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# Psychological Trauma: Theory, Research, Practice, and Policy

## Refugees, Asylum Seekers, and Practitioners' Perspectives of Embodied Trauma: A Comprehensive Scoping Review

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## **Refugees, Asylum Seekers, and Practitioners' Perspectives of Embodied Trauma:**

### **A Comprehensive Scoping Review**

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**INTRODUCTION:** Individuals seeking refuge and asylum commonly present to healthcare practitioners with embodiment of mental distress due to the traumatic nature of their migration experiences. The number of displaced individuals has doubled over the past decade due to the impacts of war, religious and political conflict, climate change and Covid-19. Studies point towards the need for a comprehensive scoping review to fully explicate the concept of embodied trauma, bridging the gap between phenomenological lived experience and the many treatments available.

**OBJECTIVES:** To inform psychotherapy guidelines by identifying the evidence for embodied trauma, clarifying key terms, examining how research is conducted, and identifying gaps in the knowledge.

**METHOD:** A five-stage scoping review protocol was operationalised to explore and analyse the existing literature and associated terminology by: 1) identifying the research question 2) identifying the relevant literature 3) selecting the studies 4) charting the data and 5) collating, summarising, and reporting the results.

**RESULTS:** Highlight the need for a clear definition of terms, the development of a culturally informed assessment and formulation for individuals experiencing embodied trauma, and reveal a gap in the research for the best treatment approach(es).

**CONCLUSION:** Proposal of a clear definition of embodied trauma and key themes for future research including culturally informed care, psychosocial support, language considerations, relational belonging, and inclusion of sexual, spiritual, and existential factors, moving away from purely westernised diagnoses and treatments towards culturally informed care.

*Keywords:* Refugees, Asylum Seekers, Embodied Trauma, Culturally Informed Care, Psychosomatic Trauma.

CLINICAL IMPACT STATEMENT: This comprehensive scoping review defines the novel term embodied trauma, and highlights a gap in the research for the best treatment approach(es) for its presentation in individuals seeking refuge and asylum. Key themes are conceptualised for a comprehensive approach to psychological assessments and a range of culturally informed psychotherapeutic interventions including humanistic, existential, psychosocial and transcultural perspectives. Furthermore, this paper advocates for a bio-psycho-social-sexual-spiritual approach to culturally informed care and future research.

The United Nations High Commissioner for Refugees [UNHCR] (2020) Global Trends Report stated that at the end of 2020 there were over 132,349 refugees and 77,245 pending asylum cases in the UK alone, with the UK Government (2021) pledging to resettle an additional 20,000 refugees following the recent humanitarian crisis in Afghanistan. Mass displacement of individuals across the globe stems from a well-founded fear of persecution for reasons of race, nationality, religion, social group, or political opinion (United Nations Convention, 1951), with the scale of the crisis more than doubling over the past decade due to the additional impacts of climate change (Berchin et al., 2017) and the Covid-19 pandemic (Raju & Ayeb-Karlsson, 2020). Border closures and industrial action post Brexit have also exacerbated the trauma inherent in the asylum-seeking process (Davies et al., 2021), with over 8,400 individuals risking their lives attempting to cross the perilous English Channel by small vessel due to a lack of safe alternative routes (Timberlake, 2021). The Home Affairs Committee (2020) confirmed that 98% of these individuals have applied for asylum, despite reports that the UK is a hostile immigration environment aiming to significantly reduce its net migration (Gentleman, 2019).

Individuals seeking refuge and asylum are often profoundly traumatised, enduring societal dehumanisation, derogatory re-categorisation, and violation of their human rights in their country of origin (Goodman et al., 2017; Taylor et al., 2020), or whilst fleeing from conflict situations of collective oppression, persecution, abuse, sexual violence, maltreatment, torture, and homicide (Kalt et al., 2013; Refugee Council, 2021). Studies have shown that these individuals are more likely to experience poor mental health and have higher rates of post-traumatic stress disorder [PTSD], depression and anxiety disorders than the local population (Fazel et al., 2005; Tempany, 2009). Increased vulnerability to mental health problems is linked to pre-migration experiences such as war trauma, and to post migration conditions such as poor housing and being separated from their families (Steel et al., 2009; Taylor et al., 2020). A recent meta-analysis of 26 papers by Blackmore et al. (2020) has also found that the lifetime prevalence for PTSD (31%) and depression (31.5%) in the refugee population was higher than that of the general public, suggesting an enhanced need for suitable mental health interventions for these traumatised groups (Schaeffer & Cornelius-White, 2021).

Awareness of this data is of critical importance to those working with individuals seeking refuge and asylum in the psychological and health care professions, as well as within the wider support services or humanitarian contexts. However, it is also necessary to note the limitations of viewing mental distress through a medicalised, pathologising lens, which directs therapeutic resources towards diagnosis and biomedical treatment of symptomology (Murphy, 2021). Recent literature has called for a more comprehensive, holistic approach to therapeutic treatments, incorporating body work, nutrition, religious practices, meditation, relaxation techniques, and using narrative accounts of trauma to re-engage the mind and body (Cesko, 2020). There is also a call to consider the social, cultural, and political aspects of trauma (Schaeffer & Cornelius-White, 2021), as well as pluralistic concepts of health outside of westernised medicine, branching into the realms of traditional and indigenous medicines and healing practices (Luci & Kahn, 2021; Murphy, 2021).

### **The Need for a Comprehensive Scoping Review**

A number of studies have pointed towards the need for a comprehensive scoping review of the literature to fully explicate the concept of embodied trauma, bridging the gap between the phenomenological lived experience of individuals and the many treatments available to support individuals seeking refuge and asylum. Murphy et al. (2021) note that there is a paucity of qualitative insights into asylum seekers' experiences of embodied mental distress, with the corpus of quantitative research centred around the codification of mental health according to diagnosable conditions. Whilst a body of qualitative work is emerging (Murphy et al. 2021), its primary focus is upon experiences of post migratory conditions and mental health support seeking behaviours, with intimate, first-person, in-depth accounts of embodied mental distress left untapped (Coffey et al., 2010; Murphy et al., 2018, 2021; Sundvall et al., 2018). Davidson (2016) asserts that by accessing these personal narratives we may better inform targeted, specialised treatments and interventions, mapping the path towards restoring meaningful and productive lives for the individual.

## **Trauma, Embodiment, Psychosomatic Symptoms, and the Therapeutic Relationship**

Trauma is a term that has been widely used, interpreted and applied (Sugarman & Linden, 2021), with epidemiological studies suggesting that 81-90% of the general population experience at least one traumatic event over the lifespan (Jowett et al., 2020). What constitutes a traumatic experience has also been the subject of much debate (Levine, 2010; Ogden & Fisher, 2015; Van Der Kolk, 2014), with the injurious nature of the trauma being dependent upon the idiosyncratic phenomenological meaning applied to the event, and upon the individual's psychobiological agility and resources available for resilience (Sugarman & Linden, 2021). However, many studies do not explicitly assess or use screening measures for trauma, which has resulted in a broader use of the term according to its personal meaning or current relevance (Jowett et al., 2020).

