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The Complex Dynamics Between Discrimination and Traumatic Experiences Among Refugees in the United States

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ABSTRACT

The National Comorbidity Survey suggest that majority of men and women among all U.S. adults aged 18 to 55 have experienced at least one traumatic event during their lives. However, a significant gap exists in comparable documentation regarding the prevalence of trauma among refugees, including associated factors such as coping mechanisms. To address this, employing a cross-sectional design, our study surveyed 222 individuals between the ages of 13 and 70 years, identifying as part of the refugee population. The purpose was to illuminate the intersection between discrimination, resilience, social support, religiosity, refugee-focused programs, and various demographic factors, including age, gender, education level, income, family size, marital status, time lived in the U.S., and refugee traumatic experiences. Our results not only confirm previous research findings on the factors associated with trauma symptoms but also unveil novel insights into the available resources that contribute to mitigating traumatic symptoms during the refugee transition into the host country. This research addresses a critical gap in understanding the unique challenges faced by refugees and the complex interplay of factors influencing their mental health. The findings contribute valuable insights to the existing body of knowledge, providing a nuanced perspective on the intricacies of the refugee experience and establishing the groundwork for tailored interventions and support mechanisms.

Keywords

Correlates, Trauma, Discrimination, Refugees, Resources.

Introduction

Understanding the imperative nature of comprehending correlates of trauma exposure is crucial, given that epidemiological studies estimate that 70% of the global population, including refugees [1], has encountered one or more traumatic events in their lifetime [2]. Refugees typically flee conditions leading to trauma, such as war, rebel assaults, ethnic cleansing, famine, hunger, and the pervasive fear of being killed, seeking refuge in Europe and North America due to the increasing difficulty and danger of staying in their home countries [3-5].

As per the United Nations High Commissioner for Refugees [6], the worldwide count of refugees peaked at 68.6 million in 2017, of which 25.4 million classified as forcibly displaced individuals fleeing persecution, war, or violence. The refugee experience has the potential to disrupt core beliefs about oneself, others, and the world, giving rise to adverse assumptions and emotions, including trauma [7].Trauma manifests when individuals confront exceptionally distressing physical, psychological, or existential circumstances that surpass their typical coping abilities [8,9].

These experiences push individuals beyond their usual coping capacities, historically playing a substantial role in the loss of human life [10]. While many individuals can regain a semblance of normalcy after enduring traumatic experiences [11], Kira [12] underscores in his cumulative trauma framework that models centered on single incidents are inadequate in fully addressing the intricate and layered nature of trauma. This is particularly conspicuous among marginalized populations contending with discrimination or navigating arduous social and cultural conditions [13]. Hence, comprehending trauma entails recognizing the manifold ways in which individuals navigate through such experiences.

Despite recognizing that the exploration of trauma among refugee populations is relatively recent, the heightened rates of trauma exposure imply that this population is at heightened risk [13,14]. Hence, the primary aim of this study is to examine the connections between trauma symptoms and several factors, including discrimination, resilience, social support, religiosity, refugee-focused programming, as well as demographic variables such as age, family size, marital status, level of education, income, gender identity, and duration of residence in the United States. Refugees, grappling with assault and perilous conditions during their migration journey [15], confront a new set of stressors upon settling in the United States. The challenges, exemplified by discrimination in an anti-immigrant environment [16], pervasively and widely manifest as hostile biases and adverse opinions directed towards a social enclave and its constituents [17]. In the backdrop of the recent upswing in xenophobic populism, hate speech, and hate crimes [5], the intensity of this discrimination amplifies. Consequently, new immigrants find themselves subjected to systematic re-traumatization.This vulnerable population often grapples with difficulties in speaking out against bigoted views and disparaging attitudes [16,18] for fear of exacerbating trauma with limited support [3,4].

While there is consistent evidence across multiple studies demonstrating the association of discrimination and detrimental mental health outcomes among black and brown individuals in the United States [19,20], a significant research gap exists concerning discrimination among refugee populations, specifically in exploring its connection with trauma. The growing demographic presence of black and brown refugees challenges traditional notions of discrimination. In the past, discussions on discrimination predominantly centered around a black-white paradigm [19], inadvertently overlooking the experiences of recent refugee immigrants from Latin American countries, Asia, and Africa. Its worth noting that refugees' encounters with racial discrimination are intricately linked to their immigration status, diverging from conceptualizations based on a black-white paradigm. Hence, an innovative approach should integrate the experiences of refugees to enhance the discourse, ensuring that the link between discrimination and mental health mirrors the evolving racial compositions in contemporary U.S. society.

