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Language Barriers and Expressive Arts Therapy with Refugees:

A Literature Review

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Abstract

Recent decades have seen a precipitous increase in global forced displacement. Events such as the 2015 Syrian refugee crisis have put a spotlight on the arduous and life threatening journeys forcibly displaced people take to try to reach safety and have also begun raising awareness about the psychological needs of forcibly displaced people. Because of experiences before, during, and after migration, refugees frequently have elevated levels of PTSD, depression, and other mental health symptoms. However, mental health service utilization by refugee populations in various host countries tends to be low. This literature review examines existing research on the barriers to mental health services faced by refugees, with a particular focus on language and explores how expressive arts therapy can be used to mitigate linguistic barriers in mental health treatment. Literature on the use of the creative therapies with refugees reports positive outcomes, including a reduction in post-traumatic stress symptoms, increase in resiliency and evidence that the arts foster empowerment and transformation with refugees. However there is a need for more research that specifically focuses on the impact of creative therapies on linguistic barriers when working with refugees. Despite the dearth of research, it is possible to extrapolate from the broader literature on the field of creative arts therapies to make inferences about how expressive arts therapy could be used as a tool to address issues of language in treatment with refugees.

Keywords: refugee mental health, language barriers in therapy, spoken language interpreters and therapy, arts and communication, expressive arts therapy and refugees, trauma-informed expressive arts therapy

Language Barriers and Expressive Arts Therapy with Refugees: A Literature Review

Introduction

Recently displaced refugees face a unique and overlapping set of experiences that can cause psychological distress. In addition to the experience of being immigrants in a new country and community, refugees may also be coping with the physical and psychological impacts of the events that caused them to leave their homes, the migration journey, and the ongoing stressors of the integration process (Forrest-Bank et al., 2019). Annous et al., (2022) highlight the prevalence of post traumatic stress disorder (PTSD), depression, and anxiety disorders among refugees, for whom therapeutic and mental health interventions are a crucial need. The trauma experienced by recently displaced refugees is multidimensional and complex. Rubesin (2018) sheds light on the paradigm of “triple trauma” (pg. 35) where trauma may be experienced by refugees in three stages: trauma of leaving the country of origin; trauma of the migration journey; and trauma of the relocation and resettlement process (Rubesin, 2018, pg. 35).

Complex PTSD, somatoform disorders, adjustment disorders, and acculturative stress are some of the many pervasive mental health disorders that can cause prolonged disruptions to the daily lives of recently displaced peoples (Im et al., 2020). Certain refugee community groups, like women, children and adolescents, and people with already existing physical or mental illness, are more vulnerable to migration stressors. Differences in domestic roles and gender expectations as well as high prevalence of experiencing or witnessing sexual violence make refugee women more susceptible to developing mental health problems (Rubesin, 2018, pg. 22). Studies also indicate that refugees fleeing war-affected regions consistently report severe mental health concerns and experience trauma, which has a detrimental impact on their physical and

mental well being, creating an urgent need to address mental health needs of conflict affected populations (Schwartz et al., 2022).

In recent years, a drastic uptick in forced displacement and migration has shed light on the need for mental health services for refugees. Efforts to raise awareness around the acute impact of pre and post-migration stressors have led to an increase in services designed specifically to address refugee mental health needs globally. The inclusion of mental health and psychosocial support for refugees as one of the primary responsibilities of international host communities in the United Nations High Commissioner for Refugees (UNHCR) global compact on refugees in 2018 is a big step towards the prioritization of mental health needs of recently displaced peoples (UNHCR, 2018). Refugee resettlement agencies, non-profit organizations, volunteer groups, school social workers, and counselors now provide a range of services to aid refugees during the integration process, including individual and group mental health services (Forrest-Bank et al., 2019). However, given the unique needs of refugees and the dearth of resources set aside for displaced populations in many host countries, there are multiple barriers to the use of mental health services by refugees in diverse contexts.

Bawadi et al. (2022) call attention to low mental health service utilization by recently arrived Syrian refugees despite high prevalence of trauma, social isolation, and other pre- and post-migration stressors in a study that describes the state of the Jordanian health care system, which has a very small number of psychiatrists and counselors. Islam and Mozumdar (2021) highlight the specific emotional and mental health problems experienced by Rohingya refugees and the challenges of providing quality mental health treatment to Rohingya refugees given the shortcomings of humanitarian service infrastructure in Bangladesh. In an investigation of mental health treatment for refugees in Canada, Huminuik et al., (2022) note that, despite high

prevalence of mental health problems, refugees in Canada use mental health services at a much lower rate than the general population due to barriers to accessing public health systems. In each of the above studies, language differences are highlighted as one of the most significant barriers to the use of mental health services by refugees.

Linguistic and cultural differences involved in working with refugees in diverse contexts requires mental health service providers to build an awareness of the specific challenges that may arise in treatment and incorporate strategies to mitigate these barriers in their interventions. Language barriers may also increase anti-newcomer sentiment amongst host communities and further exacerbate mental health problems by preventing refugees from accessing health services, social support, housing and education services, and employment opportunities (Rubesin, 2018, pg. 38). The drastic rise in displaced populations globally has created an increasing need for non-verbal psychological interventions like arts based therapy to treat trauma. Existing research on the use of creative arts in mental health treatment highlights the efficacy of expressive arts therapy in reducing symptoms of trauma and anxiety and increasing self-confidence and resilience in refugees (Kalmanowitz & Ho, 2016; Beck et al., 2016; Kalaf & Plante, 2019). However, while arts-based interventions are considered to be a promising treatment for trauma in refugees, there is a need for further research specifically on the interplay between expressive arts therapy and language barriers encountered when working with refugees.

