, fear of failure	2	1	0	
Discontent	2	1	0	
Emotional imbalance	2	1	0	
Internal emptiness ('burnt out' feeling)	2	1	0	
Mental Warning Signals				
Repetitive thoughts	2	1	0	

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Lack of concentration	2	1	0	
Empty mind ('vaguing out')	2	1	0	
Daydreams	2	1	0	
Nightmares	2	1	0	
Reduced performance / frequent mistakes	2	1	0	
Behavioral Warning Signals				
Aggressive behavior	2	1	0	
Drumming fingers, shuffling feet	2	1	0	
Clenched teeth / teeth grinding	2	1	0	
Rapid speech / stutter	2	1	0	
Interrupting others, not listening	2	1	0	
Irregular meals	2	1	0	
Consuming alcohol / prescription drugs	2	1	0	
Letting private social relationships slip	2	1	0	
Smoking more than wanted	2	1	0	
Less exercise than wanted	2	1	0	
Add all points to determine your total score:				

Evaluation: How stressed are you?

0-10 points
You can be pleased. You have good resilience, you are ready to fight off stress.

11-20 points
You have already entered the downward spiral of stress. Familiarise yourself with relaxation, self-management, and time management.

21 points and more
Take yourself and your body seriously! Your body is putting a gun to your head. Make sure you're achieving balance, relaxation, and are taking more breaks. Otherwise you are at risk of your stress symptoms becoming chronic!

Note down your own reflections on the test:

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♦ Second self-test: Checklist of Stress-Reinforcing Thoughts

	How familiar are the following thoughts to you?	Very	Somewhat	Not at all
1.	I prefer doing everything myself.	2	1	0
2.	I won't last the distance.	2	1	0
3.	It's awful if something doesn't go according to plan.	2	1	0
4.	I will fail.	2	1	0
5.	I will never make it.	2	1	0
6.	It's not acceptable if I can't manage to complete a task or don't keep an appointment.	2	1	0
7.	I just can't stand this pressure (or fear, or pain etc.).	2	1	0
8.	I always have to be available for my work.	2	1	0
9.	Problems and difficulties are just terrible.	2	1	0
10.	It's important that I keep everything under control.	2	1	0
11.	I don't want to disappoint the others.	2	1	0
12.	There's nothing worse than making mistakes.	2	1	0
13.	I must be 100% reliable.	2	1	0
14.	It's terrible when others are angry with me.	2	1	0
15.	Strong people don't need help.	2	1	0
16.	I want to get on with well with everyone.			
17.	It's awful when others criticise me.	2	1	0
18.	If I relied on others, I'd be lost.	2	1	0
19.	It's important that everyone likes me.	2	1	0
20.	When I have to make a decision, I must be 100% sure about it.	2	1	0
21.	I'm constantly thinking about what might go wrong.	2	1	0
22.	Without me, it's impossible.	2	1	0
23.	I have to get everything right all the time.			
24.	Having to rely on others is terrible.	2	1	0
25.	It's absolutely terrifying if I don't know what's coming.	2	1	0

Evaluation: Your stress-reinforcing profile

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	Instructions	Value
1.	Add your points for thoughts 6, 8, 12, 13, and 23	*Value 1:*
2.	Add your points for thoughts 11, 14, 17, 17, and 19	*Value 2:*
3.	Add your points for thoughts 1, 15, 18, 22, and 24	*Value 3:*
4.	Add your points for thoughts 3, 10, 20, 21, and 25	*Value 4:*
5.	Add your points for thoughts 2, 4, 5, 7, and 9	*Value 5:*

Now transfer these values into a bar graph like this:

Statement											**Value**
I can't!											(insert value 1, example: 5)
Be careful!											(insert value 2)
Be strong!											(insert value 3)
Be popular!											(insert value 4)
Be perfect!											(insert value 5)
Score	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

You can see that unrealistic expectations and perfectionist thought pattern on the one hand, and irrational fears on the other, play an important role in reinforcing external stressors.

The first step towards coping with daily stressors better and avoiding these self-reinforcing patterns is to try and determine exactly which situations you experience as stressful and to then observe what happens to you in these situations. During the coming days, try to observe yourself at times of stress.

Note down your own reflections on the test:

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Unit: 4.3 Staff Care

Handout 1. *"Low Impact Debriefing"*

The Low Impact Debriefing handout outlines a trauma-informed approach to sharing and processing distressing experiences in professional settings. It introduces a four-step strategy (Self-Awareness, Fair Warning, Consent, and Limited Disclosure) designed to minimize secondary trauma exposure, prevent "sliming", and promote respectful communication among colleagues.

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Low Impact Debriefing

* AKA Low Impact Processing or Low Impact Disclosure *

How do you debrief when you have seen or heard disturbing things?

Do your colleagues share all the gory details with you over lunch?

Have you ever attended a training that felt more traumatizing than informative?

What is it?