Trauma and Resilience

In addition to psychological sequelae, traumatic experiences have the potential to foster unique strengths and coping mechanisms, often referred to as resilience [21,22]. Masten [23] defines resilience as a universal process and a fundamental human adaptation to life circumstances. While individuals who are secure and functioning well generally exhibit greater adeptness in tolerating adversity or trauma, there exists no singular pathway to positive adaptation. Lenette et al. [22] studies showcase the diverse ways in which marginalized communities cultivate resilience pathways within their social environments. Additionally, in their study on resilience among Latino immigrant families, Cardoso and Thompson [24] highlight the synergy of protective factors, including strengths within the community, family, and culture. Furthermore, Pulvirenti and Mason's [25] examination of the intricate psychological experiences and emotional responses of individuals in stressful situations highlights the positive impact of resilience [13]. Despite the potential benefits linked to resilience, there is a notable shortage of well-established studies that delve into resilience as a coping mechanism for trauma within refugee populations.

Trauma and Social Support

In the realm of social support, the essential role it plays as a protective resource against traumatic stress is underscored by multiple studies [26]. Specifically, the positive regard received from family members, friends, or fellow community members has been demonstrated to significantly mitigate the effects of traumatic experiences. In the study by Noh and Kaspar [27], it was observed that for Koreans residing in Canada, social support grounded in their cultural affiliation acted as a safeguard against the impact of trauma. Conversely, a study by Gee and collaborators [28] indicated that emotional support correlated with a reduced health risk, while instrumental support was linked to an increased health challenges among Filipinos in Honolulu, though this pattern was not observed in San Francisco [19].

Trauma and Religiosity

In the realm of religiosity, past studies consistently affirm a robust association between trauma and religious beliefs [29,30]. Broadly characterized as a domain that spans both secular and sacred purposes at individual and institutional levels [31], religion involves human practices and rituals rooted in a pursuit of the sacred. These practices are guided by beliefs, customary practices, and institutional rules [32]. Refugee populations frequently contend with substantial trauma upon resettlement in their new country, often originating from religious conflicts that prompted their displacement. Such experiences may evoke emotions of anger and hatred [29]. Conversely, faith-based reactions are not uncommon among individuals grappling with traumatic experiences. Studies indicate that exposure to traumatic events heightens the likelihood of engaging in religious prayers [30], ritual practices [33], and perception of the role in God in intervening during traumatic situations [34].

Looking at it from a secular standpoint, the lifespan theory of control categorizes seeking assistance from influential entities, like God, as a vicarious management or command techniques [35]. The lifespan theory of control [35] and Pargament's interpretation of faith-based coping [33] both highlight the crucial importance of acknowledging vicarious control as a faith-based response to trauma. These viewpoints suggest that when confronted with extraordinary adversity like trauma, individuals may turn to a higher power by establishing a spiritual connection or relying on religious faith, God, or other spiritual entities. Despite the established association between faith and trauma, there is a conspicuous scarcity of research examining the role of religion specifically concerning trauma within refugee populations.

Trauma and Awareness of Refugee Focused Programming

In terms of awareness of refugee-focused programming, earlier

studies highlight the challenge that refugees, originating from regions with histories of political violence, may face. Despite enduring profound histories of trauma and numerous stressors during resettlement, their host communities may not consistently offer culturally appropriate and linguistically accessible services post-resettlement [18]. Consequently, refugees often encounter difficulties in accessing psychological well-being services [18,36,37]. In their 2017 study, Betancourt, Newnham, Birman, Ellis, & Layne identified key obstacles to accessing psychological well-being services among refugees as the sentivitivy to cultural differences (90.2%), social stigma around mental health (75.6%), mistrust and sketicism (73.2%), limited mobility (73.2%), daily living costs (53.7%), and language barriers [36,38]. Furthermore, unfamiliarity with Western mental health concepts acts as a barrier to reporting mental health symptoms, hindering refugees from receiving proper diagnoses or accessing mental health services (e.g., De Anstiss & Ziaian, 2010; Lee et al. 2010) [39,40]. While understanding these barriers is crucial, it is even more essential to determine whether refugees are aware of the existing programs and resources available to them.