In this capstone thesis, the author will synthesize findings from a literature review that highlight the historical and current contexts of refugee mental health needs, provide a deeper understanding of the ways in which language barriers impede treatment, and explore the impact that expressive arts therapy can have on language barriers when working with diverse refugee populations. Given the author's interest in working with forcibly displaced people, immigrant

communities, and refugees in different countries, the concern about language differences as a barrier to mental health care is paramount. Through a literature review and analysis of current research the author aims to understand the ways in which language differences impact mental health treatment with refugees and examine if expressive arts therapy can be used to reduce these barriers and create more avenues for communication in therapy. In this paper the author will seek to answer the question: What is the meaning of expressive arts therapy on language barriers when working with diverse refugee populations?

Method

The author used the Lesley University Library to gain access to a range of databases including ProQuest Central, EBSCOHost, ERIC, and Elselvier among others. Literature was also gathered using Google Scholar. To gather data the author used key search terms including: refugee mental health; language barriers in therapy; spoken language interpreters and therapy; arts and communication; expressive arts therapy and refugees. Data were primarily gathered from peer reviewed journals and academic books. Policy notes and published reports by the United Nations Refugee Agency UNHCR, and International Non-Governmental Organisation (INGO) reports on the mental health needs and psychosocial support programming specific to refugees in various contexts were also used to collect relevant data. Inclusion criteria was limited to studies and reports that were published within the past fifteen years; quantitative and qualitative studies, including arts based participatory research; and studies that are in English, including foreign language publications translated to English. Articles from open source search engines like wikipedia, any studies conducted more than fifteen years ago, and studies that are not available in English were excluded from this review. After gathering relevant articles the

author conducted an inductive analysis of the key findings and data collected and recorded repeating themes and unique outcomes that emerged from the literature.

Literature Review

Background Context

According to the UN refugee agency UNHCR, as of mid 2022 there were an estimated 103 million forcibly displaced people worldwide, of which 27.1 million were refugees, half of whom were under the age of 18 (UNHCR, 2022). The 1951 Refugee Convention defines a refugee as:

> "someone who is unable or unwilling to return to their country of origin owing to a well-founded 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; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it." (UNHCR,1951, p.14).

While migration due to forced displacement is not a modern day phenomenon, the large number of refugees undertaking arduous and life threatening journeys to arrive in Europe in efforts to flee from violence and persecution in Syria, caused a new wave of global attention to refugees in 2015 (Fonkem, 2020). Due to religious and ethnic persecution, economic crises, political violence, war, natural disasters, and climate change, human migration across international borders continues to grow (Rubesin, 2018; UNHCR, 2022). The persecution of the Rohingya in Myanmar, economic and political violence in Venezuela, conflict in South Sudan, decades of conflict in Afghanistan, the continuing impact of the war in Syria, and the ongoing

war in Ukraine are a few among the major global events currently driving widespread displacement around the world (UNHCR, 2021). The ongoing war in Ukraine alone has led to more than 7.8 million refugees in the past year (UNHCR, 2022). Per the United Nations Children's Fund (UNICEF), nearly five million – or more than half – Ukrainian children have left their homes as internally displaced persons (IDPs) and refugees (UNICEF, 2022). As large-scale humanitarian crises continue to drive the increase in forced displacement, attending to the mental health needs of refugees has garnered more attention (Mattar et al., 2023).

Over the past few decades there has been considerable progress made in the attempt to formulate and implement models of mental health and psychosocial support (MHPSS) services to refugee populations (Jones & Ventevogel, 2021; Silove, 2021; Fine et al., 2022). Jones and Ventevogel (2021) highlight efforts to improve mental health coverage for those affected by humanitarian crises, including the Inter-Agency Standing Committee (IASC) Guidelines for Mental Health and Psychosocial Support in Emergency Settings intended to support humanitarian aid workers in managing coordinated responses to address MHPSS needs during complex emergencies. In addition, the World Health Organization (WHO) and UNHCR's Mental Health Gap Action Programme (mhGAP), aimed at reducing the gap in global treatment for mental health conditions, offers evidence-based practices for assessing and treating mental health disorders among conflict affected populations (Fine et al., 2022). While there is a need to continue to develop and implement quality mental health services for diverse refugee populations, the recognition of mental health as a major component of humanitarian responses to refugees and the inclusion of MHPSS within official policy documents and guidelines (Jones & Ventevogel, 2021) is a positive step towards acknowledging the importance of mental health needs in the face of a growing global crisis.

Refugee Mental Health

Refugees from diverse backgrounds have varied experiences based on their historical, cultural, geopolitical, and socioeconomic contexts. However, they also share unique experiences such as: being civilians without self-protection resources and enduring immense personal, material and symbolic losses, including loss of family members, homes, profession and education (Javanbakht, 2022). Refugees also experience the cumulative impact of pre-migration trauma and ongoing psychological distress, economic hardship, and discrimination after displacement, which heightens their need for quality mental health care (Javanbakht, 2022). Refugees are disproportionately affected by trauma, and research indicates higher levels of mental health symptoms like PTSD, anxiety, and depression in refugees than the general population (Abdi et al., 2022; Huminuik et al., 2022; Silove, 2021;).

There has been extensive research showing elevated rates of common mental health disorders and PTSD among refugee populations in recent years. Fine et al., (2022) highlight findings from a systematic review of mental health among conflict affected populations that found that more than one in five refugees from different humanitarian crises suffer from mental health illnesses, an estimate that is commonly reported and known to be considerably higher than the global average. However, rates of mental health illnesses reported in refugees also vary widely based on the country of origin, level of pre-migration stress, and the migration experience, with prevalence ranging from 3% to 86% for PTSD and 3% to 80% for major depressive disorder (Terasaki et al., 2015; Im et al., 2020). Because of the increased exposure to trauma, stress, and risk factors associated with PTSD and depression, many refugees also meet the criteria for more than one mental health disorder, which can often lead to or be compounded by physiological sickness as well (Terasaki et al., 2015).

