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**INTERPROFESSIONAL  
APPROACH TO  
REFUGEE HEALTH**

**A PRACTICAL GUIDE FOR  
INTERDISCIPLINARY  
HEALTH AND SOCIAL  
CARE TEAMS**



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# 14. Flight and Post-Traumatic Stress: Their Influence on a Person's Identity

*Christine Spevak-Grossi*

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This chapter describes the impact of refugee experiences and post-traumatic stress disorder (PTSD) on a person's identity. In addition, the author aims to show ways in which refugees with PTSD can be supported in their recovery by focusing on their identity. To do this, she uses the Identity Work approach.

Based on Heiner Keupp's socio-psychological theory of identity work and Gary Kielhofner's occupational therapy Model of Human Occupation (MOHO), it is important to pay particular attention to the following targets when working with refugees with PTSD (Spevak, 2022a, 2022b):

- analysing one's occupational roles in life;
- implementing routines;
- strengthening personal causation and occupational performance;
- reflecting on narrative during therapy;
- the role of healthcare professionals as health advocates in the client's environment;
- client-centred goal setting.

To understand the term 'identity' in this context, it is important to assume that it is subject to a constant process of change. This dynamic process

allows people to constantly adapt to their ever-changing environment (Keupp 2000; O'Brien 2017).

In order to adapt to these environmental changes, people need to be or become able to act. The ability to act is often reduced in people with PTSD. This makes it difficult to adapt to environmental changes. In the case of refugees, this is exacerbated by the fact that they are experiencing severe environmental change (Grinberg & Grinberg, 2010).

In the country of arrival, refugees suffer from occupational deprivation. This means that environmental conditions prevent people from taking action, for example when an asylum seeker is not allowed to work for legal reasons. Environmental conditions, such as economic, social, and political factors prevent refugees from participation in society. This can exacerbate illness. In the sense of occupational justice, it is the task of the health professions to demonstrate that a limited ability to act and the prevention of individually meaningful occupation have a negative impact on a person's identity and thus severe negative consequences for their health (Whiteford, 2011; Wilcock, 2015). This feeds the vicious circle of PTSD: uprooting through flight, loss of identity, and illness. This needs to be broken. One possible approach is identity work, as described in this chapter using occupational therapy interventions.

## Mental Health of Refugees

Many refugees suffer from the psychological consequences of flight and their experiences in their home country, as well as from stressors in the host country after migration. This group of people is up to ten times more affected by mental illness than the autochthonous population of Western countries (Fazel et al. 2005; Crumlish & O'Rourke 2010). As a result, diseases such as depression, anxiety disorder, adjustment disorder, and post-traumatic stress disorder (PTSD), among others, often occur (Heeren et al. 2014). The study (Switzerland) by Heeren et al. (2014) found that 41.4% of the refugees and 54% of asylum seekers whose data was analysed exhibited symptoms of PTSD. In addition, the study has shown that mental illness persists even after asylum, i.e., refugee status, has been granted. This suggests a need for ongoing and

comprehensive psychosocial support for people with refugee status (Heeren et al. 2014).

Another study from 2015 showed that 64% of the 283 refugees analysed had a psychiatric diagnosis. Among them, PTSD was the most common diagnosis. This suggests that psychiatric and psychological care is extremely important and should begin as soon as possible after refugees arrive in the host country (Richter Lehfeld & Niklewski 2015). The length of the asylum procedure is a key factor in the increasingly poor quality of life of refugees and the rising prevalence of mental disorders, while access to healthcare is inadequate (Gerritsen et al. 2006).

The challenges and expectations placed on refugees are also counterproductive and can even form a further episode in the traumatisation process. They have lost all areas of their psychosocial environment due to the loss of their home, homeland, profession, social network, and in a number of cases family members (Klingberg 2011). In addition, the uncertainty regarding residence status, as well as uncertain prospects for the future, and the confrontation with many new things, are extremely stressful (Stock-Gissendanner et al. 2013: 64).

A study (Netherlands) confirms a higher suicide rate among male asylum seekers than among the autochthonous population. However, suicide attempts are higher among both genders compared to the majority population. The reasons given were the length of the application period, being in the refugee camp, loneliness and no contact with the outside world, losses, no future prospects, and mental illness (Goosen et al. 2011).

