Chapter # 17

PREVENTIVE PSYCHOLOGY IN REFUGEE MENTAL HEALTH

Trust-Building between traumatized individuals, experts, and responsible authorities

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ABSTRACT
The full-scale invasion of Ukraine on February 24, 2022, led to an unprecedented refugee crisis in Europe, necessitating the development of effective preventive psychological support strategies. In response, a trauma-focused group intervention program called "Hälsoskola" (in Swedish) was developed and implemented for 100 Ukrainian refugees in Sweden, predominantly women. The program, grounded in trauma-informed principles, aimed to create a framework for building trust in dialogue and for cultural sensitivity. Over five weeks, participants met with local experts to discuss topics of stress management, somatic and mental health literacy, human rights, employment, and social support. The results showed that the face-to-face dialogue between the participants' needs and the experts' responses was promising, leading to increased trust and somatic and mental health literacy. We provide a key concept in the field of trauma and explain how a participatory approach can be used to develop tailored “Train-the-trainers” programs for refugees of various origins. The book chapter also considers the key challenges associated with assisting refugees, including methodological and ethical difficulties such as language barriers, cultural differences, ensuring informed consent, and community involvement.

Keywords: Ukraine war, health literacy, mental health, refugees, language barriers, trauma-informed care, trust-building.

1. INTRODUCTION

The full-scale invasion of Russia into Ukraine on February 24, 2022, led to a massive displacement of the population and resulted in tremendous losses, including the loss of family members, health, possessions, security, and social status (Frankova & Sijbrandij, 2025). About 4 million people became internally displaced people, and 6.9 million refugees, of whom approximately 40,000 arrived in Sweden (UNHCR, 2022). This crisis has had a profound stress, uncertainty, and negative impact on the mental health of Ukrainians, both children and adults, increasing feelings of helplessness, depression, and anxiety (An, Wang, Chen, & Oleksiyenko, 2025; Pinchuk et al., 2024). Refugees face trauma, instability, and the disruption of social ties, which is exacerbated by living in a "state of limbo" in a new country (Anjum, Aziz, & Hamid, 2023). These outcomes are recommended by policymakers to give priority to introducing work opportunities and ensuring a safe living environment to help innocent people recover from war conflicts.

According to the American Psychiatric Association (2013), DSM-5, the concept of trauma is described as a sudden, unexpected, horrifying event apart from normal experience during a day. Trauma may be a “man-made” event that involves actual or threatened death

or serious injury, or a threat to the physical well-being of the person or of others. The person's response has been intense fear, helplessness, or horror, e.g., violence, war, torture, rape, accidents, or natural disasters such as fires, earthquakes, water floods.

One of the critical challenges in providing psychosocial support is the deep mistrust of people and institutional structures that develops as a result of trauma and forced migration. This mistrust, compounded by the fear of stigmatization of mental illness, can significantly reduce the effectiveness of interventions, making trust-building a key component of successful support. Further, results from a video conference interview highlighted the significant problems faced by refugees and other migrants and include extrinsic barriers, symptoms of psychological distress, coping and help-seeking behaviors, and interpersonal relationships (Akef, Poyrazli, & Quintero, 2024). Survey data among forced Ukrainian migrants in the U.S. showed that individuals reported various psychological factors and cultural experiences, revealing high resilience and low stress tolerance along with a strong correlation between their adopted acculturation strategies and their resilience and levels of traumatization (Andrushko & Lanza, 2024).

1.1. Six principles of a Trauma-Informed Approach

According to SAMHSA (2014), a trauma-informed approach includes the following six key principles, which have linkage to resilience and recovery and can be generalizable and used in different settings; however, application may be sector or setting-specific.

1.1.1. Safety

The target group needs to feel physically, psychologically, socially, and morally safe; that means that the physical setting is safe, and interpersonal interactions promote a sense of safety. Therefore, we must ask the target group what safety means to them, and we have to create safety for those who have different life experiences from our own.

1.1.2. Trustworthiness and Transparency

Every operation and decision in the organization is performed with transparency, with a culture of connection in relationships with the aim of building and maintaining trust with clients and relatives, among staff, and others included in the organization.

1.1.3. Peer Support/"Trauma Survivors": With Individuals Having Lived Experience of Trauma

This peer support and mutual self-help are central for building trust, safety, and hope, as well as promoting collaboration to promote healing and recovery.

1.1.4. Collaboration and Mutuality

Healing is promoted in relationships and in a meaningful sharing of power and decision-making. Everyone feels they have a role to play in the trauma-informed approach.

1.1.5. Empowerment, Voice, and Choice

Strengths and experiences of the individual's voice and choice are recognized and built upon, as well as the belief in the possibility of recovery from trauma. Empowerment means that the organization continues to support an individual's inner resilience. It is common that individuals with past trauma experience coercion and choice if significant as the individual always feels they have a choice.