Triple Trauma

Terasaki et al., (2015) used the framework of “triple trauma” (p.1045) to elaborate on the complex experiences that make refugee populations more vulnerable to developing mental health disorders. The first kind of trauma may occur due to pre-migration stressors or trauma experienced in the country of origin including: witnessing or experiencing violence, persecution, or torture; famine; disease; gender based violence and discrimination; experiencing loss of possessions or loved ones; and any pre existing physical and psychological conditions. Migration and refugee camp trauma, the second phase, refers to experiences related to the journey of escape/immigration. This includes fear of death or capture, lack of resources, including food, shelter, water, and sanitation, and separation from family or loved ones. Migration and refugee camp trauma may also include experiences of physical or sexual assault and disease and sickness that can exacerbate mental health symptoms. For many refugees, the migration journey and temporary stay at refugee camps or an intermediary country as they await permanent resettlement can span several years, or even decades, during which they may be exposed to uncertainty, deprivation, and more violence (Terasaki et al., 2015).

The third stage is the trauma of post-migration and resettlement that encompass issues experienced by refugees once they are resettled in host countries including: social isolation; financial, housing, and employment issues; language barriers; loss of social status; survivor’s guilt; loss of identity; and discrimination due to anti-newcommer sentiment, racism, and religious prejudice prevalent in the host country (Im et al., 2020; Rubesin, 2018; Terasaki et al., 2016). Additionally, war-related stress via exposure to news, legal procedures, and worries about family members still residing in conflict areas can cause high levels of psychological distress during the resettlement process (Javanbakht, 2022). Resettlement and post-migration stressors

exacerbate trauma symptoms faced by refugees, and studies suggest that post-migration stressors can often have more devastating impacts on mental health than pre-migration trauma (Im et al., 2020). At this stage, linguistic differences play a major role in contributing to stress as they permeate into all aspects of life in a new country and increase the level of difficulty and frustration when navigating structural and cultural differences (Huminuik et al., 2022). Along with being associated with heightened levels of PTSD, post-migration and resettlement stressors also contribute to several barriers to accessing mental health services provided to refugees in host countries.

Barriers to Mental Health Services

Despite the high prevalence of mental health disorders in refugee populations, several studies show that mental health service utilization by refugees remains very low (Bawadi et al., 2022; Huminuik et al., 2022; Im at al., 2020; Rubesin, 2018, pg. 36). This is due to several barriers that prevent or hinder refugees from accessing mental health services. There is extensive research documenting the different barriers to seeking help for mental health problems among refugees, (Byrow et al., 2020) which can be organized into two key categories: Structural barriers; and refugee-specific cultural and linguistic barriers.

Structural Barriers

Refugees new to a host country face several logistical and structural challenges that impact their ability to access mental health services. This includes lack of access to transportation to and from camps to service clinics, medical costs, and difficulty understanding and accessing the health care system. Further, problems with continuity of service, ongoing immigration concerns, and lack of time to receive mental health support due to prioritization of

meeting basic survival needs like housing, food, and childcare create additional challenges for refugees (Im et al., 2020; Huminuik et al., 2022; Byrow et al., 2020).

Adams and Kivlighan (2019) conducted a qualitative study that highlights elements refugees feel are missing from mental health services including the lack of practical help finding employment, language education, literacy training, and access to basic health care. The authors note that the most salient challenges reported by refugees were psychosocial barriers outside the clinical setting (Adams & Kivlighan, 2019). Through a systematic analysis of literature on barriers to refugee mental health, Byrow et al., (2020) found that structural and systemic barriers have a significant impact on help seeking behaviors especially in the case of refugees displaced from lower and middle income countries who have fled with limited material possessions and financial resources and have high levels of unmet basic needs. The experience of navigating government policies, finding employment or education in a country where previous qualifications are not recognized, and a lack of familiarity with appropriate services available can create low incentive for refugees to seek out mental health services (Byrow et al., 2020).

Issues of language further complicate refugees' ability to effectively understand legal systems, find gainful employment, or advocate for their physical and mental health needs (Byrow et al., 2020). Rubesin (2018) highlights opportunities for language acquisition training as a protective factor for refugee mental health. For refugees in a new country, the issue of language barriers is a motivator to seek opportunities for language acquisition as a way to mitigate some post-migration stress and increase accessibility. However, language education for refugees is often hindered by lack of language services offered by host communities, time needed for language education, and cultural and gender related factors that impact decisions around formal education (Rubesin, 2018). Studies on barriers to refugee mental health are consistent with

broader research that indicates that structural barriers are a common impediment to help-seeking in low-income communities. For refugees, structural barriers are just one of the many factors affecting access to mental health care.

Poor Reception and Integration Services

Refugees in many parts of the world are met with hostility and face social and political discrimination, racism, and prejudice that can add to feelings of distrust towards medical and mental health services offered in the host country (Im et al., 2020). The lack of investment in reception and integration services in host countries adds to the structural barriers faced by refugees. Mental health services for refugees in host countries are often understaffed and service providers lack training and clinical supervision that is important when working with trauma affected refugees (Bawadi et al., 2020; Islam & Mozumdar, 2021; Mattar et al., 2023). In a phenomenological study of the challenges of providing quality mental health treatment to Rohingya refugees in camps in Bangladesh, Islam and Mozumdar (2021) highlight results that show critical concern for lack of clinical experience and supervision for providers, inadequate training on dealing with language differences, and inadequate ethical standards followed by mental health practitioners. Bawadi et al's., (2020) qualitative study on help seeking behavior among refugees in Jordan revealed that despite the large numbers of Syrian refugees in Jordan, there is a dearth of psychiatrists and mental health workers, with only an estimated two psychiatrists per 100,000 residents. The lack of psychiatrists and nurses is especially an issue when coupled with state policy that restricts other mental health professionals from prescribing medication, providing diagnoses, and making referrals for treatment (Bawadi et al., 2020; Im et al., 2020).

