Post-traumatic Integration
Low-level Psychosocial Support
and Intervention for Refugees

Post Traumatic Integration
Awareness Raising Guidelines

https://posttraumatic-integration.eu

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PROJECT CONSORTIUM

The project consortium comprises a multidisciplinary team that includes legal, social, and medical research organizations, learning and media education specialists, and ICT communication experts.

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The story behind our logo

This logo represents refugees as a *(migratory)* **bird** trying to fly again. For this reason, the **wings** are partially open pointing upwards (*the first step has been taken),* ready to open. One wing is wounded ***(red color** – indicating a trauma, caused by "war's **flame** that continues to burn causing internal pain").* The red wing is partially hidden behind the body *(a trauma is not always visible, but it exists for real and must be properly treated).* The **blue color** is the color of the sky*, (flying to a better future, a hopeful upward glance)* - the unlimited sky, a direct connection without borders with the refugees' homeland, their freedom of choices, "the head up" for a new life/start in the host country.

From another perspective the logo is reminiscent of a flower which, in order to flourish, needs to grow its roots in the ground where it happened to be found and to be adopted within the hosting ecosystem.

(Christopher Rigas, designer of the PTI logo)

These guidelines have been drawn up in the frame of the project "Post-traumatic Integration – Low level Psychosocial Support and Intervention for Refugees"" co-financed by the European Union, Erasmus +, 2017-1-BE02-KA202-034725.

The views expressed are purely those of the project consortium in the frame of the project and in no way reflect the views of the EU, governments or other parties.
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INTRODUCTION TO THE PROJECT

Although the massive migration movement that has brought in 2015 more than one million refugees into European countries has become smaller in recent years, it can be expected that many refugees will continue to arrive in Europe in the years to come.[1] This huge challenge requires not only additional budgets for registration, accommodation, food, medical care and education, but also a large work force.

While some of these workers have the respective professional background as psychologists, or social workers, the overwhelming part of people working with refugees, especially in the NGOs and voluntary sector, have administrational, or other professional, background and just their good will to help. But there exists a need for more trained voluntary helpers, educators and first-liners who are in direct contact with high numbers of refugees on a daily basis.

This aspect is especially important when we take into consideration that around 50 percent of the refugees who arrive in Europe are experiencing psychological distress and mental illness resulting from trauma (BPtK, 2017). As many as half of those refugees could be suffering from PTSD - posttraumatic stress disorder (BPtK, 2017). However, post-traumatic problems are often overlooked, simply because most first-liners (people in direct contact with arriving refugees) are not aware of them. As shown by the first findings of the project survey in 2018, which involved 158 first-line workers coming from the seven different project countries:

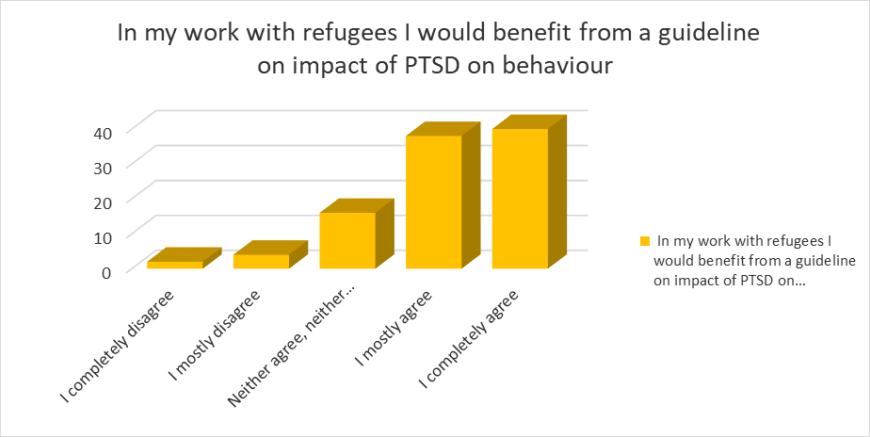

Figure 1. Survey results of the project *Post-traumatic Integration – Low-level Psychosocial Support and Intervention for Refugees,* 2018.

The objectives of the 'Post-traumatic Integration' project are two-fold therefore:

[1] The term 'refugees' in this project is used in the generic sense to refer to all persons fleeing their country of origin or residence in order to seek 'refuge' in another country. A large section, but not all of them, will apply for asylum in another country, and a section thereof will eventually be granted the legal status of refugees. See infra.

- First of all, to raise the awareness about the occurrence of post-traumatic problems and about low-level psychosocial support among professionals working with refugees. These include in particular: (a) all those who are working as front-liners with refugees (such as medical, social and legal persons); and (b) the educators (such as teachers, trainers, mentors and youth workers), who work with children, adolescents and young adults (and sometimes adults) from the refugee communities. We wish to encourage both groups to be well equipped in their workplaces in order to detect and respond properly to the symptoms of post-traumatic stress disorder.
- Secondly, by providing adequate answers to the post-traumatic problems of refugees, this project ultimately aims at a more rapid and more effective integration of these persons into their host countries in Europe, or wherever their final destination may be.

While the target groups of our project are first-liners and educators working with refugees, it should therefore be clear that the ultimate beneficiaries are the refugees themselves. Therefore, raising awareness on this issue is required and their integration and social inclusion into their new environment will hence be facilitated.

In order to reach these objectives, the project team has developed awareness raising, information, learning materials and first-line management recommendations for non-specialist refugee-care providers, teachers and trainers in order to enable them to give low-level psychosocial support and early low-level mental health interventions to refugees, which will help the latter to promote their rapid and effective integration.

These materials include:

- Awareness Raising Guidelines about PTSD, which will be a simple and practical tool for a complex support and informational background for the people working with refugees.
- Action Sheets containing: **Activities** as recommendations and key actions to meet the needs of refugee clients, and **Training Modules** on post-traumatic problems and PTSD that address diverse client behaviours and key findings from research.
- Online Networking Platform, where all the materials are accessible at an internet-based information system for refugee workers (www.posttraumatic-integration.eu). It includes also an interactive forum for exchanging experiences and best practices. The platform´s forum uses the new machine translation technology that facilitates real-time translation and which is already powerful enough to break down the language barrier between users speaking different languages.

- Smartphone application: selected materials are available also in a Smartphone application (name of the application / where to download it).

The following Partner Organizations are participating in this project:

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The products that the project consortium developed are meant to cover the gap in skills requirements of the target groups and to add impact on low level psychosocial support for final beneficiaries.

The products are not meant to be used as diagnostic tools or to substitute any other action which is covered by official medical, psychological and social experts.

1. BACKGROUND INFORMATION

What are the recent facts and figures concerning refugee flows in Europe and regarding post- traumatic problems in refugees?

What are the main International and European legal instruments dealing with mental health of refugees?

It is first of all useful to situate this project within a broader socio-political and legal frame.