Demographic Variables

Regarding gender, studies have yielded diverse results concerning the traumatic experiences of men and women. Specifically, Vogt et al. [41] propose that the distinct experiences of men and women may lead to different reactions to trauma. In many parts of the world, women's trauma is linked to cultural violence, political violence, and social violence, potentially causing them to appear calm despite feeling scared and distressed, leading to the development of internalizing mental health outcomes such as trauma [42,43]. Yet, in a study conducted by Schubert and Punamäki [44] on mental health outcomes among individuals who survived torture as refugees and resettled in Finland, no noteworthy gender differences in traumatic experiences were identified. Regarding age, global refugee data currently lacks age-based disaggregation, and research on trauma in relation to age has yielded mixed results. For instance, Maschi et al. [45] propose that elderly individuals are more likely to experience trauma compared to younger cohorts, while other studies suggest that youth are more prone to trauma but may have their traumatic symptoms mislabeled as conduct problems [46]. Concerning income, refugees often anticipate finding employment equivalent to their skills but may face challenges in achieving this expectation. Studies indicate that individuals with lower incomes and lower socioeconomic status are more exposed to trauma than those with higher incomes and higher socioeconomic status [46,47].

Concerning educational levels, research indicates that lower levels of education represent a significant risk factor for trauma [10,46]. That is, individuals with poor educational backgrounds are more vulnerable to trauma, whereas those with higher education levels often belong to higher social groups and are less exposed to trauma [47].

In terms of marital status, earlier studies suggest that being married is associated with a reduced incidence of traumatic stress symptoms [48]. That is, marriage appears to function as a protective buffer against the onset of traumatic stress symptoms, particularly benefiting married men who receive nurturing support from their wives in response to trauma or stressful situations.

Regarding household size, findings on the relationship between household size and trauma are inconclusive. Some studies propose that having more siblings or a larger family may offer protection against trauma [49], while others suggest that larger families might elevate the likelihood of mental problems in elder siblings [50].

Regarding the residency in the U.S., studies suggest a negative association between time lived in the U.S. and trauma. In the initial resettlement stages, individuals may experience a heightened sense of Americanness and a decrease in traumatization compared to those who have resided in the U.S. for an extended period [51]. However, as refugees establish longer-term residency in the U.S., traumatic symptoms may rise, contributing to a diminished sense of belonging [51,52].

This study primarily focuses on exploring the link between trauma symptoms and how refugees perceive discrimination. The investigation extends to understanding the relationship between trauma symptoms and various factors such as resilience, social support, religiosity, and awareness of refugee programming as potential resources. Additionally, demographic variables, including age, gender, level of education, income, household size, and marital status, are examined to further elucidate the relationship between trauma symptoms and these aspects.

Methodology

Research Design

Employing a cross-sectional design [53], the study deemed this approach suitable as it refrained from implementing any intervention, relying instead on distinctions among participants that are already present, shaped by their responses to shared experiences upon their arrival in the United States. Data were gathered from refugee families in Buffalo, New York, with the collection process involving obtaining informed consent from participants and, for those aged 13-17, from their parents. Stringent measures were implemented to ensure confidentiality and prevent the deductive disclosure of participants' identities. The study received its final approval from the State University of New York (SUNY)-Empire State University Institutional Review Board.

The study's sample consisted of 222 participants aged between 13 and 70, all of whom willingly participated. Given that more than 5% of data were missing for some independent variables, data imputation was performed using the expectation maximization algorithm to enable subsequent analysis. It is noteworthy that the conclusions remained consistent after comparing the results obtained from the original dataset and the imputed dataset.

Measures

The trauma assessment was conducted using three items derived from the Brief Trauma Questionnaire (BTQ), which had been

adapted from the Brief Trauma Interview [54]. The items, such as "*Your life is in danger or might be seriously in danger*," "*Close family member/friend died violently*," and "*Ever witnessed someone seriously ill or injured*," were recorded as dichotomous variables (1=No, 2=Yes). Higher scores on the scale indicated higher levels of trauma (short version; Cronbach's Alpha = .918). Discrimination was assessed using the Everyday Discrimination Scale (short version; Alpha = .77) [55], with variables measured on a range from 1=Never to 5=Yes, at least once a week (Cronbach's Alpha = .848).

