

Chapter 6

Characteristics of life in exile: vulnerability factors for substance use

Marjolein Muys

The aim of this chapter is to provide a theoretical understanding of the nature and extent of substance use among refugees. A theoretical model of self-medication is constructed and illustrated by means of data obtained from empirical research among refugees. The subjects of this chapter are those who have fled their home countries and applied for asylum in another country (asylum seekers), and those who have been granted asylum (refugees). Throughout, the term ‘refugees’ is used unless only asylum seekers are being discussed. The chapter contains a review of existing empirical studies of asylum seekers and refugees in Europe, North America and Australia. The empirical data are presented in order to illustrate a theoretical model that aims to provide a basis for future empirical studies.

Because many aspects of life in exile are associated with stress (for example, experiences of war in their home country, lack of privacy in asylum seekers’ centres, adaptation to new situations, and boredom), the theoretical model of this study departs from the stress experience. ‘Stress’ is studied from the perspective of the conservation of resources (COR) theory, which has been presented by Hobfoll^{1,2} as a general theory for understanding the nature and influence of stress. First the theoretical model is outlined, and then it is applied to life in exile. The general theoretical model departs from resource loss as a stress-inducing event. Because refugees experience an array of resource losses in all domains, it is argued that they lead a stressful life. Due to pre- and post-migration resource losses, poor mental health is expected. The next section uses empirical data to illustrate the fact that many refugees suffer from psychiatric disorders, and discusses why refugees are at high risk of adopting passive–avoidant strategies in order to cope with stress and

poor mental health. The final section argues that because refugees have few resources in their host country, little control over their new situation and/or few personal resources (such as self-esteem), they are vulnerable to the problematic use of alcohol, prescription medication and illegal drugs.

It should be emphasised that the focus of this chapter on the vulnerability factors associated with living in exile does not detract from the remarkable resilience that is shown by many refugees.

Conservation of resources (COR) theory

COR theory is based on the premise that individuals strive to obtain, retain and protect that which they value – their ‘resources.’ These are the objects, conditions, personal characteristics and energies that are valued for survival, either directly or indirectly, or that serve as a means of achieving these resources:

internal and external characteristics that individuals maintain and accumulate in service of having coping options and adjusting well.¹⁻⁴

Loss of resources

In the COR model of stress, losses or gains of resources are the units of analysis. Stress will ensue under any of three conditions:

- 1 when there is threat of significant resource loss
- 2 when there is actual resource loss
- 3 when resources are invested without resulting in significant resource gain.

Resource loss can be acute or chronic. Acute resource loss is likely to result in stress because it is very rapid and the resource reservoir is emptied in the short term. Chronic resource loss exhausts all available resources to the extent that the entire resource reservoir can be emptied in the long term.⁴

COR theory posits that resource loss is central to the stress experience because it has a negative emotional impact. Exposure to stressful life events may have (long-lasting) implications for mental health.^{5,6} Furthermore, resource loss cycles into further resource loss.⁷

Loss cycles

In order to deal with stress, people develop coping strategies, which have been defined as ‘behaviours that are enacted to respond to recovery demands’.⁸ COR theory postulates that additional resources must be invested in order to cope with previous resource loss.⁹

Two clusters of coping strategies can be distinguished, namely active–approach and passive–avoidant strategies. Active–approach coping strategies are directly aimed at changing the environment – the coping efforts actively address the stressor itself. Passive–avoidant coping strategies attempt to evade thoughts and feelings associated with the stressor.^{5,8} The strategy adopted depends on the level of resources available to the individual, the extent to which the stressor can be controlled and/or the personal characteristics of the individual.

People with few resources are more likely to develop avoidance coping strategies, as they lack resources that could be invested in approach strategies. This implies that the fewer resources an individual has, the more likely they are to be overwhelmed by the (threats of) losses they encounter, and coping efforts may therefore induce loss spirals among individuals with minimal resources. For example, an individual may engage in avoidance coping in order to prevent the loss of self-esteem that would result from focusing on the problem. This strategy may induce further loss, as the individual fails to address problems in their environment.^{1,10}

The nature of the coping strategy that will be applied depends on the controllability of the stressor – that is, the degree to which stress can be mitigated or eliminated by an appropriate response.¹¹ Passive–avoidant coping strategies that address the emotions that accompany stress are likely to be applied when the stressor is outside the individual's control, and will be continued for as long as the stressor must be endured, or until a solution is possible. Individuals who are unable to control the source of stress and its solution are likely to adopt passive–avoidant strategies.