1.1 Socio-political frame of the project

The migration and refugee question is one of the main challenges that the international community is currently facing and that will have an enormous impact in the future, from a social, political and economic point of view. In the European Union, as well as among the Members States, how to cope with the migration flow is a main point of debate and creates a challenging political and societal tension that is putting in discussion the very essential principles on which the EU integration process is grounded. The EU Member States have established asylum procedures across the EU so that all those applying for asylum in EU Member States are guaranteed certain basic conditions of reception, protection and access to the asylum procedures. Despite this, some policies in the MS turn some refugees into undocumented migrants and shield EU Member States from their international legal obligations.

One of the most important issues discussed at the national, as well as European level, is the social integration of refugees into the host society. In relation to this, and for the scope of our project, it is worth to mention that relevant studies show that the circumstances and experiences of forced migration have profound effects on refugees' health and integration into the host society. Thus, refugees' levels of integration depend on a number of factors, including pre-migration experiences, the departure process and the post-arrival experiences and environment. Studies have shown that the presence of these potential traumatic experiences can cause post-traumatic syndromes that influence directly the refugee status decision-making process, posttraumatic stress disorder (PTSD), or other post-traumatic disorders (Robila, 2018)

1.1.1. Ongoing conflicts and causes of displacement

About 65 million people live in forced displacement: almost 1 percent of the world's population (World Bank, 2017). The conflict in the Syrian Arab Republic and the resulting flow of refugees toward the EU are only part of a much broader story. The crisis of forced displacement is not new: for decades, large numbers of people have been forced to flee from their homes by conflict, violence and poverty. What is new is the increasing scale and complexity of the crisis in a globalized world and the growing recognition that it is a humanitarian and a development challenge as well as a political and economic one (World Bank, 2017).

The international community has developed the right to international protection, a need that arises when national protection is denied or is otherwise unavailable and the person is unable to return home because they would be at risk there. Risks that give rise to a need for international protection classically include those of persecution, threats to life, freedom or physical integrity arising from armed conflict, serious public disorder, or different situations of violence (UNHCR, 2017). Refugees are, by definition, in need of international protection. In addition, individuals who are outside their country of origin but who may not qualify as refugees under international or regional law, may in certain circumstances also require international protection, on a temporary or longer-term basis. According to this "subsidiary protection" States may offer protection on a humanitarian basis to persons whose own country is unable to protect them against serious harms, for instance in the context of natural hazards or public health emergencies (UNHCR, 2017). Furthermore, the European Directive 2011/95/EU, the so called Qualification Directive, recognize subsidiary protection to third country nationals (or stateless persons) who do not qualify as refugees but who have well-founded reasons to believe that, if returning to their countries of origin, they would run the actual risk of undergoing serious damage. According to the above mentioned EU directive serious damage means: death sentence or execution, torture or other forms of sentence, inhuman or demeaning treatment, serious and personal death threat or threat for a civil deriving from indiscriminate violence in a situation of domestic or international armed conflict.

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1.1.2. Facts and figures

In 2018, there were 634,700 applications for international protection in the EU plus Norway and Switzerland, a decrease compared to 728,470 applications in 2017 and almost 1.3 million in 2016 (European Parliament, 2018). According to Eurostat (2019), in 2018, 37% of EU-28 first instance asylum decisions resulted in positive outcomes that is grants of refugee or subsidiary protection status, or an authorisation to stay for humanitarian reasons. For first instance decisions, some 56% of all positive decisions in the EU-28 in 2018 resulted in grants of refugee status.

In numbers, the EU countries granted protection to almost 333,400 asylum seekers in 2018, down by almost 40% on 2017. Almost one in three (29%) of these were from Syria while Afghanistan (16%) and Iraq (7%) rounded up the top three (European Parliament, 2018), all countries going through prolonged violent conflicts. According to Eurostat (2019) regarding the countries of destination in 2018, Germany registered the highest number of applicants (31%), followed by Italy (20%) and France (14%).

Although relevant studies have demonstrated that refugees present high prevalence of trauma-related mental disorders, the rates of mental disorders identified vary substantially across these studies (World Health Organization). This is due to three main factors: the characteristics and backgrounds of the refugee groups studied; the context in the host country (the poorer the host country the higher the prevalence of mental disorders); and the quality and sampling method of the studies (World Health Organization). Thus, numbers and conclusions can vary significantly from one study to another. In a recent publication on refugees and social integration in Europe, the UN states that the most common disorders among refugees are post-traumatic stress disorder and major depression, trauma and loss. It, furthermore, reports that psychiatric surveys of refugees have indicated that 9% of adults were diagnosed with PTSD, 4% with generalized anxiety disorder and 5% with major depression, and 11% of children with PTSD (Robila, 2018). The World Health Organization, on the other hand, states that the depression as well as psychosis rates in refugees in Europe are similar to those in the general population in Western countries.

It is important to highlight, however, that the above mentioned studies agree on two major points: refugees coming into Europe are much more likely than the general population in Western

countries to have post-traumatic stress disorder (PTSD, 9% of refugees in general and 11% of children and adolescents) and the stress factors that refugees can be exposed to and that influence their mental health include: pre-migration factors (such as persecution, economic hardship), migration factors (physical danger, separation), and post-migration factors (detention, hostility, uncertainty).

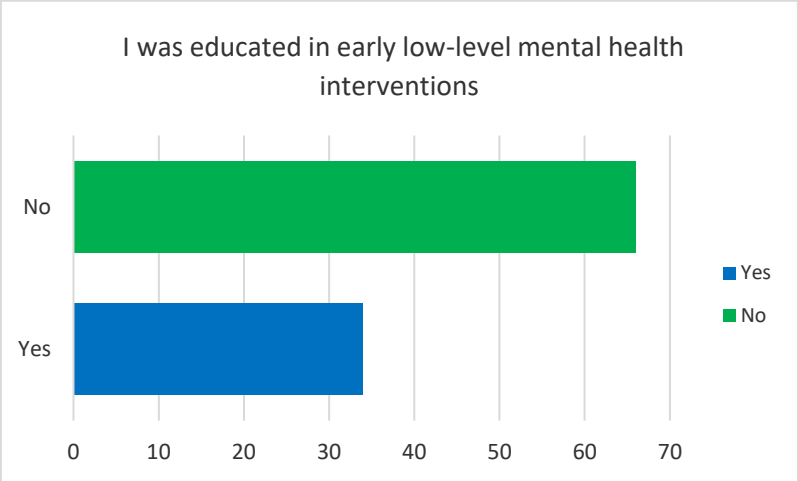

Figure 2. Survey results of the project *Post-traumatic Integration – Low-level Psychosocial Support and Intervention for Refugees,* 2018.

1.2 Legal frame of the project

Some key definitions are crucial to provide a better understanding of this project:

- Refugees in the broad sense are people with a well-founded fear of persecution for reasons of race, religion, nationality, politics or membership of a particular social group who have been accepted and recognized as such in their host country. As already mentioned, in the EU, the Qualification Directive of 2011 (that is part of the so called CEAS – Common European Asylum System) sets guidelines for assigning international protection to those who need it. Currently third-country nationals must apply for protection in the first EU country they enter (Dublin Regulation of 2013).
- Filing a claim means that they become asylum applicants (or asylum seekers).
- They receive refugee status or a different form of international protection only once a positive decision has been made by national authorities.