Lack of Training

Mattar et al. (2022) argue that the lack of training among mental health providers working with refugees is a major barrier to refugee mental health. Counselors and service providers working with refugee populations should have in-depth knowledge of the institutional and systemic barriers faced by refugees, understand immigration and acculturation processes, and acknowledge sociopolitical dynamics of resettlement that often mimic systems of racism and oppression. Specialized training that focuses on cultural responsiveness, trauma-informed approaches, and the ability to contextualize refugee struggles using global mental health delivery considerations is often lacking. As a result, mental health counselors tend to overpathologize refugees, ignore structural inequalities, and cause harm to refugee communities by reinforcing oppressive power dynamics in treatment (Mattar et al., 2022). Working with counselors who lack an understanding of socio-cultural dynamics and the specific needs of refugees can exacerbate feelings of being disrespected, disconnection, distrust, and cultural isolation that can discourage refugees from seeking mental health support (Mattar et al., 2022). To understand refugees' help-seeking behaviors, it is important for providers in host countries to show cultural humility and learn about historical contexts, potential stigma attached to mental health, gendered considerations, religious or spiritual influences, and non-Western ways of attending to mental health concerns (Im et al., 2020; Rubesin, 2018). Cultural humility, flexibility, and quality supervision are especially important for providers working across cultural and language barriers.

Cultural and Linguistic Barriers

Stigma

In a meta-analysis of barriers to mental health care among refugees, Byrow et al. (2020) found that help-seeking behavior across refugee populations is influenced to a great extent by personal and communal perceptions about the causes of mental health problems and attitudes

towards treatment. Studies on refugee attitudes towards mental health treatment highlight cultural stigma against mental health as a major factor that impacts help-seeking behavior (Abdi et al., 2020; Huminuik et al., 2022; Mattar et al., 2020). While stigma attached to mental health affects the general population as well, when coupled with refugees' sense of loss of identity and status, and troubles navigating structural barriers to accessing basic needs, stigma and shame about mental illness can increase the resistance to seeking mental health support despite the presence of acute symptoms. Stigma attached to mental health remains one of the most commonly cited reasons for low mental health service utilization among refugees. However, Shannon et al. (2014) also highlight the importance of looking beyond stigma to understand how factors like political repression, shame, fear of being persecuted, isolated, or hospitalized, and the belief that talking cannot help cure mental health pressures affect the ways in which refugees communicate about mental health problems.

Gender Norms

Perceptions of privacy, communal living, and gender roles also impact help-seeking behaviors in refugees from different communities. In a study on barriers affecting mental health service utilization by Syrian refugees in Jordan, Bawadi et al. (2022) found that stigma and stereotypes attached to mental health had a significantly larger impact on refugee women, who expressed concerns over privacy and having to hide their treatment from their husbands. Women are often more susceptible to issues that lead to social stigma, like sexual assault, genital mutilation, or domestic violence (Rubesin, 2018, pg. 56). Refugee women who have experienced gender based violence may feel intensified physical and mental health repercussions, yet refrain from seeking support related to abuse because of distrust, gender roles, and shame (Rubesin, 2018, pg. 22). Some refugee survivors of sexual assault feel the severity and scope of sexual

violence is too large to begin to express and fear that they will be blamed for their traumatic experiences (Shanon et al., 2014). Refugee women in Western countries also fear being misunderstood due to cultural differences in certain disclosures, like the use of corporal punishment with children, or traditional gender norms that may be seen as oppressive in Western cultures. For counselors working with refugees it is especially important to understand gender and cultural norms and contexts to minimize potential harm caused by the imposition of Western standards and perceptions around justice, empowerment, and healing (Knapp & VandeCreek, 2007; Abdi et al., 2022).

Collectivist Culture

Refugees from collectivist cultures worry about how negative perceptions around mental health could impact both them and their families, leading to heightened levels of self-stigma, social pressure, and exacerbation of symptoms (Bawadi et al., 2022; Byrow et al,. 2020). Western models of medicine and mental health care that focus on individual approaches to treatment may not feel appropriate for refugees whose trauma is interconnected with collective community experiences and goes beyond individual suffering (Im et al., 2020). It is important for providers to spend time understanding cultural nuances around communication about individual suffering and perceptions about healing to serve refugee communities effectively. Strategies like involving community leaders in mental health service processes and diversifying treatment styles to incorporate non-Western concepts of healing can help to encourage help-seeking behavior (Abdi et al., 2022). However, the structural barriers discussed above work in parallel with cultural factors that lead to feelings of mistrust and further stigmatization of mental health treatment. At the same time, issues of linguistic difference create more roadblocks for refugees trying to navigate structural and cultural factors in a foreign country.

Language Barriers

Language differences between refugees and mental health service providers in host countries are widely reported as one of the major barriers to refugee mental health. Several studies addressing the barriers to mental health services for refugees highlight language barriers as a significant challenge that impacts refugee help-seeking behavior (DeSa et al., 2022; Huminuik et al., 2022; Mianji et al., 2020; Torres Stone et al., 2020). When working with diverse refugee populations, the challenge of language is nuanced and intertwined with cultural factors that affect refugee perceptions of mental health care. Issues around language differences are felt by refugees in their daily lives in new host countries and can often lead to further social isolation, feeling misunderstood, and frustration when trying to access public services (Huminuik et al., 2022; Rubesin, 2018).

Language Interpretation and Stigma

When it comes to accessing mental health services, the challenge of language is an especially important consideration. Refugees already dealing with structural barriers, concerns about stigma, and cultural isolation may find it very hard to describe their mental health symptoms to practitioners who do not speak their language. In several cultures the term “mental health” is often associated with negative connotations like “crazy” or “abnormal”, and people suffering from mental illness are shamed and isolated from their communities (Byrow et al., 2020). Terms used by providers trained in Western models of mental health may not have equivalent words in other languages. When directly translated, some terms used by Western mental health providers, can have stigmatized meanings in other languages that can discourage clients from seeking support (Im et al., 2020; Torres Stone et al., 2020). The difficulties involved in communicating about mental health symptoms, perceiving treatment objectives, and

understanding concepts such as depression and PTSD across linguistic and cultural barriers can discourage refugees from seeking support despite having acute mental health needs (Torres Stone et al., 2020).