### Trauma and PTSD and the Importance of the Ability to Act

Fischer and Riedesser defined psychological trauma in 2003 (revised version from 2009) as:

a vital experience of discrepancy between threatening situational factors and the individual's ability to cope, which is accompanied by feelings of helplessness and defenceless abandonment and thus causes a lasting shattering of self-awareness and understanding of the world (Fischer & Riedesser 2009: 84)

The shattering of the understanding of oneself and the world refers to the loss of self-confidence and self-efficacy as well as the disillusionment of possibly being close to death at many moments in our lives. Everyone needs a certain amount of illusion in order to face reality without fear. For example, when we get into a car, we assume that we will reach our destination safely and without incident. Without this illusion we would be constantly anxious and try to avoid many situations. People need a certain capacity for illusion in order to cope with everyday life. However, if this is lost, people suffer from hyperarousal, withdrawal, hopelessness, and a lack of prospects for the future (Fischer & Riedesser 2009: 90). In a threatening situation, people respond with actions such as fleeing or fighting to save themselves. The situation becomes a trauma because the person experiences that these actions do not protect them from the danger. This destroys their confidence in their own ability to act (Fischer & Riedesser 2009: 98; Bering 2011: 29). It can be concluded that the restoration or expansion of the ability to act is important for the recovery of traumatized people. Spontaneity and creativity, which are necessary to cope with change, new situations, and social contacts, are also reduced (Blaser & Csontos 2014: 135). For health professionals, this means promoting the ability to act, spontaneity, and creativity in their work with clients.

The extent to which the traumatizing experience causes a lasting shock in the sense of the definition depends on the level of threat, and the coping strategies of the person at the time of the event (Fischer & Riedesser 2009: 90). Reddemann distinguishes between three types of events and their degree of impact on mental health. "Personal" traumatisation has the strongest impact on the person's psyche, as the traumatizing experience only affects "me" and is caused by another person. This includes physical or sexual violence, torture, neglect, or witnessing violence. There is also a distinction between this and "a personal" traumatisation, which refers to situations that cannot be influenced by people, such as natural disasters, accidents, or diseases. These can be defined as a stroke of fate. Another threatening situation can be war or flight, which are defined as "collective" traumatic experiences. Feeling that you are not the only one affected, and that you can share what you have experienced, helps you to cope. Of course, these types of events can also occur in combination, which leads to

an increased or decreased risk of severe traumatisation (Reddemann 2006). A distinction is also made according to the temporal component, depending on the frequency with which the traumatic event is repeated. In 1979, Leonore Terr distinguished between type I, with a single event, and type II, with multiple repetitions of the event. The more often the situation occurs and the more threatening it is, the greater the impact it has on mental health (Reddemann 2006; Wintersperger 2006).

However, it cannot be ruled out that a person who has experienced a traumatic event will be able to process it through their own resources. It is not possible to predict whether this will be possible without support. The post-exposure stress reaction sets in after the experience. In this phase, people initially avoid thinking about the event. Over time, uncontrolled memories and thoughts of the situation keep coming back, which is known as intrusion. According to the American psychoanalyst Mardi Horowitz, the unfinished action is organized and completed through the recurring alternation of denial and intrusion. Completion is when the person can consciously remember the event and control whether or not they think about it (Fischer & Riedesser 2009: 98). Symptoms of PTSD do not always occur immediately after the traumatizing experience, but only become apparent after weeks or years. Whenever these symptoms occur, if they do not subside within six months of their first appearance, they are referred to as post-traumatic stress disorder (PTSD) (Reddemann & Dehner-Rau 2006: 26).

According to ICD-11 6B40, PTSD is a delayed reaction to a threatening situation. The typical symptoms on a psychological level are flashbacks and intrusions, whereby the traumatizing situation is relived. Further characteristics of the disorder are: a lack of emotion and indifference towards other people as well as apathy and avoidance behaviour towards situations that could be reminiscent of the traumatic experience. Other symptoms include: anxiety, depression, sleep disturbance, increased vigilance, and an overexcited nervous system, as well as suicidal thoughts. The course can last for weeks or months but can also take a chronic course over many years until the personality changes (Dilling et al. 1991).

Social consequences result from the psychological symptoms. Avoidance behaviour, flashbacks, and chronic overexcitement have a serious impact on the social life of those affected and their relatives.

Withdrawal or cancellation of social contacts, mistrust of people with whom one is close, etc., are a heavy burden on relationships (Lindert 2016: 389).

As already mentioned, the probability of PTSD occurring is related to the cause and frequency of traumatisation. In terms of epidemiology, there is a 50% prevalence of PTSD after rape and among victims of war, displacement, and torture; 25% for violent crimes other than rape; and 10% of road accident victims and serious organ diseases such as heart attacks (Flatten et al. 2011).

The next section takes a closer look at action and its function as a therapeutic tool. Occupational therapy focuses on the ability to act and the meaning of action for the individual.

### Activity and Occupational Therapy

There is a lot of talk about activity, but what is it? Here are some of the characteristics of action.

Activity is purposeful and conscious, which means that the person sets a goal, which must be realistic in order to be satisfactorily achieved. A debilitating environment prevents people from setting goals. Activities are structured. Each activity follows a plan of action, has a beginning and an end, and has a goal. After completion, the activity is evaluated by the performer and the environment. Activity is influenced by environmental factors and opportunities. Conversely, people shape their environment through their activities. Actions and their meanings change over the course of life, which means that activities change, and so do the roles and possibly the groups in which I participate. However, this requires the ability to adapt actions and respond flexibly to environmental conditions. People are constantly changing through their activities and therefore constantly redefining themselves.