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Persons who request international protection, are generally vulnerable persons, given that people who leave their home and familiar environment are confronted with a number of difficult challenges. However, at the UN as well as at the EU level, it is acknowledged that from among these persons there are a number who are confronted with additional difficulties - identified as vulnerable groups - and who therefore require additional support. The next paragraphs provide an overview of the main legal elements relevant for our project.

1.2.1. International Refugee Law and International Human Rights Conventions

At the international level several legal documents relate to the status of refugees in the broad sense of the word. The most important legal document remains until today the 1951 Geneva Convention. Its Article 1 defines as refugee someone who has a "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". According to the High Commissioner for Refugees of the United Nations, asylum seekers are people who "left their country of origin, have sought international protection, have applied to be recognized as a refugee and are awaiting a decision from the host government" (Robila, 2018).

Next to these specific instruments for the categories of refugees, the latter can also rely on the international legal instruments relating to human rights in general, i.e. that are valid for all human beings. Among the most important ones at the universal level are the Universal Declaration of Human Rights; the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social and Cultural Rights; the Convention for the Elimination of all forms of Racial Discrimination; the Convention on the Elimination of all forms of Discrimination Against Women; the Convention Against Torture; the Convention on the Rights of the Child; and the Convention against Enforced Disappearance. At the regional level, the European Convention for Fundamental Rights and Freedoms, the Inter-American Convention on Human Rights and the African Charter on Human and Peoples' Rights merit special mention as legal instruments containing several protection provisions for refugees.

It should be noted that international human rights conventions recognize the enjoyment of the highest attainable standard of (mental) health as a fundamental human right of every individual, regardless of race, religion, political belief, economic or social condition, and immigration status.

There is no single comprehensive international instrument protecting the rights, including health related rights, of all those who migrate, as their rights are recognized in several instruments and branches of international law (Pace, 2009).

1.2.2. Common European Asylum System

Since 1999, the EU has been working to create a Common European Asylum System (CEAS) and improve the current legislative framework. In the years several legislative measures harmonising common minimum standards for asylum were adopted. Since the beginning of this harmonization of asylum policies in the EU particular care for persons belonging to vulnerable groups among refugees and asylum seekers is obligatory for EU Member States.

More specifically, according to Article 21 of the Reception Conditions Directive (2013/33/EU), "*Member States shall take into account, in the national law implementing this directive, the* ***specific situation of vulnerable persons*** *such as minors, unaccompanied minors, disabled people, elderly people, pregnant women, single parents with minor children, victims of human trafficking, persons with serious illnesses,* ***persons with mental disorders and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence,*** *such as victims of female genital mutilation*". Though persons with PTSD are not included as such in these categories, we can nevertheless assume that some of the persons identified as vulnerable are likely to suffer symptoms of PTSD.

The Council Directives of the European Union want to ensure that Member States provide the necessary treatment to vulnerable persons for the damages caused by the above mentioned situations, thus, that their special needs are effectively addressed through the adoption of specific measures. These measures include adequate support in all stages of the asylum procedure; special reception needs, including material reception conditions; access to appropriate medical and psychological treatment or care (Art. 19 and 25). Moreover, the Asylum Procedures Directive (2013/32/EU) provides special procedural guarantees for those applicants assessed as vulnerable (Art. 29), as well as adequate support throughout the asylum procedures.

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The main challenge that our project wants to address is that, in order to have access to the above mentioned measures, the person (refugee and/or, asylum seeker) has to be recognized as having special needs, after an individual evaluation of their situation (Art. 22 RCD). Thus, the early identification of asylum seekers/refugees having suffered traumatic experiences is now a key issue for all the organizations involved in the field of asylum in Europe, as well as for European and national institutions.

It is noteworthy to mention that experts agree (Hruschka & Leboeuf, 2019) that there is no consistent or exhaustive category of 'vulnerable persons' across the EU directives as well as imprecisions regarding the definition of the vulnerabilities. This has led to disparities among domestic legal regimes regarding who constitutes vulnerable asylum seekers. As highlighted in an ECRE (European Council on Refugees and Exiles) report (2017) asylum seekers with mental disorders, for example, are recognized as vulnerable in some Member States but not in others.

On 6 April 2016, the Commission presented a communication entitled 'Towards a reform of the Common European Asylum System and enhancing legal avenues to Europe' and since then the EU Member States are discussing the revision of the Common European Asylum System including the Reception Conditions Directive and the Asylum Procedures Directive. The treatment of vulnerable groups in the EU has been one of the priority areas of the reform of the CEAS proposed by the Commission in 2016 (ECRE, 2017). It is important to mention that the EU Parliament position on the reform of the Reception Directive also advocates for a wider indicative list of categories with specific reception needs, which includes persons with post-traumatic stress disorder, among others (ECRE, 2017).

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2. PSYCHOSOCIAL ASPECTS OF REFUGEE EXPERIENCES

What are the challenges faced by traumatized refugees once arrived in Europe?

What are the main principles that should be considered for the psychosocial assistance of traumatized refugees?

According to the UNHCR, more than 20 million refugees had to flee their countries of origin due to war, man-made disasters and severe human rights violations by state as well as non-state actors (until 2018). Many of these refugees did not only experience violence in their countries of origin, but also during their escape and even in the countries of reception.

Many refugees who survived man-made disasters suffer from traumatization and are therefore special vulnerable persons with the right to rehabilitation according to the EU Reception Directive. However, these rights are currently thwarted by more and more restrictive asylum legislations and the political will to deport as many refugees as possible. Asylum procedures in general tend to assume that refugees do not have legal reasons to flee their countries. The latter have to prove that they survived severe human rights violations like torture, which is nearly impossible without a good documentation of torture. Furthermore, many traumatized refugees are not able to speak about the violence they experienced in a procedure with decision-makers who assume they are lying and confront them with questions that remind many refugees of being interrogated again. These procedures can bear severe negative consequences for traumatized refugees as they are again affected, this time by EU states authorities that refuse to accept them and to fulfil their obligations concerning their treatment and rehabilitation. Refugees also experience widespread xenophobia and racism in the societies of reception that fuel their insecurity and could lead to further sequences of traumatization. This is very often the case in mass accommodations for refugees where is no privacy and a high risk for sexualized violence, especially for solitary women or LGTBQI. Surviving violence and fleeing the country of origin implies a lot of strength for refugees to have to bear, but being a refugee in the EU forces them to generate more strength and resources to confront all barriers that minimize their rights and can lead to an

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institutionalization of trauma by systematic powerlessness, helplessness, loss of control and dependency.

In EU countries, there are psychosocial centres that offer rehabilitation services for traumatized refugees. They have the necessary professional background, intercultural competencies and the will to assist refugees to obtain a legal status and to integrate their traumata into their biography in order to generate personal resources and objectives for a new life after trauma. They are mostly working with the approach of empowerment and help refugees to help themselves.