The next construct of the questionnaire was derived from the Multidimensional Scale of Perceived Social Support [56]. In total, there were 12 statements to which participants responded in a 7-point Likert-scale (1 = Very Strongly Disagree to 5 = Very Strongly Agree; Cronbach's Alpha = .912). Resilience was measured utilizing the Brief Resilience Scale [57], with six survey items, with responses from 1=Strongly disagree to 5=Strongly agree (Cronbach's Alpha = .725). Religiosity was assessed using 10 items from the Hodge Intrinsic Religiosity Scale, with responses from 1=Strongly disagree to 5=Strongly agree. A higher score suggest a higher level of religiosity (Cronbach's Alpha = .785). Refugees' awareness of programming was assessed through an index item asking about awareness levels, ranging from 1=Very unaware (complete lack of awareness) to 5=Very aware (complete awareness), with higher scores indicating greater awareness.

Control variables included education level, measured on a range from 1=Less than high school to 7=Graduate degree, with higher scores indicating higher education. Income was measured on a 5-point scale representing household income levels from less than $20,000 to more than $50,000. Other control variables encompassed age (13-70), gender (1=Male, 2=Female, 3=Transgender, 4=Others), marital status (1=Single, 2=Married, 3=Divorced), household size (1=One person, 12=12 people), and residency in the US (or time lived in the US; Less than 1 year - 30 years).

Analytical Procedures

To examine the variance in Brief Trauma scores within the refugee community, an Ordinary Least Squares (OLS) regression model was employed. The model aimed to assess the linear combinations of various independent variables and their ability to explain a significant proportion of the variance in Brief Trauma scores. The independent variables considered in the analysis included gender, age, marital status, income, household size, residency in the US (or time lived in the US), perceived discrimination, social support, resilience, religiosity, and awareness of refugee-focused programming. The goal was not only to determine the overall significance of this set of independent variables in explaining the Brief Trauma scores but also to compare the relative importance of each variable by examining beta weights.

The resulting regression equation took the form: Constant + b_1 [Discrimination] + b2 [Level of Education] + b3 [Age] + b4 [Marital status] + b5 [Time lived in the US] + b6 [Gender] + b7 [Income] + b_8 [Family size] + b9 [Social support] + b10 [Resilience] + b11 [Religiosity] + b12 [Awareness of Refugees Focused Programming] = Brief trauma score.

Results

The sample composition comprised 51% male, 47% female, and 1% transgender individuals. The study's participants predominantly belonged to the age range of 13 to 30, with a mean age of 22 during the study period. About 80% of participants had attained less than a high school diploma, with 79% identifying as single, 15% as married, and 6% as divorced. Family size varied from 1 to 12 people, with an average of 4 people. Approximately 68% of respondents reported an annual income of less than $20,000, and the residency in the US or time lived in the U.S. ranged from less than a year to 29 years, with an average of 6 years.

Examining the descriptive statistics (refer to Table 1), trauma exhibited mean of 1.88, suggesting that the majority of respondents considered themselves as experiencing some level of trauma. Religiosity exhibited a mean of 3.15, indicating that the majority of respondents considered themselves religious. Social support had a mean of 4.45, suggesting that most respondents received social support from family, friends, and others. Household size had a mean of 4.11, indicating that most respondents came from larger families. Awareness of refugee-focused programming had a mean of 2.74, indicating that most respondents were minimally aware of the programming offered by agencies catering to refugees. In other words, awareness of the programming was either inadequate or unclear for the refugees who participated in the survey. Zero-order correlations among study variables (refer to Table 1) revealed several findings.

There was a detrimental association between trauma and discrimination ($r = .19;\ p < .01$) among the surveyed refugees. Additionally, there were positive associations between trauma and relying on religious faith as a coping mechanism ($r = -.17;\ p < .05$), having a higher level of education ($r = -.19;\ p < .05$), and earning a higher income ($r = -.18;\ p < .01$) among the refugee population.

An intriguing discovery emerged regarding the relationship between trauma and awareness of refugee-focused programming ($r = -.18;\ p < .01$). This indicates that lower awareness of such programming was linked to higher levels of trauma among the surveyed refugees (e.g., language programs, counseling, attorney representation, among others; see Figure 1).

Upon examining the beta weights and relationships with perceived discrimination scores (refer to Table 2), a significant connection was evident between discrimination and trauma ($\beta = .156,\ p < .05$) among the surveyed refugee participants.

Importantly, this association persisted even after accounting for demographic variables such as time lived in the U.S., household or family size, higher income level, higher education level, female gender, single marital status, and age or older age.

Table 1: Zero order correlations and Descriptive Statistics (N = 222).

