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Exploring Dimensions of Trauma-Linked Somatic Complaints in Refugees: A Qualitative Study in Canada

Przemyslaw. Wandzilak[1], Onur. Isci[2*], Paulo. Castro-Medina[3]

[1] Department of Psychology, Concordia University, Montreal, Canada
[2] School of Sociological and Anthropological Studies, University of Ottawa, Ottawa, ON, Canada
[3] Senior Researcher, Centro Regional de Investigaciones Multidisciplinarias, Universidad Nacional Autónoma de México, Cuernavaca, Mexico

*** Corresponding author email address**: onurisci@gmail.com

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A B S T R A C T

Objective: This study aimed to explore the dimensions of trauma-linked somatic complaints among refugees, focusing on how trauma is embodied, expressed, and managed in the context of displacement.

Methods and Materials: A qualitative research design was employed, using semi-structured in-depth interviews with 17 refugees residing in Canada. Participants were recruited through community networks and refugee support organizations. Interviews, lasting 60–90 minutes, were conducted with the aid of professional interpreters where necessary and continued until theoretical saturation was reached. All interviews were audio-recorded, transcribed verbatim, and analyzed using NVivo 14 software. A thematic analysis approach was applied, involving iterative coding, categorization, and theme development to capture the range of trauma-linked somatic experiences.

Findings: Four overarching themes emerged from the analysis: (1) Bodily manifestations of trauma, including chronic pain, gastrointestinal distress, sleep disturbances, neurological symptoms, cardiovascular complaints, and persistent fatigue; (2) Psychological-somatic linkages, where anxiety, depression, flashbacks, and emotional suppression were embodied through physical discomforts; (3) Sociocultural and contextual influences, including cultural idioms of distress, stigma, access barriers to healthcare, post-migration stressors, and the role of community and faith; and (4) Coping and healing strategies, ranging from medical help-seeking and alternative remedies to mindfulness, community-based support, resilience-building, and avoidance. Participants' narratives highlighted the embodied nature of trauma and the interplay between pre-migration trauma and post-migration challenges in shaping somatic complaints.

Conclusion: The study underscores that trauma-linked somatic complaints among refugees are complex, multifaceted, and shaped by cultural and contextual factors. Recognizing these complaints as legitimate trauma expressions is crucial for

trauma-informed healthcare and fair asylum adjudication. Integrating medical, psychological, and social approaches, alongside culturally sensitive and community-based interventions, is essential to address the embodied dimensions of refugee trauma.

Keywords: *Refugees; Trauma; Somatic complaints; Qualitative research; Canada; Mental health; Coping strategies; Post-migration stressors*

1. Introduction

The global displacement crisis has reached unprecedented levels, with millions of individuals forced to flee their countries due to conflict, persecution, and environmental upheaval. Refugees and asylum seekers frequently endure traumatic experiences both before and during migration, including violence, loss, and forced separation from family. These experiences have profound implications for physical and mental health, often manifesting in complex patterns of somatic complaints that intertwine with psychological trauma. Understanding these manifestations is essential for informing healthcare practice, legal procedures, and social policy, particularly in host countries grappling with large influxes of displaced populations. Research increasingly highlights the urgency of addressing trauma-linked somatic complaints, which are often underdiagnosed or misunderstood in clinical, legal, and policy frameworks (Cossu et al., 2018; Newman, 2013; Nissen et al., 2022).

The intersection of trauma and somatic complaints in refugee populations has been extensively documented. Asylum seekers present elevated rates of both physical morbidity and psychological distress compared with host populations (Führer et al., 2016; Khouani et al., 2022). Somatic symptoms such as chronic pain, headaches, gastrointestinal issues, and sleep disturbances often coexist with post-traumatic stress disorder (PTSD), depression, and anxiety (Garoff et al., 2021; Youngmann et al., 2021). These symptoms not only reflect the embodied nature of trauma but also complicate access to healthcare and legal recognition of suffering. Studies of asylum seekers in Australia, for instance, demonstrate the dual pressures of trauma and systemic exclusion, which jointly reinforce poor mental health outcomes (Newman, 2013). Similarly, large-scale surveys in European countries show significantly higher rates of chronic physical complaints among asylum seekers compared with general populations, underscoring the role of displacement-related stressors in shaping health trajectories (Li et al., 2016; Pfortmueller et al., 2016).