Working with traumatized refugees needs a holistic approach of psychosocial assistance that takes into account the following aspects:

- their personal story/narrative as well as the situation of the family members
- the reasons to flee and what happened on their way to Europe
- the living conditions in the country of reception and their legal and socio-economic needs like residence permits, accommodation, access to education, work and health services or language barriers, mongering
- their sexual orientation in the case of gender-based prosecution
- their special needs as special vulnerable person

The following principles for the psychosocial assistance of traumatized refugees should be respected:

1. acknowledgement instead of pathologisation
2. address the needs that traumatized refugees express
3. protect the privacy of refugees suffering
4. address the socio-political processes of traumatization
5. reflect the process of psychosocial assistance
6. act as an ally instead of being impartial
7. understand psychosocial assistance as active human rights work

The psychosocial work with traumatized refugees is very often the only kind of acknowledgment for what they had to experience in the context of systematic impunity of the perpetrators of man-made disasters.

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Common Myths about PTSD

Myth #1: People suffer symptoms of PTSD right after a trauma
Symptoms often show up in the first few months after a traumatic event, but sometimes symptoms do not appear until years after. It is different for everyone who develops PTSD.

Myth #2: People with PTSD are dangerous
The majority of people with PTSD do not show violent behaviour. PTSD is associated with an increased risk of violence, but most people with it have never acted violently. Research shows that when risk factors correlated with PTSD are taken into account, the association between PTSD and violent behaviour drops significantly.

Myth #3: PTSD can only affect adults
Another myth that surrounds PTSD is that children and teens cannot develop this mental health disorder because they have resilience and the ability to overcome serious hardship. However, children even younger than six can have symptoms of PTSD.

Myth #4: Symptoms of PTSD go away as a person heals from trauma
Symptoms of PTSD can come and go, and can vary in intensity over time. Reminders of the trauma, even many years later, can cause long-dormant symptoms to reappear. It is called re-experiencing a trauma, and it is common in people with PTSD.

Myth #5: Everyone reacts to trauma the same way
While people go through similar traumatic experiences, this does not mean it will affect them exactly the same way. Your mental health and life experiences are not identical to anyone else's, so your reaction to trauma, and your recovery will not be identical to anyone else either.

Myth #6: Without physical injury PTSD does not require medical attention
Even without a physical wound, PTSD is a sign of an injury. The daily lives of many people with PTSD are interrupted by symptoms such as panic attacks and sleeplessness.

Myth #7: PTSD only affects weak people
It is not a question of strength, or of emotional stamina. There are a number of factors that determine whether a person who's gone through a trauma develops PTSD. The risk of getting PTSD depends, in part, on a combination of risk factors and resilience factors.

Myth #8: PTSD is all in a person's head
Traumatic events can change how the brain functions. PTSD leads to measurable changes in the brain and body after a person has been exposed to a trauma.

Myth #9: PTSD is not treatable
It is actually quite treatable, even if it is not completely curable in everyone. PTSD is frequently treated with drugs combined with psychotherapy. The most frequently used are counselling, exposure therapy, and behavioural therapy and EMDR. Nutrition is a key component in any healing regimen and there is also evidence that meditation can help people with PTSD.

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3. SHORT-TERM PSYCHOLOGICAL EFFECTS OF TRAUMA

What is psychological trauma? Is it different from a traumatic event?

What is homeostasis?

What is hyperarousal?

What are typical reactions to traumatic event(s)?

What is Acute Stress Disorder?

It is difficult to define what is a traumatic event or a psychological trauma. All organisms tend to preserve themselves and to be in the state of balance, called homeostasis. Whenever something (from the inside or the outside) endangers -i.e. ”stresses” the homeostasis- the organism sets in motion complex mechanisms to restore the original state. The complex mechanisms constitute synergistic interactions between biological and psychological systems in terms of adaptive responses to stressful events. Often an event is defined as stressful if its impact surpasses the organism’s ability to cope and adapt without efforts. Therefore, whether an event is perceived as stressful is an individual assessment as it is closely related to one’s subjective appraisal. The same is true for trauma but -in general- traumatic events are those that involve death or threatened death, actual or threatened serious injury, or threatened sexual violation. Important characteristics of traumatic events are that they evoke emotions of fear, helplessness and overwhelming stress. The human response to danger is a complicated system of adjustment at the physical, cognitive and emotional level. When faced with threatening situations the human brain sends out all kinds of alarms and we become hyperaroused in order to preserve ourselves. Hyperarousal is characterized by heart racing, sweating, changes in attention and sensory awareness (we look for specific clues, get easily startled, etc.), and we feel fear or anger. Our system is preparing us for actions of fight of flight. In most cases, we recover shortly after the event and we go back to homeostasis. However, the research in field of PTSD has shown that after prolonged of repetitive exposure to traumatic events a homeostatic condition may not be re-established (Wilson & Keane, 2004). The organism remains in the state of prolonged hyperarousal and continues to function as if the trauma is ongoing. Basically, the red alarm is still on even though the crisis has long ended.

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Most of us will experience at least one traumatic event in our lifetime, but a refugee who has left his/her place of origin due to a war conflict has probably experienced more than just one. Not only have they experienced life threatening events that made them leave their country, but they also continue to experience traumatic and/or stressful events on their migration road. This makes migrants more susceptible to prolonged and pathological effects of trauma exposure.

To better understand the short-term effects of trauma that today's migrants experience it is useful to know the typical reactions, i.e. posttraumatic states that are not considered disorder but normal reactions to abnormal conditions, that come together like Combat and Operational Stress Reactions (COSR) that are presented in Table 1.

Table 1. Combat and Operational Stress Reactions

Physical	Mental	Emotional	Behavioural
• fatigue, exhaustion • inability to fall asleep or stay asleep • sweating, heart pounding • nausea, digestion problems • headaches, back and neck pain • jitters, trembling or jumpiness numbness, tingling or total loss of function of limbs or other body parts	• difficulty concentrating, confusion • inability to make decisions, to process information • nightmares • memory loss • flashbacks, reliving the trauma • loss of sense what is real • hallucinations or delusions	• fear, worry, extreme nervousness • irritability, anger • mood swings • despair and sadness • feeling of isolation	• carelessness or recklessness • outbursts of anger or aggressiveness • staring into space • inability to do your job • increased use of alcohol or drugs • misconduct or crime • complete unresponsiveness to others

Feeling some of these reactions after exposure to trauma is common and constitutes a natural way of an organism in adapting to the circumstances. In most cases this reactions subside in a couple of days. However, the prolonged exposure to stress makes things more complicated. If the reactions persist for longer than seven days and are accompanied with dissociative phenomena (detachment from immediate surroundings, or from physical and emotional experiences) we speak of psychopathological reactions, which is called acute stress reaction or Acute Stress Disorder (ASD). It has been created as a complementary diagnostic category to PTSD in order to acknowledge the transient nature of posttraumatic reactions. ASD is similar to PTSD as they share the same symptoms but a different time frame, the symptoms develop and diminish within a month from the event. More on PTSD can be found in the next chapter.

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Of course, not everyone will experience COSR and even fewer people will go on to develop ASD or PTSD as the reactions to traumatic and stressful events depend on individual personal resources, previous traumatic exposure, type of trauma, and resources available after the trauma. In the aftermath of traumatic events, or during and after stressful events, the most important thing is to provide basic needs and to give social support to those in need, in order to allow for a spontaneous recovery.