Treatment Planning and Communication

Mental health assessments, diagnosis, and treatment planning depend heavily on communication and the development of a trusting relationship between the client and mental health professionals (Torres Stone et al., 2020). Additionally, treatment compliance and ethical standards in providing mental health care, including patient confidentiality and informed consent, can be impacted significantly by language barriers (Mianji et al., 2020). In a systematic review of literature on barriers to access to mental healthcare for refugee women in high income communities, DeSa et al. (2020) found that due to a limited grasp of English, refugees expressed difficulties understanding health systems and mental health terminology, which hindered appointment scheduling and ability to participate effectively in services. As a result, mental health and medical providers working with refugees often have to rely on spoken language interpreters to assist in communicating with refugees. However, using the services of language interpreters is not always ideal due to issues of confidentiality, lack of training, and breaches of trust (Dubus, 2016).

Use of Spoken Language Interpreters

Due to a shortage of culturally and linguistically diverse mental health providers, practitioners in host countries working with new immigrant and refugee clients often need to use spoken language interpreters (Wright, 2014). The presence of interpreters can help to bridge language and cultural gaps and improve client-therapist engagement. However, working with interpreters raises a number of ethical challenges including lack of interpreter supervision,

boundary crossing, and potential breaches of trust and confidentiality (Mianji et al., 2020; Torres Stone et al., 2020). While some refugees prefer working with language interpreters from their community, others worry about breaches in privacy and fear of stigmatization when working with interpreters who share their cultural identity (Byrow et al., 2020; Mianji et al., 2020).

Mistrust. Shannon et al. (2014) conducted a participatory-action research project to explore the experiences of refugees from four different cultural groups in which refugees identified mistrust of interpreters as a factor that restricted their ability to discuss mental health issues openly. Refugees worried about private matters becoming gossip in the community, and some feared that local community interpreters would relay personal information to authorities that could endanger their family (Shannon et al., 2014). Some refugees fleeing persecution resented the assumption that shared language between clinicians and interpreters leads to shared socio-political experiences, values, and beliefs (Humunuik et al., 2020).

In their research on the outcomes of refugees working with counselors in their first language in Canada, Huminuik et al. (2020) found that trust building between refugee clients and clinicians from the same background took a lot of time. Many refugees initially expressed that it is easier to discuss mental health outcomes with clinicians who are not from their country of origin because they were perceived to be less biased and more capable of providing safe and confidential care (Humunuik et al., 2020). Several studies reported that refugee clients working with interpreters are often frustrated and feel that they receive less attentive care from providers, do not trust that what they are saying is being translated accurately, and the presence of interpreters interferes with the therapist-client interaction, especially when discussing sensitive topics (Doğan et al., 2019; Mianji et al., 2020; Shannon et al., 2014).

Lack of Interpreter Training and Supervision. Research highlights that without adequate training, supervision, and focus on trauma informed considerations, interpreters can negatively impact refugee participation in mental health treatment (Doğan et al., 2019; Mianji et al., 2020). Several studies on refugee mental health interventions call for the use of trained, trauma informed, bilingual clinicians and interpreters who can bridge language gaps and act as cultural brokers by using their knowledge about the community being served to advocate for their specific needs in mental health settings (Abdi et al. 2022; Dubus, 2016; Shannon et al., 2014). Despite multiple studies highlighting the barriers presented by language differences, there is a dearth of research on strategies that can be used to minimize the issue of language in mental health treatment. Given the complex mental health needs and compounding challenges faced by refugees, it is important for providers to develop creative solutions and expand the scope of mental health services beyond traditional talk therapy interventions.

Expressive Arts Therapy with Refugees

Arts-based interventions have been used in therapy with refugees to foster resilience, explore trauma narratives, increase self-worth and empowerment, and build community (Kalaf & Plante, 2019; Kalmanowitz & Ho, 2017; Rubesin, 2018, pg. 70). Expressive therapies or creative arts therapies, apply the use of music, dance/movement, art, drama, and poetry/creative writing within the context of counseling and psychotherapy, rehabilitation, and health care (Malchiodi, 2005). In recent years, the expressive therapies have been highlighted among best practices for refugee mental health as they increase options for clients to engage with mental health interventions, develop coping tools for anxiety, stress, trauma and depression, and increase social engagement, self-awareness, and resilience (Rubesin, 2018, pg. 73).

Building on the use of creativity and creative arts in psychotherapy, expressive arts therapy proposes the use of an interdisciplinary or multimedia approach that invites clients to engage in all forms of creative expression as a tool for reflection, therapeutic connection and cathartic healing (Richardson, 2015). The field of expressive arts therapy is founded on the commitment to move away from arts practices based on specialization and instead create "a radically inclusive practice" (Estrella, 2019, pg. 28) that extends to the use of all art forms in therapy to provide individuals with avenues for self-expression and healing that can be leveraged as powerful tools for social change. The intermodal approach of expressive arts therapy has been generating more data highlighting its benefits in treating trauma (Hinz, 2009; Kossak, 2009; Malchiodi, 2005; Richardson, 2015). While there is a lack of research that specifically documents the use of expressive arts therapy or a multimodal arts approach with refugee populations, there has been an increase in literature that highlights the use of different creative arts therapies with refugees in recent years.

Art, Music, Drama, Poetry, and Dance in Therapy with Refugees

Using Imagination to Access Trauma

Kalmanowitz and Ho (2017), conducted a study to examine the effects of combining mindfulness meditation and art therapy practices when working with asylum seekers suffering from trauma. The authors used a social constructivist paradigm to design four day-long art therapy and mindfulness workshops that were conducted with twelve refugees from seven different communities at a studio in Hong Kong. Findings from their workshop highlighted the importance of using imagination to explore inflexible trauma responses, tendencies to avoid dealing with trauma memories, enhancement of resilience through mindfulness, and increase in self-worth and identity through autobiographical stories.