Low Impact Debriefing (LID) is a trauma-informed technique for sharing and processing the difficult stories and images that we encounter in our work.

Contagion

Helping professionals can unwittingly spread secondary trauma among their colleagues, family, and friends. Some helpers believe that sharing the "gory details" is a normal part of their work. And others may be so desensitized to trauma work that they forget that ordinary citizens may be horrified or shocked by our stories.

These reactions are normal and common.

An important part of LID is to stop the contagion effect. We can do this by removing unnecessary details of traumatic events. This reduces the cumulative exposure to traumatic information while ensuring that we can safely reach out to others.

What is "Sliming"?

After a hard day, it is normal to want to talk to someone to help alleviate the burden of what you have experienced. However, if not done properly, this can leave the person on the receiving end feeling as though they now carry the weight of this - traumatic information too.

The term "sliming" describes the feeling of receiving or witnessing unnecessary traumatic content without warning or permission. Sliming can be contagious.

Two Types of Debriefing

1 THE FORMAL DEBRIEF

The formal debrief happens in a structured, scheduled way. Peer consultation, supervision, and Critical Incident Stress Debriefing (CISD) are types of formal debriefs.

Research has shown that mandatory debriefing done in large groups may increase levels of psychological distress for some participants*. Psychological First Aid and other approaches can be used to help build communities of practice for safe, formal debriefing.

2 THE INFORMAL DEBRIEF

The informal debrief happens in a casual, ad hoc way. Spontaneous conversations that happen in a colleague's office or during the drive home are types of informal debriefs.

Helpers who have been exposed to traumatic events need to debrief right away and cannot wait for a scheduled supervision meeting. Informal debriefs can be harmful when the listener feels as though they have been "slimed," rather than participating in a safe debriefing process.

LID outlines four steps you can use to protect your colleagues, friends, family, and yourself.

* Rose, S.C., Bisson, J., Churchill, R., & Wessely, S. (2002). Psychological debriefing for preventing post traumatic stress disorder (PTSD). *Cochrane Database of Systematic Reviews*, 2. https://doi.org/10.1002/14651858.CD000560

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Note: Sourced from TEND Academy. The full handout is available as a standalone .pdf resource in the Repository under the title **4_4.3 – Handout 1. "Low Impact Debriefing"**.

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Glossary

acculturation Term first introduced in: Module 1 pg. 48

The dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members. At the group level, it involves changes in social structures and institutions and in cultural practices. At the individual level, it involves changes in a person's behavioral repertoire.

Source: Berry, J. W. (2005). Acculturation: Living successfully in two cultures. *International Journal of Intercultural Relations*, 29(6), 697–712. https://doi.org/10.1016/j.ijintrel.2005.07.013

The processes by which groups or individuals adjust the social and cultural values, ideas, beliefs, and behavioral patterns of their culture of origin to those of a different culture. **Psychological acculturation** is an individual's attitudinal and behavioral adjustment to another culture, which typically varies with regard to degree and type.

Source: American Psychological Association. (n.d.). Acculturation. *APA Dictionary*. Retrieved April 11, 2025, from https://dictionary.apa.org/acculturation

acculturative stress Term first introduced in: Module 1 pg. 42

The psychological impact of adapting to a new cultural environment. It encompasses the challenges and pressures that individuals face during the process of acculturation, which can lead to significant stress and affect their mental health and well-being.

Source: Sluzki, C. E. (2010). Psychologische Phasen der Migration und ihrer Auswirkungen. In T. Hegemann & R. Salman (Eds.), *Handbuch Transkulturelle Psychiatrie* (pp. 108-123). Psychiatrie Verlag.; Machleidt, M. (2013). *Migration, Kultur und psychische Gesundheit. Dem Fremden begegnen* (1st ed.). W. Kohlhammer GmbH.

See definition of "*stress*" in this glossary.

adversity-activated development (AAD) Term first introduced in: Module 1 pg. 32

The newly developed positive characteristics, skills, and habits that arise after enduring highly challenging or adverse life circumstances.

Source: Papadopoulos, R. K. (2007). Refugees, trauma and adversity-activated development. *European Journal of Psychotherapy & Counselling*, 9(3), 301–312. https://doi.org/10.1080/13642530701496930

biopsychosocial model Term first introduced in: Module 1 pg. 54

An approach to understanding mental and physical health through a multi-systems lens, taking into consideration the influence of biology, psychology, and the social environment. A biopsychosocial approach to healthcare acknowledges that these systems overlap and interact to impact each individual's

well-being and risk for illness, and that understanding these systems can lead to more effective treatment. It also recognizes the importance of patient self-awareness, relationships with providers in the healthcare system, and individual life context. Dr. George Engel and Dr. John Romano developed this model in the 1970s, but the concept has existed in medicine for centuries.

Source: Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196*(4286), 129–136. https://doi.org/10.1126/science.847460

children Term first introduced in: **Module 3 pg. 51**

Every human being below the age of 18 years, unless under the law applicable to the child, majority is attained earlier.