References:

- American Psychiatric Association (2013), *Diagnostic and Statistical Manual of Mental Disorders (DSM–5).* Arlington, VA: American Psychiatric Publishing.

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- Wilson, J.P. & Keane, T.M. (2004), *Assessing Psychological Trauma and PTSD*. New York, NY: Guilford Press.

What is allostasis? How it relates to PTSD?

What is PTSD? Which are the symptoms of PTSD?

What is complex PTSD?

Are refugees and migrants more vulnerable for mental disorders?

Can experienced trauma have positive outcomes?

4. LONG-TERM PSYCHOLOGICAL EFFECTS OF TRAUMA

While the previous section described what happens shortly after experiencing stressful or traumatic events, this section will discuss what happens when the reactions to trauma are prolonged or delayed.

In cases when psychological balance (homeostasis) is not re-established, the organism stays in a state of 'allostasis', i.e. a post-traumatic stress response pattern to seek stability in functioning following a change in the homeostatic baseline. This post-traumatic stress response is called post-traumatic stress disorder (PTSD) and it is a significant health issue described as a chronic condition related to social and work difficulties as well as to numerous other health issues. Unlike other mental health disorders, PTSD has an external cause, namely the trauma. One can be directly exposed to a traumatic event, learn about the traumatic exposure of a close one (family member, close friend), or be continuously -directly or indirectly- exposed to traumatic events through work (for example, emergency workers or those who work with traumatized populations).

PTSD symptoms are grouped into a triad of symptoms:

- **Re-experiencing the traumatic event:** intrusive images, thoughts or perceptions; distressing dreams acting or feeling as if the event is recurring; psychological and physiological reactivity to internal or external cues resembling the event.
- **Avoidance:** efforts to avoid thoughts, feeling or conversations about trauma; efforts to avoid activities, places, or people that remind of trauma; inability to recall important

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aspects of trauma; diminished interest in significant activities, restricted range of affect, sense of foreshortened future.

- **Hyperarousal:** sleep difficulties; irritability and outbursts of anger; difficulty concentrating; hypervigilance; exaggerated startle response.

The three groups of symptoms are dynamically interrelated. For example, a reminder of a traumatic stressor, like seeing news footage on the war, will activate the memories on the trauma (*re-experiencing*), which in turn will active physiological response of fight or flight like changes in heart rate and affect (*hyperarousal*). The unpleasantness of feelings leads to the conscious effort not to think about trauma or for example to alcohol abuse (*avoidance)*. PTSD can develop at any point in the life span but depending on the onset and duration of symptoms it can be recognized as acute (less than three month), chronic (three month or longer), or with delayed onset. In the general population the prevalence of PTSD is around 10%, but in populations that were exposed to war and/or combat trauma, or in those exposed to sexual trauma, it can be as high as 30%. In most cases PTSD symptoms spontaneously disappear or go into remission five to seven years after the trauma, and in most cases they reappear around the time of anniversary of the event.

However, intense and prolonged exposure to traumatic events, combined with other risk factors such as age, pre-trauma mental health issues, early life trauma, and lack of social support, can lead to significant changes in personality development. This long-term effect of trauma is called 'complex PTSD'. In addition to PTSD symptoms, the complex form emphasizes changes at the personality level through alterations in regulation of affect and impulses, attention or consciousness, self-perception, relations with others, systems of meaning and somatizations.

One of the features of complex PTSD are cognitive distortions. Trauma, and hence PTSD, have the ability to alter the sense of identity, self-worth and core beliefs about the world. Those who suffer from complex PTSD have persistent negative beliefs about themselves (i.e. "I am no good") and the world ("I cannot trust anyone"), and an exaggerated blame of self or others for causing the trauma ("I deserved this to happen to me").

It is also important to notice that almost 80% of individuals with PTSD have at least one more mental health disorder, most commonly depression and substance abuse.

Being a refugee does not make individuals significantly more vulnerable for mental disorders, but refugees can be exposed to various stress factors that influence their mental well-being.

The traditional approach to psychological well-being of refugees was focused on “trauma", or on “emotional burn out” among those who work with traumatized populations. The downside of this approach is that it focuses on the negative consequences at the individual level. However, traumatic events can and should be viewed at the social level as they affect the community as well (directly or through distressed individual), but they should also be viewed in terms of positive effects. Traumatic experiences can enhance resilience and enforce positive change through adversity-activated development. Many who have survived extremely traumatic events have for example found meaning in their suffering, were able to transmute their negative experiences in a positive way and have found new strength in themselves.

When working with refugees it is important to keep in mind two things:

- first, that post-traumatic reactions are a way of natural coping with an abnormal situation;

- secondly, that PTSD is a serious condition that requires professional attention.

References:

- American Psychiatric Association (2013), *Diagnostic and Statistical Manual of Mental Disorders (DSM–5)*. Arlington, VA: American Psychiatric Publishing.

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What can you do as self-care in order to stay emotionally healthy yourself?

How to avoid overload and stress in the work with refugees?

5. ROLE OF SUPPORTERS AND SOCIAL ASPECTS

People working with refugees on a voluntary basis seldom have a relevant professional education as a social worker or psychologist. Most of them are highly motivated to support people in need and consequently, they have joined (or even established) informal ad-hoc groups or joined one of the many NGOs that work in this sector. Whatever their job is, they are likely to deal with individuals with traumatic backgrounds that have an influence on their mental state.

Any supporter should be aware that s/he will likely be in contact with refugees or traumatized people, and that s/he will very likely require further information in order to be able to help. In this context, supporters should ask themselves the following questions:

- What do I have to expect when dealing with people who have suffered from such severe emotional distress?
- How can I help?
- What can I do wrong?
- Which aspects do I have to consider with regard to self-care?

These Guidelines and Action Sheets (Training Modules and Activities) will provide information on psychological traumatization, its causes, symptoms and possible help. At the same time, the users will be offered information about self-care to stay emotionally healthy themselves.

Apart from the good will to help, there are certain psychological requirements in volunteer refugee assistance that might pose problems for volunteer refugee workers:

- Unrealistic expectations of volunteer work
- Diverse, sometimes difficult tasks to solve

- Traumatisation of refugees
- Rejection by refugees or fellow citizens
- Threats or aggressive actions by refugees or fellow citizens

These mental demands can lead to physical as well as mental and emotional overload and stress. Especially if the supporters are doing voluntary work in addition to their everyday life with obligations that also require their high commitment (job, family, etc.), there is a risk for overload and strain.

The following paragraphs will give a short overview of the most frequent events and situations that helpers should be aware of in order to avoid overload and stress in working with refugees.

- **Realistic expectations**

The most important aspect is to have realistic expectations of the voluntary work. If great commitment does not lead to the desired success, it can be frustrating. This can happen in every voluntary activity, and especially when working for refugees. For example, the integration of individual refugees may not be successful, refugees may be sent to other regions or countries or their asylum applications will be rejected. These events may lead to strong feelings of compassion and guilt, frustration at one's own powerlessness or anger. Therefore, it is very important that helpers are to start the activity with realistic expectations and not "swallow" their feelings.