PTSD limits a person's ability to act, which has a major impact on their daily life. The flexibility to adapt to new situations or respond to problems that arise is also reduced by the condition. This requires support to promote action and creativity. Occupational therapy addresses both aspects in its work with clients.

## Occupational Therapy and People with PTSD

The aim of occupational therapy when working with people with PTSD is to improve their ability to act in the areas of life that are subjectively important to the client. Occupational therapy is less trauma-focussed and more resource-oriented. The present, the here and now, takes centre stage (Döring et al. 2008).

Occupational therapy uses activities as a therapeutic tool. Activities are individually selected and adapted, and their performance is analysed with the client. In order to be able to perform activities, however, it is also necessary to adapt the environment. Occupational therapy is intensively concerned with human occupation and deals individually with the meaningful occupation of a person (DACHS 2007). Occupational therapy is used at every stage of treatment for people with PTSD. These phases include crisis intervention, stabilisation, trauma processing, reintegration, and rehabilitation (Döring et al. 2008: 5).

The International Classification of Functioning, Disability and Health (ICF), is used interprofessionally. As a result, it supports coherent communication between the health professions. When working with people with PTSD, the following areas should receive particular attention: cognition, communication and interaction skills, social integration, occupational balance, identifying and resuming occupation that is meaningful to the person, the plan of action and problem solving, making decisions, coping strategies and overcoming avoidance behaviour, identifying personal needs, and adapting environmental factors. All in all, working on these areas leads to the improvement of the person's ability to act (Flotho 2009: 369).

## Meaningful Activity and Accessibility

The central core of the occupational therapy approach is that meaningful occupation is a basic human need. It is an innate need to express oneself through activity, to be a part of society and thus to fulfil one's role in society (Wilcock 2015: 86-89). Being able to engage in meaningful occupations is a human right (WFOT 2019). What constitutes a meaningful occupation

is subjective and is based on socio-cultural and personal factors such as socialisation and abilities. It is therefore important that people are free to choose their activities. However, environmental factors such as economic or socio-cultural aspects can prevent people from performing the activity they experience as meaningful. The possibility of filling time with meaningful occupation is not available to all population groups or classes in a society. In occupational therapy, this is referred to as “occupational injustice” (Whiteford 2011: 304–305; Wilcock 2015: 392; WFOT 2019).

Many refugees experience occupational deprivation in their country of arrival. This refers to reduced or no opportunities to participate in activities that are meaningful to the individual in everyday life. Occupational deprivation has no apparent time limit, and the person concerned has no control over their options for activity. External factors such as social, economic, geographical, historical, or political reasons prevent participation in meaningful activities. Uncertainty regarding residence status, which means uncertain prospects for the future and confrontation with the new environment, is a burden on the recovery from psychotrauma (Herzig et al. 2001; Moser 2021). Occupational deprivation means that refugees are deprived of the opportunity to implement structure, meaning, and coherence in their daily lives through familiar activities (Christiansen & Townsend 2010; Whiteford 2011: 305; Wilcock 2015: 285). If groups of people are unable to perform meaningful occupations, they cannot subsequently fulfil any roles and therefore cannot participate in society (Whiteford 2011).

Being part of society or a group is an important, meaningful factor for every person. Occupational injustice has a negative impact on people’s health and can shorten their life expectancy. Ann Wilcock assumes that a person’s health is strongly characterized by their opportunities to “do” and consequently by their opportunities to “be”, “become”, and “belong” (Wilcock 2015: 134–138).

By experiencing participation through independently chosen and initiated activities, people gain an understanding of who they are and who they want to be. This is summarized by the term occupational identity. Based in turn on volition (values, interests, and personal causation), habituation (habits, routines, and roles) and experiences

with the resources and limitations of the body, mind, and soul, people create future identity projects and goals (Keupp et al. 2002; Heras de Pablo 2017). These are pursued through meaningful occupations. These identity projects are largely characterized by the opportunities provided by the environment. Identity shaping is a continuous process and accompanies people throughout their lives (Keupp et al. 2002).

### Flight and PTSD Influence Identity

People who have experienced displacement frequently suffer from Post-Traumatic Stress Disorder (PTSD) due to drastic environmental changes and extreme demands before, during, and after migration. These can lead to disruption of the identity-building process (Bennett et al. 2012; Stock-Gissendanner et al. 2013). Identity work is a lifelong process that is an important prerequisite for achieving life satisfaction. The context of life is constantly changing and demands continuous adaptation. People are required to adapt their actions, roles, and routines to the demands of their environment (Keupp et al., 2002). In this sense, fleeing to a foreign country requires a great deal of individual identity work. Identity work is particularly important when working with people who have experienced flight and PTSD (Stock-Gissendanner, Calliess, Schmid-Ott, & Behrens, 2013).