Source: UNHCR (2024). *Refugee children and youth.* https://www.unhcr.org/handbooks/ih/age-gender-diversity/refugee-children-and-youth

coping skills (or coping strategies) Term first introduced in: **Module 4 pg. 6**

An action, a series of actions, or a thought process used in meeting a stressful or unpleasant situation or in modifying one's reaction to such a situation. Coping strategies typically involve a conscious and direct approach to problems, in contrast to defense mechanisms.

Source: American Psychological Association. (n.d.). Coping strategy. *APA Dictionary*. Retrieved April 11, 2025, from https://dictionary.apa.org/coping-strategy

crisis Term first introduced in: **Module 2 pg. 48**

An unstable condition involving an impending abrupt or significant change that requires urgent attention and action to protect life, assets, property or the environment.

Source: World Health Organization. (2020, April 9). *Glossary of health emergency and disaster risk management terminology*. https://www.who.int/publications/i/item/glossary-of-health-emergency-and-disaster-risk-management-terminology

cultural awareness Term first introduced in: **Module 3 pg. 16**

The ability to recognize, understand, and respect the differences and similarities between cultures. It involves considering cultural factors, such as values, beliefs, customs, and behaviors, to improve communication and build meaningful relationships across diverse cultural groups. This awareness is essential in fostering inclusive practices, especially in healthcare settings, where it can enhance service delivery and patient care.

Source: Gilbert, J., Goode, T. D., & Dunne, C. (2007). Cultural awareness. *National Center for Cultural Competence, Georgetown University Center for Child and Human Development*.

cultural competence Term first introduced in: **Module 3 pg. 16**

The ability to collaborate effectively with individuals from different cultures in personal and professional settings. This usually involves a recognition of the diversity both between and within cultures, a capacity for cultural self-assessment, and a willingness to adapt personal behaviors and practices. Cultural competence, also known as intercultural competence, has become a central concept in business, education, health care, government, and many other areas.

Source: American Psychological Association. (n.d.). Cultural competence. *APA Dictionary*. Retrieved April 11, 2025, from https://dictionary.apa.org/cultural-competence

cultural concepts of distress Term first introduced in: **Module 2 pg. 11**

The ways in which different cultural groups experience, understand, and communicate suffering, behavioral problems, or troubling thoughts and emotions.

Source: American Psychiatric Association. (2013). *Diagnostic and Statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

cultural curiosity Term first introduced in: **Module 3 pg. 21**

The genuine desire to explore, learn, and appreciate the customs, traditions, languages, and perspectives of cultures different from our own. It involves recognizing the beauty in our differences and finding common ground amid the rich tapestry of humanity.

Source: Culture Encounters. (n.d.). *Cultivating cultural curiosity*. Retrieved April 13, 2025, from https://cultureencounters.org/cultivating-cultural-curiosity

cultural essentialism Term first introduced in: **Module 2 pg. 18**

The belief that individuals within a particular cultural or social group share a set of inherent and unchanging traits. This perspective views cultural traits as fixed and natural, attributing specific qualities to all members of a group based on their shared heritage or background. It simplifies identities by attributing fixed characteristics to all members of a group, often overlooking diversity within that group.

Source: adapted from Haslam, N., Bastian, B., & Kuppens, P. (2006). The social psychology of essentialism. *Personality and Social Psychology Review, 10*(2), 1–18. https://doi.org/10.1207/s15327957pspr1002_1

cultural formulation interview (CFI) Term first introduced in: **Module 2 pg. 12**

Instrument developed in the DSM-5 to help clinicians understand a patient's cultural context, including how cultural factors influence their health beliefs, behaviors, and treatment expectations. It involves 16 open-ended questions across four domains, guiding clinicians to gather culturally relevant information that can enhance diagnosis and treatment planning.

Source: Lewis-Fernández, R., Aggarwal, N. K., Hinton, L., Hinton, D. E., Kirmayer, L. J., & López, S. R. (2016). *DSM-5 handbook on the cultural formulation interview*. American Psychiatric Publishing. https://doi.org/10.1176/appi.books.9780890425596

cultural integration Term first introduced in: **Module 1 pg. 40**

See definition of "*integration*" in this glossary.

cultural mediator Term first introduced in: **Module 3 pg. 29** (version for interpreters and cultural mediators) **Module 3 pg. 28** (version for other profiles)

A professional who facilitates communication (including interpretation) between people speaking different languages and coming from different cultural backgrounds.

Note:

1. Cultural mediators provide information on different sets of value, orientations to life, beliefs, assumptions, and socio-cultural conventions by clarifying culture-specific expressions and concepts that might give rise to misunderstanding.

2. The terms cultural mediator and intercultural mediator are used differently in EU Member States and different standards apply.