Contemporary literature now broadly gives theoretical support to the link between trauma and the body, which manifest in psychosomatic events incorporating the Central Nervous System [CNS] due to an absence of dualism; the concept of dualism here refers to the assumption that the body and mind are separate and distinct (Descartes, 1641), including the works of Jung (1943, 1966; Holifield, 2020), Ramos (2004), Schore (2009), Van Der Kolk (2014) among others. Yet, embodied trauma remains an elusive term with no formally agreed definition (Hustvedt, 2013). Recently, researchers and practitioners across modalities have begun to recognise and utilise the novel term embodied trauma to orient their treatment strategies and interventions towards the physiological aspects of trauma in the body (Buckley & Punkanen, 2021). Pioneering research into polyvagal theory and physical manifestations of trauma have also highlighted the critical bi-directional nature of communication between the body and brain (Geller & Porges, 2014; Levine, 2010; Porges, 2011; Van Der Kolk, 2014). Polyvagal theory (Porges, 1995) uses neuroscientific, psychological and evolutionary theory to explain a mammalian shift towards a two vagal system for regulating emotions, social cues and providing a response to fear. Porges (2018) suggests that the autonomic nervous system [ANS] is not functionally distinct from the central nervous system [CNS], but is anchored to structural and regulatory motor pathways where the brain and bodily organs influence mental state, perception of

the environment, and threat to life, with any disruptions leading to impaired homeostatic function, such as heart disease or irritable bowels. Traumatic memories become stuck in the body which oscillates between states of hypo or hyper arousal, resulting in the constant dis-regulation of the nervous system (Buckley & Punkanen, 2021; Levine, 2010; Van Der Kolk, 2014). Contrary to Cartesian Dualism where the mind and body were seen as distinctly separate (Descartes, 1641), it is now widely acknowledged that the mind and body's responses to trauma are inseparable (Lemma, 2010), with our thoughts and cognitions being reliant upon a physical body which exists in a biological, psychological, and cultural context (Varela et al., 1993).

Neuroscientific discoveries have also revealed that trauma experiences are mediated non-verbally throughout the body due to the suppression of Broca's area of the brain which is responsible for language (Van Der Kolk, 2014). Positron Emission Tomography [PET] and Functional Magnetic Resonance Imaging [fMRI] have shown that all trauma is classified as preverbal (Van Der Kolk, 2014). The frontal left lobe of the cortex, or Broca's area, one of the speech centres, is shut down in a similar way to that of a stroke patient with a disrupted blood supply remaining so whenever a flashback is triggered (Van Der Kolk, 2014). Recent studies also assert that functional neurological symptom disorders [FNSD] are one of the most common conditions seen within outpatient clinics (Gray et al., 2020). Clients present with disabling, seizure-like symptoms, and other manifestations akin to physiological or structural pathologies, yet which are distinctly associated with psychiatric comorbidities (Gray et al., 2020). Some patients with FNSD have difficulty recalling, or are unable to recall traumatic experiences (Gray et al., 2020). Gray et al. (2020) note the need for more accurate methods of screening, assessment and capture of both poly-traumatisation, where trauma is classified as exposure to several types of trauma rather than to a single event (Karsberg et al., 2021), and complex post-traumatic stress disorder [CPTSD], a new diagnosis within the ICD-11 which is prevalent in two-thirds (66.23%) of the asylum-seeking population, reflected in a recent London-based study of trauma-specialist services for asylum seekers (Jowett et al., 2021).



Psychosomatic aspects of trauma have also been validated using imaging studies (Lanius et al., 2010) which show that emotions become stored somatically in the core of the body (Sugarman & Linden, 2021). Somatic resources refer to the physical abilities of the body to self-regulate, enhancing the individual's embodied resilience by utilising techniques such as movement, alignment, grounding, and breath work (Buckley & Punkanen, 2021). Somatic resources can help the dissociative parts of the individual to become visible, allowing the individual to work on their skills-based deficits within their window of tolerance, or optimal zone of arousal for the individual to function in everyday life (Siegel, 1999), stabilising the client in the moment, and making a shift away from maladaptive bodily reactions which fixate them in states of fight, flight, freeze or collapse (Buckley & Punkanen, 2021).

As relational beings (Paul et al., 1996; Weiss, 1999), it is suggested that the key to restoration and reconnection to the body after trauma resides in relationship and community, utilising our body's non-verbal genetic schema or precognitive functions, such as changes in muscular tonus and state of arousal to adjust our body to objects or others using a perceived structure of the world and our relationship to it, for example, when falling (Halak, 2021; Merleau-Ponty, 1962; Van Der Kolk, 2014). Interpersonal neuroscience provides robust evidence that relational trauma is held in the body, with the ANS being perpetually attuned towards environmental safety, and non-traumatised individuals being wired to seek out connection or love from others (Quillman, 2020). The relational nature of being is also integral to change, using the therapeutic relationship for healing through narrative listening or non-verbal storytelling, temporal touring of the past and utilising neuroplasticity for healing and repair (Sugarman & Linden, 2021). Yet these imperative relational concepts are not yet fully explicated or applied by all practitioners working within trauma-informed care in the UK National Health Service [NHS] or in independent practice. It is also argued that despite a recent paradigm shift towards relational considerations in trauma-informed mental health services (NHS Education for Scotland, 2017; Sweeney et al., 2018), that not all practitioners have adopted these ways of working.

A clinical vocabulary gap still exists, which struggles to settle upon a key term to encapsulate these subjective phenomenological lived experiences of trauma manifested in the body (Seng & CAsCAid Group, 2019). This comprehensive scoping review therefore proposes the use of the term embodied trauma to capture these combined physiological states and psychosomatic symptoms of trauma collectively. The section that follows will review the field of embodied trauma research to date, highlighting the existing gaps.

### **A Review of Embodied Trauma Research to Date**

Research into the field of embodied trauma exists on a popular cutting-edge between medical discoveries and individual phenomenological lived experiences, yet qualitative insights into the manifestations of embodied trauma remains limited (Murphy et al., 2021). Recent findings indicate that mental distress interweaves with physiology, impacting the whole being, severely diminishing the individual's capacity to connect and interact with the environment, leaving them in an anaesthetised state (Murphy et al., 2021). More research is required to bridge the gap between an individual's phenomenological lived experience of migratory embodied trauma and recent discoveries at the neurobiological and whole-systems level, which access and process trauma through the body (Levine & Land, 2016; Van Der Kolk, 2014). Recent studies have suggested the usefulness of body-based interventions for refugees (Aranda et al., 2020; Kita, 2020; Schaeffer & Cornelius-White, 2021), yet there is still a need to better conceptualise the term embodied trauma, and to explore the breadth of treatments that are available to understand what is working effectively and why. In this paper our review focuses on a modern concept of embodied trauma and its manifestation in the various bio-psycho-social-sexual-spiritual levels (Butler, 2021; Deps et al., 2021; Sugarman & Linden, 2021; Van Der Kolk, 2014), in order to propose the psychological and psychosocial interventions that could be useful to individuals in the refugee and asylum-seeking population.