In the country of arrival, previously identity-forming occupations, relationships, and behavioural norms are questioned (Sluzki 2016; O'Brien 2017). A process of adaptation and rejection is set in motion. Attempts can be made to replace these identity-forming occupation and behavioural norms with those customary in the country of arrival or to maintain the familiar ones with all one's might. A rejection or idealisation of the society of origin or the society of arrival can be set in motion. Any path to an extreme, over a longer period of time, leads to a destabilisation of identity. If a person reacts by idealizing the society of arrival with a strong adaptation of identity-forming occupation and behavioural norms, the continuous course of the identity process is interrupted. This process needs time and an anchor point through the familiar occupation and behavioural norms of the society of origin. Stagnation or destabilisation of identity can also occur over a longer period of time due to adherence to familiar occupation and behavioural

norms (Sluzki 2016; Stock-Gissendanner et al. 2013; O'Brien 2017; Heras de Pablo 2017). At the same time, there is a high demand to adapt one's occupation to the new environment. During the migration process, constant humiliation and ongoing negative events can lead to psychological trauma (Grinberg & Grinberg 2010; Sluzki 2016). Discrimination and negative events put a strain on a person's identity (Stock-Gissendanner et al. 2013). A traumatized basis of the person leads to a further discontinuous course of identity in this adaptation process. The psychological state at the time of arrival and the migration attempt can be responsible for the extent to which this phase manifests itself as traumatic or how the migration proceeds (Grinberg & Grinberg 2010). It would therefore make sense to look at identity as such and in relation to people who have experienced displacement.

Aspects such as environment, identity goal, narrative, personal causation, and roles are essential in the identity process, as is confidence in one's subjective ability to act. This is a prerequisite for the feeling of being able to shape one's own areas of life. Heiner Keupp says about people's ability to act:

The ability to act represents the most general framework quality of a human and humane existence, in that the availability and mouldability of living conditions forms the antithesis to feelings of being at the mercy of circumstances, of fear and lack of freedom. (Keupp et al. 2002)

A humane existence is made possible through the free and independent organisation of living conditions. The basis for this is the ability to act. Occupational therapy is the profession that aims to (re)enable people to engage in meaningful activities. This in turn is essential for strengthening a person's sense of identity. Aspects of identity work are therefore addressed and described in the following section. We will then look at each of these aspects and how they can be addressed in occupational therapy interventions.

### Important Aspects for Identity Work in Occupational Therapy

The following section outlines the aspects that are particularly important for identity work in occupational therapy. The definition of these aspects will therefore be explained in more detail.

**Roles:** Can be predefined, such as the role of the daughter, or self-chosen. Roles require certain activities. By performing these and participating by doing them, the person can identify with the role. The importance of the individual roles can change and vary (Wook Lee 2017a).

**Personal causation:** According to the definition of the Occupational Therapy—Model of Human Occupation (MOHO), the term “personal causation” consists of two dimensions called “sense of personal capacity” and “self-efficacy”. Sense of personal capacity includes the judgement that a person has of their own physical, mental, social, and intellectual abilities. Self-efficacy defines the conviction of being able to shape and change the environment through these abilities—for example, the confidence to be able to cope with new, unforeseeable situations. The term also includes a person’s satisfaction with their own activities. The expectations that a person has of their own ability to act are characterized by experiences and the demands of the environment, and therefore influence their self-image (Wook Lee 2017b).

**Narration:** Through the narrative, the person expresses themselves and reflects on their life and occupation in the past. From this, they can plan the future. The image a person has of their life and how they choose their activities in the future as a result can be recognized through a person’s story about themselves (Keupp et al. 2002).

**Environment:** Working on and, above all, with the environment is an important aspect of the identity process. In addition to adapting to the physical environment, recognition and belonging must be experienced in the social environment. The term environment also addresses economic, cultural, institutional, and political factors. The environment is constantly changing (O’Brien 2017).

**Identity goals:** Identity concepts are created in advance. If necessary, these ideas or dreams are communicated to the environment in order to carry out a reality check. This results in concrete identity projects that lead to the identity goal (Keupp et al. 2002).

**Capacity to act:** The ability to act is the realisation of the person’s identity projects. The correct assessment of the ability to act is the basis for matching identity projects with one’s own abilities and transforming them into identity projects with their goals. Adequate capacity to act gives the person the confidence to adapt, organise, and cope with

everyday life. The ability to act therefore also means being able to comply with norms of behaviour and action established by society or the cultural context, and being part of them. The ability to act enables a self-determined life (Keupp et al. 2002).

It would appear that building an occupational identity starts with self-knowledge of our capacities and interests from experience and extends to constructing a value-based vision of the future we desire. (Kielhofner 2008: 106)

The following section looks at the practical implementation and opportunities for occupational therapy intervention. The aim is to support clients with PTSD and refugee experience to strengthen their identity. The section is therefore structured according to the aspects of identity work and the Model of Human Occupation (MOHO) (Spevak, 2022a, 2022b).

## Roles in Occupational Therapy Intervention

In occupational therapy, those affected deal with their own present, past, and future roles.