3. Cultural mediator should not be confused with the term **interpreter**, as intercultural mediation is a much wider and a more enriched means of communicating messages from sender to receiver than interpreting. For more information, see also the entry of interpreter.

Source: European Commission. (n.d.). *Cultural mediator*. European Migration Network Glossary. Retrieved April 11, 2025, from https://home-affairs.ec.europa.eu/networks/european-migration-network-emn/emn-asylum-and-migration-glossary/glossary/cultural-mediator_en

culture Term first introduced in: **Module 1 pg. 7**

Values, beliefs, language, rituals, traditions, and other behaviors that are passed from one generation to another within any social group. Broad definitions include any socially definable group with its own set of values, behaviors, and beliefs. Accordingly, cultural groups could include groups based on shared identities such as ethnicity (e.g., German American, Blackfoot, Algerian American), gender (e.g., women, men, transgender, gender-nonconforming), sexual orientation (e.g., gay, lesbian, bisexual), and socioeconomic class (e.g., poor, working class, middle class, wealthy).

Source: American Psychological Association. (n.d.). Culture. *APA Dictionary*. Retrieved April 11, 2025, from https://dictionary.apa.org/culture

System of shared beliefs, symbols, behaviors, values, and customs that members of a society use to make sense of their world and interact with each other. These elements are passed down through generations, helping to create a distinct and cohesive community identity. People from a common culture often feel a sense of belongingness with each other while also feeling different from other groups.

Source: International Organization for Migration. (2022). *Manual on community-based mental health and psychosocial support in emergencies and displacement* (2nd ed.). IOM. https://doi.org/10.18356/9789210562954

diagnostic and statistical manual of mental disorders (DSM-5) Term first introduced in: **Module 1 pg. 54**

A comprehensive guide (5th edition) published by the American Psychiatric Association that provides standardized criteria for diagnosing mental disorders, including descriptions, symptoms, and diagnostic features. It is used by clinicians and researchers to ensure consistent and accurate diagnoses across various mental health conditions.

Source: American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Publishing. https://doi/book/10.1176/appi.books.9780890425596

displaced minor(s) Term first introduced in: **Module 3 pg. 50**

A child or adolescent who has been forced to leave their home due to conflict, disaster, or crisis. They may be unaccompanied or separated from their family, facing significant vulnerability and hardship.

See *"unaccompanied and separated children"*, *"displacement"* and *"children"* in this glossary.

Source: International Organization for Migration. (n.d.). *Key Migration Terms*. International Organization for Migration. Retrieved April 13, 2025, from https://www.iom.int/key-migration-terms

displacement Term first introduced in: **Module 1 pg. 13**

The movement of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters.

Source: International Organization for Migration. (n.d.). *Key migration terms*. International Organization for Migration. Retrieved April 11, 2025, from https://www.iom.int/key-migration-terms

ecological systems theory (EST) / socio-ecological model (SEM) Term first introduced in: **Module 1 pg. 26**

A theoretical framework developed by Urie Bronfenbrenner in 1979, emphasizing that human development is influenced by various environmental systems surrounding an individual. These systems range from immediate, direct settings like family and school (microsystem) to broader societal and cultural contexts (macrosystem). The **Socio-Ecological Model (SEM)** builds upon this framework by exploring how individuals interact with dynamic social systems throughout their lives, highlighting the reciprocal relationship between personal and environmental factors. At its core, it suggests that individual behavior is shaped by a complex network of influences – spanning intrapersonal, interpersonal, institutional, community, and public policy factors.

Source: Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist, 32*(7), 513–531. https://doi.org/10.1037/0003-066X.32.7.513

empathic communication coding system (ECCS) Term first introduced in: **Module 3 pg. 5**

A validated instrument developed by Carma Bylund and Gregory Makoul in 2002 to assess empathic communication in professional-client encounters. It identifies and categorizes client statements that

express emotions, progress, or challenges, and evaluates clinicians' responses to these empathic opportunities.

Source: Bylund, C. L., & Makoul, G. (2002). Empathic communication and gender in the physician–patient encounter. *Patient Education and Counseling, 48*(3), 207-216. https://doi.org/10.1016/S0738-3991(02)00173-8

empathy Term first introduced in: **Module 3 pg. 4**

Understanding a person from their frame of reference rather than one's own, or vicariously experiencing that person's feelings, perceptions, and thoughts. Empathy does not, of itself, entail motivation to be of assistance, although it may turn into sympathy or personal distress, which may result in action. In psychotherapy, therapist empathy for the client can be a path to comprehension of the client's cognitions, affects, motivations, or behaviors.

Source: American Psychological Association, (n.d.). Empathy. *APA Dictionary*. Retrieved April 11, 2025, from https://dictionary.apa.org/empathy

explanatory model (EM) Term first introduced in: **Module 2 pg. 12**

In the explanatory model, clinicians ask the patient the questions -***What, Why, How,*** and ***Who*** to address cultural differences and consider how a person with a different cultural background understands and feels mental health challenges while maintaining a common purpose: therapy.