Music Therapy & PTSD

Beck et al. (2016) conducted a non-controlled pre-test-post-test pilot study in Denmark to assess the usefulness of guided imagery and music (GIM) in treating traumatized refugees. The pilot revealed significant results including overall reduction in PTSD symptoms ($p=0.002$), increase in sleep quality ($p=0.002$), and improvement of social functioning ($p=0.0007$). While Beck et al. (2016) highlight the benefits of music therapy with refugees, the authors also discuss the need for modified GIM that is aimed at stabilization and propose that using music from participant's home regions helps to avoid evocation and provide an experience guided by participants' expertise in their own culture.

Drama Therapy to Reduce Stress and Build Community

Landis (2014, pg. 305) highlights the unique outcomes of using trauma informed drama therapy techniques including mirroring, metaphor as a therapeutic tool, rituals, and fictional role play that incorporates trauma narratives when working with a group of newly arrived refugee women in New York City. Drama therapy groups with refugees were able to relieve distress associated with loss, alleviate tensions of being a minority in a new society, and increase integration and social adjustment by creating spaces to explore trauma narratives at a safe distance while encouraging creativity and allowing refugees to expand their role repertoires and imagine new possibilities (Landis, 2014, pg. 304). Drama therapy techniques of improvisation and playing with metaphors also set the stage for emotional regulation and foster community by inviting spontaneity into the therapeutic setting (Dieterich-Hartwell & Koch, 2017).

Creative Expression and Sense of Self

Hosseini and Punzi (2022) describe the therapeutic experience of narrative writing and poetry among Afghan unaccompanied refugee minors going through the resettlement process in

Sweden. The study examined the ways in which Afghan refugee youth used poetry and creative writing to feel a connection to their cultural traditions, express emotions, find connection in the new community, and feel a sense of recognition for their struggles (Hosseini & Punzi, 2022). Dieterich-Hartwell and Koch (2017) highlight the ways in which dance/movement therapy (DMT) concepts like embodiment integrate physical, kinesthetic and movement-based perspectives into mental health treatment that are especially beneficial in treatment for traumatized refugees. DMT is based on the theory of interconnectedness of body, mind, and spirit. By incorporating embodied practices into therapy with refugees, DMT helps to increase a sense of security, control and safety in one's body, and encourages authenticity and improved self-image (Dieterich-Hartwell & Koch, 2017).

Resilience

Kalaf and Plante (2019) examined the relationship between creative arts and resilience through a descriptive phenomenological study on the experience of ten Syrian refugee youth who participated in Art4lives, a pilot expressive arts workshop conducted over ten days in Lebanon. The primary goal of the workshop was to engage participants in a collaborative production of a short stop-motion animated movie on resilience. Participants reflected on adversity and resilience by engaging in art therapy and other forms of creative expression like drawing characters, story telling, collage making, and acting that inspired a collaborative storyline and script of the final movie. The workshop resulted in positive relationship building among participants, community engagement as a means to build trust and collective responsibility, and art making as a way to foster meaning and purpose. While highlighting the efficacy of expressive arts therapy in addressing symptoms of trauma and highlighting resiliency factors, the authors propose the need for cultural sensitivity when using expressive therapies with refugee youth from various regions.

It is evident in recent literature that the use of creative arts in mental health treatment for refugees has significant benefits. However, there are very few studies that directly explore the ways expressive arts therapy can be used to address cultural and linguistic barriers faced by refugees in treatment. To understand how expressive arts therapy impacts language barriers in therapy with refugees, it can be beneficial to look at how the expressive arts impact language and communication in other mental health settings.

Expressive Arts Therapy and Communication

Arts as a Preverbal Language

Dieterich-Hartwell and Koch (2017) write that "creative arts therapies with their attention to preverbal language—music, imagery, dance, role play, and movement—are able to reach individuals through the senses and promote successive integration, which can lead to transformation and therapeutic change" (pg. 1). Expressive arts therapies – art, music, drama, dance, poetry, and play therapy – are among the few somatic trauma-focused approaches to treatment that have drawn on ancient practices that predate contemporary mental health treatment (Estrella, 2019; Richardson, 2016). Ancient indigenous cultures have used the arts, song, dance, painting, and storytelling as a way to celebrate joyous moments, grieve losses, and build healing connections with oneself, the community, and nature (Rogers, 1993, pg. 48). Modern day expressive arts theorists have drawn on these ancient practices and emphasized the need for both the client and therapist to listen deeply to communication from the client's inner creative impulses as a way to build a strong client-therapist relationship and create a safe environment for healing (Kossak, 2009; Rogers, 1993).

Accessing the Unconscious

Rogers (1993) states that through using several expressive modalities, we are "led…into the unconscious...[which] allows us to express previously unknown facets of ourselves, thus bringing to light new information and awareness" (pg. 8). Landoni (2019) presents research that highlights the non-verbal aspects of expressive arts as best practice when working with survivors of trauma. Because experiences of trauma can impair verbal and declarative memory, somatic-based treatments allow trauma survivors to communicate information retained in their body through non-verbal modes (Landoni, 2019). The use of creative arts, then, not only helps clients to communicate effectively without the need for spoken language but also creates access to internal and unconscious feelings that can be explored in the therapeutic setting.

Concretizing Trauma Memories

Dieterich-Hartwell and Koch (2017) discuss the benefits of using non-verbal therapies specifically with refugees who have experienced trauma, for whom the creative arts serve as a "temporary home" (pg. 10). The creative arts therapies provide refugees with the opportunity to explore emotions through symbolic language and integrate it into therapy while maintaining a sense of cultural identity, aesthetic distance, and control over their trauma narrative. Creative arts therapy can help to build a safe container and a bridge for their mental health treatment by incorporating ritual, inviting cultural artistic influences into therapy, and allowing for the concretization and externalization of traumatic memory or emotions without fully depending on expression through verbal and spoken language (Dieterich-Hartwell & Koch, 2017).