Fundamental goals are a necessity for role formation. This means that there must be a certain degree of awareness of one's own ability to act and the effect this has on the environment. In this phase of therapy, the focus is placed on the person's resources and further, familiar activities are thematized and activated again.

Roles can have negative connotations; therefore, caution is advised at the beginning of therapy. Dealing with current roles with negative connotations or the loss of roles should only be addressed at a later point in the therapy. This requires a certain degree of stability on the part of those affected. Later on, it is important to build up new roles or deal with these negative roles.

### Future (New) Roles

The occupational therapist supports those affected in finding new roles. These result from the requirements of the environment and the interests of the person concerned. The environment has a significant influence on

the opportunities to develop and take on new roles. Examples of these new roles are 'learner' through learning German in language courses or the role of 'worker' in a new, unknown profession, etc.

### Current Roles

If necessary, current roles are adapted to the current environment in order to experience more satisfaction.

### Past (Old) Roles

The occupational therapist identifies past roles during the interview. These point to activities that were important in the past or in the home country. Being able to perform these activities again conveys a sense of security and strengthens the feeling of identity. Nevertheless, those affected experience a great deal of insecurity when confronting old roles for fear of no longer being able to fulfil them. Dealing with and resuming past roles and the activities that were meaningful at the time is very effective for the recovery of those affected, but requires a high level of sensitivity on the part of the occupational therapist.

By activating past roles, those affected begin to feel anew what they want and what they like (interests). They get to know themselves again through their 'old' activities (personal causation).

### Dysfunctional Roles

Dysfunctional roles, in other words roles that lead to activities that cause long-term physical and/or psychological damage, are addressed later in the course of therapy. The aim is to discard these roles and replace them with functional ones. This is an extremely difficult and long process. It requires a great deal of sensitivity on the part of the occupational therapist. In order to discard dysfunctional roles, work is done on the personal causation. Sensitivity and dialogue in a multi-professional team about possible dysfunctional roles is beneficial for the recovery of those affected, but also for the mental hygiene of the therapist.

## Routines in Occupational Therapy Intervention

Routines are essential intervention goals when working with people affected by PTSD and complex PTSD (CPTSD). Routines can create or reinforce a sense of safety. In people with PTSD, basic routines have often been broken and need to be rebuilt. This rebuilding process involves observing which routines are already in place and how these can be reinforced. A basic action such as 'eating' is one example. Eating structures everyday life and 'taking care of others' is an important aspect of this activity.

### Routines Help in Saving Energy

Psychological energy is often reduced in people who have experienced flight and PTSD or CPTSD. Consequently, it is important to address energy balance and improve energy management when working with the target group. Activities that encourage sleep are identified to establish a consistent sleep routine.

Energy management in occupational therapy further includes the analysis of activities and their energy expenditure. Instructions are given on how to save and mobilize energy. An additional goal consists in finding activities that provide energy and can be performed regularly. The objective is to work on occupational balance.

### Rituals in Therapy Sessions

As rituals provide a sense of safety and stability, they constitute an important part of therapy sessions with people from the target group. The sequence is always the same. The unit begins and ends with the same activities. In between are the actions that require courage from the person concerned. Even if the occupational therapist has the feeling that they are repeatedly performing the same activities, this repetition gives those affected a sense of security. As a result, the therapy is predictable, which is important for those affected.

On the basis of security and predictability, those affected can make gradual progress in therapy.

## Personal Causation in Occupational Therapy Intervention

Personal causation is a key issue for the occupational therapist when working with the target group. The personal causation is often shaken by the illness and the experience of flight. The work that is done in the field of occupational therapy on the personal causation of those affected is very complex. It is often difficult for people with PTSD or, in particular, CPTSD to formulate goals for therapy but also for their own future. In these cases, it is necessary to work on their personal causation in advance in order to regain a sense of their own abilities.

By experiencing the ability to act, the personal causation is simultaneously promoted; see also 'Promotion of occupational performance'.

### The Occupational Therapist's Attitude

Working on their personal causation constitutes a significant challenge for those affected. As measures must be repeated frequently, the therapist needs to possess a certain level of endurance. Genuine interest on the part of the occupational therapist is a prerequisite for finding out together who the person concerned is. This discovery already supports the person's personal causation.

### Promotion of Personal Causation through Activity

Personal causation and occupational performance are closely intertwined. A person's sense of personal causation can be observed in the evaluation of their own actions; a negative evaluation entails a self-devaluation. The guilt and shame experienced by those affected often manifests itself in negative self-talk. This negative personal causation, which has been shaped by past experiences, causes a lack of confidence in one's own actions. The experience of having successfully performed an action and a subsequent positive response from the environment strengthens the personal causation. Performing actions creates an awareness of resources, which has a positive influence on the personal causation. If those affected have had the experience of being able to

carry out actions and influence the environment through these actions, this conveys a certain degree of control over the situation. As a result of this experience, the feeling of being at the mercy of the environment is counteracted and a feeling of coherence is promoted.