Studies in the field of counselling and psychotherapy tend to be theoretically informed according to the practitioner's training or modality, and are often influenced by convenience sampling of the local refugee or asylum-seeking community, or by the utilisation of specific sites of research

(Cesko, 2020; Murphy et al., 2021; Rova et al., 2020). These selective methodological practices have narrowed the scope of research in this field according to the practitioner's worldview and discipline. By performing a comprehensive scoping review, a broader vista of the existing research will be captured, spanning across modalities and applicable to a wide range of practitioner disciplines that work with refugee and asylum-seeking communities who have experienced trauma.

Social sciences have also proposed that we approach the concept of embodiment not only from a self-regulation stand-point, but also explore the broader influences of political and social norms on embodied trauma and its healing (Schaeffer & Cornelius-White, 2021), considering the culturally imperative impacts of kinship, gender, age, social position, and race, and also how individuals perceive and evaluate their own bodies within these culturally specific normed interactions (Fox, 2018). However, the focus of this paper will be on the psychotherapeutic aspects of embodiment.

Butler (2021) suggests that we challenge our projected Westernised societal attitudes and labelling of these individuals, which oscillate between victimisation, dehumanisation, or as Lobo (2013) suggests, racialisation, where individuals are racially categorised according to their phenotypic appearance by the host country, unable to hold a personal identity which is category free from racial content (Tewolde, 2021). Butler (2021) also challenges us to expand our thoughts of treatment beyond the realms of PTSD to consider the existential, phenomenological, and narrative, focussing on the individual's deeper sense of self. This assertion could also be applied to other types of trauma, whether diagnosed or not. However, only a small number of texts define or conceptualise embodiment in these terms, fully encapsulating the active, injured, or constrained, interactive, and transformative views of the individual's body that has experienced the trauma (Rajah & Osborn, 2021). The authors concur that these views of the body merit further exploration by both researchers and practitioners alike.

Having noted throughout this review, the methodological, bio-psycho-social-spiritual, political, cultural, therapeutic, semantic and medicalised limitations of the existing literature (Butler, 2021; Cesko, 2020; Davidson, 2016; Fox, 2018; Murphy et al., 2021; Schaeffer & Cornelius-White, 2021; Seng & CAsCAid Group, 2019), noting additionally the limitation of international sources, we advocate on behalf of the critical need for a conceptualization or formulation of trauma which includes a widely international, holistic understanding of the individual, including their cultural presentations of trauma and its embodiment. This is particularly important when working with individuals seeking refuge and asylum who descend from a vast array of countries and cultures, and present with a diverse range of complex psychological distress and trauma experiences. Having identified the gaps in literature, as well as the need for a comprehensive scoping review, the following section outlines its aims and objectives.

### **Aims and Objectives of the Comprehensive Scoping Review**

The purpose of this comprehensive scoping review is to determine the volume and coverage of the literature concerning embodied trauma within these client groups, giving a broad overview of its focus (Munn et al. 2018). By searching for, selecting, and extracting the relevant aspects of the current research literature in the field of embodied trauma, we aim to broadly identify and summarise its key concepts.

The aim of this comprehensive scoping review is to describe the scope of the research in this field, and to synthesise, summarise and disseminate the results. It will not critically appraise the results but rather provide an overview and map of the evidence. In line with Munn et al.'s, (2018) guidelines for scoping reviews, this comprehensive scoping review will:

- Identify the types of available evidence for embodied trauma
- Clarify key concepts and definitions
- Examine how the research is conducted
- Act as a precursor to a systematic review
- Identify and analyse knowledge gaps

## **Methods**

As with a systematic review, the methodology of the comprehensive scoping review will be grounded in open science, using a replicable, rigorous, and transparent approach to collection, analysis, and interpretation of the data. It is noted that in contrast to the systematic review, a full quality assessment is not performed, as the spotlight focuses solely on the findings rather than the methodology used (Weeks & Strudholm, 2008). However, it was important for the authors as researchers to ensure a high calibre of literature in the review, therefore only peer reviewed journal articles were selected and broadly analysed for quality and reputable publication, based upon the journal title and abstract. A methodological framework was also applied using a five-stage scoping review protocol (Arksey & O'Malley, 2005; Taylor & Pagliari, 2018). This type of quasi-systematic review is now commonly used to understand emerging concepts which are poorly indexed, and whose research literature is dispersed across different academic disciplines (Arksey & O'Malley, 2005; Armostaris & Munn, 2020; Levac et al., 2010; Taylor & Pagliari, 2018). By using this type of literature review it is anticipated that the amount, focus and nature of an overarching research question will be literally scoped out, in order to report back on the state of the field, identify gaps in the knowledge and make recommendations (Seidler et al., 2018).

### **Structure of the Methodology**

We followed the five-stage scoping review protocol (Arksey & O'Malley, 2005; Taylor & Pagliari, 2018):

- 1) Identifying the research question
- 2) Identifying the relevant literature
- 3) Selecting the studies
- 4) Charting the data
- 5) Collating, summarising, and reporting the results

It is important to note the reflexive nature of the methodology which uses an iterative and non-linear approach to ensure comprehensive coverage of the research literature gathered.

### Stage 1: Identifying the Research Question

The research question that guided this comprehensive scoping review is:

*What is known from the existing literature about the concept of embodied trauma experienced by individuals seeking refuge and asylum, and how is it being effectively treated by practitioners?*

In order to fully explicate this overarching question, a subset of research questions was defined using Taylor & Pagliari's (2018) approach (see **Table S1**).

### Stage 2: Identifying the Relevant Literature

This comprehensive scoping review aims to gather data from a range of electronic databases. Working with a specialist librarian the following databases were selected to perform the search; AMED, APA Psych Articles, APA PSYCHINFO, CINAHL, MEDLINE, SOCINDEX. Medical databases with a special focus on healthcare and medicine such as MEDLINE, AMED and CINAHL were selected to ensure the inclusion of multi-disciplinary team member research, as well as allied and complementary medicine practitioners. In order to be included in this comprehensive scoping review, studies were expected to provide sufficient information to allow participants and/or groups to be considered as having experienced embodied or somatic aspects of trauma. Studies lacking this information were excluded from the review. To avoid double-counting data, the sample in a given study should not have been used in a previous study of those included in the review. In cases with overlap, the data from the primary source was used.

### Selection Criteria:

Selection criteria were split into inclusion/exclusion criteria by characteristic (see **Table S2**).