1.1.6. Cultural, Historical, and Gender Issues

Cultural stereotypes and biases are actively moved past, and access to gender responsive services is paid attention to, as well as the individual's unique racial, ethnic, and cultural needs due to historical trauma. Particular attention is paid to the problem of stigma, which exists on several levels: self-stigma, stigma by association, public stigma, and structural stigma. These barriers often prevent refugees from seeking help.

Therefore, our intervention is based on the principles of trauma-informed and culturally safe practice. Trauma-informed practice involves an awareness of the prevalence of trauma and its impact, as well as creating an environment that helps to avoid re-traumatization. Culturally safe practice requires specialists to respect the cultural identities of others, recognize their own biases, and ensure that the needs, expectations, and rights of participants are met safely. The goals of such trauma healing and recovery practice include restoring a sense of safety and control, as well as promoting connections with other people and a sense of belonging.

This is in accordance with European policy for refugee mental health (European Union Agency for Asylum, 2024) and WHO action plan for refugee and migrant health in the WHO European Region 2023-2030 (2023) intending to support countries to make health for all, including refugees and migrants a reality and integrating mental health into primary care, providing flexible and culturally sensitive services and promoting human rights protection, social inclusion and support for vulnerable groups.

2. BACKGROUND

The present study relies on several key works that shape the modern understanding of refugee mental health issues. An et al. (2025) and Pinchuk et al. (2024) provide fundamental data on the impact of the war on the mental health of the Ukrainian population, confirming the relevance of preventive interventions. The work of Anjum et al. (2023) introduces the important concept of "life in limbo," which accurately describes the state of uncertainty experienced by refugees and emphasizes the need for programs that restore a sense of control.

The methodological basis of our research is supported by the works of Seagle et al. (2020) and Minas, Diocera, & Colucci (2025), which highlight the ethical and practical challenges in working with migrants, such as the need to build trust, respectful engagement, and overcome language barriers. Our trauma-focused group intervention (Ekblad, Gramatik, & Suprun, 2024) is a direct response to these challenges. The theoretical understanding of the six principles of the trauma-informed approach described above by SAMHSA (2014) formed the basis for creating a safe and unbiased environment in our target groups. Another theoretical model for working with resilience is Salutogenesis (Antonovsky, 1979). This model focuses on factors that promote health. The key concept is the "Sense of Coherence," which consists of three components:

- Comprehensibility: The belief that events are predictable and understandable.
- Manageability: The belief that resources are available to cope with problems.
- Meaningfulness: The feeling that life has emotional meaning and that challenges are worth addressing.

3. OBJECTIVES, DESIGN, METHODS, AND RESULTS

3.1. Objectives

Explore whether a brief trauma-focused group intervention for traumatized participants, followed by psychosocial support on mobile, promotes health behavior, resilience and trust?

3.2. Study Design and Participants

The study is a mixed-method design with a group intervention using a participatory methodology. The program involved 100 Ukrainian refugees (predominantly women) who arrived in Sweden under the European Union activated the Temporary Protection Directive (Council Directive 2001/55/EC). A workshop was held before among potential participants to explore the needs and content of each session.

3.3. The Trauma-Focused Group Intervention

The program consists of five weekly two-hour sessions, is a voluntary gathering of participants affected by the war to acquire knowledge, skills, and mutual support. The group size is approximately 10 participants and with a moderator, interpreter, and expert for each topic below. Each meeting was dedicated to one of the key topics identified based on the participants' needs:

- Stress management and recovery: basics of psychological first aid, relaxation techniques, a dialogue with psychologists (the authors).
- Human rights and the law enforcement system: a dialogue with a police representative.
- The health literacy, including the healthcare system: a dialogue with a representative from medical services.
- Employment and education: a dialogue with an employment manager from the municipality and a school representative.
- Social support: a dialogue with a social worker.

Each session included a presentation from a local Swedish expert and a subsequent Q&A session, which ensured a direct dialogue. The meetings were held in Ukrainian/Russian with the participation of a professional interpreter and were supervised face-to-face and online by two Ukrainian psychologists and a Swedish project manager (the three authors).

To create a safe and trusting atmosphere, eight key rules were established and strictly observed:

1. Full confidentiality of the interpreter.
2. The "four walls rule": everything said remains within the group.
3. No mobile phones during the session.
4. Full presence "here and now."
5. Exclusion of sensitive topics (politics, religion) from the discussion.
6. An organized order for questions (by raising a hand).
7. A closed group format.
8. Voluntary participation and confidentiality of information.