In addition to characteristics such as age, gender and previous exposure to stress, the reaction to stress is also shaped by internal or personal resources. Most important in this respect are aspects of self-esteem, linked to a sense of ability to successfully control and impact upon one's environment, especially in challenging circumstances.^{5,6,9}

Substance use

The self-medication hypothesis postulates that substances are used as a means of achieving relief from symptoms of pre-existing stress and stress-related psychiatric disorders. Based on COR theory, it will be argued that there is a pathway from stress to substance use. Because people who experience great resource loss suffer from personal distress, those with few resources and low self-esteem who find themselves in uncontrollable situations will apply passive–avoidant coping strategies. Substance use is a typical example of passive–avoidant coping, as this strategy is a relatively easy way to cope with problems. Although minimal substance

use (of illicit drugs, of prescription drugs obtained either via a doctor or illicitly, or of alcohol) may aid individuals during initial periods of distress, prolonged use of large amounts can lead to problematic use.¹²

Resource loss among refugees

There is often a multitude of loss experiences among refugees. In this section, it is argued that they may experience acute as well as chronic resource loss. Traumatic experiences in their home country may have induced acute loss, and refugees experience chronic loss if their resource reservoirs are not refilled in the host country.

Acute level: pre-migration trauma

From the perspective of COR theory, trauma can be characterised as acute loss, as it is rapid and extensive, and it results in rapid resource depletion. The individual is overwhelmed by the extent of what is lost, as traumatic loss affects all resource domains and leaves all resource reservoirs empty.^{13,14}

Worldwide, many refugees have experienced severe trauma in their home countries. Table 6.1 provides an overview of the nature and prevalence of trauma exposure among refugees as demonstrated by empirical research and shows that data on refugee trauma are often conflicting and difficult to interpret because a variety of methods and instruments have been used for data collection, analyses and reporting.^{15–30} In addition, the different kinds of trauma that refugees experience are diverse, and the prevalence rates for these traumas are equally diverse, even when similar ethnic groups are studied in similar settings.

Chronic level: post-migration loss

Resettlement stressors may be labelled as chronic stressors, since the conditions reported by refugees have a long duration. When people are bombarded by a series of ongoing stressful life events, COR theory suggests that, as resources are chronically threatened or depleted by their living conditions, coping options can be reduced and psychological distress may result.^{1,31} The great losses suffered by refugees, discussed below, are those of cultural resources, the family, social status and future perspectives.

Refugees are usually confronted with a radically different environment in their host country. They face a new culture with a different social structure and specific social demands. This confrontation may cause

Table 6.1: Empirical data on the nature and prevalence of trauma exposure among refugees*

<i>Reference</i>	<i>Country of origin</i>	<i>Host country</i>	<i>Setting†</i>	<i>Number of participants</i>	<i>Instruments‡</i>	<i>Being close to death</i>	<i>Forced isolation</i>	<i>Refugee camp</i>	<i>Imprisonment</i>	<i>Lack of food or water</i>	<i>Lack of shelter</i>	<i>Murder of family members or friends</i>	<i>Forced separation from family members</i>	<i>Torture</i>	<i>War, combat situation</i>	<i>Witnessed murder</i>
16	Various	Norway	COS	240	HTQ	81%			36%				74%	15%	74%	33%
17	Iraq	UK	CLS	84	HTQ STAR					38%				65%		
18	Vietnam	Australia	COS	1,161	HTQ	14%	2%		13%	20%	3%	3%	11%	1%	6%	8%
19	SE Asia	USA	CLS	91	HTQ	60%	60%		37%	80%	70%		70%	50%	60%	
20,21	Various	Australia	ASC	40	HTQ	45%			16%	33%		58%	42%	26%	50%	29%
22	Kosovo	UK	ASC	842	WTQ	88%				70%						42%
23	Cambodia	USA	COS	50	PTI	80%		100%		80%		80%				
24	Bosnia	USA	CLS	20	CTEI			100%		100%		100%	100%			
25	SE Asia	USA	COS	129	CTEI		79%	92%		85%	82%	59%	81%			20%
26	Indochina	USA	CLS	52	LESHQ									100%		
27	Vietnam	USA	CLS	201		7%			5%					5%	3%	7%
28	Turkey Iran	Netherlands	COS	156			15%		83%			59%		59%	46%	
29	Cambodia	USA	COS	124	WTS			95%		85%	62%	85%	60%	21%		
30	Various	Sweden	CLS	149			5%		9%					70%	6%	10%

* Percentage values in italics are those from papers that did not give exact percentages.