Source: Kirmayer, L.J. and Bhugra, D. (2009). Culture and mental illness: social context and explanatory models. In I.M. Salloum and J.E. Mezzich (Eds.), *Psychiatric diagnosis: Patterns and Prospects* (pp.29-37). New York: John Wiley & Sons.; Kleinman, A. (1980). *Patients and healers in the context of culture.* Berkeley, CA: University of California Press.

functional adaptation Term first introduced in: **Module 1 pg. 40**

The process through which individuals adjust to and manage the challenges posed by their new environment, particularly regarding psychological and social functioning. This adaptation includes learning how to navigate the host society's social norms, laws, and cultural practices, while maintaining the ability to cope with the stressors of migration.

Source: Sluzki, C.E. (2010). Psychologische Phasen der Migration und ihrer Auswirkungen. In T. Hegemann & R. Salman (Hrsg.), *Handbuch Transkulturelle Psychiatrie* (S. 108-123). Berlin: Psychiatrie Verlag.

health Term first introduced in: **Module 1 pg. 21**

A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Source: World Health Organization. (1946). *Constitution of the World Health Organization* (adopted 22 July 1946, entered into force 7 April 1948), 14 UNTS 185, Preamble.

IASC MHPSS Intervention Pyramid Term first introduced in: Module 3 pg. 45

A framework developed in 2007 by the Inter-Agency Standing Committee (IASC), a UN-established body for coordinating humanitarian response. It guides the provision of mental health and psychosocial support (MHPSS) in emergency settings through a tiered system of care. The pyramid consists of four levels of intervention: (1) basic services and security, (2) community and family supports, (3) focused, non-specialized supports, and (4) specialized services, including psychiatric care. It emphasizes starting with broad, population-level strategies and progressing to targeted, individual support for those with more severe mental health needs.

Source: Inter-Agency Standing Committee (IASC). (2007). *IASC guidelines on mental health and psychosocial support in emergency settings*. Retrieved from https://interagencystandingcommittee.org/iasc-guidelines-mental-health-and-psychosocial-support-emergency-settings-2007

idioms of distress Term first introduced in: Module 2 pg. 13

Specific expressions of psychological distress, which may not refer to specific symptoms or syndromes, but rather reflect a collective and shared understanding of personal distress.

Source: Von Lersner., U., & Kizilhan, J. I. (2017). *Kultursensitive Psychotherapie*. Hogrefe Verlag.

interdisciplinary collaboration Term first introduced in: Module 3 pg. 43

The cooperation of professionals from different disciplines to achieve common objectives, often in complex contexts like healthcare, humanitarian work, or research. This approach ensures the integration of diverse expertise, which enhances problem-solving, decision-making, and overall effectiveness in meeting the needs of individuals or communities.

Interdisciplinary approach is defined by the APA as a manner of dealing with psychological, medical, or other scientific questions in which individuals from different disciplines or professions collaborate to obtain a more thorough, detailed understanding of the nature of the questions and consequently develop more comprehensive answers. For example, an interdisciplinary approach to the treatment or rehabilitation of an individual who is ill, disabled, or experiencing distress or pain uses the talents and experiences of therapists from a number of appropriate medical and psychological specialties.

Source: American Psychological Association, (n.d.). Interdisciplinary approach. *APA Dictionary*. Retrieved April 11, 2025, https://dictionary.apa.org/interdisciplinary-approach

international statistical classification of diseases and related health problems (ICD-11) Term first introduced in: Module 1 pg. 54

A standardized classification system (11th edition) developed by the World Health Organization (WHO) for coding diseases and health conditions. The purpose of the ICD is to permit the systematic recording

analysis, interpretation and comparison of mortality and morbidity data collected in different countries or areas and at different times. The ICD is used to translate diagnoses of diseases and other health problems from words into an alphanumeric code, which permits easy storage, retrieval, and analysis of the data. In practice, the ICD has become the international standard diagnostic classification for all general epidemiological and many health management purposes and is widely used across European contexts.

Source: World Health Organization. (2016). *International statistical classification of diseases and related health problems* (10th ed.). World Health Organization. https://icd.who.int/browse10/2016/en

interpreter Term first introduced in: **Module 3 pg. 29** (version for interpreters and cultural mediators) / **pg. 28** (version for other profiles)

A professional who is expected to convert oral communication from a source language (language/s of the country of origin of a migrant) to a target language (language of the host country) and vice versa to ensure appropriate communication between migrants and staff of public authorities in particular who do not speak the same language.

Note: The role of interpreters in asylum and migration procedures is expected to provide accurate and complete message transfer into the target language and vice versa preserving the content and intent of the source message without omission or distortion.