### Search Parameters

Four main lists were collated to inform the final search parameters and were reviewed and approved by both researchers (see **List S1**). **Table S3** shows the final search strategy used for the databases. The comprehensive scoping review also utilised Moher et al.'s (2009) Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines [PRISMA] for its paper search and selection (see **Figure S1**).

### **Stage 3: Selecting the Studies**

All database hits (N= 3,355) were downloaded to a .csv file and merged into an excel spreadsheet where duplications were removed using Cochrane Collaboration guidelines (Deeks et al., 2008). All paper titles and abstracts in the spreadsheet were scanned by two researchers (COB, DC) independently, classifying them for inclusion ('Y') or exclusion ('N'). When cases were not able to be assessed from title alone the full article was retrieved by the reviewer. Inclusion and exclusion criteria were followed as listed (see **Table S2**) and results tabulated (see **Table S4**). Notably, only adult studies were included.

### **Stage 4: Charting the Data**

The purpose of charting the data is to produce a descriptive summary of the results, to identify any gaps in the literature and to highlight key concepts for analysis. Columns were included in the excel spreadsheet to record the extracted data from each article to describe:

- Amount – of papers defined by year of publication
- Focus – therapy or therapeutic theme
- Nature – practitioner type, type of article, clients' country of origin and title of groups studied.

The extracted dataset also included columns for the article title, author, journal title (volume, issue, pages, DOI), keywords, article link, methodology, abstract, child focussed or key papers.

### **Stage 5: Collating, Summarising and Reporting the Results**

The abstract of each paper in scope was read by one researcher (COB), annotated, and broadly categorised by topic using free line-by-line coding of their findings (Seidler et al., 2018). The results were summarised using a qualitative descriptive approach, grouping key concepts with topical similarity. The data was then checked for accuracy by the other reviewer (DC), using an independent inter-rater qualitative method to ensure rigor and to avoid subjective interpretation by a single researcher. A descriptive summary was produced using pivot tables of the extracted data in the excel spreadsheet, and an overall summary of the results was produced (see **Table S4**). The aim of the

comprehensive scoping review was to reflect an overall summary of the main results without any further synthesis or distillation in order to answer the research question.

## **Results**

### **Search Strategy, Study Selection and Data Extraction**

An executive summary of the results was produced within the excel spreadsheet showing that 3,355 articles were identified by the electronic database searches, 2,088 papers were screened of which 241 were selected based on their use of embodied trauma or somatic terminology (see **Table S4**). An inter-rater reliability of the descriptive data extraction process was 100% in agreement.

### **Descriptive Summary of the Research on Embodied Trauma**

Frequency analysis via pivot tables helped to answer the research questions (see **Table S1**).

#### **Amount of Research on Embodied Trauma**

The number of papers referring to embodied trauma has risen significantly in the past two years but is still exceeded by those considering psychosomatic symptoms (see **Figure S2**).

#### **Focus of Research on Embodied Trauma**

The main therapies identified to treat embodied or psychosomatic trauma are psychopharmacology, closely followed by culturally informed care or treatment for depression and psychological therapy (see **Table S5**). Key interventions studied also include inpatient care, culturally adapted Cognitive Behavioural Therapy [CBT], mental health support, psychosomatic rehabilitation and a combination of psychopharmacology and psychotherapy. There is notably a vast array of alternative therapies studied which encompass the bio-psycho-social-spiritual aspects of the individual, with a particular focus on culturally informed care.

The key therapeutic themes identified alongside the therapeutic interventions are a need for culturally informed care, psychosocial support, and relational aspects of belonging, identity and family when working with embodied trauma (see **Table S6**). Language support was also a significant therapeutic theme, with papers supporting the use of interpreters when working with individuals seeking refuge and asylum. Acculturation and holistic care were also highlighted as key themes for



working with individuals experiencing embodied trauma. Other minor existential themes such as hope, home, security, agency, and communal memory contribute to a holistic sense of shared experience and collectivism across these groups.

### **Nature of Research on Embodied Trauma**

The nature of the research on embodied trauma is defined by the practitioner type, type of article, clients' country of origin and title of groups studied. Psychiatrists and Psychologists made up the vast majority of researchers in this field (see **Figure S3**). Findings also note the significant contribution to this body of research by medical scientists, psychotherapists, social workers, nurses, and social scientists. Exploratory studies make up the majority of papers in embodied trauma research, highlighting the need for more qualitative and quantitative studies which are more prevalent in somatic papers (see **Table S7**). Studies mainly include participants from mixed countries of origin with no consideration for individual background. Commonly studied participants are from Afghanistan, Africa, China, Cambodia, Latin America, Myanmar, Turkey, and India (see **Figure S4**). A significant breadth of backgrounds is noted, yet many remain poorly studied including Aboriginal, Korean, Iranian, Iraqi, and Eastern European. The main groups studied are refugees, followed by the most commonly used group titles of migrants and immigrants. Asylum seekers tend to be studied alongside refugees but have less studies of their group alone.

### **Discussion**

This comprehensive scoping review has highlighted a number of important aspects to consider when conducting research into trauma with refugees and asylum seekers. Firstly, the need for a clear definition of terms, both for embodied trauma and for those individuals seeking refuge and asylum who experience it. Secondly, the need for future research into key themes and therapeutic interventions including culturally informed practice and care, psychosocial support, language considerations, and spiritual and existential aspects of embodied trauma, considering both the physical and psychological impacts on the individual. The sections that follow will consider each of these points in turn.

## Definition of Terms

### ***Definition of Embodied Trauma***

Having noted the absence of a unified definition of embodied trauma and a desperate need to elucidate the term in the literature (Hustvedt, 2013), the authors propose the following definition, utilising the key concepts found in this comprehensive scoping review and its associated background literature (Buckley & Punkanen, 2021; Levine, 2010; Van Der Kolk, 2014; Varela et al., 1993):

*Embodied trauma is the whole body's response to a significant traumatic event, where mental distress is experienced within the body as a physiological, psychological, biological, cultural, or relational reaction to trauma. Embodied trauma may include psychosomatic symptoms alongside the inability to self-regulate the autonomic nervous system and emotions, resulting in states of dissociation, numbing, relational disconnection, changed perceptions or non-verbal internal experiences which affect every-day functioning.*

### ***Re-Defining the Terms Refugee and Asylum Seeker***

Dehumanising terms are found widely throughout this comprehensive scoping review. Terms such as migrant, immigrant, refugee and asylum seeker frequent the research literature and public discourse, with a struggle remaining over the correct framing of such individuals (Lee & Nerghes, 2018). Each of these terms have the potential to negatively impact how individuals seeking refuge and asylum are perceived and received by host countries (Lee & Nerghes, 2018), bearing their own inherent political, social, or cultural stigma and non-European sense of othering (Sajjad, 2018). The authors therefore propose the use of the term *displaced individual*. This term recognises that the person is outside of their country of origin, but also respects, supports, and empowers each individual's right to assert their own sense of culture and identity, moving away from derogatory group categorisation.