† CLS, clinical setting; COS, community study; ASC, study in an asylum seekers' centre.

‡ HTQ, Harvard Trauma Questionnaire; STAR, Survivor of Torture Assessment Record; WTQ, War Trauma Questionnaire; PTI, Post-Traumatic Inventory; CTEI, Communal Traumatic Experiences Inventory; LESHQ, Life Events and Social History Questionnaire; WTS, War Trauma Scale.

feelings of not belonging, as familiar behaviour is no longer effective and social roles need to be played in a different manner. Such feelings of not belonging are associated with depression, and may be suppressed by substance use.^{32–34} Every individual who faces a new environment will to some extent try to adapt to it. During this process, known as acculturation, individuals and groups undergo mutual changes when they come into contact with other cultures, and each culture influences the other. Refugees may therefore lose their traditional ways of living and suffer from acculturation stress.^{35,36}

Many refugees are separated from their family and are stressed by worrying and thinking about the family members whom they left behind.²¹ In the case of separation from a spouse and/or children, psychiatric disorders may occur.³⁷ Loss of family members in the sense of their death or disappearance is also associated with mental health problems.^{29,38}

Despite persecution and danger in the country of origin, many refugees had a certain rank there that carried responsibilities and advantages, but in the host country, social position and social roles remain unclear, especially while refugees are waiting for a decision on asylum applications. This loss of prestige may cause depression.^{32,39}

Loss of important life projects, such as a home that was built as a legacy to be passed on to the next generation, a business, or an anticipated retirement after a lifetime of employment are salient sources of distress for refugees. Because of these losses of acquired resources and a perspective on the future, many have become dependent on others and on social welfare in their host country.⁴⁰

Mental health of refugees

Table 6.2 presents an overview of empirical data on the prevalence of psychiatric disorders (post-traumatic stress disorder, depression and anxiety) among refugees studied in clinical and community settings. The table reveals disparate findings. Several factors may in part account for these differences – for example, the time elapsed since the trauma, methods of sampling and measurement, and ethno-cultural differences in psychological responses. It is also possible that the significance and meanings underlying trauma experiences are more important than the detail of discrete events in determining risk of mental health problems. The discrepancies within the empirical data may be due to the non-applicability of western criteria to non-western cultures. Emotional distress experienced by members of a non-western culture may not be expressed in the same manner as that experienced by individuals in western countries.⁴¹

Table 6.2: Prevalence of mental disorders among refugees

<i>Reference</i>	<i>Country of origin</i>	<i>Host country</i>	<i>Length of stay</i>	<i>Setting*</i>	<i>N</i>	<i>Instrument†</i>	<i>PTSD‡</i>	<i>Depression</i>	<i>Anxiety</i>
16	Various	Norway	3 years	COS	240	HTQ	15%		
17	Iraq	UK		CLS	84	PSE, DSM-II-R, HTQ	11%		
21	Various	Australia	Mean = 3 years	ASC	40	CIDI, HSCL-25	37%	33%	25%
22	Kosovo	UK		ASC	120	CAPS, DSM-IV	39%	16%	
23	Cambodia	USA	4–6 years	COS	50	PTSD Checklist	86%	80%	
24	Bosnia	USA	Newcomers	CLS	20	PTSD Scale	65%	35%	
25	Kosovo	USA	Newcomers	COS	129	PDS	60%		
26	Indochina	USA		CLS	52	LESHQ, DIS	50%		
27	Vietnam	USA		CLS	201	SCID, ADIS-PTSD	3%	5.5%	3%
29	Cambodia	USA	Mean = 8 years	COS	124	DIS, DICA-R	45%	51%	
30	Various	Sweden	No data available	CLS	149	PTSD-I	83%		
36	Former Yugoslavia	Sweden	Newcomers + 3 years later	CLS	27		63%		
37	Vietnam	Norway	T1: 3 months T2: 3 years	COS	145	SCL-90-R, PSE	T1: 9% T2: 4%	T2: 18%	T2: 2%
38	Bosnia	Australia	More than 3 years	COS	126	CAPS	63%		
42	Bosnia	Sweden	3–4 years	COS	163	HSCL-25	28%	94%	97%
43	Bosnia	Sweden		ASC	206	PTSS-10	33%		
44	SE Asia	Canada	T1: new T2: 2 years T3: 10 years	COS	T1: 1,348 T2: 1,169 T3: 674	RPPSI Symptom Inventory		T1: 6% T2: 4% T3: 2%	

* CLS = clinical setting; COS = community study; ASC = study in an asylum seekers' centre; DSM-II-R = Diagnostic and Statistical Manual II Revisited; DSM-IV = Diagnostic and Statistical Manual IV; SCID = The Structured Clinical Interview for DSM-IV (SCID); ADIS-PTSD = Anxiety Disorders Interview Schedule Revised for Post Traumatic Stress Disorder; RPPSI = Refugee Resettlement Project Symptom Inventory.