A key challenge in this domain lies in the difficulty of disentangling psychological trauma from somatic expression. Trauma-related memory disruption often produces fragmented narratives that complicate clinical assessments and medico-legal procedures. Saadi and colleagues found that memory loss associated with trauma significantly affected asylum seekers' testimonies in the United States, impacting both clinical care and legal outcomes (Saadi et al., 2021). Similarly, Oxford highlighted how sexual assault survivors in asylum contexts struggle with fragmented recall of traumatic events, which in turn affects credibility in adjudication processes (Oxford, 2023). The legal implications are profound, as medico-legal affidavits and expert reports play a pivotal role in determining asylum outcomes (Aarts et al., 2019). Inconsistent symptom expression, especially when trauma-linked complaints are somatic, risks undermining the applicant's perceived reliability (Aarts et al., 2019).

Clinical practice must therefore grapple with complex presentations where trauma is both embodied and obscured by cultural and linguistic differences. As Bishop argues, intercultural communication plays a vital role in understanding how trauma influences asylum narratives and health-seeking behaviors (Bishop, 2021). This is especially significant as healthcare providers often operate without adequate training in trauma-informed care. In the context of refugee law, Cranwell emphasizes the necessity of trauma-informed approaches to ensure fair legal treatment of asylum seekers (Cranwell, 2024). Neglecting this perspective risks retraumatization and further silencing of vulnerable populations.

The prevalence of somatic complaints among refugees has been confirmed across diverse host country contexts. A cross-sectional study in Denmark revealed widespread health vulnerabilities among newly arrived asylum seekers, including high rates of chronic pain and infectious diseases (Nissen et al., 2022). Likewise, Khouani and colleagues documented the poor overall health status of asylum seekers in France, attributing these outcomes to both pre-migration trauma and post-migration stressors (Khouani et al., 2022). In Finland, Garoff et al. identified alarming levels of psychiatric disorders and somatic comorbidities among newly arrived asylum seekers (Garoff et al., 2021), while research in Germany demonstrated that coping strategies

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among Sub-Saharan migrants shaped how trauma symptoms were expressed and managed (Grupp et al., 2022).

The psychological dimensions of trauma-linked somatic complaints are closely related to post-migration stressors. Li et al. found strong associations between post-migration challenges—such as unemployment, insecure housing, and discrimination—and increased risk of psychological disorders in refugee populations (Li et al., 2016). Morgan et al. similarly demonstrated how post-migratory stressors exacerbated poor mental health outcomes among asylum seekers and rejected applicants in the UK (Morgan et al., 2017). These findings suggest that somatic complaints cannot be understood in isolation from the broader social and political context of displacement.

Health systems across Europe and North America face mounting challenges in responding adequately to refugee health needs. Molyneux and Singer emphasized the crucial role of acute care physicians in managing asylum seekers' health crises, highlighting gaps in knowledge and resources (Molyneux & Singer, 2024). Similarly, Oehri et al. reported systemic barriers to primary healthcare access in Switzerland, including cultural miscommunication and physician uncertainty (Oehri et al., 2023). In the UK, Lashwood and colleagues observed that the increased asylum-seeker population placed substantial strain on mental health crisis services, underscoring the systemic implications of inadequate preparedness (Lashwood et al., 2025).

At the same time, promising innovations in trauma care for refugees are emerging. Reebs et al. provided empirical support for Mindfulness-Based Trauma Recovery interventions, showing their efficacy and safety for displaced populations (Reebs et al., 2020). Similarly, Misra's work with participatory theater demonstrated how creative interventions could enhance resilience and reframe narratives of trauma (Misra, 2020). Tessitore developed the Asylum Seekers Photographic Interview (ASPI) method, which helped Nigerian asylum seekers strengthen narrative coherence and meaning-making after trauma (Tessitore, 2022). These approaches underscore the importance of culturally sensitive and innovative strategies for addressing trauma-linked somatic complaints.