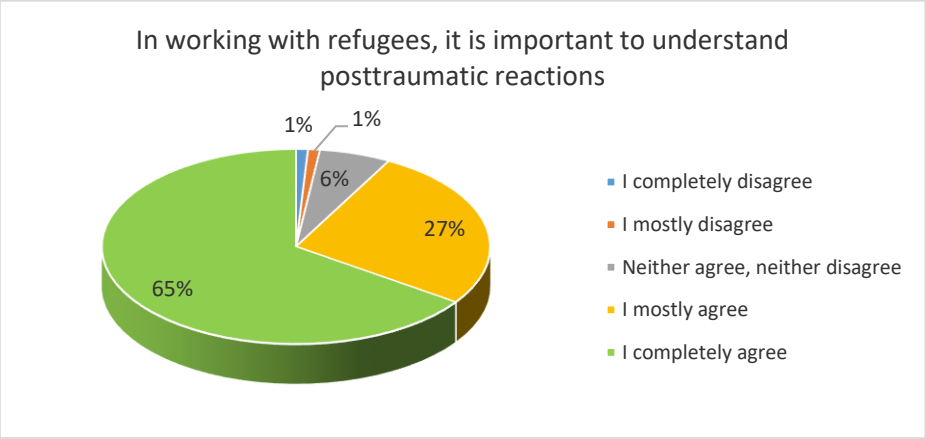

Figure 3. Survey results of the project *Post-traumatic Integration – Low-level Psychosocial Support and Intervention for Refugees,* in 2018.

- **Dealing with a variety of tasks, some of which are difficult to solve**

Volunteers will be confronted with a variety of different tasks within a short time. Some of these may only be tackled with great personal commitment. Maybe some volunteers will invest so much time and energy in these efforts that it will be difficult to reconcile work, family and private interests. As a consequence, conflicts will arise. In addition it may be that their environment does not understand or approve their involvement in refugee assistance.

- **Dealing with traumatised fugitives**

Many people who have fled war and crisis zones suffer psychologically from experiences in their homeland and during the flight. Some of them are psychologically traumatised. Signs of severe psychological trauma can often be seen in the behaviour of those affected.

- **Dealing with rejection**

Most refugees have suffered bad experiences and do not know how their future will turn out. In most cases, their social situation is difficult and there are often few possibilities to get diversion from problems and worries. Waiting for applications to be processed and dealing with negative asylum decisions are very frustrating for those affected. These stress factors can also lead to negative behaviour towards aid workers. Rejection or distanced behaviour may also have cultural reasons, especially when refugees come from traditions with different dealings or different communication patterns between men and women or between old and young people.

- **Dealing with threats and aggressive actions**

Particularly in collective accommodation, narrowness and lack of privacy, insecure future situation, cultural differences can lead to threats or even violent conflicts among residents. Frustration about decisions of authorities can also lead to threats or attacks against employees or volunteer helpers. Unfortunately, threats and acts of violence may also occur by fellow citizens towards refugees or towards helpers.

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6. HOW TO (AND HOW NOT TO) INTERVENE

How can you intervene?

What kind of tools do we offer?

What information do the Action Sheets (Training Modules and Activities) contain?

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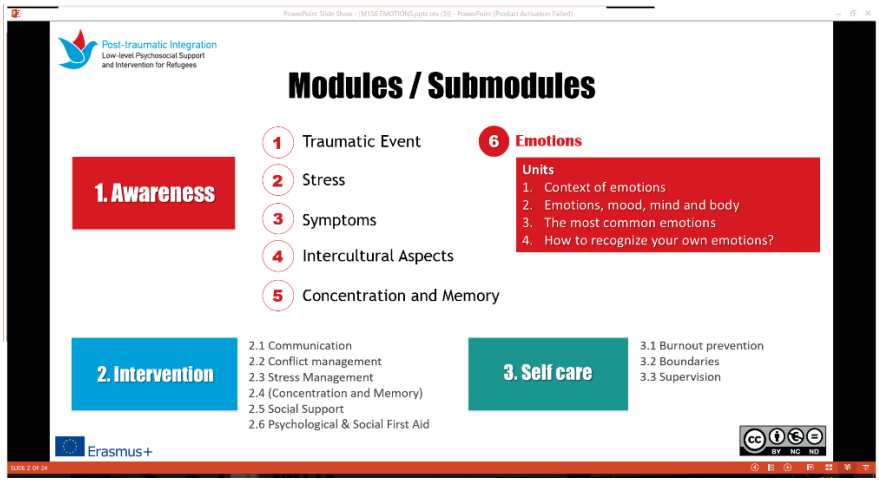
To enable non-specialist refugee-care providers to identify and to give low-level psychosocial support and early low-level mental health interventions to refugees with post-traumatic problems (and PTSD) we developed practical tools to support and inform them in a comprehensive way. One of these tools are the Action Sheets that contain: Activities as recommendations and key actions for meeting the needs of refugee and migrant clients; and brief Training Modules on the assessment and management of post-traumatic problems (including PTSD), dealing with challenging behaviour of clients, intervention and delivery design, and key findings from the research. They will offer a modular range of awareness raising, training and demonstration materials. The Training Modules and Activities are hosted by the PTIP Open eClass Platform and are easily accessible for the users (see chapter 7 for the details on how to access the online material).

The Action Sheets (Training Modules and Activities) are organized around 3 Modules: **Awareness, Intervention and Self – care.**

Each Module contains different Submodules, Units and Activities. In the following tables you can find an overview of the Training Modules and related Activities.