Arts as a Catalyst for Conversation

In an arts based participatory research study with Karen refugee women from Burma, Rubesin (2018), found that the expressive arts often served as a catalyst for non-directed conversation and disclosures related to mental health concerns. For instance, Rubesin (2018)

highlights how movement-based introductory activities led to disclosures of physical pain, issues of age and the body, social isolation, financial stress, and depression among the women, who expressed enjoying arts based warm ups despite initial hesitation and self-doubt. Rubesin (2018) used key theories of expressive arts therapy like the expressive therapies continuum which states that different properties of various artistic mediums can be used to elicit emotion and structure for a therapy session (Hinz, 2009). The use of the expressive therapies continuum framework with refugees helps to create stability and safety before engaging clients in more cognitive or symbolic art making (Rubesin, 2018). In this way expressive arts therapy moves beyond the mere inclusion of arts activities in therapy and creates a more comprehensive approach to that uses the aesthetic, symbolic, active, empowering, and communicative qualities of creative arts to broaden the scope of therapeutic practice and build a container in which non-verbal expression can help to foster stronger therapeutic alliances despite the existence of multiple barriers to treatment.

Discussion

The above literature review sought to make an inquiry into the ways in which language barriers impact refugee mental health and examine if expressive arts therapy can be used as a tool to bridge linguistic differences when working with diverse refugee populations. Literature on refugee mental health highlights the need and importance of quality mental health practices to serve refugees who have suffered from traumatic experiences (Im et al., 2020; Rubesin, 2018; Terasaki et al., 2015). Over the years, there has been an increase in literature that elucidates how refugees around the world are impacted by complex trauma, making them increasingly vulnerable to mental health issues. What stands out from these studies, however, is the low mental health service utilization by refugees globally, despite the existence of acute needs. It is

clear from the literature that assessing refugee mental health requires a deep inquiry into the various barriers that impact help seeking behavior among refugee populations. While several studies indicate the various barriers to refugee mental health, it is evident that issues around language permeate into all stages of the post-migration experience, exacerbating the impact of structural, cultural, and socio-political issues faced by refugees.

Pervasive Language Barriers

Literature on refugee mental health, barriers to help seeking behavior, and mental health interventions with refugees, report linguistic differences as a major challenge for providers and refugee clients (DeSa et al., 2022; Huminuik et al., 2022; Mianji et al., 2020; Torres Stone et al., 2020). The literature highlights how language does not exist in isolation, but is also a factor contributing to other barriers to refugee mental health. When reporting on structural barriers, including access to medical treatment, transportation, and problems with economic and financial opportunities, several studies highlight the lack of access to language acquisition courses and linguistic issues when navigating systems in the host country as major challenges faced by refugees (Byrow et al., 2020; Huminuik et al., 2020; Im et al., 2020; Sá et al., 2022). Byrow et al. (2020) report that linguistic barriers that cause difficulty in finding employment, financial stress, and lack of professional interpreters are major factors contributing to higher suicide rates among Bhutanese refugees in the United States, indicating that linguistic differences not only prevent refugees from seeking mental health treatment but can also exacerbate trauma symptoms and post-migration stress.

Linguistic differences also play a role in contributing to stigma and cultural misunderstanding around mental health. It is important for mental health providers to understand different cultural beliefs around mental health. Terasaki et al.(2015) call on providers to find

alternative ways to discuss symptoms and treatment that do not rely solely on formal medical language and diagnosis, which are often associated with “being crazy”. For instance, inquiring about sleep can be a non-threatening way to make further inquiries on trauma related nightmares, worries, and sadness (Terasaki et al., 2015). Terasaki et al., (2015) write that “communication can be tricky at times when unintended linguistic nuance can lead to a misunderstanding, even with a professional interpreter” (pg. 1046). Language barriers also make it difficult for refugees to build relationships with mental health providers and interpreters, which can cause additional feelings of doubt and mistrust, especially in Western mental healthcare settings (Im et al., 2020). Despite the evident pervasiveness of language barriers in multiple facets of the refugee experience that contribute to experiences of post-migration trauma, there is a dearth of research that directly addresses this issue.

Spoken Language Interpreters as the Only Solution?

While language barriers are major factors impacting refugee mental health, there is an insufficient number of studies that directly address ways to overcome or minimize these issues. Many studies present the use of spoken language interpreters in therapy with refugees as a way to overcome issues of language. However, research suggests that the use of interpreters is often complicated by structural and cultural factors, like lack of professional training and supervision, and refugee fears related to lack of confidentiality and privacy (Shannon et al., 2014). The use of an interpreter in therapy with refugees can create more distress when done without cultural sensitivity, training, and consideration for structural and cultural issues faced by refugees within and outside the mental health setting.

Mianji et al., (2020) write that “the challenge of translation is not resolved simply by speaking the same language but depends on being deeply informed in cultural understanding of

the patient's narrative. This requires that interpreters play the role of culture brokers, providing the missing context to make sense of patients' accounts" (pg. 504). There is a need for more investigation into how language interpreters can be used as cultural brokers to enhance the therapeutic relationship and minimize language barriers. The complexities around language also create an urgent need to conduct an inquiry into other strategies that can be used to provide quality, trauma-informed, mental health treatment to refugees.