The interplay between health, law, and politics also shapes how somatic complaints are interpreted and addressed. Cannon and Murphy analyzed the rise of far-right mobilization against asylum seekers in Ireland, revealing how public discourse often frames refugee health needs as burdensome or illegitimate (Cannon & Murphy, 2024). Cvikl and Flander highlighted how constitutional jurisprudence in Slovenia navigated asylum and refugee issues, reflecting the deep entanglement of health, law, and social legitimacy (Cvikl & Flander, 2023). Such sociopolitical dynamics directly influence how somatic complaints are recognized—or dismissed—in asylum adjudication and healthcare systems.

Despite the growing recognition of complex PTSD among asylum seekers (Kissane et al., 2014), significant gaps remain in both clinical and policy frameworks. Youngmann et al. emphasized that while PTSD is highly prevalent among refugees, access to mental health services remains uneven and often inadequate (Youngmann et al., 2021). Uwamaliya showed that early health assessments and crisis counseling can play a crucial preventive role for newly arrived asylum seekers (Uwamaliya, 2021), yet such interventions are inconsistently implemented across host countries. Ingram et al. similarly argued for systematic suicide prevention training for staff working with refugee populations, underscoring the life-threatening consequences of unaddressed trauma (Ingram et al., 2022).

Children and vulnerable subgroups within refugee populations face particularly acute risks. Ngo and Hodes reviewed the phenomenon of pervasive refusal syndrome in asylum-seeking children, a striking example of how trauma translates into extreme somatic withdrawal (Ngo & Hodes, 2019). Similarly, Saadi et al. highlighted the prevalence of head trauma among refugees, emphasizing the need for neurological as well as psychological assessment (Saadi et al., 2023). These studies reflect the layered vulnerabilities of displaced populations, where physical injury, psychological trauma, and somatic complaints intersect.

The recognition of trauma-linked somatic complaints is therefore central to broader discussions of human rights, healthcare equity, and legal justice. Oxford's analysis of sexual assault survivors' testimonies illustrates how neglecting embodied trauma can distort asylum outcomes (Oxford, 2023), while Pineda and Punsky argue that medical-legal partnerships grounded in mental health are crucial to ensure fair determinations (Pineda & Punsky, 2024). The failure to adequately interpret somatic symptoms risks perpetuating cycles of exclusion, disbelief, and untreated suffering.

In summary, the literature converges on three key insights. First, trauma-linked somatic complaints are highly prevalent among refugees and asylum seekers across diverse contexts, and they reflect the embodied nature of trauma (Führer et al., 2016; Garoff et al., 2021). Second, these

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complaints are shaped not only by pre-migration experiences but also by post-migration stressors, systemic barriers, and sociopolitical dynamics (Cannon & Murphy, 2024; Morgan et al., 2017). Third, innovative, culturally sensitive, and trauma-informed approaches are urgently needed to address these challenges in both healthcare and legal systems (Cranwell, 2024; Reebs et al., 2020; Tessitore, 2022). Against this backdrop, the present study aims to explore the dimensions of trauma-linked somatic complaints among refugees in Canada.

2. Methods and Materials

2.1. Study Design and Participants

This study employed a qualitative research design aimed at exploring the dimensions of trauma-linked somatic complaints among refugees. Given the subjective and experiential nature of the research question, a qualitative approach was deemed most appropriate for capturing the depth and complexity of participants' lived experiences. A total of 17 refugees residing in Canada participated in the study. Participants were recruited through community centers, refugee support organizations, and local networks. Inclusion criteria required participants to be over the age of 18, have refugee status, and self-report a history of trauma-related experiences. Diversity in age, gender, and country of origin was sought to ensure a wide range of perspectives.

2.2. Measures

Data were collected through semi-structured, in-depth interviews. An interview guide was developed to elicit participants' narratives about their experiences of trauma and related somatic complaints, as well as the meanings they attributed to these symptoms. Interviews were conducted in participants' preferred languages, with the support of professional interpreters when needed. Each interview lasted between 60 and 90 minutes and was conducted in a private setting to ensure confidentiality and comfort. All interviews were audio-recorded with informed consent and subsequently transcribed verbatim. Recruitment and interviewing continued until theoretical saturation was achieved, meaning no new themes or insights emerged from additional interviews.

