Social Isolation and its Impacts on Refugee Mental Health

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Abstract

While the process of leaving one's home country and resettling into a new location and culture can bring with it a variety of challenges and health care considerations, the experience of social isolation is also important to address as it can have an impact on mental health and wellbeing. This paper explores the recent literature addressing social isolation including how it has been defined, factors that increase the risk of social isolation as well as protective factors that help ameliorate social isolation, the ways in which social isolation can negatively impact mental health, and intervention strategies to combat social isolation. In addition to published literature, methods the IFMC have used are included as additional potential intervention strategies to implement moving forward.

Introduction

OA is a 49-year-old male refugee from Iraq who arrived in the United States 11 years ago with his wife and two sons. He sought refugee status after experiencing trauma and arrived with post-traumatic stress disorder symptoms. In addition to the challenges inherent to living this diagnosis, his interpersonal relationships with staff at agencies specializing in assisting refugees with resettlement would at times exacerbate his symptoms. It was noted that he expressed stress related to the "progressive loss of their (socio-economic) status resulting in housing instability, a perceived decreased in autonomy as a caretaker and a mistrust in the state provided services." The patient, despite being employed, experienced financial instability and was concerned with what he found to be inadequate and unsanitary housing. With English as a non-primary language, learning how to communicate and interact with the community was an ongoing challenge. Alongside these challenges, he struggled with peer relationships at work and in the community, feeling discrimination occurred and finding few friends. His family remained a main source of support. Another source of support was found in conjunction with his Muslim faith as he regularly attended religious services in the community. With these significant psychosocial challenges in the setting of attempting to manage PTSD, he was followed and treated by a psychiatrist. As time has passed, some of these stressors are becoming more manageable, although interpersonal challenges remain a source of concern.

Social isolation and its definitions

Social isolation is often multifactorial and, although not unique to refugee patients, exacerbated by challenges in acculturation. It also should be defined, as there are objective measures as well as subjective experience to consider. Among the reviewed literature, social isolation was defined in different ways by different authors. Some authors used subjective experiences of participants to assess social isolation, while some authors used more objective measurements of social connection such as living alone or not. A theme noted among a sample of nine older adult Bhutanese refugees was the subjective sense of loneliness and isolation.[1] Another study indicated that multiple refugee groups had feelings of abandonment, isolation, and being alone.[2] For a group of Somali refugees in Finland, it is known that there is rare social contact and friendship with native Finns, which can be one objective measure of social isolation from local society.[3] This past year due to the COVID-19 pandemic, social isolation has taken on additional objective measures, such as specific distancing between persons and gathering size restrictions as well as the general advice to stay at home when possible. These public health measures to physically separate people in order to decrease viral spread has disproportionately impacted vulnerable populations including refugees by

causing increases in barriers to accessing basic needs and care.[4] A group of authors studying depression among Canadian-dwelling refugees and non-refugees defined isolation as a spectrum of being not isolated to extremely isolated, categorizing the study participants into three groups on this spectrum based on reported contact frequency with other persons inside and outside of their household.[5] In addition to categorizing social isolation by contact frequency, the refugees were also grouped by living arrangements with categories of "living alone" or "not living alone," leading to a total of six categories analyzed based on the combination of living arrangement and contact frequency.[5] These authors generally emphasized objective measures of isolation in the study design.

Social isolation protective and risk factors

With social isolation defined in various, albeit overlapping, ways as described above, determining risk factors or protective factors that generalize to all refugees should be attempted with caution. However, multiple authors noted themes and reviewed known contributors to social isolation, which had some overlap between groups and resettlement locations. Multiple studies addressed various groups of older adult refugees and considered factors influencing social isolation among these groups, indicating that there may be increased or unique challenges for older adult refugees.[1-3, 6] Older adult Bhutanese refugees noted that, although they were adjusting to life in the United States, there was sadness regarding missing family who was left behind, as well as some having made the choice to come to the United States for their children's sake rather than their own desire.[1] Language was named in this group as a prominent issue that limited their ability to obtain a driver's license and employment,[1] which inhibits community integration and increases isolation. Along with limited English language proficiency limiting mobility, it also led to feelings of loneliness through difficulty in communicating thoughts and feelings with community members when they did get the opportunity to meet others.[1] With the limited ability to find employment and independent transportation, many refugees included in this study spent days at home alone or with a spouse while their adult children worked outside the home.[1] These participants were also confronted with the inability to attend funerals or other ceremonial events with their family members left behind, with this being one of the "little sorrows" mentioned.[1] In a group of displaced older adults living in the country of Georgia, perceived lack of care from the government as well as lacking family support were factors that were spoken of when discussing social isolation.[2] Again, living without a job and being alone for much of the time as well as struggling to integrate into local culture were brought up with the feeling of having "nothing to do" with their time.[2] Arguments among family members, often resulting from financial instability or generational tensions, left older adults often feeling isolated and unnecessary.[2] As occurs with many refugee families, resettlement may be in multiple locations and even in different countries, which is a further limitation on the ability to connect with important family members and engage with others who understand their culture well, especially in this current time of increased restrictions for travel. The importance of family was underlined when participants described future expectations including support from adult children.[1] In a study comparing the role of religion in older adult refugee and non-refugee participants in Lebanon, participation in organized religion among the refugee population was protective against depression.[6] This was thought to be related to the social engagement opportunity that organized religion provides as well as the role of religion as a support in settings of difficulties related to acculturation and low socioeconomic status.[6] Notably, the participants as a whole had a large majority with some religious commitment, indicating that religious participation may provide more social benefit in this setting than others.[6] Among older adult Somali refugees living in Finland, work and societal