Expressive Arts Therapy as a Trauma-Informed Tool

The field of expressive arts therapy is relatively new when compared to traditional Western theories of psychotherapy. However, there is a host of research that shows the efficacy of expressive arts therapy as an evidence based practice that is successful in addressing mental health issues including complex trauma (Richardson, 2016). Literature on the use of the creative therapies with refugees reports positive outcomes, including a reduction in post-traumatic stress symptoms and an increase in resiliency factors like higher self-worth, strong connection to community, and creating a safe distance when exploring trauma narratives (Dieterich-Hartwell & Koch, 2017). Available research provides ample evidence that the arts foster empowerment and transformation with refugees, but a thorough investigation into how expressive arts therapy can be leveraged to minimize issues caused by linguistic and communication barriers is yet to be made. Despite the dearth of research, it is possible to extrapolate from the broader literature on the field of creative arts therapies to make inferences about how expressive arts therapy could be used as a tool to address issues of language in treatment with refugees.

Empowerment and Connection

Richardson (2016) describes the use of expressive arts therapy as a transformative process that debunks the myth that the arts belong only to the gifted and empowers all

individuals and communities to use creative expression as a "means to unite, celebrate, grieve and express all elements of human existence" (Richardson, 2016, p. 4). The refugee experience is often one of isolation, disconnection, loss, and disempowerment that is magnified by structural and linguistic barriers. By increasing the scope of mental health treatment to include creative expression and highlighting the arts as an internal resource, expressive arts therapy can foster feelings of connection to self and community (Rubesin, 2018). In expressive arts therapy practices, the therapist has multiple roles: they may participate in the art making; take on the role of a mirror; provide inspiration; be an active witness to the clients' creative process; and create artistic responses when needed (Richardson, 2016, pg. 9). By actively participating and collaborating in the creative arts process, therapists with the help of spoken language interpreters can build trust and connection with refugee clients despite language differences.

Expressive Arts Transcend Spoken Language

Dieterich-Hartwell and Koch (2017) posit that "when feelings are physically represented through movement, statues, and sculptures, language can be transcended" (pg. 11). Expressive arts therapy invites clients to tap into their inner creative instincts, such as making sounds, moving our bodies through space, scribbling, etc., that precede spoken communication and embrace knowledge that presents itself through imagination, symbolism, and sensory experiences (Dieterich-Hartwell & Koch, 2017). When working through language differences, the transcendental nature of the creative arts can support refugee clients' healing process by allowing them to be in control of how they express their trauma narrative without solely relying on spoken language to communicate with the therapist. Participating in art processes like making music, singing cultural hymns in community can increase refugees' sense of self while also creating an environment of solidarity, empathy, and connection.

Expressive Arts Therapy and Social Justice

The act of using the arts as a tool for individual healing cannot be separated from sociopolitical and cultural contexts and an examination of dynamics of power, privilege and oppression (Estrella, 2019, pg. 63). Contemporary expressive arts therapy practitioners, like Sajnani (2012), call for a bolder assertion of sociocultural and critical race feminist models to push for a more equitable practice of expressive arts therapy. Proponents of sociocultural models urge expressive arts therapists to actively engage in the societal and political aspects of their work to facilitate individual, interpersonal and systemic change (Sajnani, 2012). When working with refugees, social justice based expressive arts therapists can use their practice to build connection with their clients. They can also leverage the arts as a tool to actively advocate for systemic changes that would minimize the barriers faced by refugees beyond the therapeutic setting, such as calling for more investment in refugee integration services, training and supervision for interpreters, access to language acquisition training, and access to basic rights and respects for refugees in host communities. Ultimately, expressive arts therapy can be used as an overarching framework that calls for disruption of current systems and highlights the need for change to the complex and interconnected linguistic and structural barriers faced by refugees. Dismantling oppressive structures within mental health systems by centering refugee voices and honoring their unique experience in treatment are ways in which expressive arts practitioners can earn deeper trust and work collaboratively with refugee communities to mitigate barriers to mental health treatment.

Limitations

The literature reviewed in this paper was gathered using limited databases available to the author via the Lesley University Library and Google Scholar. Most of the data were gathered

from peer reviewed journals and academic books. Literature from news publications and informal sources was not included in the above review. While the paper reviews the state of refugee mental health in different parts of the world, a thorough analysis of barriers to treatment globally is beyond the scope of this paper. Future research on the impact of language barriers and expressive arts therapy with specific refugee populations in specific regions will be beneficial for providers working with refugee populations. Given the magnitude of past and current trends in global migration, literature on refugee mental health remains limited. Even more insufficient are the number of articles that specifically research issues related to the impact of language barriers, expressive arts therapy with refugees, and successful integration of interpreters in mental health treatment. While this paper begins to make connections between the use of expressive arts therapy and mitigating language barriers in refugee mental health, more in-depth qualitative and quantitative research is required to thoroughly back this hypothesis.

Conclusion

This study highlights the unique mental health needs of diverse refugee populations, and presents an overview of systemic and cultural barriers to mental health treatment faced by refugees. While issues related to linguistic differences are just one of the many barriers faced by refugees in host countries, language barriers are pervasive and often exist alongside other structural and cultural factors impacting refugee help seeking behaviors. This study highlights some ways that expressive arts therapy can be used with refugees to transcend some linguistic and cultural barriers and expand the scope of mental health counseling beyond talk therapy. While there is a need for more qualitative and quantitative research on the use of expressive arts therapy and language differences with refugees, the findings presented in this thesis are relevant

to mental health practitioners working with diverse refugee populations and can be used to facilitate further discussions and research on this topic.

In a final synthesis of themes discussed in this thesis, the author created a visual theoretical model for mental health practitioners considering the use of expressive arts therapy with refugees to minimize linguistic barriers. The model depicts the scope of expressive arts therapy with refugees. While minimizing impacts of language barriers through the use of the arts to transcend spoken language, expressive arts therapy can also be used to mitigate other barriers and create a more culturally responsive approach by including: trauma informed practices; collaboration with refugees and community leaders; training and supervision for spoken language interpreters and their inclusion in arts based interventions; community based mental health approaches; and social justice based practices that include advocacy for refugee clients within and outside the therapeutic setting.

Figure 1

Scope of expressive art therapy with refugees

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THESIS APPROVAL FORM

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