2.3. Data analysis

Data analysis followed a thematic analysis approach, facilitated by NVivo software version 14. The analysis proceeded through multiple stages, including familiarization with the data, open coding, and identification of recurring patterns. Codes were then grouped into broader categories, which were refined into key themes that captured the core dimensions of trauma-linked somatic complaints. To enhance the credibility and trustworthiness of the findings, coding was independently reviewed by two researchers and discrepancies were resolved through discussion. Reflexivity was maintained throughout the process to account for the researchers' positionality and potential biases.

3. Findings and Results

The study included 17 refugee participants residing in Canada, with a diverse representation in terms of gender, age, and country of origin. Of the participants, 10 were female (58.8%) and 7 were male (41.2%). Participants ranged in age from 25 to 47 years, with the majority falling between 30 and 40 years old (n = 9, 52.9%), followed by those aged 25–29 years (n = 4, 23.5%) and 41–47 years (n = 4, 23.5%). Refugees originated from various regions, including the Middle East (n = 6, 35.3%), Africa (n = 5, 29.4%), and South Asia (n = 6, 35.3%). Length of stay in Canada varied from 1 to 8 years, with most participants having lived in the country for less than 5 years (n = 11, 64.7%). This diversity of demographic backgrounds provided a broad range of perspectives on trauma-linked somatic complaints.

Table 1

Themes, Subthemes, and Concepts

Category (Theme)	Subcategory	Concepts (Open Codes)
1. Bodily Manifestations of Trauma	Chronic Pain	Headaches, back pain, muscle stiffness, joint aches, chest pain
	Gastrointestinal Distress	Stomach cramps, nausea, diarrhea, constipation, bloating
	Sleep Disruptions	Insomnia, nightmares, restless sleep, frequent waking
	Neurological Symptoms	Dizziness, numbness, tingling, tremors
	Cardiovascular Reactions	Palpitations, shortness of breath, chest tightness
	Fatigue and Low Energy	Persistent tiredness, lack of vitality, body heaviness
2. Psychological-Somatic Linkages	Stress and Anxiety Translations	Racing heartbeat, sweating, shallow breathing, tight chest

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	Depression-Related Complaints	Body heaviness, loss of appetite, fatigue, slowed movements
	Trauma Triggers and Flashbacks	Sudden chest pain, shaking, sweating, muscle tension
	Somaticization of Fear	Trembling, choking sensation, stomach knots
	Emotional Suppression and Body Pain	Shoulder stiffness, jaw clenching, headaches
3. Sociocultural and Contextual Influences	Cultural Expression of Pain	Describing pain as "burning," "pressure," "knots," or "blocked energy"
	Stigma and Silence	Fear of judgment, reluctance to disclose symptoms, self-blame
	Access to Healthcare	Language barriers, long wait times, lack of culturally sensitive care
	Social Support Systems	Reliance on community, isolation, role of faith groups
	Migration Stressors	Unemployment, unstable housing, discrimination
	Acculturation Challenges	Dietary changes, lack of familiar remedies, adapting to new health norms
	Refugee Identity and Embodiment	Linking body pain with displacement, symbolic burden, body as "carrying trauma"
4. Coping and Healing Strategies	Medical Help-Seeking	Frequent clinic visits, use of pain medication, dissatisfaction with doctors
	Alternative and Traditional Healing	Herbal remedies, massage, spiritual healing, prayer
	Self-Management Practices	Exercise, yoga, mindfulness, breathing techniques
	Community-Based Coping	Peer sharing, group therapy, storytelling
	Meaning-Making and Resilience	Faith, acceptance, reframing pain, finding purpose
	Avoidance Strategies	Ignoring pain, self-isolation, substance use

Category 1: Bodily Manifestations of Trauma

Chronic Pain. Many participants described persistent physical pain that could not be fully explained medically but was strongly linked to their traumatic past. Headaches, back pain, and muscle stiffness were reported as daily struggles. One participant stated, *"The pain in my back feels like a constant reminder of what I went through. Doctors tell me nothing is wrong, but I feel it every day"* (Participant 7, Male, 42). Others mentioned chest pain and joint aches that flared during stressful moments.