† HTQ, Harvard Trauma Questionnaire; PSE, Present State Examination; DSM-II-R, Diagnostic and Statistical Manual II Revisited; CIDI, Composite International Diagnostic Interview; HSCL-25, Hopkins Symptom Checklist-25; CAPS, Clinician-Administered PTSD Scale; DSM-IV, Diagnostic and Statistical Manual IV; PDS, Post-traumatic Diagnostic Scale; LESHQ, Life Events and Social History Questionnaire; DIS, Diagnostic Interview Schedule; SCID, The Structured Clinical Interview for DSM-IV (SCID); ADIS-PTSD, Anxiety Disorders Interview Schedule Revised for Post Traumatic Stress Disorder; DICA-R, Diagnostic Interview for Children and Adolescents – Revised; SCL-90-R, Symptom Checklist-90-Revised; PTSS-10, Post-Traumatic Symptom Scale; RPPSI = Refugee Resettlement Project Symptom Inventory.

‡ PTSD, post-traumatic stress disorder.

Predictors of passive coping among refugees

As discussed earlier in this chapter, individuals who have few resources, who find themselves in stressful situations that they cannot control and/or who have low self-esteem are likely to adopt passive–avoidant coping strategies.

Few resources

Because of the long-lasting difficulties in the host country, coping resources become overextended, resulting in destructive cycles of continued loss. Refugees have few resources to counter the loss of resources due to migration, and the scarcity of coping resources includes a lack of social resources, as well as language barriers, unemployment and poverty.

Social resources (particularly social support) are related to better emotional outcomes in the face of stress.⁹ Refugees have a low level of social support, and this is associated with mental health problems.^{16,17,21,36,37,42,45} However, social isolation might be the consequence of an individual's poor mental health, and not only its antecedent, as in many cases traumatised individuals tend to isolate themselves from others. Negative social conditions, which imply an unfavourable situation for mourning over traumatic losses, have a negative impact on the mental health of many refugees, and as a result post-traumatic stress disorder symptoms persist.^{16,36,37}

Many refugees are unable to speak the language of their host country, even ten years after resettlement.⁴⁴ This causes stress^{29,38} and makes it difficult to extend social networks to members of the host population.¹⁶

Unemployment rates among refugees are high,^{16,21,46} and unemployment is known to be stressful.^{16,17} Asylum seekers experience stress because they are not allowed to work, and refugees experience it because they are unable to find work.²¹ The consequent loss of meaningful structure and activity in daily life is associated with mental health problems.²¹

Several empirical studies have examined the prevalence and impact on mental health of poverty, defined as 'not having enough money', 'financial problems', 'economic difficulties' and 'high dependence on social welfare'.^{17,21,29,36,40,42} These studies show that insufficient income for safe and adequate housing and other basic necessities is a common source of stress among refugees.

Lack of control

Asylum seekers are typically concerned about a lack of control over their lives. For instance, many of them report frustration that an asylum

seekers' centre takes care of all aspects of their lives (e.g. food supply, parenting, education, medical care, personal hygiene).⁴⁷ These frustrations and a lack of future perspective because of the unknown outcome of the asylum application render asylum seekers vulnerable to excessive use of alcohol, tobacco and other drugs.^{48,49}

Low self-esteem

As was noted earlier, the self-esteem of refugees is affected by feelings of not belonging in the host country, and this can be exacerbated by experiences of racism. Approximately a quarter of studied samples of refugees have reported experiences of racism and discrimination.^{17,45,50} These feelings and experiences hinder their attempts to see themselves as fulfilled and legitimate members of the host society.^{32,47}

Substance use

The few studies that have investigated the use of alcohol, prescription medication and illegal drugs among refugees support the self-medication hypothesis – that substances are used to relieve symptoms of stress and mental ill health. Moreover, refugees are exposed to some risk factors that make them vulnerable to substance use, although some protective factors also exist.