Source: European Commission. (2024, April 29). *EMN Asylum and Migration Glossary*. Directorate-General for Migration and Home Affairs https://home-affairs.ec.europa.eu/networks/european-migration-network-emn/emn-asylum-and-migration-glossary_en

Intersectionality Term first introduced in: **Module 2 pg. 23**

A concept first introduced by Professor Kimberlé Crenshaw in 1989, which acknowledges that individuals experience oppression and discrimination in distinct and complex ways due to the intersection of multiple social identities. For example, a middle-aged white woman from a disadvantaged background may face different forms of marginalization compared to a young Black woman from a privileged socioeconomic status or an older Hispanic man with a disability. Social identity is shaped by a variety of factors, such as gender, race, class, sexual orientation, age, physical ability, and mental health, all of which interact in ways that influence an individual's experiences.

Source: Mental Health Europe. (n.d.). *Intersectionality & mental health: Embracing diversity*. Retrieved April 13, 2025, from https://www.mentalhealtheurope.org/what-we-do/intersectionality/

involuntary dislocation Term first introduced in: **Module 1 pg. 14**

A concept first introduced by Professor Renos K. Papadopoulos which refers to two distinct but interrelated facets or *moments* of dislocation: (a) the experience in which a person, family, or community no longer feels 'at home' in their own home – this represents a specific form of dislocation, a loss of the sense of belonging within one's own environment; and (b) the subsequent movement away (primarily

physical and geographical, but also psychological, cultural, and social) from the space that has lost its feeling of home.

Source: Papadopoulos, R. K. (2021). *Involuntary Dislocation. Home, Trauma, Resilience and Adversity-Activated Development* (p. 39). London: Routledge.

language barriers Term first introduced in: **Module 3 pg. 28**

The challenges in communication that arise when individuals or groups do not share a common language or have limited proficiency in each other's language. These barriers can impede access to essential services, including healthcare, education, and social support, leading to misunderstandings, reduced quality of care, and social exclusion.

Source: European Commission. (2024). *The language barrier: the invisible yet critical cross-border obstacle.* Retrieved April 13, 2025, from https://futurium.ec.europa.eu/en/border-focal-point-network/library/language-barrier-invisible-yet-critical-cross-border-obstacle

mental disorder Term first introduced in: **Module 1 pg. 55**

A clinically significant disturbance in an individual's cognition, emotional regulation, or behavior. It is usually associated with distress or impairment in important areas of functioning. Mental disorders may also be referred to as mental health conditions. The latter is a broader term covering mental disorders, psychosocial disabilities, and (other) mental states associated with significant distress, impairment in functioning, or risk of self-harm.

Source: World Health Organization (2022). *Mental disorders – key facts*. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

mental health Term first introduced in: **Module 1 pg. 4**

A state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community.

Source: World Health Organization. (2022, June 17). *Mental health – strengthening our response*. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

mental health inequities Term first introduced in: **Module 1 pg. 17**

The unequal distribution of opportunities for individuals to lead a flourishing life and enjoy good health, both between and within societies. These disparities are influenced by factors such as socioeconomic status, access to healthcare, and social determinants of health.

Source: World Health Organization. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health.* WHO Document WHO-IER-CSDH-08.1. https://www.who.int/publications/i/item/WHO-IER-CSDH-08.1

mental health and psychosocial support (MHPSS) Term first introduced in: **Module 1 pg. 6**

A term used to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorders. The term 'psychosocial' denotes the inter-connection between psychological and social processes and the fact that each continually interacts with and influences the other.

Source: Inter-Agency Standing Committee (IASC). (2010). IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings, *Mental Health and Psychosocial Support in Humanitarian Emergencies: What Should Humanitarian Health Actors Know?*

migrant Term first introduced in: **Module 1 pg. 9**

An umbrella term, not defined under international law, reflecting the common lay understanding of a person who moves away from their place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons. The term includes a number of well-defined legal categories of people, such as migrant workers; persons whose particular types of movements are legally defined, such as smuggled migrants; as well as those whose status or means of movement are not specifically defined under international law, such as international students.

Note: At the international level, no universally accepted definition for "migrant" exists. The present definition was developed by IOM for its own purposes and it is not meant to imply or create any new legal category.

Source: International Organization for Migration. (2019). *International migration law no. 34: Glossary on migration*. International Organization for Migration. https://publications.iom.int/books/international-migration-law-ndeg34-glossary-migration

migration Term first introduced in: **Module 1 pg. 9**

The movement of persons away from their place of usual residence, either across an international border or within a State.

Source: International Organization for Migration. (2019). *International migration law no. 34: Glossary on migration*. International Organization for Migration. https://publications.iom.int/books/international-migration-law-ndeg34-glossary-migration

migratory mourning Term first introduced in: **Module 1 pg. 46**

The psychological and emotional challenges migrants face during the process of migration. Inspired by the mythical journey of the Greek hero Odysseus (Ulysses), this model may help field workers identify specific areas in migrants' lives that need special attention to promote resilience and prevent severe mental health challenges.

