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Trauma, Psychopathology, and the Refugee Crisis: A Call to Action

In 2014, there were an estimated 19.5 million refugees worldwide and 38.2 million internally displaced persons. Nearly half of these refugees and displaced persons were children. For example, there was a fourfold increase in the number of asylum seekers in the Western Balkans from 2012 to 2014. The United Nations High Commissioner for Refugees expects these numbers to grow exponentially within the next decade, worldwide.[1] Not only have many people been relocated from their homelands, but also families are being separated, and displaced children often arrive unaccompanied seeking asylum. This humanitarian crisis will result in a dramatic shift in how public health professionals deal with international research, develop interventions, and transform policy to accommodate evolving global crises.

Of particular concern surrounding this global public health issue is the striking evidence that trauma-exposed children are more likely to have behavioral problems when they lack consistent, responsive caregiving.[2–4] With so many children being separated from their families and facing the stress of the modern refugee process, it is reasonable to predict a growing crisis in terms of their developmental trajectories, suggesting dramatic implications for the care and education of these displaced children. Lack of continued support of these children where they are cared for in these destination countries involves further associated risks. Without careful attention to improving the refugee migration process, future complications associated with improvements can also occur.[3,4]

TRAUMA AND PSYCHOPATHOLOGY

Immediate neurological implications of prolonged exposure to war-related trauma can have profound effects on the mental health of both children and adults.[2–6] Not only are their home countries a source of trauma and exposure to violence, but refugee camps can also serve to precipitate risks associated with trauma, violence, and mental health concerns.[5] Data from the Health Information System of the United Nations High Commissioner for Refugees implicate epilepsy and seizures as the number-one reason why both male and female refugees seek mental, neurological, and substance use treatment within refugee camp settings. This is consistent with research suggesting that refugees are at increased risk for psychotic disorders, epilepsy, substance use, and other neurological conditions.[5]

Many of the other conditions prevalent throughout refugee camps include behavior problems, depression and anxiety, concerns with adjustment and impulse control, and posttraumatic stress disorder.[3,4] Young children are especially susceptible given the developmental, cognitive, and emotional vulnerabilities experienced in areas of conflict. Ethnic–political violence is the source of more than 1 million children being recruited to serve as soldiers by both government agencies and enemies of the state.[4] The use of children as soldiers has led to nearly two million child deaths, four to six million injured, and more than 12 million children abandoned or made homeless.[4]

Witnessing and especially participating in acts of violence and potential sexual abuse can interfere with children's emotional and cognitive processing of these experiences.[4,6] Social learning and information processing theories attribute much of this to children observing and enacting violent behaviors, and then transferring these behaviors into self-schemas. Over time, children become desensitized to violence and develop underaroused emotional systems. On the other hand, some children may become overaroused by violence and develop posttraumatic stress disorder.[2,3,6] This can create an entirely different set of symptoms and behaviors, each of which requires support and treatment to prevent pervasive symptoms.

After entering a transit or host country, refugees may have to relocate frequently because of housing shortages, poor accommodations, or changes in political climate.[3,6] These relocations become an additional obstacle for families to obtain support services. In moving between states or even counties within the United States, paperwork may be mishandled and lost, or there may be partisan discrepancies regarding rights and access to services. These experiences can lead to further trauma and create feelings of apprehension.[6] From the perspective of children's long-term health and development, rejection by peers, perceived discrimination, and racism each contribute to youths' development of self and ethnic identity.[3,6] When development is compromised, mental health routinely suffers. When one is considering programs and services that support refugee children, it is important to be mindful of developmental implications and the effects on postsettlement adjustment.[6]

A CALL TO ACTION

Seven days into his presidency, Donald Trump signed an executive order suspending entry to the United States for anyone from the countries of Iraq, Syria (indefinite), Sudan, Iran, Somalia, Libya, and Yemen. Initially the executive order included those with permanent US citizenship, green cards, and visas. The seven countries banned according to the 2017 executive order comprise nearly 33% (20.4 million) of the global persons of concern figure. Persons of concern are categorized as refugees, asylum seekers, or internally displaced persons.[1] Following the wake of civil unrest, protests at airports across the country, and legal actions in some states declaring the order to be illegal, the White House revised the order to

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permit entry to those with legal status in the United States only after revoking 100 000 visas from the seven Muslim-majority countries. The alarming nature of the executive order presumes that one chooses to be displaced or a refugee. But most refugees are forced out of their countries because of persistent war, torture, or persecution, and have the eventual goal of returning home once the environment has been deemed safe.

Fortunately, many US organizations offer safe spaces for refugees and those looking to resettle. For example, New York State, long a site of refuge for immigrants, continues to open its doors to refugees and offers many locations that provide safety and security for those in need. More than just resettlement, the Mohawk Valley Resource Center for Refugees also provides free adult learning courses, job placement, legal consultation, and mental health and physician services as needed (bit.ly/2oASu2t). Similar facilities across the United States have garnered support from activist organizations such as the International Refugee Assistance Project, the American Refugee Committee, and Lutheran Immigration and Refugee Service (bit.ly/2oASu2t). Donations for these organizations have skyrocketed since the signing of the 2017 executive order.[7]

Public health professionals can serve this vulnerable population by first highlighting the precarious journey that refugees experience, then by understanding the devastating effects displacement can have on both children and adults, and finally by supporting refugees as they recover from the extreme trauma and stress.[7] Promoting resiliency is an investment in both the short- and long-term health, treatment, and care of displaced and refugee persons in communities across the world.

To avoid a potential mental health crisis, it is imperative that we act to care for and provide appropriate and supportive resources to displaced and refugee children. By extending services beyond physical needs, these children are more likely to have better developed neurological and biological systems—systems crucial for prosocial and nonviolent, resilient behavior. AJPH

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Public Health Research Priorities to Address US Human Trafficking

In February 2017, the US presidential administration affirmed a commitment to address human trafficking. The US Trafficking Victims Protection Act of 2000 (Pub Law No. 106-386) defines human trafficking as "the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery." Human trafficking is often confused with smuggling, which involves the consensual but illegal transportation of a human across a national border.

Victims of human trafficking include US-born and naturalized citizens, permanent residents, legal visitors, and undocumented immigrants. They are trafficked in commercial sex and myriad forms of labor, including domestic work, agricultural work, and construction work. Minors engaged in commercial sex are considered to be trafficking victims, regardless of the use of force, fraud, or coercion. In fiscal year 2015, the US Department of Homeland Security and the US Department of Justice opened 2847 investigations of suspected human trafficking cases and prosecuted 377 defendants for human trafficking crimes.[1] In that same year, the 21 federally funded victim services agencies in the United States reported 3889 open client cases. These cases are believed to represent a fraction of all human trafficking activity in the nation.[2]

The negative health consequences of human trafficking are well established and include neurologic, gastrointestinal, cardiovascular, musculoskeletal, dermatological, reproductive, sexual, dental, and mental health problems. Nonetheless, many questions remain about the nature and scope of human trafficking, its determinants, and how to mitigate the problem.

A public health approach to human trafficking involves estimating the size of the problem; identifying risk and protective factors for victimization, perpetration, survival, and resilience

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