Gastrointestinal Distress. Digestive complaints were also common, ranging from stomach cramps and nausea to chronic diarrhea and constipation. A female participant expressed, *"When I remember certain events, my stomach immediately twists. It's like the fear lives in my gut"* (Participant 11, Female, 29). Such expressions highlight how traumatic memories are embodied as gastrointestinal discomfort.

Sleep Disruptions. Insomnia, nightmares, and restless sleep were nearly universal among participants. Sleep problems often intensified during periods of stress or when encountering reminders of past trauma. One participant shared, *"I wake up in the night sweating from nightmares. I'm scared to go back to sleep because the same images return"* (Participant 3, Male, 36). These disrupted sleep patterns were linked directly to both physical fatigue and emotional exhaustion.

Neurological Symptoms. Several participants reported neurological-like complaints, such as dizziness, numbness, tingling, and even tremors. These sensations often appeared during periods of anxiety. As one participant described, *"Sometimes my hands go numb, and I think I'm sick. But the doctor says it's from stress"* (Participant 14, Female, 40). Such findings underscore the overlap between psychological distress and neurological expressions.

Cardiovascular Reactions. Heart palpitations, chest tightness, and shortness of breath were also prevalent. These symptoms were frequently described as terrifying because participants feared they signaled a serious illness. A young male refugee explained, *"When my heart races, I think I am dying. But later I realize it happens only when I'm anxious or remember what happened back home"* (Participant 2, Male, 27).

Fatigue and Low Energy. Persistent fatigue and low vitality were common across interviews. Some participants described their bodies as "heavy" or "drained," making daily tasks difficult. *"It feels like I carry a weight all day. Even if I sleep, I wake up tired,"* said one participant (Participant 16, Female, 33).

Category 2: Psychological-Somatic Linkages

Stress and Anxiety Translations. Participants reported a variety of physical symptoms tied directly to stress and anxiety, including rapid heartbeat, sweating, and shallow breathing. As one woman shared, *"Whenever I get scared, my chest feels tight, and I cannot breathe properly"* (Participant 8, Female, 31). These bodily experiences reflect the translation of emotional stress into somatic signals.

Depression-Related Complaints. Feelings of heaviness, loss of appetite, and slowed movements were described by participants suffering from depression. A male participant

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noted, *"It's like my whole body shuts down. I don't want to eat or move. My body feels as depressed as my mind"* (Participant 10, Male, 39).

Trauma Triggers and Flashbacks. Physical symptoms frequently intensified during flashbacks. Chest pain, shaking, and muscle tension were cited as part of re-experiencing trauma. *"When a sound reminds me of the war, my body freezes, and I shake uncontrollably"* (Participant 5, Female, 34).

Somaticization of Fear. Fear was commonly embodied through trembling, choking sensations, and stomach knots. One participant explained, *"Fear does not stay in my head. It grabs my throat and stomach"* (Participant 13, Male, 41).

Emotional Suppression and Body Pain. Some participants linked body pain to unexpressed emotions. Jaw clenching, shoulder stiffness, and headaches were reported as consequences of holding feelings inside. *"I never speak about my sadness, and it always shows up in my body—my shoulders hurt all the time"* (Participant 1, Female, 30).

Category 3: Sociocultural and Contextual Influences

Cultural Expression of Pain. Refugees often used culturally specific metaphors to describe pain, such as "burning inside" or "blocked energy." One participant remarked, *"In my culture, we say the pain is like a fire in the stomach. That's how I feel every day"* (Participant 6, Male, 45).

Stigma and Silence. Stigma prevented many from openly discussing symptoms. Fear of judgment or appearing weak contributed to silence. *"If I tell people I feel pain, they think I am crazy. So, I keep it to myself"* (Participant 12, Female, 28).