3.4. Outcome Measures: Indicators

3.4.1. Quantitative and Qualitative Measures (Mixed Methods) Target Group of Participants

Participants: demographic background (age, gender, education, family status, children, native language, residence, work, leisure)

- Screening questionnaire at baseline measuring users' perceived health and lifestyle habits based on the severity of worry/anxiety/stress symptoms
- Pre-post perceived health immediately and 3 months after
- Group dynamics operationalized by estimating the activity of participants during dialogue within an expert in trauma-focused group intervention
- Evaluation of psychosocial support on mobile after 3 months
- Acceptance and usability based on needs and perceived health measured with WHO's Wellbeing Survey (WHO-5, 2024) after 3 months for follow-up

3.5. Ethical Considerations

The project received approval by the Swedish Ethical Review Authority (2023-00092-02). All participants gave their written informed consent in accordance with the Declaration of Helsinki (World Medical Association, 1964). Participation was completely voluntary.

The project is low-risk and consists of a series of semi-structured interviews. There were no medical procedures, interventions, or patient involvement. The risk of psychological or emotional distress is low, but some participants may experience mild discomfort when reflecting on their life experience. However, this is expected to be minimal and transient. To eliminate the risk of privacy breaches, all data is anonymized during transcription, and any identifiers are removed from the interview transcripts. The data is stored securely with limited access; all interview content reported in publications will be anonymized. Participation was completely voluntary; participants could withdraw at any time without giving a reason, and they could choose not to discuss or answer specific questions during the interview. The process follows the principle of proportionality according to the Ethics Review Act. The potential minimal risks to the well-being and integrity of the informants are outweighed by the scientific and societal value of the project. The project will develop new knowledge that can benefit both healthcare professionals and the public.

3.6. Results

The trauma-focused group intervention demonstrated high effectiveness and feasibility. For detailed results, see Ekblad, Gramatik, & Suprun, (2024). The direct dialogue between the participants' needs for knowledge and the local experts' answers contributed to a noticeable strengthening of trust and an increase in health and mental health literacy. The participants gained practical knowledge that helped them better navigate Swedish society and reduce their stress levels.

An important result was that about a third of the participants required subsequent individual psychosocial support, organized via mobile phone. This indicates the program's ability not only to provide preventive care but also to effectively identify individuals in need of more in-depth therapeutic work. In our experience, it was personal, direct interaction that was critical in building trust. It was noted that, in contrast to face-to-face meetings, building and maintaining trust online was significantly more challenging (Ekblad, Gramatik, & Suprun, 2025). This difference was felt in both individual and group sessions, as we worked with different groups both offline and online. Similar difficulties arose when using

telephone interpreters, which also hindered the establishment of deep contact and mutual trust in the group. These observations confirm that when working with traumatized people who have experienced loss of safety, physical presence, and direct dialogue are key to creating the safe and predictable environment necessary for successful intervention.

3.7. Discussion

The success of the trauma-focused group intervention ("Hälsoskola") program can be attributed to its ability to directly address the fundamental challenges of mistrust. These observations have deep theoretical underpinnings related to the principles of a trauma-informed approach. Face-to-face interactions directly enabled the principle of "Safety" to be realized, creating a physically and psychologically protected space that was difficult to replicate online. Moreover, it facilitated the principle of "Mutual Support," as the immediate presence of a group increased the sense of community and belonging, which is critical for trauma recovery and the development of a "Sense of Coherence" (Antonovsky, 1979).

The creation of a safe, structured, and predictable environment, the use of the native language, and the involvement of reputable local experts made it possible to overcome the barriers that often prevent refugees from receiving help. The program empowered these participants by providing them with knowledge and agency, which facilitated the transition from a passive "newcomer" identity to an active role in their own integration.

These results are consistent with findings in other studies that emphasize the importance of social connections, inclusive interventions, and respectful engagement for the psychological well-being of refugees (Rizzi et al., 2023; Minas et al., 2025). The program effectively countered stigma by normalizing discussions of problems and seeking help in a safe group environment.

Conducting such research is associated with several methodological challenges. Minas et al. (2025) identified the necessary knowledge, skills, and engagement strategies for working with migrants. These include respectful interaction skills, knowledge of the context, and the ability to speak the participants' language. Practical difficulties include language barriers, limited resources, and ensuring safety.

Moreover, acute survival needs, fear of stigma, and traumatic experiences can create direct or indirect obstacles to obtaining meaningful informed consent and establishing trust (Seagle et al., 2020). The language barrier and the lack of previous medical records are key constraints in providing medical care to refugees (Biesiada, Mastalerz-Migas, & Babicki, 2023), which further emphasizes the need for tailored approaches like trauma-focused group intervention.

The systematic review by Rizzi et al. (2023) confirms that social connections and inclusive community interventions play a vital role in improving the psychological well-being of Ukrainian refugees. Tailored approaches are needed, including both face-to-face and digital interventions based on the principles of psychological first aid (mobile applications).

The target group and the content in this model are always recommended to be clarified for consideration when generalizing the results. In this model, most of the Ukrainian refugees coming to Sweden were women and children, and in the meantime, the husbands were soldiers in Ukraine and had restrictions on leaving the country if no disabilities.