discrimination were associated with mental health problems, these discriminatory behaviors being described as "unfair treatments, mistrust, and malevolent attitudes" toward Somali refugees.[3] Understanding that Finns are rarely socially engaging with this group of refugees,[3] this may be a underlying risk factor for social isolation in this group of refugees.

Some authors addressed social isolation in broad and diverse groups of refugees.[5, 7] A study of a diverse group of refugees and immigrants living in Canada found evidence that refugees may be prone to emotional isolation and discussed a variety of possible reasons, including past psychological trauma and social separation from life-long friends and family.[5] In this study, affectionate social support was an attenuating factor for the association between refugee status and depression.[5] It was noted that older age was associated with higher levels of stress related to homesickness in a diverse group of refugees resettled in Utah.[7] This trend of homesickness is also noted in younger refugees who are not participating in formal education, indicating that education is a mechanism of gaining social and other support after resettling.[7] However, among other refugee populations with large family networks relocated together, this stress related to homesickness is lower.[7]

Other authors addressed specifically female refugees and concerns that may be unique to this group and their experience of social isolation. In North Carolina, the community of Arab Muslin female refugees infrequently have obtained a driver's license or found employment or education opportunities feasible given finances and other responsibilities.[8] These were considered isolating factors and also to be barriers to accessing healthcare. In a group of 38 Afghan refugees resettled in Australia who were also young mothers, many emotional challenges of new motherhood were attributed to separation from family members, especially mothers and sisters; they were less likely to seek support from non-familial friends.[9] These mothers expressed a tradition in Afghanistan of family and community members assisting with responsibilities and being personally treated very well for the first 40 days after birth, allowing the mother to rest and focus on caring for her new baby, which they missed after giving birth in Australia.[9] The social implications of being a refugee and mother in Australia also relates to how freely children can play, as multiple women noted that children would be watched over in a communal way while playing with cousins and extended family in Afghanistan, but that each mother needed to watch over her own child while they played in Australia.[9] Women in this study also reflected on how their distance from support of older women and mothers negatively impacted their marital relationships, with their understanding of their own mental health being closely tied to both of these types of relationships.[9]

Social isolation's impacts on mental and physical health

In the Bhutanese group of study participants, there was an overall improvement in quality of life in the United states compared to the refugee camps where they had previously lived, although there is still a high rate of suicide among Bhutanese refugees after resettlement.[1] This group noted a 'unique sadness' associated with the profound isolation they experienced.[1] Among the displaced persons living in the country of Georgia, social isolation or loneliness were perceived causes of depressive symptoms, with other stressors causing anxiety symptoms.[2] Social isolation and lack of activities in this group was thought to cause worrying, insomnia, 'negative thoughts,' and feeling helpless.[2] Among the Somali refugees living in Finland, higher levels of religiosity were protective of PTSD and somatization symptoms related to war trauma, thought to be due in part to how religion can be a space of consoling and social support as well as a method of making sense of one's experience.[3] In the study comparing refugees to non-refugees living in Canada,

refugee status was correlated with depression even with adjustment for objective social isolation measures (living alone, low frequency of social contact), although affectionate social support factors decreased this association to the level of non-significance.[5] This indicates that the type of social isolation that impacts mental health has more to do with the emotional isolation or perception of being isolated than the objective measures. The authors describing care for Arab Muslim refugee women in North Carolina note that social isolation is a fear that may prevent women from disclosing domestic violence concerns, and also that some women may not realize that these concerns are reportable.[8] Among the young refugee mothers in Australia, many experienced some symptoms of post-partum depression and related these symptoms to feeling alone in the situation of being a new mother.[9] The most common impacts on mental health among all groups of refugees studied were depression-related symptoms as well as anxiety-related symptoms, along with the sensation of loneliness.

Interventions to target social isolation

Clearly, there are a variety of factors that increase the perception of social isolation among refugees. With so many options to start to address, the factors that were common to multiple refugee groups are explored here with some possible interventions noted to begin to minimize the impact of the risk factors present.