Organisations such as the European Commission (2021) and the UNHCR (2021) actively use terms such as displaced group or person to capture those seeking refuge and asylum, including those who are internally displaced and require humanitarian assistance. Amnesty International (2021) also

suggest moving away from terminology based on a person's temporary or legal status, asserting that it does not fully capture an individual's identity. However, the term *displaced individual* goes one step further towards supporting the idiosyncratic identity of each person in their own right. Sabik et al. (2021) agree that there is a critical need to use an intersectional lens when conducting scientific research with people seeking refuge and asylum, in order to avoid erasing the individual. They suggest expanding the concept of difference beyond groups, to consider the individual's own background and phenomenological experiences which are often overlooked in psychological research (Sabik et al., 2021). The authors therefore propose the use of the term *displaced individual* to highlight the individual nature of the person beyond group categorisation, and legal, social, or political position.

### **Key Therapeutic Themes**

#### ***Culturally Informed Care***

A key theme acknowledged across the literature is the need to develop culturally informed care for individuals seeking refuge and asylum, given each individual's distinct differentiation of distress based on cultural background (Vermier et al., 2021). Raghavan et al. (2017) note that as refugee populations grow, health professionals must learn to implement ethnically and culturally informed assessments and treatment plans to support individuals from diverse backgrounds. The individual, phenomenological lived experience of migration trauma is also often overlooked due to the societal grouping and labelling of such individuals (Lee & Nerghes, 2018). For example, Hinton et al. (2016) note that a key presentation of distress in Cambodian refugees is "thinking a lot" (p.570), which is distinctly shaped by a socio-cultural context. However, each person can also have specific aspects of mental distress or illness according to individual factors, such as gender, which affect treatment selection and the techniques utilised by health care professionals (Alemi et al., 2017).

The authors therefore advocate for the use of a humanistic, person-centred (Rogers, 1951, 1957a&b, 1959, 1961, 1963), culturally informed, comprehensive psychological assessment and formulation for each person who may be experiencing embodied trauma. This would provide a holistic, individualised conceptualisation of distress, deriving a specifically tailored treatment plan and

psychological intervention which is culturally appropriate, and which supports an idiosyncratic pathway to actualisation, whereby each individual harnesses their own innate, organismic tendency to move towards their full potential (Maslow, 2013; Rogers, 1963). However, this culturally informed approach to care requires further detailed research.

### ***Psychosocial Support***

Psychosocial support is another key theme found in this comprehensive scoping review, impacting the subjective wellbeing of individuals seeking refuge and asylum in host countries, yet which suffers from a deficit of qualitative research (Hocking, 2021). Psychosocial factors such as poor accommodation, lack of access to culturally appropriate healthcare services, family separation, loneliness, loss, unemployment, and lack of gainful activity (Hocking, 2021), can keep individuals entrenched in a fixed state of mental distress due to the nature of their environment and the inability to improve their socio-economic status (Schmalbach et al., 2021). Consistent research findings attribute the mental ill health and psychosomatic symptoms of individuals seeking refuge and asylum to psychosocial causes (Hocking, 2021; Papadopoulos et al., 2004). Bailey et al. (2021) note the importance of targeting hopelessness, poor-self efficacy and promoting familial social support in improving the wellbeing of immigrants, acknowledging that those receiving higher levels of family support report lower levels of distress. Schmalbach et al. (2021) also assert that whilst many individuals experience psychosocial issues in the migration process, more research into the impact of these factors is required.

### ***Language Considerations***

A number of articles mention the need for language support and specialist understanding of linguistic differences when working with individuals seeking refuge and asylum (Jurcik et al., 2013; Lanzara et al., 2019; Löfvander, 2019; Schreiter et al., 2016; White et al., 2021). Research suggests that despite a trend of migration towards the global west, little is known about how to adapt western services to assist individuals using foreign languages, whose collectivism, traditional values, emotional norms, and gender relations differ from the locally familiar (Jurcik et al., 2013). Lanzara et al. (2019)

advocate for healthcare services which are both culturally and linguistically appropriate to the individual, using translated materials when administering quantitative scales, and adapting therapy to the language needs of the individual. Research by Löfvander (2019) also found that support by professional interpreters may better facilitate a shared understanding between individuals seeking refuge and asylum and their care givers.

Schreiter et al. (2016) note that language considerations go beyond that which can be translated, highlighting the different forms of conceptualisation and expression of mental illness across cultural backgrounds. Moreno & Grodin (2002) question the clinical competence of practitioners and their understanding of the phenomenological meaning behind the cultural conceptualisations of mental distress identified by the DSM-5. Such cultural conceptualisations of mental distress found in the literature include the Ethiopian expression of worms in the ear (Grisaru, 2016), Congolese descriptions of a boiling hot brain (Murphy et al., 2021), Southern Sudanese body talk of traveling pains, burning sensations, or local dialectic expressions of lafa rasi which is a description of the dizzy tendency to fall down (Coker, 2004). Without due consideration of cultural and linguistic background it is questionable if these concepts of embodied trauma can be fully understood.

Giammusso et al. (2018) note that where communication is unavailable in the individual's mother tongue, language barriers to mental health care services are encountered. Western medicine has the cultural tendency to intellectualise distress (Becker, 1997), however, through the employment of effective cross-cultural training, and by forming a culturally informed therapeutic working alliance between the interpreter, clinician and client, a solution could potentially be found (Bordin, 1979; Giammusso et al., 2018). Yet these solutions and linguistic interventions are not frequently used due to cost (Moreno & Grodin, 2002), and little is known about the impact of using an interpreter on all aspects of care, including the therapeutic relationship (Giammusso et al., 2018).

White et al. (2021) suggest a clinical need for a cultural model and that a potentially cross-cultural language for understanding trauma could be found. Hustvedt (2013) also suggests that using

imaging studies alongside narrative strategies can help practitioners to better understand culturally based embodied simulation of mental distress. We therefore recommend further research into the impact of language and the use of interpreters on the assessment, formulation and treatment of individuals seeking refuge and asylum presenting with embodied trauma, with special attention paid to what cultural meaning may be lost in translation.

### ***Relational Belonging***

There is a growing body of literature which highlights the inherent relational qualities and needs of human beings, showing how relationships can be restorative (Hocking, 2021; Paul et al., 1996; Strømme et al., 2020; Weiss, 1999). In this comprehensive scoping review the importance of relationship and belonging are key themes found throughout the literature when working with embodied trauma, and remain central concepts for continued integration into therapeutic practice with individuals seeking refuge and asylum. Mattes & Lang (2021) suggest that the notion of embodied belonging includes three social conditions inscribed in human bodies. Firstly, the socio-economic and political inequality or exclusion that can impact human health, secondly the phenomenology of self-perception and belonging to the body, and thirdly belonging to a particular space or location which can affect wellbeing and health (Mattes & Lang, 2021). Mackenzie & Guntarik (2015) argue that developing a sense of belonging to a new home is a critical rite of passage for an individual seeking refuge or asylum in a host country, including the development of a new cultural and political identity. Creating new primary support structures, social networks, and new concepts of self, home, and place in society shifts the individual from outsider to settler (Mackenzie & Gutarik, 2015).