4. FUTURE RESEARCH DIRECTIONS

4.1. Goals and Objectives of the Training Program

The Ukrainian health and mental health care system is unable to meet the enormous present demand, especially due to a shortage of resources and staff. The whole generation of the Ukrainian population is traumatized. In the project “train-the-trainer”, knowledge transfer is planned to be held for local psychologists in Ukraine. The overall goal of the research program is to develop, implement, and evaluate a training program for local psychologists using the "train-the-trainer" method. The specific objectives are:

- To provide local psychologists with the necessary skills, tools, and intervention strategies to effectively address core mental health problems at the individual, family, and community levels.
- To help local psychologists develop new strategies for health promotion, prevention, and early intervention at the community level.
- To establish a training model that promotes a commitment to ongoing skills enhancement, documentation, and outcome evaluation.

4.2. Principles of Partnership and Mutual Learning

- The training program should be designed in consultation with local organizations to ensure that the mental health model it promotes is consistent with the needs of the beneficiaries.
- A partnership model is created in which external experts collaborate closely with existing staff in a spirit of mutual learning, where all participants play an active role.
- It is necessary to recognize that local Ukrainian psychologists also live in traumatic conditions, and both the content and style of the training must be designed with their psychosocial needs and professional development in mind.

4.3. Training Structure

- Local psychologists will be trained by experts in a one-week seminar on-site or online, followed by annual support over 3 years.
- Knowledge tests will be conducted at the end of each training week, and detailed feedback will shape the content of the next session.
- Mechanisms will be established to maintain contact with all local psychologists and Master's students in psychology (internet, email, Teams/Zoom meetings) to ensure close project monitoring.

4.4. Practical Organization of Supervision

Supervision is an integral part of supporting trained psychologists. It is conducted by the project experts in the format of regular group online meetings. Additionally, supervision can be provided on an ad-hoc basis upon request if a group of psychologists has an urgent need.

4.5. Involving Psychology Students

Involving senior psychology students (bachelor's and Master's) is a valuable resource. Possible roles for students (under mandatory supervision):

- Assisting with the organization of meetings and preparation of materials.
- Helping to organize activities and support for the children of participants who attend the meetings.

- Assisting in the collection and analysis of anonymous data to evaluate program effectiveness.

4.6. Outcome Measures

4.6.1. Quantitative and Qualitative Measures (Mixed Methods)

- Actor (e.g., NGO, university) background data.
- Local psychologists' and Master students in psychology: job satisfaction is operationalized by measuring a satisfaction scale of 1-5 with comments and internal and external motivation to implement the trauma-focused group intervention.
- Acceptance and usability of trauma-focused group intervention and psychosocial support on mobile.
- Perceived qualitative experience of local psychologists and Master's students in psychology participation on mobile.
- Measures of satisfaction with the collaboration and local NGOs after dissemination are measured, with online questions on a satisfaction scale of 1-5 and comments.

4.7. Development of Hybrid Models of Support

Our future work plan includes the development and testing of a hybrid model that combines the effectiveness of face-to-face meetings with the accessibility of online formats. The aim is to overcome the limitations of pure online interactions and provide sustainable support. This approach will use a dedicated digital platform that will allow participants to self-select and implement mental and physical exercises at their own convenience. Such a tool aims to empower people by allowing them to actively participate in their mental well-being and self-healing, in line with the principle of "Empowerment, Voice and Choice".

5. CONCLUSION/DISCUSSION

The trauma-focused group intervention is an effective, scalable, and culturally sensitive model of preventive mental health support. Group interventions based on participation and trust-building are a vital tool for promoting resilience, well-being, and social integration of refugees. While participation is essential in societal development, it needs to be managed with care, according to the level of trust in society (Hirai, 2020). Further, how experiences with corruption and conflict challenge the establishment of transfer of institutional distrust from their home country to the governmental institutions of the host country remains insufficiently explored in academic literature; it is a critical knowledge gap. Although the trauma-focused group intervention requires further empirical validation and adaptation to evolving circumstances, its implementation is promising for reducing institutional distrust and strengthening social cohesion.

We recommend integrating such models into Master students in psychology at universities, primary psychosocial care systems, and community organizations. The "train-the-trainer" approach, described in detail in our Handbook guide (Ekblad, Gramatik, & Suprun, manuscript), allows effective scaling of this program and its adaptation for different refugee groups and settings.

6. LIMITATION OF OUR STUDY

An important limitation of our study is that the target group was predominantly female. Recruiting men to participate in the program was difficult, which is likely due to the demographic situation in the first months after the outbreak of a full-scale war, when most refugees were women with children. This is an important factor to consider when interpreting our results, and future studies should aim for a more representative sample that includes both men, including war veterans, and women.

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