	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Brief Trauma	-	0.19**	-0.17*	-0.04	-0.08	-0.18**	-0.03	-0.07	-0.18**	-0.19*	0.04	0.07	0.06
2. Discrimination		-	-0.12	-0.10	-0.21**	-0.01	-0.02	-0.15*	-0.12	-0.01	0.02	0.35**	0.07
3. Religiosity			-	0.14*	0.58**	0.07	0.27**	0.09	0.05	0.07	0.01	-0.20**	-0.03
4. Resilience				-	0.14*	0.15*	0.00	-0.14*	0.04	0.11	0.08	0.20**	0.22**
5. Social Support					-	0.02	0.19**	0.11	0.05	0.08	0.01	-0.23**	-0.04
6. Awareness of Prog						-	0.10	0.03	0.05	0.01	0.03	0.15*	0.13
7. Residency in the US							-	0.18**	0.26**	0.20**	0.00	0.22**	0.08
8. Family Size								-	0.05	0.11	0.03	-0.36**	-0.25**
9. Income									-	0.25**	0.20	-0.03	0.32**
10. Level of Education										-	0.11	0.03	0.20
11. Female											-	0.18**	-0.09
12. Single												-	-0.25**
13. Age													-
Mean	1.88	2.78	3.15	2.86	4.45	2.74	6.84	4.11	1.07	2.23	1.49	2.44	22.11
SD	0.25	1.27	0.65	0.65	1.10	1.50	5.19	2.74	0.93	1.75	0.56	1.38	7.23
Min	1	1	1	1	1	1	0	1	1	1	0	0	13
Max	2	6	5	5	7	6	29	12	5	8	4	4	66

*(*p < .05, **p < .01, ***p < .001)*

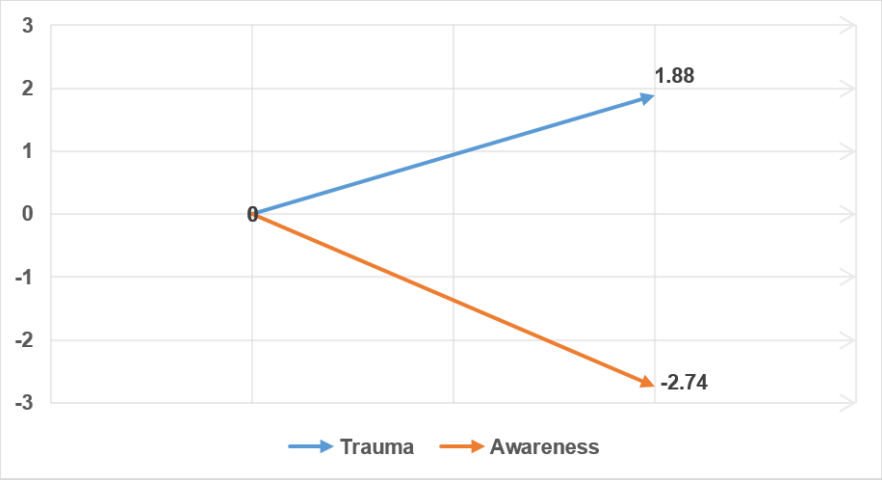

Figure 1: Trauma and Awareness of Services.

Table 2: An Ordinary Least Squares (OLS) Regression Model for Trauma (N=222).

Coefficients[a]					
Model	**Unstandardized Coefficients**		**Standardized Coefficients**	**t**	**Sig.**
	B	**Std. Error**	**Beta**		
(Constant)	1.903	.135		14.114	<.001
Discrimination	.031	.014	.156	2.249	.026
Level of Education	-.030	.010	-.216	-3.077	.002
Income	-.033	.019	-.120	-1.692	.092
Female	-.016	.028	-.037	-.568	.571
Single	-.012	.014	-.068	-.872	.384
Family Size	-.015	.006	-.160	-2.267	.024
Residency in the US	.005	.003	.094	1.330	.185
Age	-.002	.003	-.071	-.971	.333
Resilience	-.018	.026	-.045	-.665	.507
Religiosity	-.063	.031	-.164	-2.069	.040
Social Support	-.011	.018	-.050	-.632	.528
Awareness of refugee programs	-.030	.011	-.178	-2.743	.007
Dependent Variable: Trauma					

Concerning resources, the study revealed the most robust association between trauma and the level of education, signifying lower levels of trauma among surveyed refugee participants with higher education levels ($\beta = -.216;\ p < .05$). Following this, the associations were observed with awareness of refugee-focused programming ($\beta = -.178;\ p < .01$), religiosity or religious affiliation ($\beta = -.164;\ p < .05$), and, lastly, individuals from larger families or those with a larger household size ($\beta = -.160,\ p < .05$).

