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The Paralysing Impact of Shame: Resilience and Vulnerability of Refugee Youth

Background

Refugee and asylum-seeking (RAS) youth are considered more vulnerable to mental health problems than the general public (Ehntholt & Yule, 2006). This risk is associated with exposure to trauma, displacement, loss, and uncertainty surrounding the future (Lustig et al., 2004). Additionally, RAS youth may encounter difficulties with education (Weine et al., 2014), family mental health problems (Fazel, Reed, Panter-Brick, Stein, 2012), discrimination (Stark, Plosky, Horn & Canavera, 2015) and isolation (Bronstein & Montgomery, 2011). Despite such risks to well-being, RAS youth also possess a number of strengths and resources and show significant resilience in the face of adversity (Papadopoulos, 2007).

A strong sense of identity and self-worth have also been identified as protective of mental health among RAS youth with the opposite (shame and low self-worth) proving detrimental (Stotz, Elbert, Muller & Schauer, 2015). Shame has been defined as the global negative evaluation of the self, often from the perspective of others (Stotz et al., 2015) and has been associated with experiences of trauma, discrimination and mental health problems in clinical populations (Gilbert & Procter, 2006). Emerging literature has suggested a similar connection with the RAS experience (e.g. Stotz et al., 2015). The influence of caring, compassionate connections has been found to mediate the effect of shame and low self-worth (Gilbert & Irons, 2004) with the establishment of compassionate and supportive relationships in the country of settlement similarly being considered a critical component for the well-being of RAS youth (Oppedal & Idsoe, 2015) There is, however, a paucity of literature exploring this concept in detail despite the connection between the experience of shame and the myriad of challenges faced by RAS youth.

Research question

The experience of shame increases the vulnerability to, and severity of, mental health problems. This study explored the impact, risk and protective factors for the experience of shame among refugee youth as perceived by their service providers.

Participants

The participants of this study included three men and six women from different agencies in Perth, WA, providing mental health, social, and/or community support services to refugee youth. Between them, the participants had from one to 26 years of experience working with refugee youth (*M*=5.9, *SD*=7.8). In the preceding 12 months participants reported working with five to over 100 refugee youth from various countries including Iran, Afghanistan, Pakistan, Iraq, Syria, Sudan, Uganda, Sri Lanka, Burma, Thailand, Vietnam, Cambodia, Tanzania, Burundi and Somalia. Two participants identified themselves as case workers, two as community workers, one as a general psychologist, one a family support worker/counsellor, one a social worker, one a teacher, and one a youth project officer.

Method

Semi-structured interviews were conducted with nine service providers working with refugee youth. Interviews were analysed using thematic analysis. The data were analysed from an approach where themes were interpreted from the participants' own experiences and meanings.

What I found

Three overarching categories were identified using theoretical thematic analysis. The first two categories addressed the impact of shame and the risk/protective factors influencing shame. Risk and protective factors were further categorised as individual, family/cultural and community/societal factors. The final category identified the barriers and improvements for engaging in services (see Appendix).

Discussion

The results of this study suggest that refugee youth face a myriad of challenges that leave them vulnerable to shame, and that shame has a detrimental effect on mental health and well-being. Participants reported that the impact of shame was both precipitated, and compounded by, the presence of a risk factor and could be ameliorated by the presence of a protective factor.

Risk Factors and Vulnerability

According to service providers, experiences such as trauma and detention resulted in vulnerability to shame and mental health problems. Results are consistent with previous research suggesting refugee youth exposed to trauma or violence are at greater risk of experiencing psychological disturbance (Fazel et al., 2012) and shame (Stotz et al., 2015). In the current study, service providers reported that youth were more likely to experience a negative self-evaluation and the desire to isolate, hide or minimise their experiences after experiencing trauma. Accordingly, individuals from traumatic backgrounds who experience a limited degree of safety and reassurance typically report a heightened sense of internal shame and greater self-criticism (Gilbert & Procter, 2006).

The connection between shame and negative self-evaluation highlighted in the current study is consistent with previous research suggesting that each can lead to, and exacerbate, the other (Gilbert & Procter, 2006). Negative self-evaluation has been considered a key component of internal shame and leads to self-criticism, self-attacking and an inability to be content with oneself (Gilbert & Procter, 2006). Service providers in the current study reported that youth often internalised a negative self-perception that they were worthless, weak, undeserving and inadequate and were consequently more vulnerable to mental health problems. Accordingly, internal shame and resultant self-criticism are often precursors to psychological distress, perpetuate problems and increase the risk of relapse (Tagney & Dearing, 2002). Constant self-criticism and self-attacking creates an internal world that is threatening and hostile (Gilbert & Procter, 2006) and when this is compounded by external stressors shame may manifest in despair, hopelessness and depressive symptomology (Lee, Anderson & Klimes-Dougan, 2016). The desire to hide or minimise aspects of the self to reduce internal shame is also consistent with previous research (Gilbert & Procter, 2006) and is likely to act as a barrier to help-seeking (e.g. Shannon et al., 2015).

In contrast to internal shame, the negative impressions of, and pressure from, loved ones to conform to traditional practices was considered to create external shame. Cultural conflicts have been found by other researchers as impacting on the family dynamic (Fazel et al., 2012) and, like internal shame, can result in the desire to conceal and hide emotions, personality traits or difficulties (Gilbert & Procter, 2006). Cultural expectations around mental health also resulted in stigma when experiencing such difficulties and participants reflected that youth were likely to isolate, withdraw or hide their struggle. This, in turn, was considered more likely to increase shame and worsen mental health and is consistent with previous research among adult refugees (Drummond, Mizan, Brocx & Wright, 2011).