Self-medication hypothesis

Dupont *et al.*⁴⁹ postulated that asylum seekers and refugees use substances in order to 'kill time', which suggests a functional pattern of use in relation to their past, present and future. Substance use may be related to past trauma in the country of origin, or to the eradication of memories of trauma before emigration. In the present, it may be related to the asylum-seeking process, with its long waiting periods, severe restrictions, insecurity and boredom. Substance use is also correlated with uncertainty about the future while waiting for the official decision on refugee status. Other studies on substance use among refugees support the self-medication hypothesis.^{51–54}

Thus refugees are vulnerable to substance use, because this coping strategy enables them to self-medicate mental health problems that originate from pre- and/or post-migration loss. Because they have few resources with which to offset loss, little control over the situation in which they find themselves and/or low self-esteem, it is predicted that they may apply this passive–avoidant coping strategy.

Risk factors

The most significant risk factor for substance use in the host country is prior consumption in the home country. Refugees may use substances that are traditionally consumed by their ethnic or national group. The kind of substance refugees prefer, is, to a certain degree, connected to their country of origin and is influenced by the lifestyle, the cultural convictions and the values of the ethnic group.

Refugees may not only continue the patterns of substance use they brought with them from their home countries, but they may intensify them (e.g. khat use amongst Somalis in England, where the substance is taken in larger amounts than in Somalia; *see* Chapter 5). Restrictions on traditionally used substances in their home country may no longer apply in the country of resettlement: the self-medication motive may lead to the use of substances in larger amounts than the usual quantities consumed.^{52,53}

Many refugees originate from countries without the traditions of alcohol or cannabis use found in the west.⁵³ The perceived permissive socio-cultural norms in the host country concerning the use of, particularly, these two substances, render new immigrants vulnerable to their use. During the acculturation process, refugees may adapt to patterns of substance use that are culturally accepted in the host country,^{49,51,52} especially where some substances are widely available. Those who originate from cultures in which substance use is taboo are not acquainted with the risks and have not been educated to deal with them, and are also vulnerable to use escalating to a problematic level.

Protective factors

Despite the vulnerability of many refugees to substance use, several protective factors need to be taken into account. First, they may not want to jeopardise their residence permit by risking being discovered using drugs, and asylum seekers may not use drugs because they want to be considered 'good citizens' in order to obtain a residence permit. Secondly, those who acculturate less, and maintain a protective cultural identity⁵⁵ according to which substance use should be rejected, are at lower risk of substance use. A third protective factor exists if refugees follow a religion.⁵⁵ Many of the refugees interviewed by Fountain⁵¹ cited their religion as a reason for not using drugs, and among Muslims the prohibition of alcohol has a protective effect on those who are devout.⁵⁶ Fourthly, some social factors protect against drug use, such as inclusion in peer groups, positive social contacts, and lasting relationships with people from the home country and new relationships forged with members of the host country's population.^{55,56}

Conclusion

Using empirical data, this chapter has demonstrated that many refugees suffer from pre-migration and post-migration losses. Many have suffered severe trauma in their home country, including solitary confinement, imprisonment, torture, the murder of their families and friends, and war. In their host country, refugees suffer from the additional losses of cultural resources, loved ones and the extended family, social status and future perspectives. Based on COR theory, which emphasises the significance of resource loss, it has been shown that refugees are therefore subject to major stress.

In order to deal with stress and its negative impact on mental health, coping strategies are developed. However, the nature of these strategies (active–approach vs. passive–avoidant) will depend on the individual's situation and personal characteristics. Based on three characteristics (few resources, low controllability and/or low self-esteem) of life in exile, this chapter has argued that refugees are vulnerable to adopting passive–avoidant coping strategies because they have few resources at their disposal to counter the loss of resources. Consistent with the self-medication hypothesis, it has been argued that substance use is a plausible example of a passive–avoidant coping strategy.

In order to clarify the situation with regard to substance use among refugees, a better understanding of how and why refugees adopt coping strategies is needed.⁵⁴ The author is currently empirically testing the relative importance of the different elements of the theoretical model in the evolution of patterns of substance use. These elements will be studied in a multidimensional model that accounts for pre-migration trauma, post-migration stress, adaptation to patterns of use in the host country (acculturation), intensification of patterns of use from the home country, and the availability of substances in the host country. The relative importance of these elements in determining refugees' adoption of substance use as a coping strategy will be addressed. The general theoretical model will be tested by means of a case study of Iranian asylum seekers in Belgium. Because of their particularly stressful status compared with refugees, only asylum seekers and those without a residence permit will be interviewed. The aim of the study is to identify the most important factors that influence the evolution of patterns of substance use, and to examine the impact of those factors. On a theoretical level, the relative importance of these factors will be clarified in order to identify the most important risk factors for substance use among all refugees.

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