Post-traumatic Integration
Low-level Psychosocial Support
and Intervention for Refugees
Modules / Submodules
1. Awareness
1 Traumatic Event
2 Stress
3 Symptoms
4 Intercultural Aspects
5 Concentration and Memory
6 Emotions
Units
1. Context of emotions
2. Emotions, mood, mind and body
3. The most common emotions
4. How to recognize your own emotions?
2. Intervention
2.1 Communication
2.2 Conflict management
2.3 Stress Management
2.4 (Concentration and Memory)
2.5 Social Support
2.6 Psychological & Social First Aid
3. Self care
3.1 Burnout prevention
3.2 Boundaries
3.3 Supervision
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Module 1: AWARENESS			
Submodules	**Overview**	**Units**	**Activities**
M1S1 - Traumatic Events	Before posttraumatic reaction(s) there must be a traumatic event (TE). It is the aim of this submodule to define what traumatic events are and how people adapt to them. Along with the main features of TE such as frequency and duration, common reactions to TE are described as well as the specifics related to refugees' traumatic experiences.	1. What is a traumatic event? 2. Adaptation to traumatic events 3. Refugees and traumatic events	1. Why do people flee? 2. Life events checklist LEC-5
M1S2 - Stress	Submodule 1.2 is dealing with the background of stress reactions and shows that in our life, most stress is produced not so much through what happens to us but through how we take it. It gives information about the mind and body connection and highlights some important strategies and solutions how one can decrease one's level of	1. How do I know when I am having stress? 2. Mind and body connection 3. Stress and traumatic events 4. Stress reduction script	1. External and Internal Triggers 2. My resilience
M1S3 - Symptoms	Submodule 1.3 is dealing with processes that cause posttraumatic reactions. We will learn how to distinguish and recognize possible signs and symptoms of posttraumatic reactions and posttraumatic disorders. The clinical picture of acute and chronic posttraumatic disorders will be presented as well.	1. Background of posttraumatic reactions 2. Signs and symptoms of posttraumatic reaction 3. Acute stress disorder 4. Posttraumatic stress reaction	1. Harvard trauma questionnaire 2. Hopkin's symptom check list-25 3. PTSD test
M1S4 - Intercultural aspects	The assistance context in which front-line care providers work with refugees that can be characterized by extreme cultural diversity, both in terms of the different cultural backgrounds of refugees as well as the cultural distance between them and the front line worker itself. This can lead to potential for miscommunication and misunderstanding, even more when addressing highly sensitive topics as post traumatic distresses and PTSD. Different cultural settings can vary extremely in the ways to approach mental health problems, often considered taboos. Therefore, the preferred approach to addressing the needs of refugees with psychosocial problems requires particular attention to their culturally different backgrounds.	1. Traumatic experiences faced by refugees 2. How much culture matters for PT 3. Taboos and stigmatization 4. Cultural competences	1. Circle of My Multicultural Self 2. Understanding the Depth and Breadth of "Multicultural"
M1S5 - Concentration and memory	Submodule 1.5 is dealing with the effects that PTSD has on the concentration and memory abilities of a person. It shows that the damages in the brain caused by PTSD can cause problems with learning, with short term memory and with concentration. It will explain the effect of anxiety disorder on memory and concentration and show that many persons suffering from PTSD are fighting with learning difficulties.	1. PTSD and Memory 2. PRSD Symptoms: A Disease of the Memory 3. Anxiety Disorder and Concentration Problems 4. Learning Difficulties for People with PTSD	1. Recording Daily Thoughts 2. Rebuilding concentration with focused attention
M1S6 - Emotions	What is an emotion? It is a complex subjective experience comprising psychological appraisal, physiological (body), behavioral and cognitive (mind) reactions to internal and external events. Some of us are very good in recognizing subtile different emotional states and otherwise some of us have difficulties in identifying and describing feelings and in distinguishing feelings from the bodily sensations of emotional arousal. In order to effectively manage our emotions we must first learn how to accurately recognize them.	1. Context of emotions 2. Emotions, mood, mind and body 3. The most common emotions 4. How to recognize your own emotions?	1. Alexithymia test 2. Wheel of emotions

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Module 2: INTERVENTION			
Submodules	**Overview**	**Units**	**Activities**
M2S1 - Communication	Communication is the key to solving all problems, issues, obstacles and most importantly, to build relationships. In this submodule, you will learn about different communication styles, about cultural barriers and specifics about communication with a PTSD person, but most importantly, you will learn a few tips on how to overcome these barriers and how to communicate effectively.	1. Communication styles 2. Nonviolent Communication 3. Cultural barriers to communication 4. Communication with a PTSD person	1. Non-violent communication 2. Getting into a person's mind
M2S2 - Conflict Management	Conflict appears, when different people have different needs and both of them want their needs to be fulfilled. It is a very natural thing, but quite frequently viewed as something bad or irritating. Nevertheless, if we choose the right strategy and develop needed skills and techniques, solving conflicts might be creative,	1. Stages of a conflict 2. Conflict management strategies 3. Resolving a conflict	1. The orange negotiation 2. Different ways of listening
M2S3 - Stress Management	This Submodule deals with stress management and arousal and how to decrease the arousal in the body which is a vital step in the process to desensitize the nervous system. It will show helpful strategies and techniques which are important to resolve stressful memories, and give an overview on memory work where the PTSD patient learns to see clearly what passed and can understand the effect of his or her memories.	1. Stress Management and PTSD 2. Reducing Arousal 3. Helpful Strategies 4. Memory Work 5. Moving On	1. The Power of Breath 2. Cultivating Self – Nature of the Mind
M2S4 - PTSD and the Brain	This Submodule will inform about effects of trauma on the brain and how PTSD impairs learning and memory- It will give tips to improve one's concentration and show the influence of nutrition on PTSD.	1. Effects of Trauma on the Brain 2. How PTSD Impairs Learning and Memory 3. Tips to Improve Your Concentration 4. PTSD and Nutrition 5. Sleep Problems in PTSD	1. Core beliefs 2. When sleep can't come
M2S5 - Social Support	This submodule will provide you with information about social needs and the importance of social support for people with trauma. You will learn about tyes of social support and social groups, and what could help people to overcome their insecurities or problems. You will learn about empowerment and competencies needed to help them with their social needs. You will also learn about the role of language and translators in providing social support.	1. Social needs 2. Types of social support 3. Empowerment 4. Competences 5. Language	1. Special Vulnerability 2. Working with translators 3. In the shoes of a refugee
M2S6 - Psychological & Social First Aid	Psychological first aid (PFA) is a humane, supportive response to a fellow human being who is suffering and who may need support. It is not a psychological method. PFA is oriented towards practical care and support, while assessing the needs and concerns in a non-intrusive way. In this submodel the reader will learn about PFA's basic principles and "who, when, and where" can benefit from them and how to recognize symptoms of stress and good self-care behaviours. The importance of cultural awareness and recognition of vulnerable groups is emphasized.	1. What is psychological first aid (PFA)? 2. Providing psychological first aid 3. Self care and PFA 4. Cultural awareness and vulnerable groups	1. PFA role play 2. The s+A13:D18till face experiment

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Module 3: SELF - CARE			
Submodules	**Overview**	**Units**	**Activities**
M3S1 - Burnout prevention	Many people in today's society display symptoms of burn-out and also consider themselves to be in this condition. They argue that the current-day working and social conditions, coupled with the excessive use of new technologies, create excessive exhaustion. Some persons maintain that the problem of burn-out, although growing in recent years, is far from new and already exists for more than 30 years. This submodule deals with three main aspects: first, to understand burn-out, and distinguish it from depression; second, to highlight the main stressors that cause burn-out and the ways for preventing it; and thirdly, to indicate how to overcome a burn-out once it has manifested itself.	1. What is burn-out? 2. How to prevent burnout? 3. How to overcome burnout?	1. Workshop about burn-out with BAT (Burn-out Assessment Tool) 2. A group discussion about burn-out and how to prevent it
M3S2 - Boundaries	An important part of one's identity and a crucial aspect of well-being and mental health is the ability to set boundaries. They can be physical or emotional and of course they can also range from being loose to rigid. In that sense, self care in volunteering or helping others (e.g. refugees) is an important part of the mentally healthy life for individuals. In this Submodule we will look at particular boundaries by giving some hints to empower the helpers and volunteers working with people with PTSD.	1. Setting boundaries and limits 2. Preventing Emotional Oveload	1. Somatic Inventory of Emotional Overload 2. Questionnaire Secondary Traumatization
M3S3 - Supervision	This submodule deals with basic purpose and benefits of supervision and explains the procedures necessary to begin the supervision process. It informs about intervision and its difference to supervision, the power of the group and teamwork in the delivery of helping others, and gives an overview about reflection as a	1. Purpose, Function and Benefits of Supervision 2. Supervision Policy 3. Groups and Team Work 4. Reflection and Evaluation	1. Self Assessment Scale for the Group Members 2. Keeping a reflective diary