### Focus on Perception

Due to trauma, those affected are often strongly focused on their external environment. This heightened awareness of what is happening around them and the urge to adapt to the present environment were essential for survival during traumatic phases. As a result, their attention is directed outward, placing the value of the external world above their own. Therefore, it is necessary to strengthen their personal causation and support the establishment of boundaries to the environment. The affected individuals are guided to train their perception of feelings, bodily sensations, and thoughts. For this reason, the process-oriented approach is used in occupational therapy, often applied through craftwork. They need a protected space where they can act without being judged or observed. The craft itself does not need to have a deeper meaning, which is experienced as liberating. Even if a piece is created with guidance, it still holds personal expression and involves an internal process during its creation. In the follow-up discussion, the focus is on the process, specifically on the emergence of the piece. Feelings, thoughts, and bodily sensations experienced during the creation are discussed and thus communicated externally.

### Promotion of Creativity

Open-ended tasks and new actions often pose a significant challenge for people with PTSD and CPTSD. These tasks involve a certain unpredictability and uncontrollability. In everyday life, we frequently encounter situations where we must find flexible and spontaneous solutions—for example, when the chosen train is cancelled or a bus is missed. Thus, creativity is required to respond effectively, combining environmental factors with an awareness of one's own capacities and trust in them. Therefore, therapy must create situations where those affected have to try something new or out of the ordinary. Patients are guided with minimal instruction to find their own way rather than

following the therapists or other group members. Besides enhancing their perception, this approach fosters creativity and confidence in their own effectiveness, which positively shapes their personal causation.

### Different Ways to Express Personal Causation

Using creative media enables individuals to express their self-image and make their feelings and needs transparent both to themselves and to the therapist. This approach is particularly valuable when working with people who have experienced displacement and have limited language abilities, providing a means of communication. While verbal language is often necessary when the occupational therapist wants to reflect on the product, the act of expression through activities such as painting can have a profound impact. Even when individuals are capable of verbal expression, they might still struggle to articulate their emotions. Therefore, expression with creative media offers a valuable way to communicate. As previously mentioned under the topic of narration, this method is essential not only for self-presentation to others but also for self-reflection, which ultimately influences one's personal causation.

### Handling Emotions

The facial expressions of those affected are often blank. It is considered a success when tears flow, allowing the pain to find expression. Patients are encouraged to understand that expressing emotions is allowed. For example, screaming or crying can be a relief for them. In occupational therapy, various techniques such as throwing clay or boxing a punching bag are used to help mobilize emotions.

When dealing with the emotions of those affected, the therapist needs to have knowledge and a heightened awareness of the patient's socialisation. The intensity of emotional expression must be manageable for the individual to prevent the feeling of being overwhelmed.

### Narratives: Verbal and Nonverbal Communication in Occupational Therapy Intervention

Narratives, whether verbal or nonverbal, are essential for identity work.

## Narratives at the Beginning of the Intervention

At the start of occupational therapy interventions with individuals who have experienced forced migration and suffer from PTSD or CPTSD, communication is often nonverbal. It is conveyed that they are here to engage in action. Speaking is not required; the actions themselves can be viewed as a form of language. This allows for communication as well as therapy. The assessment of occupational performance can be conducted by observing the person's actions. However, language is necessary for a more detailed diagnosis.

## Narratives in Later Phases of the Intervention

In later stages of therapy, verbal communication becomes increasingly important. Professional interpretation services are highly recommended and can be repeatedly utilized in occupational therapy interventions. Although the application of these services is straightforward, their implementation within an institution often poses challenges. Unfortunately, it is often the case that family members or friends act as translators. For example, a child may have to translate a diagnosis for his or her mother. Apart from possible translation errors, this is emotionally stressful for the child. Trust in the relationship may be violated. It is therefore clear that family members and friends should be avoided as translators if professional work is to be carried out.

Individuals affected may be highly distrustful due to their condition. Therefore, it is crucial to be very careful with expressions, gestures, and facial expressions in communication to avoid, in extreme cases, the risk of therapy being discontinued due to misunderstandings. A key part of therapy is taking responsibility and asking clarifying questions to understand what a statement meant. High transparency in documentation and reporting is essential. The individuals must feel involved to maintain trust.

## Social, Physical, Economic and Cultural Environment in Occupational Therapy Intervention

Understanding the immediate environment of the individuals is a prerequisite for effective intervention.

## The Occupational Therapist as a Health Advocate

Occupational therapy has the potential to more frequently incorporate methods from environmental therapy. This does not mean integrating the affected individuals but rather adapting the environment. There is a significant lack of environmental adjustments for individuals with mental health conditions. For example, a person with early childhood trauma who frequently dissociates may not be able to consistently arrive at work on time. This is an environmental issue, not a problem with the individual. Often, these individuals are highly intelligent but unable to work in a typical job setting due to their mental health conditions.