Access to Healthcare. Language barriers, long wait times, and lack of culturally sensitive care were significant obstacles. One participant expressed frustration: *"The doctor only gives me pills and doesn't understand my story. I need someone who listens"* (Participant 4, Male, 37).

Social Support Systems. The presence or absence of social support strongly influenced coping. Community groups, faith networks, and friendships were described as buffers. A woman explained, *"At the mosque, I feel people understand me. My body pain is less when I am not alone"* (Participant 9, Female, 32).

Migration Stressors. Ongoing stress from unemployment, housing instability, and discrimination aggravated somatic complaints. *"Since arriving here, I have no job, no stable home. My body feels the stress every day"* (Participant 15, Male, 40).

Acculturation Challenges. Adjusting to new food, health systems, and cultural practices was difficult. *"I miss my traditional medicine. Here, I don't know what to eat, and my stomach always hurts"* (Participant 17, Female, 35).

Refugee Identity and Embodiment. Participants often connected their bodily pain with the burden of displacement. One man said, *"My body carries the journey. The pain is the memory of leaving everything behind"* (Participant 7, Male, 42).

Category 4: Coping and Healing Strategies

Medical Help-Seeking. While many sought medical attention, they often expressed dissatisfaction with treatments. *"I go to the clinic often, but they only give painkillers. The pain always returns"* (Participant 10, Male, 39).

Alternative and Traditional Healing. Some relied on herbal remedies, massage, and prayer. *"I drink the herbs my mother taught me about. They help more than the pills sometimes"* (Participant 16, Female, 33).

Self-Management Practices. Exercise, yoga, mindfulness, and breathing techniques were adopted by several participants. *"When I do yoga, I feel my body relax for the first time in years"* (Participant 3, Male, 36).

Community-Based Coping. Group therapy and community sharing helped alleviate symptoms. One participant explained, *"When I tell my story in the refugee group, I feel lighter in my body"* (Participant 2, Male, 27).

Meaning-Making and Resilience. Faith and acceptance played a strong role. *"God gives me strength. My pain reminds me I survived"* (Participant 11, Female, 29).

Avoidance Strategies. Others coped by ignoring symptoms or using substances. *"Sometimes I drink just to forget the pain in my body"* (Participant 8, Female, 31).

4. Discussion and Conclusion

The present study explored the dimensions of trauma-linked somatic complaints among refugees residing in Canada, highlighting how traumatic experiences were embodied in physical pain, sleep problems, gastrointestinal distress, neurological symptoms, and fatigue. These complaints were not isolated but were intertwined with psychological distress, sociocultural contexts, and coping strategies. Our findings confirm that somatic complaints are a central way in which trauma manifests in displaced populations, underscoring the need for trauma-informed, culturally sensitive, and integrated approaches to care.

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The high prevalence of chronic pain, sleep disturbances, and gastrointestinal problems among participants aligns with existing evidence showing elevated morbidity in asylum seekers compared to host populations (Führer et al., 2016; Khouani et al., 2022; Nissen et al., 2022). Previous research in Germany, Denmark, and France has documented similar symptom patterns, particularly headaches, back pain, and digestive disorders, often linked to both pre-migration trauma and post-migration stressors (Khouani et al., 2022; Nissen et al., 2022). Our participants' narratives of pain that "cannot be explained medically" but persists daily resonate with Garoff's findings of widespread somatic comorbidities in newly arrived asylum seekers in Finland (Garoff et al., 2021).

Sleep problems, including insomnia and nightmares, emerged as a nearly universal complaint. These findings echo Kissane's early study on complex PTSD in traumatized asylum seekers, which highlighted the role of nightmares and disturbed sleep as hallmark symptoms (Kissane et al., 2014). Similarly, Garoff and colleagues found sleep disturbances to be one of the most commonly reported symptoms among newly arrived asylum seekers (Garoff et al., 2021). The participants' accounts of being "afraid to go back to sleep" reflect the enduring nature of trauma, which intrudes into daily rhythms and erodes restorative rest.