Von Posner et al. (2020) also propose the essential nature of shared embodiment and affective community, where shared sensations, spatiality, and sense of an ephemeral community of care can elicit embodied knowledge that positively contributes to the therapeutic process. The authors therefore suggest that belonging is a key area for therapeutic research, considering implications for the therapeutic relationship, group approaches to therapy, and using connections to the community as vehicles for healing.

### ***Cultural, Spiritual and Existential Support***

Cultural, spiritual, and existential themes are often overlooked by a generally secularised approach to westernised treatment models (Butler, 2021; Cesko, 2020). Butler (2021) asserts the importance of exploring existential meaning, seeing it as a human given, and a cultural prerequisite for healthier wellbeing, which can also support an interpersonally oriented context for the therapeutic relationship. Pouille et al. (2020) also note throughout their research that over a third of the literature regarding recovery among migrants cite the need to create, regain or reconnect with variations of a cultural identity and a sense of belonging to a cultural community. Matamonasa-Bennett (2017) calls for useful engagement in cultural activities and re-traditionalisation, which can elicit feelings of purpose and belonging. Furthermore, it has been found that religious beliefs and spiritual acts such as prayer and the reading of spiritual texts can support and encourage a relationship with a higher power, aiding therapeutic recovery (Cesko, 2020; Pouille et al., 2020).

Cesko (2020) powerfully suggests that a cultural therapeutic model is essential to the treatment process, with due consideration not only given to the background of the practitioner but also to the individual seeking refuge and asylum. Without appreciation of all aspects of difference, including the cultural, spiritual, and existential, individuals seeking refuge and asylum could experience stereotyping, prejudice, and micro aggression throughout their treatment, impacting the therapeutic relationship and the recovery process (Corey et al., 2019). It is therefore suggested that these cultural, spiritual, and existential aspects of individuals seeking refuge and asylum, should be formulated, and explored as part of culturally informed care. More research is needed into the therapeutic nature of these protective factors and strengths, which can support resilience and recovery in the aftermath of migration related trauma experienced by these vulnerable individuals (Lusk et al., 2021; Matheson et al., 2020).

## Key Therapeutic Interventions

A key finding from this comprehensive scoping review is the breadth of therapeutic interventions available for working with embodied trauma. Hynie (2018) notes, in their summarised findings from recent systematic reviews and primary research, that most refugees who have permanently resettled (and are not awaiting a court decision) do not suffer from mental disorders or distress one year after resettlement, however, their resiliency can be undermined by their current conditions. Yet there are few studies which investigate the successful interventions used, and even less which utilise a controlled methodology allowing us to draw conclusions about their effectiveness. This comprehensive scoping review has shown, however, that commonly used therapies include psychopharmacology (Hinton et al., 2012; Sonne et al., 2016; Strømme et al., 2020), culturally informed care or treatment for depression (Bhogal, 2020; Lee, 2015; Wolf et al., 2017), psychological therapy (Reich et al., 2015; Sambucini et al., 2020; Webber et al., 2020), inpatient care (Anderson et al., 2021; Handtke et al., 2021; Schaffrath et al., 2017) and culturally adapted CBT (Hinton & Jalal, 2019; Jalal et al., 2018; Kananian et al., 2020). The authors have noted, however, a paucity in comprehensive psychological assessment and interventions for individuals seeking refuge and asylum, and highlight the need for a culturally informed psychological assessment, formulation, treatment plan and intervention for each individual who may be experiencing embodied trauma, from a humanistic, person-centred (Rogers, 1951, 1957a&b, 1959, 1961, 1963), psychosocial (Bailey et al., 2021; Hocking, 2021; Schmalbach et al., 2021) and transcultural perspective (Charura & Lago, 2021; Zahid, 2021).

Alternative approaches to treating embodied trauma such as body-oriented work (Cesko, 2020), working with embodied emotions (Niner et al., 2014; Russo, 2014) and utilising movement and creative art techniques (Dieterich-Hartwell et al., 2020; Rova et al., 2020) still require further research and analysis due to their promising nature which is based on theoretical, neuroscientific, and biochemical discoveries. There is also a paucity of data available concerning combined multidisciplinary approaches to the treatment of embodied trauma, or the use of multimodal interventions which



provide different aspects of care such as medication, social support, and psychotherapy (Hynie, 2018), and reportedly even less consider treatment beyond the individual, expanding to families, groups, or communities (Nickerson et al., 2011). The authors also note that whilst key themes and therapeutic interventions focus on the bio-psycho-social-spiritual aspects of care, consideration of the impacts of sexual trauma are markedly absent. Deps et al. (2021) reveal that 37% of women and 4% of men seeking asylum, together with one in five women in the UK have experienced sexual violence, which is now deemed to be a public health crisis of epidemic proportions (Gainsbury et al., 2020). We therefore advocate on behalf of a bio-psycho-social-sexual-spiritual approach to care, and for culturally sensitive treatment of these individuals.

### **Recommendations for Researchers**

The authors of this comprehensive scoping review recommend further international qualitative research into the modern conceptualisation of embodied trauma as defined in this paper, to better understand the phenomenological lived experiences of individuals seeking refuge and asylum. The authors also recommend that researchers and practitioners use our modern definition of the term embodied trauma within their work. Further research into the provision of culturally informed care for working with embodied trauma is also recommended. This includes creating a culturally accurate, comprehensive psychological assessment and formulation of distress for each individual seeking refugee or asylum from a person-centred, humanistic (Rogers, 1951, 1957a&b, 1959, 1961, 1963), psychosocial (Bailey et al., 2021; Hocking, 2021; Schmalbach et al., 2021) and transcultural perspective (Charura & Lago, 2021; Zahid, 2021). This will help to inform a culturally appropriate intervention and treatment plan, tailored to the individual's language and mental health needs. Finally, we recommend a qualitative investigation into practitioners' experiences of working therapeutically with embodied trauma, and further research into the displaced individual's experience of embodied trauma treatment in order to bridge the gap between our knowledge of the interventions available and what is actually working in the field and why.