There is a need for greater awareness and education regarding psychiatric conditions. Stigmatisation is widespread. It is little known that people with refugee experiences often suffer from PTSD or CPTSD and the limitations these conditions impose on all areas of life. Advocacy is needed to regulate the workplace for these individuals, including managing breaks, work hours, noise reduction, and so on.

When occupational therapists work with this target group, networking becomes increasingly important. For example, communication with refugee shelters or employers where the affected individuals are involved is essential. Occupational therapists can inform the environment about the needs and challenges of individuals regarding their occupational performance. The goal is to discuss and implement possible adaptations to the environment with employers, educators, social workers, associations, etc. Refugee shelters can be conflict-laden without offering a perspective for the affected individuals to escape this situation. Developing future perspectives may require occupational therapy support over several years. Language skills are crucial for individuals' future opportunities.

Changes to the environment have a direct impact on the roles of the affected individuals. Therefore, when the roles of these individuals are addressed in therapy, work is indirectly being done on or with the environment.

## Occupational Performance in Occupational Therapy Intervention

People with refugee experiences and PTSD or CPTSD often have a very low sense of self-efficacy. They need to regain their occupational performance, which in turn supports their personal causation. Occupational therapy and its methods promote self-efficacy and consequently promote the identity of the affected individuals. Expanding their ability to act is a central theme in working with traumatized refugees in occupational therapy. Occupational performance is not something that is achieved once and for all. Even different life phases demand that individuals acquire new skills or perform them differently. It is important to maintain the ability to act and to adapt to changing environmental conditions. Actions taken also affect the environment.

### Fostering Self-Efficacy

The impact of self-initiated action on the environment strengthens the belief in one's effectiveness. The stronger the belief in one's self-efficacy, the greater the ability to adapt one's actions to everyday situations. Self-efficacy is consciously enhanced through reflection after performing an action. Self-efficacy, which occupational therapy is well-equipped to foster, is the key to improve well-being. Dissociation significantly reduces the sense of self-efficacy. Dissociations cause unpredictable memory gaps, leading to uncertainty about one's own effectiveness. Therefore, at the beginning of therapy, the most crucial approach is to enhance the sense of self-efficacy through action.

### Taking Action as Soon as Possible

For those affected, the immediate priority is to engage in action. This helps individuals start to re-experience themselves, laying the foundation for rediscovering what they can do, what they enjoy or dislike, and which actions are important and meaningful to them. This process not only strengthens occupational performance but also reinforces values, personal causation, and interests.

## Execution of Action

People with flight experience and PTSD or CPTSD may struggle with concentration difficulties, leading them to perform actions in a rushed and careless manner. This often results in dissatisfaction with the outcome. The discrepancy between the expected and actual result can be frustrating for those affected. Some may also exhibit perfectionism in their actions, yet still feel unsatisfied with the outcome. In such cases, feedback from a group about the action can be very effective. Additionally, addressing perfectionism in the execution of actions can gradually lead to changes in personal causation over time. Group activities that promote occupational performance and social skills (e.g., the ability to handle criticism and communication skills) are particularly beneficial.

In occupational therapy, individuals with flight experience and PTSD or CPTSD are supported in discovering more about their own abilities and skills. This discovery process is facilitated through action and is implemented throughout the course of therapy, from beginning to end.

## The Personal Causation and External Perception Do Not Match

Individuals often underestimate their abilities, which leads to self-imposed limitations in their actions. For a person, the external perception of their abilities serves as an important mirror. The environment must recognize successful actions to help the individual become aware of their own resources. In occupational therapy, reflection on actions occurs both during and after the performance. The occupational therapist observes and analyses each step and the necessary skills and functions involved. These are then reflected upon with the individual, focusing on the resources and deficits within the different components of an action. This process helps to identify why an action may not have been carried out satisfactorily. More importantly, it makes resources transparent by identifying the parts of the intervention that are working well.

The experiences during the action must be reflected upon through discussion and further exploration. This reflection is crucial for

reinforcing the experience of the action. Reflecting after the completion of an action is especially effective in a group setting led by the occupational therapist. It is essential that the individuals understand the reasoning behind the interventions. This understanding is vital for their motivation and comprehension of the therapy process. In this phase, it is advisable to use professional interpretation services. The impact of the final product on the environment can also be perceived nonverbally. The occupational therapist considers this and creates situations in which the completed product is put to use.

### Finding Trust in One's Own Ability to Act without Pressure

People with PTSD and CPTSD often struggle with the action sequence of 'initiating an action'. They may experience fear when starting a task. To help them overcome this, it is important that they first participate in the group without any pressure. Initially, it is essential for them to feel like part of the group simply by being present. Once this sense of belonging is established, external prompts at the right moment can gently encourage the initiation of independent action. This approach can also work nonverbally. The more trust the individuals have in the occupational therapist, and the more frequently they experience self-efficacy, the easier it becomes for them to begin an action independently.