With language learning as a common contributor to remaining socially isolated, improving access to language learning opportunities is one option for increasing ability for integration into the new culture. In the group of Bhutanese refugees, not learning the English language was one factor increasing social isolation, and the authors suggested increasing language learning classes especially for older adults who may have increased difficulty with new language learning.[1] Language learning was also noted to be a challenge that limited obtaining a driver's license and limited comfort with public transportation in female refugees in North Carolina, emphasizing the importance of language learning as a means of accessing both social connection as well as other needs.[8] This underlines the need for reasonable transportation options to make a service like language learning classes truly accessible.

In the study of refugees living in Lebanon, the authors discussed the need for caution in applying their finding of religious participation as a protective factor due to the possibility of pressuring the acceptance of one's own religious ideals.[6] However, as the benefit of religious participation was at least subjectively described in other groups as well, one way to support refugees in a community could include improving transportation and availability of applicable religious services.[3, 6, 9]

A challenging factor contributing to isolation and mental health concerns is the "everyday discrimination" experienced by refugees in the study of those resettled in Finland, as this would require widespread societal change in attitude and behavior toward refugees.[3] One would imagine that increased integration into the local community would both decrease the isolation experienced by these refugees as well as break down stereotypes and negative attitudes toward resettled refugees. This is a complex need that will require multiple approaches and interventions. One method of combatting these negative attitudes currently in place in Charlottesville include programs that provide community members and university students to mentor or tutor refugee children and youth.

The older adult Bhutanese refugees also reported concerns with more generalized cultural adaptation and familial changes that often resulted in decreased social support compared to life prior to resettlement, which was common in other studies as well, with the individual focus of western culture being a challenging component of integration.[1, 2, 5] The study of displaced persons living in the country

of Georgia included interviews in which respondents named some coping methods for experiencing social isolation and familial conflict including "talking, sharing problems, and socializing" for relational concerns. These respondents also identified "receiving help from neighbors and family and encouraging each other… fulfilling responsibilities such as taking care of children, working on garden plots, and getting involved in community programs" as strategies to combat isolation, feelings of passivity and nervousness, and relational conflict.[2] Of course, understanding that a viral pandemic that the world has been living through has contributed to social isolation, continued efforts to gain herd immunity through vaccination distribution efforts will likely aid in improving social isolation, especially in refugees whose families are geographically separated. Among the refugees resettled into Canada, the finding that affectionate social connection is protective of depression leads the authors to suggest interventions to nurture these types of relationships, potentially in group-based interventions.[5] Group visits for medical conditions in non-refugee patients have been found to have benefit in a variety of settings. Based on this model, the IFMC provided group visits prior to the pandemic that focused on relevant health education topics for Bhutanese older adults. Providers noted high levels of participation and observed benefit for patients who participated, especially related to the social connections that were made.[10] In a study of African refugees settled in Australia, participation in a community garden fostered a sense of community belonging as well as reconnection with agriculture during a transition to a new geographic location with different dietary customs.[11] In Charlottesville, the International Rescue Committee runs a program called New Roots that supports refugees through involvement in their farm as well as some community gardens, along with providing nutrition education (https://www.rescue.org/volunteer/new-roots-farm-volunteer).

In the study of young mothers resettled in Australia, the women with English language proficiency were able and excited to form social connections both within their cultural community as well as the larger community of local Australian women.[9] In the same study, women comfortable with only their native language preferred to connect with other women from Afghanistan and found that increased social connection improved their wellbeing.[9] Similarly to the group visits for older adult Bhutanese refugees, one option for refugees who are new mothers could be to have a group visit option available to allow for education as well as social support. One clinic noted that a group of Japanese women living in Michigan who had limited English proficiency were too often underserved, and found that providing group visits for prenatal care served as a form of social support among other pregnant women as well as to provide health education.[12] Some providers within the IFMC clinic have also advocated for local gyms and swimming pools to be culturally sensitive by inviting only women at certain times in an effort to allow for more freedom in gathering socially with other refugee and local women as well as gaining opportunities for physical activity, although this has been challenging with distancing restrictions this past year. With limitations in transportation being common among refugee women, providing transportation to these locations, as well as child care, would likely improve access to these opportunities.

Conclusion

Social isolation tends to be defined in the literature as a subjective experience more than by objective measures, and findings suggest that this subjective experience has a greater impact on mental health than do the objective measures. Many factors can increase social isolation in refugees, including language learning challenges, limitations in transportation and ability to participate in employment opportunities, and changes to family relationships. Protective factors against

isolation include participation in organized religion, larger local family networks, and affectionate social support. Interventions to target social isolation may address language learning, availability of desired religious services, battling discrimination, and providing opportunities to gain social support among other refugees as well as in the local community. Further research to assess the efficacy of intervention strategies is needed.

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