Source: Achotegui, J. (2022). Immigrants living extreme migratory grief: The Ulysses syndrome. *International Journal of Family & Community Medicine, 6*(6), 303–305. https://doi.org/10.15406/ijfcm.2022.06.00295

nonverbal communication Term first introduced in: **Module 3 pg. 7**

The act of conveying information without the use of words. Nonverbal communication occurs through facial expressions, gestures, body language, tone of voice, and other physical indications of mood, attitude, approbation, and so forth, some of which may require knowledge of the culture or subculture to understand.

Source: American Psychological Association, (n.d.). Nonverbal communication. *APA Dictionary*. Retrieved April 11, 2025, from https://dictionary.apa.org/nonverbal-communication

non-violent communication (NVC) Term first introduced in: **Module 3 pg. 11**

A communication process developed by American psychologist and mediator, Marshall B. Rosenberg, designed to resolve conflicts through compassion and understanding. It focuses on creating meaningful connections by fostering empathy, expressing needs, and finding mutually beneficial solutions that address the needs of all parties.

Source: Center for Nonviolent Communication. (n.d.). *What is Nonviolent Communication (NVC)?* Retrieved April 11, 2025, from https://www.cnvc.org/learn/what-is-nvc

oversimplification Term first introduced in: **Module 2 pg. 18**

A process of describing or explaining something in a way that excludes essential details or complexity, resulting in a misleading or inaccurate understanding of the issue. It often occurs when nuanced problems are reduced to simple statements or solutions that do not reflect their true nature.

Source: Cambridge English Dictionary. (n.d.). *Oversimplification*. Retrieved April 11, 2025, from https://dictionary.cambridge.org/us/dictionary/english/oversimplification

post-traumatic growth Term first introduced in: **Module 1 pg. 31**

The positive psychological changes that can occur as individuals struggle with and process highly challenging life events. Among migrants and refugees, it involves a reflective meaning-making process through which individuals reinterpret their traumatic experiences, often leading to strengthened relationships, a deeper appreciation of life, personal resilience, new possibilities, and spiritual or existential growth. This transformation is not the absence of distress but rather a parallel process, where growth arises through the struggle – not despite it.

Source: Chan, K. J., Young, M. Y., & Sharif, N. (2016). Well-being after trauma: A review of posttraumatic growth among refugees. *Canadian Psychology / Psychologie canadienne,* 57(4), 291–299. https://doi.org/10.1037/cap0000065

psychosocial well-being Term first introduced in: **Module 1 pg. 6**

The interplay between individual psychological processes (such as emotions, thoughts, and behaviors) and the broader social environment, including relationships, community, culture, and societal conditions. It

captures how people function emotionally and socially, and how external factors such as displacement, discrimination, or support systems influence their mental health and overall quality of life.

Source: Eiroa-Orosa, F. J. (2020). Understanding psychosocial wellbeing in the context of complex and multidimensional problems. *International Journal of Environmental Research and Public Health, 17*(16), 5937. https://doi.org/10.3390/ijerph17165937

reflective practice Term first introduced in: **Module 3 pg. 10**

A process through which professionals critically examine and learn from their experiences to deepen understanding, particularly in complex situations. It fosters continuous professional development and improves clinical decision-making through self-awareness and contextual insight.

Source: Prosser, M., Stephenson, T., Mathur, J., Enayati, H., Kadie, A., Abdi, M. M., Handuleh, J. I. M., & Keynejad, R. C. (2021). Reflective practice and transcultural psychiatry peer e-learning between Somaliland and the UK: A qualitative evaluation. *BMC Medical Education, 21*, 58. https://doi.org/10.1186/s12909-020-02465-y

refugee Term first introduced in: **Module 1 pg. 13**

Under international law, the United Nations Convention on the Status of Refugees, 1951, defines a refugee as a person who 'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, as a result of such events, is unable to or, owing to such fear, is unwilling to return to it' (Article 1 (A)(2)).

Source: United Nations High Commissioner for Refugees. (2011). *Handbook and guidelines on procedures and criteria for determining refugee status under the 1951 Convention and the 1967 Protocol relating to the status of refugees* (HCR/1P/4/ENG/Rev. 3). https://www.unhcr.org/publications/legal/handbook-and-guidelines-procedures-and-criteria-determining-refugee-status

A person who, owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.

Source: United Nations. (1951). *Convention relating to the status of refugees* (adopted 28 July 1951, entered into force 22 April 1954), 189 U.N.T.S. 137, Article 1A(2). https://www.unhcr.org/3b66c2aa10

resilience Term first introduced in: **Module 1 pg. 30**

In the context of humanitarian, development, peacebuilding, and security policies and operations, the ability of individuals, households, communities, cities, institutions, systems, and societies to prevent, resist, absorb,

adapt, respond and recover positively, efficiently, and effectively when faced with a wide range of risks, while maintaining an acceptable level of functioning and without compromising long-term prospects for sustainable development, peace and security, human rights, and well-being for all.