### Relaxation Techniques

Relaxation techniques allow people with PTSD and KTPBS to calm the stress system and distance themselves from survival mode. One consequence of traumatisation is a strong focus on the environment, which constantly stimulates the person's stress system. This reduces the ability to act (Kubny 2020).

### Goals in Occupational Therapy Intervention

In occupational therapy, goals are usually set at the beginning of therapy. These are client-centred, which means they are adapted to the client's needs. Progress can be made visible through goals.

## Overwhelming the Affected Individuals with Goal Setting

At the beginning of therapy, individuals with flight experience and PTSD or CPTSD often find it challenging to articulate goals. Before they can do so, their personal causation needs to be strengthened—in other words, they need to build trust in their ability to influence their environment through their actions. Setting goals at the start of therapy can be overwhelming for them, meaning that a client-centred approach may not be possible from the outset. However, this should not be a reason to exclude them from occupational therapy interventions. The occupational therapist must be able to justify to the team why the goals they have formulated are not client-centred.

## Possible Approach to Goal Setting

Initially, it is helpful to allow the individuals to create identity drafts and fictional goals. They are encouraged to dream. For example, the first goals of people with refugee experiences might often be to leave the refugee shelter, enrol in a language course, or find work. As they move into a phase where they recognize the difficulty of achieving these goals, they will need support. During this process of discovery, individuals learn to accurately assess their current situation and become familiar with the opportunities and limitations offered by their environment. Support during this phase is crucial to help them ultimately set realistic identity goals.

Trust in their own ability to act fuels intrinsic motivation and broadens their perspective. Consequently, a goal can eventually be formulated in a truly client-centred manner.

## Conclusion

Experiences in the home country, during flight and the challenges in the country of arrival very often lead to mental illness, most frequently post-traumatic stress disorder (PTSD). Moreover, the suicide rate among male refugees while waiting for asylum is higher than that among the host society. At the same time, it is evident that access to psychiatric care is difficult or impossible, although there is an increased need for it.

The degree of traumatisation is influenced by the extent of personal resilience and, in contrast, the cause of the situation or who caused it, as well as its duration and frequency. A person can also process a traumatic experience independently. Whether this is successful cannot be predicted. If the symptoms persist for a period of six months, we can speak of PTSD, which can become chronic and result in personality changes.

People who have experienced flight and post-traumatic stress disorder (PTSD) are affected by occupation deprivation and occupation injustice, which has a negative impact on their occupation identity. This group of people is up to ten times more affected by mental illness than the autochthonous population of Western countries due to their experiences in their country of origin and arrival as well as their flight. Socio-economic status and psychosocial stress in the country of arrival have a significant influence on their health. These factors have a negative impact on people's life satisfaction and put a strain on identity work. Identity work is a continuous process. People change roles, meaningful activities, interests, etc., throughout their lives. This aspect is intensified by illness and the experience of flight. Therefore, people should be supported in these phases to stabilize their identity. The following aspects of identity work need to be supported in occupational therapy: the areas of roles and routines, personal causation, narrative, environment, occupational performance, and goal setting.

Roles can be a sensitive issue and are addressed and worked on over a longer period of time. The loss of roles is associated with psychological pain and the fear of no longer being able to fulfil them. Self-efficacy conviction, personal causation, and occupational performance influence the resumption of and satisfaction with the respective role. At the same time, the revitalisation of past roles is very effective for the identity of those affected. Routines provide stability and support the energy balance of those affected.

Personal causation is a central issue in occupational therapy interventions for the target group. Dealing with this is a lengthy process. The personal causation is strengthened by reflecting on the performance of the activity. Process-oriented measures are also used to reflect on subjective perception. The feelings and needs of those affected are addressed. To do this, the occupational therapist uses the expression-centred method, among other things.

The expression-centred method promotes narratives or the telling of one's own emotional experience and needs, but action can also be used as a means of communication. In the later course of therapy, when trust in the therapist is established, it is advisable to use professional interpreters.

In their occupational therapy expertise as a health spokesperson, the occupational therapist represents those affected. People with mental illnesses need advocates who educate people about mental illnesses and point out stigmatisation. There is a need to adapt to environmental conditions for people with mental illnesses. Interprofessional networking should be sought.

Promoting the occupational performance, and reflecting on the execution and the end result of these actions, influences the personal causation and the conviction of self-efficacy. It helps those affected to (re)formulate (identity) goals. Working on occupational performance in occupational therapy promotes the personal causation and subsequently the identity of those affected.

At the beginning of therapy, those affected usually find it difficult to independently formulate goals for the therapy but also for the future. As the therapy progresses, the focus is on creating realistic goals in the current environment. The occupational therapist supports the process from a draft of identity to realistic identity goals.

Occupational therapy offers effective intervention options when working with people with PTSD. It can intervene at all stages of the therapy process. It works in a stabilising, resource-oriented and action-promoting way.

Occupational therapists have extensive knowledge of how they can support people who have experienced flight and PTSD in their identity work.

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