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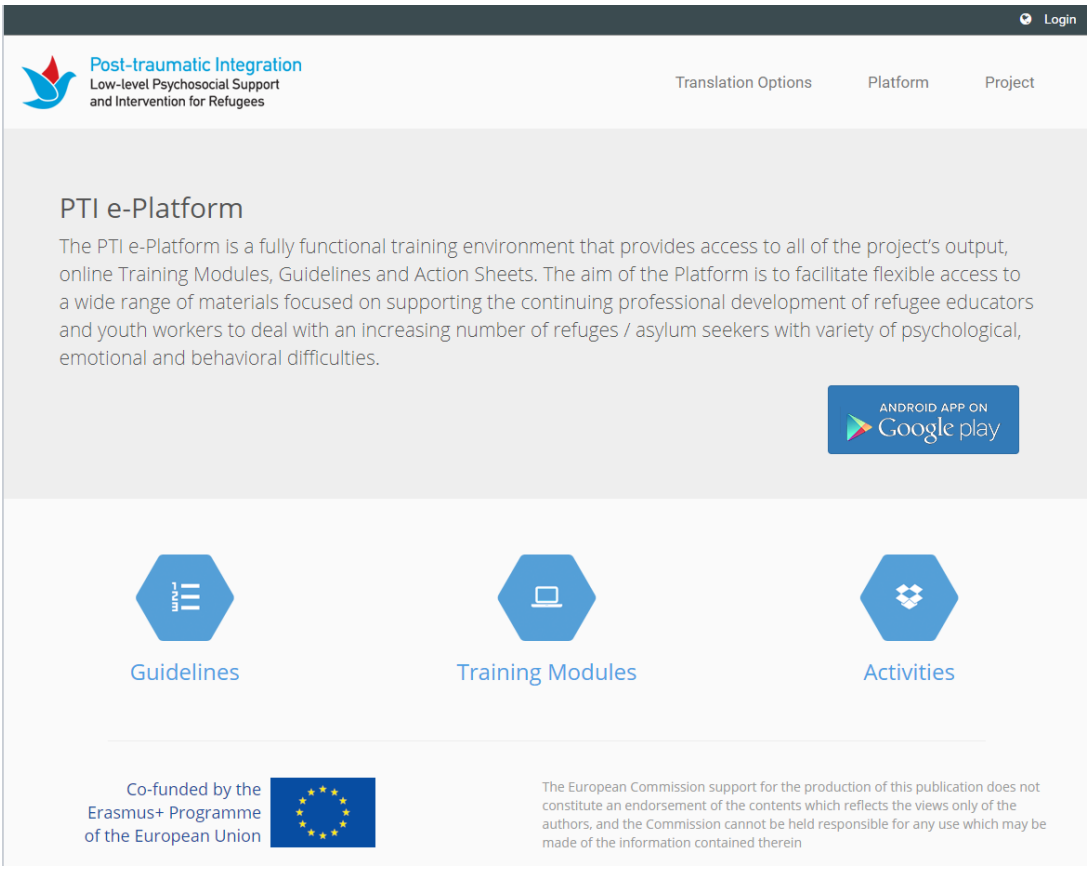
7. HOW TO USE THE ONLINE MATERIALS

In this chapter it is presented how to use the online material of the project, that is the outputs developed. All the material is hosted by the PTIP Open eClass Platform, referred to as online Platform, and it is open, both in terms of access – no registration or login is required for accessing the material – and licences – Creative Commons licences are applied to the material.

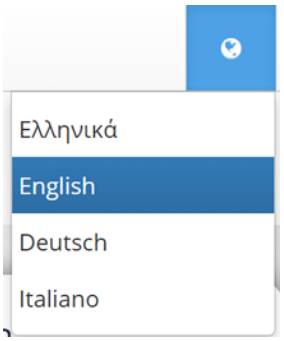
An end user may find the Toolbox platform on the internet, through the following URL:

https://onlinematerial.posttraumatic-integration.eu



This platform is hosting and provides online the material produced in the context of the project. The content is multilingual and the user may visit the Project's website by clicking on the link "Project".

First, **choose the correct language for you**, on the upper right corner by clicking on the earth-sphere button.



The Platform provides material which has been categorised as:

- Guidelines
- Training Modules
- Activities

The Platform was designed to make the selection of the Activities, the access to the Guidelines and Training Modules as user-friendly as possible, given the time period and resources in the context of the PTIP Project.

Platform functionality for the Guidelines

The user may select the proper for him/her language and then the "Guidelines" button. Then, the snapshot of the first page appears along with a short description about the Guidelines, the Authors and the Copyright notice.

Platform functionality for the Training Modules

The user may select the proper for him/her language and then the "Training Modules" button. Then, the list of the available modules appears.

In the sequel, the user may select the module s/he wishes to follow by selecting the title. Then, the online module appears without the need of any login.

Each training module consists of a Summary, the module's objectives and outline.

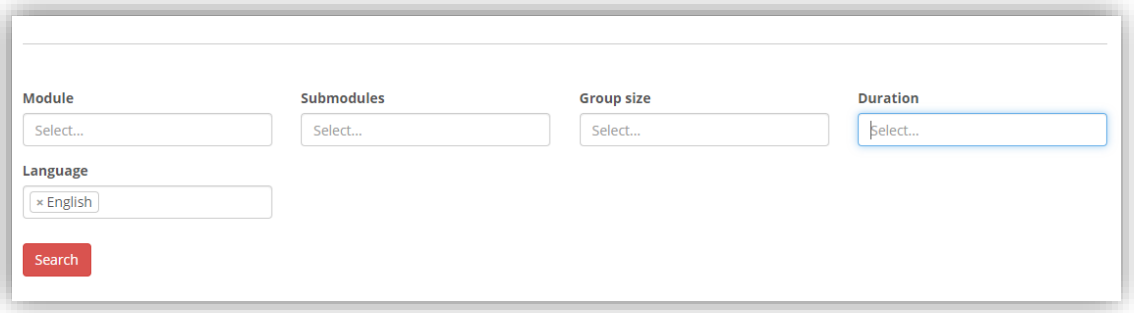
The module presentation is organized in units. The unit's outline along with a picture are available. The content is based on the chosen template and was developed by all partners by following the principles of User-Centered Design (UCD).

The end users may either watch online the slides or download them as pdf file.

How to search and find the Activities

The users can easily search and find the Activities they are looking for, upon selection of different search criteria such as **Module, Submodule, Group Size, Language.** Also, the users may enter a

text as a keyword for searching the content. The end user may use the Search Form (picture below) in order to search for the resources that fit to his search criteria (one or more criteria are applicable).



Then, the end user may click on the search button, and the activities that fit his/her search criteria will appear (Search Results).

S/he may then click on a specific activity title to view the specific activity. The access is open that means that neither login nor registration is required. The user may also download the activity in pdf format by clicking on the “Downloading in the pdf format” button.

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