Source: United Nations Development Group, & Inter-Agency Standing Committee. (2015). *Joint letter from UNDG and IASC chairs on guiding principles on advancing resilience* (p.3). https://interagencystandingcommittee.org/system/files/undg-iasc_joint_letter_on_resilience_final.pdf

risk and protective factors Term first introduced in: **Module 1 pg. 29**

The multiple individual, social, and structural determinants throughout our lives that may combine to protect or undermine our mental health and shift our position on the mental health continuum.

Source: World Health Organization. (2022). *World mental health report: Transforming mental health for all*. World Health Organization. https://www.who.int/publications/i/item/9789240049338

social determinants of health Term first introduced in: **Module 1 pg. 18**

The conditions in which people are born, grow, live, work and age and are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries.

Source: World Health Organization. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health*. Final report of the Commission on Social Determinants of Health. World Health Organization. https://www.who.int/publications/i/item/WHO-IER-CSDH-08.1

stigma Term first introduced in: **Module 2 pg. 7**

The negative attitudes and beliefs directed toward individuals or groups based on certain characteristics, such as mental health conditions. It can manifest in several forms, including **s**elf-stigma (internalized negative beliefs), help-seeking stigma (fear of seeking help due to perceived judgment), associative stigma (stigma associated with being connected to a stigmatized individual), public stigma (societal prejudices and discrimination), and anticipated stigma (fear or expectation of being stigmatized).

Source: Crowe, A., Averett, P., Glass, J. S., Dotson-Blake, K. P., Grissom, S. E., Ficken, D. K., & Holmes, J. (2016). Mental health stigma: Personal and cultural impacts on attitudes. *Journal of Counselor Practice, 7*(2), 97–119. https://doi.org/10.22229/spc801925

stress Term first introduced in: **Module 4 pg. 6**

The physiological or psychological response to internal or external stressors. It involves changes affecting nearly every system of the body, influencing how people feel and behave. For example, it may be manifested by palpitations, sweating, dry mouth, shortness of breath, fidgeting, accelerated speech, and the intensification of negative emotions, especially if already present. While stress is often seen in a negative light, optimal levels of stress (also known as 'eustress') can enhance performance and motivation, helping individuals manage challenges effectively. However, severe stress is characterized by the General

Adaptation Syndrome (GAS), a three-stage process that describes the body's reaction to stress over time: the alarm stage (the initial "fight or flight" response), the resistance stage (where the body adapts but remains on alert), and the exhaustion stage (where prolonged stress depletes the body's resources, leading to burnout). These mind–body changes contribute to psychological and physiological disorders, negatively impacting both mental and physical health, and reducing overall quality of life.

Source: American Psychological Association, (n.d.). Stress. *APA Dictionary*. Retrieved April 11, 2025, from https://dictionary.apa.org/stress

stressor(s) Term first introduced in: Module 4 pg. 5

Any event, force, or condition that results in physical or emotional stress. Stressors may be internal or external forces that require adjustment or coping strategies on the part of the affected individual.

Source: American Psychological Association, (n.d.). Stressor. *APA Dictionary.* Retrieved April 11, 2025, from https://dictionary.apa.org/stressor

structural competence Term first introduced in: Module 3 pg. 22

The trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g., depression, hypertension, obesity, smoking, medication "non-compliance," trauma, psychosis) also represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health.

Source: Wang E. E. (2019). Structural Competency: What Is It, Why Do We Need It, and What Does the Structurally Competent Emergency Physician Look Like?. AEM education and training, 4(Suppl 1), S140–S142. https://doi.org/10.1002/aet2.10415

translator Term first introduced in: Module 3 pg. 30

A professional who converts written text from one language into another, ensuring that the meaning, context, style, and tone are accurately preserved. This process involves not only linguistic skills but also cultural understanding to convey nuances appropriately.

Source: Translators without Borders. (n.d.). *Field guide to humanitarian interpreting & cultural mediation.* Retrieved April 10, 2025, from https://translatorswithoutborders.org/wp-content/uploads/2017/04/Guide-to-Humanitarian-Interpreting-and-Cultural-Mediation-English-1.pdf

unaccompanied and separated children (UASC) Term first introduced in: Module 3 pg. 50

Children, as defined in Article 1 of the Convention on the Right of the Child, who have been separated from both parents and other relatives and are not being cared for by an adult who, by law or custom, is responsible for doing so.

Note: In the context of migration, children separated from both parents or other caregivers are generally referred to as unaccompanied migrant children (UMC).

Source: United Nations Committee on the Rights of the Child. (2005). *General comment No. 6: Treatment of unaccompanied and separated children outside their country of origin* (CRC/GC/2005/6, para. 7). United Nations. https://www.unhcr.org/media/convention-rights-child-general-comment-no-6-2005-treatment-unaccompanied-and-separated

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