## Conclusion

This comprehensive scoping review of refugees, asylum seekers and practitioners' perspectives of embodied trauma has served to better inform counselling and psychotherapy guidelines through its examination of the amount, focus and nature of the literature available. It provides a clear definition of terms and proposes key themes for future research including culturally informed care, psychosocial support, language considerations, relational belonging, and cultural, spiritual, and existential aspects of support. Given the impact and disruption to wellbeing and belonging that individuals seeking refuge and asylum experience, and drawing upon the key therapeutic themes identified from scoping the literature, we conclude with the following:

- i. The importance of practitioners having competencies which evidence cultural sensitivity.
- ii. The need to engage with a bio-psycho-social-sexual-spiritual therapeutic approach to the conceptualisation, assessment, formulation, and treatment of individuals experiencing embodied trauma.
- iii. The need to pursue the recommendations for future research as outlined by this scoping review to bridge the gap in our knowledge and to propose the best approach(es) to treatment.

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## Supplemental Material

**Table S1**

*Research Questions*

Aspect	List of Questions
General	<p>What is the total number of studies published by year?</p> <p>What terms are used to describe the nature of this research?</p> <p>Which academic communities are most active in this field?</p> <p>What geographical refugee and asylum communities are studied?</p>
Topic	What topics are being explored in this research?
Therapies	What types of therapy are being researched in this field?
Extract and Analysis	What type of analyses are being applied?

**Table S2**

*Inclusion and Exclusion Selection Criteria*

Characteristic	Inclusion Criteria	Exclusion Criteria
Type of Outcome	Clinical outcome measures related to trauma, mental or physical health and quality of life.	Absence of trauma or migratory experiences.
Population of Studies	Diagnosis of trauma or discussion of trauma experiences. Age 18 or older. No restrictions on gender, ethnicity or demographic characteristics.	Studies focussed on children or non-migrant groups.
Type of Studies	Quantitative, qualitative, cross-sectional, comparative, exploratory and mixed method.	Review articles or primary research not considering trauma, e.g. exclusively diabetic or addiction studies with non-migrant groups.
Type of Publication	Published peer-reviewed journal articles.	Non-peer reviewed publications, no full text available, data based on conference abstracts, dissertations, thesis or grey literature.
Publication Date	Published since January 2011.	Published before January 2011.

Language	English language only.	Non-English language.
Location	No limits.	None.

**Table S3***Final Search Strategy Used for Databases*

1. asylum seeker or refugee or immigrant or migrant or displaced persons AND embody or embodi* or soma* or psychosomatic or trauma or loss or grief or bereavement or torture or abuse or post traumatic stress or PTSD AND counsellor or counsellor or counselling or counseling or therapist or psychologist* or occupational therap* or nurs* or psychiatr* or doctor or therapist or physiotherap* or yoga or practitioner or therapy or intervention or treatment AND humanistic or person cent* or psychodynamic or art or drama or dance or movement or body or breath or mindful* or cognitive or behavioural or behavioral or systemic or narrative or medication or pharmacology or cultural or transpersonal or trauma focussed or existential
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**Table S4***Executive Summary of Papers Included and Excluded from Study*

Total Number of Papers Identified	3355
Total Number of Papers Excluded (all reasons)	1267
Sub-Total of Papers Excluded (Children)	1066
Sub-Total of Papers Excluded (Duplicates)	91
Sub-Total of Papers Excluded (Non-English Language)	110
Total Number of Papers Screened	2088
Sub-Total of Embodied Papers Included	71
Sub-Total of Somatic Papers Included	171
Sub-Total of Non-Embodied or Somatic Papers Excluded	1847
<b>Total Number of Papers Used in Study</b>	<b>241</b>

*Note.* One paper was classified as both embodied and somatic but is only counted once in the total.

**Table S5***Therapies Identified*

<b>Interventions</b>	<b>Count of Embodied Papers</b>	<b>Count of Somatic Papers</b>	<b>Total</b>
Psychopharmacology	2	9	11
Culturally Informed Depression Care		10	10
Psychological Therapy		9	9
Inpatient Care		8	8
Culturally Adapted CBT		7	7
Mental Health Support		6	6
Psychosomatic Rehabilitation		5	5
Psychopharmacology and Psychotherapy		5	5
Body Therapy	3	2	5
Emotional Regulation	4	1	5
Trauma Focussed Interventions		4	4
Narrative Exposure Therapy	1	3	4
Stress Management		4	4
Group Interventions		4	4
Movement Therapy	3	1	4
Complementary Therapies		3	3
Religion and Spiritual Support	1	2	3
Creative Arts	3		3
Participatory Photography	1	1	2
Therapeutic Relationship		2	2
Psychoeducation		2	2
Psychotherapeutic Interventions		2	2
Addiction Support		2	2
Dynamic Narrative Therapy & Neuroimaging	1		1
Existential Therapy	1		1
Gestalt Therapy	1		1
Person-Centred Therapy	1		1
Analytic Therapy	1		1
Nutritional Psychiatry		1	1
Environmental Interventions		1	1
Outdoor Therapy	1		1
Sensory Scaffolding		1	1
Improved Quality of Life		1	1
Acupressure and Breathing Techniques		1	1

**Table S6***Key Therapeutic Themes*

<b>Main Themes</b>	<b>Count of Embodied Papers</b>	<b>Count of Somatic Papers</b>	<b>Total</b>
Culturally Informed Care	8	34	42
Psychosocial Support	4	15	19
Belonging	12		12
Language Support	1	11	12
Acculturation	2	9	11
Identity	7		7
Holistic Care		5	5
Family	3		3
Hope	3		3
Home	2		2
Communal Memory	2		2
Agency	2		2
Security	1		1

**Table S7***Type of Article*

<b>Type of Article</b>	<b>Count of Embodied Papers</b>	<b>Count of Somatic Papers</b>
Comparative Study		1
Cross-Sectional Study		3
Exploratory Study	49	12
Mixed Method		1
Qualitative Study	19	68
Quantitative Study	3	86