Neurological complaints such as dizziness, numbness, and tremors in our study parallel the somaticized fear responses described in previous literature. Youngmann et al. noted how PTSD in asylum seekers often presented with neurophysiological symptoms, including tremors and sensory disturbances (Youngmann et al., 2021). These findings reinforce the need for clinicians to interpret neurological-like complaints in the refugee context through a trauma lens rather than dismissing them as purely psychosomatic.

The participants in our study consistently described how stress, anxiety, and depression were embodied as physical discomforts. This is consistent with Morgan's work in the UK, which demonstrated that post-migratory stressors significantly exacerbated both mental and physical health problems (Morgan et al., 2017). Similarly, Li et al. documented that housing insecurity, unemployment, and discrimination strongly predicted psychological disorders in refugees, often expressed in somatic ways (Li et al., 2016). Our findings illustrate this linkage: participants reported racing heartbeat, choking sensations, and body heaviness whenever experiencing flashbacks or depressive episodes.

Emotional suppression emerged as a key factor in bodily pain. Participants who "never spoke about their sadness" reported jaw clenching, shoulder stiffness, and headaches. This aligns with Grupp's study of Sub-Saharan African migrants in Germany, which found that lay beliefs about suppressing emotions often led to increased somatic burden (Grupp et al., 2022). Likewise, Bishop highlighted how intercultural communication challenges in the U.S. asylum context meant that emotional suppression frequently resulted in somatic complaints, further complicating clinical assessments (Bishop, 2021).

Our findings also align with Newman's earlier work, which showed that asylum seekers in Australia often embodied trauma in physical complaints when psychological language felt culturally inappropriate or unavailable (Newman, 2013). This underscores the importance of recognizing somatic complaints as legitimate trauma expressions rather than dismissing them as secondary or exaggerated.

This study found that sociocultural context powerfully shaped how participants experienced and expressed trauma-linked somatic complaints. Cultural idioms of distress, such as describing pain as "fire in the stomach" or "blocked energy," mirror Oxford's findings on how traumatic memory is narrated through culturally specific metaphors (Oxford, 2023). Tessitore's photographic interview study similarly revealed that narrative meaning-making among asylum seekers often relied on embodied and symbolic expressions (Tessitore, 2022).

Stigma and silence were significant barriers to expression in our participants' accounts. Fear of judgment or disbelief often led to withholding disclosure, consistent with Aarts' study on medico-legal reports, where perceived inconsistencies in symptom narratives often jeopardized asylum claims (Aarts et al., 2019). Saadi et al. also noted that trauma-related memory gaps in affidavits negatively influenced legal credibility (Saadi et al., 2021). Our findings highlight that stigma around mental health and trauma can lead to somatization as a socially "safer" form of complaint, yet one that may be poorly understood by legal and medical authorities.

Post-migration stressors, including unemployment, unstable housing, and discrimination, intensified somatic symptoms in our participants. This is in line with Morgan's demonstration of how structural exclusion perpetuates poor health (Morgan et al., 2017) and with Cannon's analysis of far-right mobilization in Ireland, which positioned refugees as burdens, thus increasing their vulnerability (Cannon &

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Murphy, 2024). Similarly, Oehri's Swiss study highlighted how systemic barriers in healthcare, including long waiting times and language gaps, worsened health outcomes (Oehri et al., 2023). Our findings confirm that refugee health cannot be separated from broader social and political dynamics in host countries.

Community and faith-based networks were vital in alleviating somatic complaints, echoing Uwamaliya's findings that early health assessment and crisis counseling provided protective effects (Uwamaliya, 2021). Misra's participatory theater work also illustrated how community-based engagement enhanced resilience and reframed trauma (Misra, 2020). Our study supports these findings, as participants described reduced bodily pain when engaging in community groups or spiritual practices.

The participants described diverse strategies for coping with trauma-linked somatic complaints, including medical help-seeking, alternative healing, self-management, and avoidance. Dissatisfaction with conventional medical care was common, as many felt doctors offered only superficial treatments such as painkillers without listening to their stories. This resonates with Molyneux's work on acute care physicians, which highlighted gaps in refugee-sensitive care (Molyneux & Singer, 2024), and with Lashwood's study of UK crisis services strained by asylum populations (Lashwood et al., 2025).