Discussion

This study extends prior research by delineating risk factors (such as perceived discrimination), available resources (including resilience, social support, religiosity, and awareness of refugee-focused programming), and demographic factors (such as age, education level, race, gender identity, household size, and duration of residence in the United States) that correlate with trauma symptoms among refugees. Furthermore, the study undertakes a comparative analysis of scores on the brief trauma scale within the refugee population.

In alignment with prior research, our findings reveal positive associations between trauma symptoms and perceived discrimination [19,20,28]. Conversely, negative associations were observed with religiosity [29], higher education levels [10,46], and higher income [46,47]. These results affirm that a lack of religious affiliation, lower education levels, and lower income are significant risk factors for trauma among refugee populations.

In contrast to prior findings, our study diverges by not establishing significant correlations between trauma symptoms and resilience [13,21,22-25] or social support [26,28]. Concerning social support, our results align with other studies [19,27] that yielded inconsistent findings regarding the efficacy of social support. Interestingly, we separately examined friend support and family support in relation to trauma symptoms, and both remained nonsignificant.

Concerning gender, our findings are consistent with Schubert & Punamäki's [44] discovery that gender was not significantly correlated with trauma symptoms, in contrast to other studies suggesting gender differences [41,43]. Moreover, contrary to earlier research that presented varied outcomes regarding age [45], our sample, characterized by a mean age of 22 in the younger age group, did not demonstrate a significant correlation between age and trauma symptoms. Likewise, in contrast to earlier research on family or household size [49,50], our study identified no significant correlation between family or household size and trauma symptoms. Additionally, in contrast to earlier studies, our results indicated no significant correlations between marital status [48] and the duration of residency in the US [51,52] with trauma symptoms. Significantly, our results demonstrated a robust negative association between trauma symptoms and awareness of refugee-focused programming, indicating that lower awareness of such programming is linked with higher levels of trauma among the surveyed refugees.

The current study comes with several limitations that warrant acknowledgment. Firstly, the use of a cross-sectional design without a control group restricts the ability to establish causality, and all conclusions are drawn based on observed associations only. Secondly, participation was limited, possibly due to the stigma associated with trauma symptoms or fears of repercussions in the participants' lives in the US. Thirdly, the absence of data on trauma exposure before arrival hampers the ability to distinguish between trauma symptoms originating before or after arrival. Fourth, challenges in researching the refugee population, such as language barriers and varying literacy rates, might have influenced the accuracy of responses. Fifth, the study's focus on refugees in Buffalo may limit generalizability to other US or global refugee populations. Sixth, the use of a self-reported single-item scale for awareness of refugee-focused programming may lack depth in assessing such programs. Lastly, self-reported measures may have limitations, including the potential for socially desirable responses.

While acknowledging the inherent limitations of our study, it is crucial to highlight that our findings align with previous research on the correlates and risk factors associated with trauma symptoms. Our research emphasizes the profound impact of perceived discrimination within refugee populations and underscores the potential positive influence of education, with a specific focus on raising awareness through refugee-focused programming.

Our study contributes valuable insights with significance for both refugee agencies and mental health professionals. The results underscore the importance of tailoring programs to meet educational objectives and address the unique needs of refugee populations. By acknowledging and addressing the role of perceived discrimination, our research advocates for a holistic approach in designing interventions to mitigate the adverse effects of trauma symptoms among refugees. The practical implications of our findings extend beyond academic discourse, providing actionable recommendations for those actively involved in supporting and assisting refugee communities. This emphasis on education and targeted programming aligns with a proactive stance toward improving the well-being of refugees and fostering resilience within this vulnerable population.

While we remain optimistic about the potential impact of our research in informing policies and practices that promote the overall mental health and integration of refugees, we acknowledge the imperative need for further research. Specifically, longitudinal studies with larger and more representative samples are essential to explore the trajectory of trauma among diverse refugee groups. Additionally, assessing the specific variables in programming that contribute to positive outcomes is crucial. A deeper understanding of the dynamics between discrimination and trauma over time, coupled with considerations of healthcare access and mental health literacy, can inform the development of more comprehensive and effective support strategies for refugees.

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