Protective Factors and Shame Resilience

When risk factors were met with a protective factor, the severity of the impact of shame on mental health was seemingly lessened. For example, it was suggested that finding purpose and meaning in their experiences, and being able to focus on the future to instil a sense of hope, could combat the negative experience of shame. Hope was in turn considered healing. These findings support those of Yohani (2010) suggesting that hope is an integral component of adjustment and positive mental health. Several personality traits made this process more likely. Youth who were motivated, ambitious, persevering, and confident were thought to encounter less mental health problems and possess more resilience to shame. Similar personality traits have been considered protective in other research (e.g. Yohani, 2010).

Service providers reflected that based on their experiences, youth had a high degree of compassion and empathy for the struggle of others, and this sense of shared understanding also acted as a buffer against shame. Accordingly, consistent with research around shame resilience (Tangney & Dearing, 2002), a sense of belonging and connection was considered by all participants as protective. Feelings of shame were lessened when met with compassion, validation and empathy from supportive peers, professionals or family members. In accordance with previous research such as Brown (2006), a reciprocation of compassion and empathy was thus considered a buffer against shame, especially if youth were able to discuss their concerns in a non-judgemental space and recognise the similarity of their feelings and experiences with others. Talking about their experiences lessened isolation, promoted healing, and increased a sense of hope.

The establishment of compassionate relationships with supportive others has been suggested by previous research as important in the acculturation and mental health of refugee youth (e.g. Oppedal & Idsoe, 2015) and research has documented the healing benefits of compassion on the experience of shame in clinical populations (e.g. Brown, 2006). In the current study, belonging, connection and compassion were sugggested to ameliorate other risk factors for shame such as discrimination and prejudice, which may otherwise lead to feelings of worthlessness and poor mental health.

Implications

In line with recommendations from service providers, there are a number of potential clinical implications to consider. The first is that a lack of training and cultural awareness acts as a barrier for youth in accessing mental health services. Research in identifying clear guidelines for evidence-based practice, culturally appropriate interventions, and the development of specialised training for mental health professionals at both an educational (e.g. university) and organisational level is necessary to improve the delivery of services for refugee youth.

Participants also reported that the demand for low-cost, culturally appropriate, accessible services is greater than that which is available. Furthermore, the stigma around psychological and emotional problems prevents help-seeking with many youth struggling in isolation. An increase in services and funding was therefore considered a priority by participants, as was the need to provide more advertising and normalising around mental health concerns.

As connection and compassion were found in this research and elsewhere as key protective factors against shame, using compassion-based therapy with refugee youth is an area that warrants further exploration. Finally, the perspective of Australian refugee youth themselves may also allow for more effective services and supports to be implemented.

Conclusions

Overall, the experiences of the nine service providers who participated in this study revealed shame to be a common and detrimental experience on the mental health of refugee youth and one that affected their general well-being, sense of self-worth and relationships. Individuals were at risk of both internal and external shame due to a number of individual, family and community factors; however, when met with a protective factor, the severity of the impact of shame could be lessened. The presence of belonging and compassion, for example, were identified by all participants as a potential strategy in ameliorating the negative effects of shame.

This area warrants further attention due to the success in compassion-based approaches among individuals with similar experiences. Further research is also needed in developing more culturally appropriate training and interventions in order to best support this vulnerable, yet resilient, group of young people.

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Table 1: **List of categories and themes**.

Category	Theme	Example
1. Impact of shame	1. Negative self-evaluation 2. Hopelessness 3. On help-seeking 4. Hiding	1.Feeling flawed, feeling crazy...not feeling worthy...not strong...in most cases seeing themselves as weak...not deserving...failures. 2.Connected a lot to the hopelessness, like 'what's the point then, being here? 3. There are also cultural barriers around mental health problems....you don't seek mental health support until you're crazy, and when you do that sort of implies that you've you know gone crazy. 4. Youth did not "talk to each other about their personal issues" so there was a desire "to hide" and "a lot of putting this front [up]" to ensure no one knew the extent of their struggle

2. Risk/protective factors for shame	Individual: 1. Trauma 2. Fostering positivity/meaning 3. Future focus/acceptance 4. Personality traits	1. 70-80% have experienced a lot of trauma 2. If youth were able to “look back...at some of the experiences that have been very dark...and reflect on...some [their] strengths” they were more likely to feel a “sense of...confidence and...competence...and their self-worth [is increased] 3. Sometimes they embrace the past experiences for what they were...they don't like to talk about it but they've moved on. 4. Youth who were considered to be “very resilient and amazingly able to find their way and sort things out for themselves” were considered to be protected from shame.
	Family/Cultural: 1. Adult role 2. Cultural factors 3. Connected	1. Children often had to be “the interpreter” for their parents 2. When what the young person was learning was not according to the...traditional teachings of that family, youth were at risk of being shamed by their family. 3. If things are very stable at home … there is less problems [with self-esteem]”.

	Community/Societal: 1. Discrimination 2. Connection, belonging, compassion	1. f***ing Muslim terrorist and go back to where you came from" affected"... it makes them feel so alone and worthless 2. In reducing shame, the "greatest help" was thought to be "to come together and talk about those moments that they've felt there's nothing else to hold on to and you know just being there [for one another]"
3. Service engagement	1. Services, resources and funding 2. Cultural awareness, understanding and knowledge 3. Cultural expectations and stigma 4. Trust and relationships	1. There was not a single drug and alcohol rehabilitation appropriate to the CALD (culturally and linguistically diverse) community 2. Increase understanding [there needs to be] more education 3. Youth needed to be made aware that "you're not alone, it's ok to feel like this". 4. Difficulties in the relationship between mental health professionals and youth were considered to be a barrier in accessing services. This was partly because it "takes so long to get to know them" because "these guys come from, you know, countries or places that...they don't trust anybody...and it takes them so long to trust a new person"