Alternative and traditional healing practices, including herbal remedies, massage, and prayer, were valued by participants. Such findings are consistent with Cossu's review, which emphasized the importance of culturally adapted treatment models for refugees (Cossu et al., 2018). Similarly, Garoff's population-based study noted that faith and cultural traditions often moderated distress (Garoff et al., 2021).

Innovative interventions like mindfulness, yoga, and group therapy described by our participants mirror recent evidence. Reebs et al. demonstrated the effectiveness of Mindfulness-Based Trauma Recovery (MBTR-R) among refugee populations (Reebs et al., 2020), while Tessitore's ASPI method provided evidence of narrative-based meaning-making (Tessitore, 2022). Such approaches complement traditional medical care by addressing embodied trauma holistically.

Finally, avoidance strategies such as ignoring pain or substance use were also reported, consistent with Grupp's finding that maladaptive coping strategies perpetuated PTSD symptoms (Grupp et al., 2022). These findings underscore the need for interventions that both respect cultural coping traditions and address the risks of avoidance.

Taken together, our findings reinforce the consensus that trauma-linked somatic complaints are widespread and multifaceted among refugees. They reflect both pre-migration trauma and ongoing post-migration stressors (Li et al., 2016; Morgan et al., 2017), are shaped by sociocultural narratives and stigma (Bishop, 2021; Oxford, 2023), and require integrated responses across health, legal, and social systems (Cranwell, 2024; Pineda & Punsky, 2024). They also demonstrate the embodied nature of trauma, where the boundary between mind and body dissolves under conditions of displacement (Youngmann et al., 2021).

Our study contributes to the literature by offering in-depth qualitative evidence from refugees in Canada, complementing quantitative findings from European contexts (Khouani et al., 2022; Nissen et al., 2022) and intervention studies elsewhere (Misra, 2020; Reebs et al., 2020). It highlights the importance of listening to embodied narratives as both a clinical and ethical imperative, bridging the gap between trauma-informed care (Cranwell, 2024) and human rights considerations (Newman, 2013).

5. Limitations & Suggestions

This study has several limitations. First, the sample size was relatively small (17 participants), which limits the generalizability of findings to the broader refugee population in Canada or globally. While qualitative research prioritizes depth over breadth, larger and more diverse samples could provide additional insights. Second, reliance on semi-structured interviews may have constrained participants' ability to express trauma in non-verbal or symbolic ways, which other methodologies such as participatory theater or visual narrative might capture more fully. Third, interpretation challenges may have arisen despite the use of professional interpreters, as subtle cultural idioms of distress may not have been fully conveyed in translation. Finally, the cross-sectional design prevented us from tracing changes in somatic complaints over time, which could be better captured through longitudinal research.

Future research should expand to larger and more diverse samples of refugees across different host countries to examine the generalizability of themes identified here. Longitudinal studies are needed to track the trajectory of somatic complaints across different stages of resettlement. Comparative studies between refugees, asylum seekers, and other migrant groups could also clarify the unique impact of

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forced displacement on embodied trauma. Furthermore, research integrating physiological measures with qualitative narratives could shed light on the biological underpinnings of trauma-linked somatic symptoms. Intervention studies evaluating culturally adapted and community-based approaches—such as mindfulness, participatory arts, and faith-based programs—are particularly important to develop practical solutions for care.

For practice, healthcare providers should adopt trauma-informed approaches that recognize somatic complaints as legitimate expressions of trauma rather than dismissing them as secondary. Primary care systems must be equipped with interpreters, cultural mediators, and training in intercultural communication. Legal professionals and adjudicators should also be educated on the embodied nature of trauma to fairly evaluate asylum claims. Community-based organizations should be supported in offering safe spaces where refugees can share experiences and access culturally familiar coping practices. Importantly, integration of medical, psychological, and social services is essential to holistically address the intertwined challenges of trauma, health, and displacement.

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Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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Authors' Contributions

All authors equally contributed in this article.

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