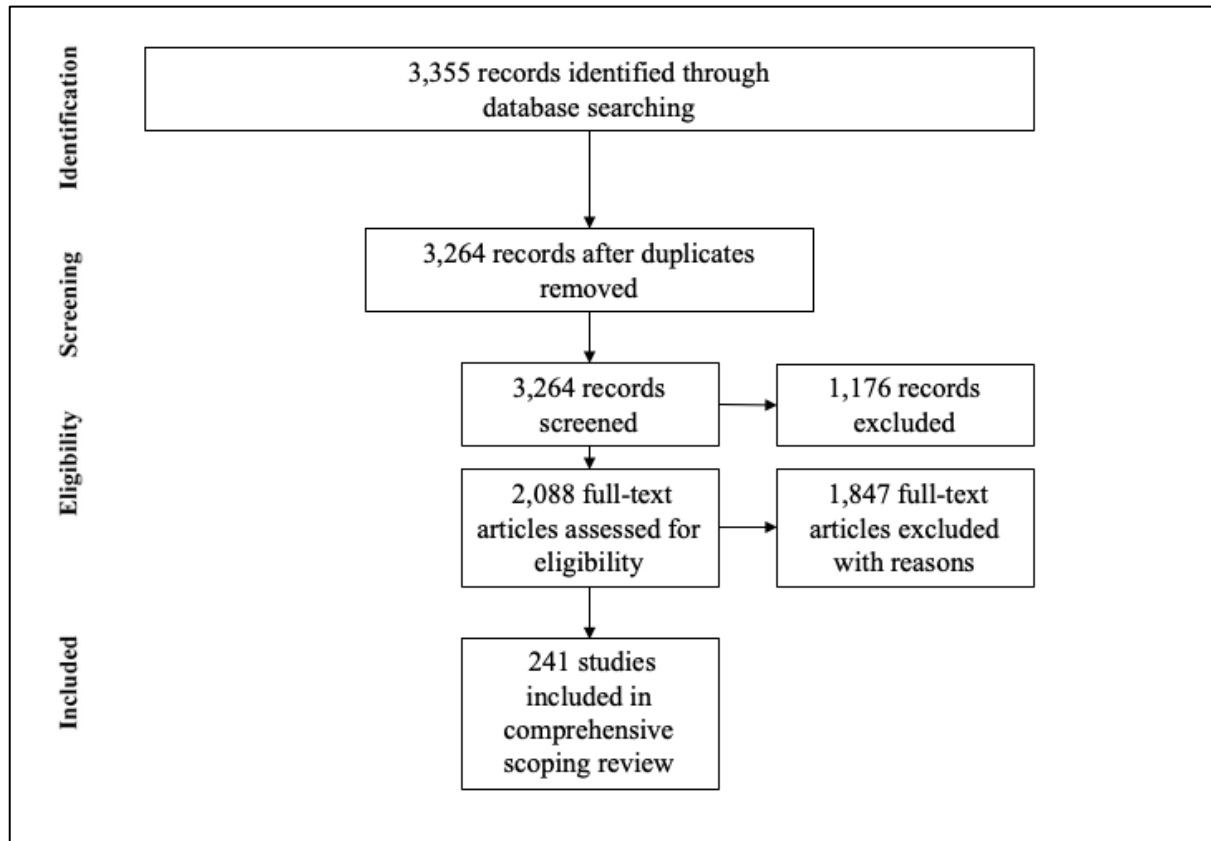
## List S1

### *List to Inform Final Search Parameters*

1. **A List of Titles** for displaced individuals including asylum seeker, refugee, immigrant, migrant, or displaced person.
2. **A List of Terminology** including embody, embodiment, embodied, trauma, psychosomatic, soma(tic), refugee, asylum seeker, migration, (im)migrants, grief, loss, bereavement, torture, abuse, post-traumatic stress, PTSD.
3. **A List of Practitioner Types** including counsellor, counsellor, counselling, counseling, therapist, psychologist (to include all e.g. counselling, clinical), occupational therapist, nurse, psychiatrist, doctor, psychotherapist, physiotherapist, yoga, practitioner, therapy, intervention, treatment.
4. **A List of Therapies and Modalities** including humanistic, person centred, psychodynamic, art, dance, movement, body work, breath work, mindfulness, cognitive behavioural therapy, systemic, narrative, medication, psychopharmacology, (trans and inter)cultural, transpersonal, trauma focussed and existential.

**Figure S1**

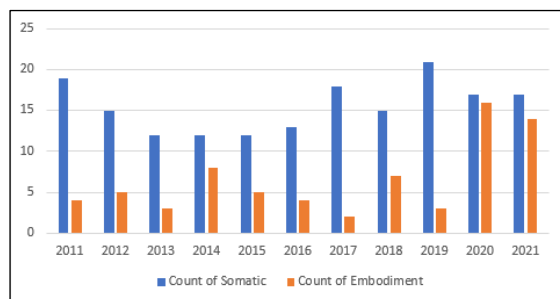
*Paper Search and Selection based on PRISMA Flow Diagram*



*Note.* This diagram shows the resulting number of papers selected. The reasons for exclusion and selection process are noted in the results section.

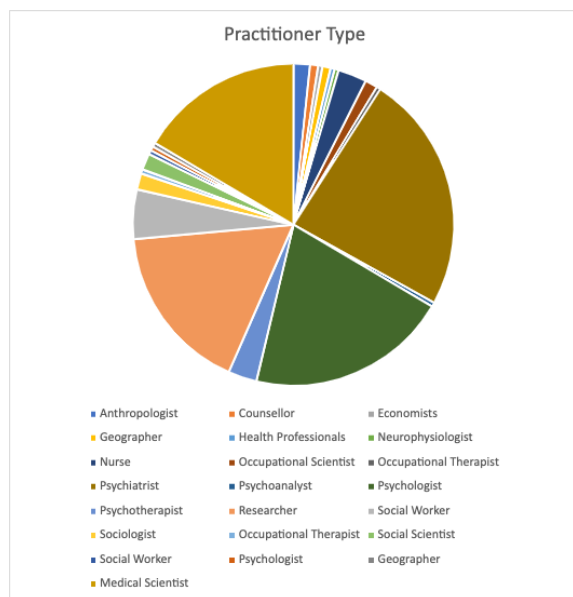
**Figure S2**

*Total Number of Studies Published by Year*

**Figure S3**

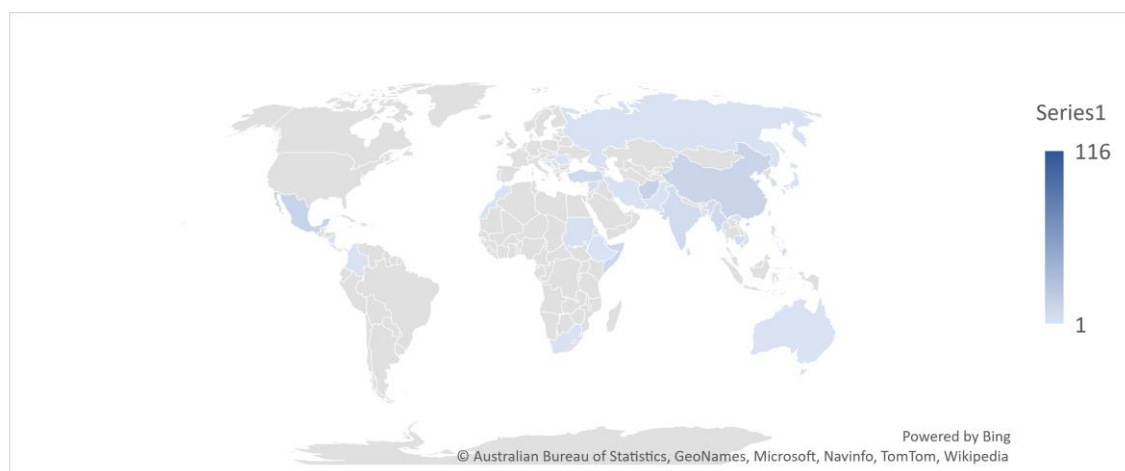


### Practitioner Type



**Figure S4**

### Clients' Country of Origin



**Figure S5**

*Title of Groups Studied*