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Trauma, Post-migration Factors, and Ulysses Syndrome in Refugees in Host Countries

Trauma, factores postmigratorios y síndrome de Ulises en personas refugiadas en países de acogida

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Abstract

Post-migratory factors related to post-traumatic stress disorder (PTSD) and Ulysses syndrome were analyzed. Fifty-six adult refugees (31.57% women) with protection measures were evaluated using the Post Migration Living Difficulties and the Harvard Trauma Questionnaire. Refugees had been exposed to a mean of 15.1 traumatic situations in conflict contexts. All of them had been in mortal danger. 32.1% had suffered episodes of torture, and 30.4% suffered from PTSD with a mean of 4.18 post-traumatic symptoms. No differences were found based on gender, nationality, or host country. Traumatic and torture episodes, living in institutionalized centers, working conditions, physical health, and social and family relationships influenced the presence of PTSD. Suffering associated with family separation, social status, and risks of physical integrity was detected, without these constituting a DSM-5 diagnosis of mental disorder but rather a case of migratory mourning in its extreme version or Ulysses syndrome.

Keywords: **Refugees; Post-migration factors; PTSD; Ulysses syndrome**

Resumen

Se analizaron factores post-migratorios relacionados con el trastorno de estrés postraumático (TEPT) y el síndrome de Ulises en 56 adultos refugiados (31.57 % mujeres). Se aplicaron el Post Migration Living Difficulties y el Harvard Trauma Questionnaire. Habían estado expuestos a 15,1 situaciones traumáticas y todas habían estado en peligro de muerte. El 32,1 % había sufrido episodios de tortura, y el 30,4 % presentaba TEPT, con una media de 4,18 síntomas postraumáticos. No se encontraron diferencias significativas en función del género, la nacionalidad o el país de acogida. Los episodios traumáticos y de tortura, la vida institucionalizada, el trabajo, la salud física y las relaciones sociales-familiares influyeron en la presencia de TEPT. Se detectó sufrimiento asociado a la separación familiar, el estatus social y los riesgos a la integridad física, sin que estos configuraran un diagnóstico de trastorno mental según el DSM-5, sino más bien un caso de duelo migratorio extremo o síndrome de Ulises.

Palabras clave: **Refugiados; Factores post-migratorios; TEPT; Síndrome de Ulises**

Introduction

Surviving in a context of forced migration exposes the displaced person to many types of victimization and places their mental and physical health at risk, despite the resilience and post-traumatic learning abilities that characterize and protect refugees (Bonanno, 2004; Guarch-Rubio et al., 2020).

The traditional study of mental health in refugees suggests that frequent exposure to traumatic situations increases the probability of developing psychological problems, such as anxiety, depression, and post-traumatic stress disorder (PTSD) (Basoglu et al., 2001; Bogic et al., 2012; De Jong et al., 2003; Gootzeit & Markon, 2011; Manzanero et al., 2020, 2024; Priebe et al., 2013; Schick et al., 2018; Steel et al., 2009). In this sense, the probability of developing psychological problems in refugees is greater than in other migrant groups. Even when faced with identical cultural characteristics, refugees present PTSD more frequently, as they are more exposed to traumatic events (Arnetz et al., 2013). Thus, the development of PTSD has been shown to be 10 times more likely in refugees settled in Western societies than in the general population of the same age in host countries (Fazel et al., 2005), and a greater psychological impact has been observed in refugees in comparison to a population not affected by war or internally displaced persons (Hollander et al., 2011; Priebe et al., 2013; Schmidt et al., 2008). Recent research (Manzanero et al., 2024) with adolescents who are victims of war shows that there could be several modalities of PTSD based on their social characteristics, which may vary in severity.

Zachary Steel et al.'s (2009) meta-analysis, which considered 181 studies that evaluated 81,866 victims of armed conflicts and forced displacement, found a prevalence of 30.6% for PTSD and 30.8% for depression. Similarly, the results of Marija Bogic et al.'s (2015) meta-analysis estimated a prevalence of psychological damage higher than 20%, detecting depression (in a range of 2.3-80%), PTSD (4.4-86%), and nonspecific anxiety disorders (20.3-80%). Regarding personality disorders, agreeing outcomes have been found albeit differences in prevalence among migrants and natives have been contextualized by acculturative stress and diagnosis bias (Najjarkakhaki & Ghane, 2021). Fortunately, the analysis of the data suggests spontaneous recovery for most cases, although the lack of a diagnosis does not exclude the presence of other mental ailments. Similarly, Lloyd Bradley and Nouran Tawfiq (2006) evaluated 97 Kurdish asylum seekers, victims of torture, and found an occurrence of psychological symptoms not present in the DSM, depicting the reflection on cultural influence as a determining factor in mental health. In this vein, most of the time researchers and participants come from different cultural backgrounds, and some symptoms can be misunderstood during the assessment (Guarch-Rubio & Manzanero, 2017). Under these circumstances, assessment tools should be designed to overcome the lack of cultural sensitivity and the usefulness of supposedly universal diagnostic instruments (Mollica et al., 1992). Despite controlling the effects due to the role of the migration process and the cultural dimensions in diagnosis tasks cannot always be guaranteed, the DSM-V (American Psychiatric Association, 2022) has strengthened its attempt to consider these variables (Najjarkakhaki & Ghane, 2021).

In this context, considering migration as a profound life transition and a risk factor for migrants' mental health, Joseba Achotegui (2002) introduced the concept that seven stages of grief should accompany every migratory journey. These stages impact critical aspects of life, including family, language, culture, social status, group affiliation, and physical well-being. They collectively define the immigrant syndrome with chronic and multiple stress, often referred to as Ulysses syndrome (Achotegui, 2005).

Refugees and asylum seekers grapple with an array of extreme stressors that amplify the challenges they face. These stressors encompass the heartache of forced family separations, an overwhelming sense of powerlessness, pervasive fear, severely limited opportunities, and complete societal exclusion. Furthermore, they confront an acute form of acculturative stress, stemming from their constant fear of expulsion and the imperative to remain concealed, which deepens the cultural divide they experience. This divide exacerbates psychological distress and gives rise to a unique set of difficulties that do not neatly align with conventional diagnostic criteria, such as those utilized for PTSD (Manzanero et al., 2024).

The concept of Ulysses syndrome posits that a majority of these immigrants and refugees, despite enduring the extreme stressors described above, do not develop a mental illness but instead display a reactive stress response. Most immigrants demonstrate resilience, albeit exhibiting a range of reactive symptoms commensurate with the inhumane conditions they endure (Achotegui, 2005). Additionally, Achotegui distinguishes between experiencing these stages of mourning in favorable conditions (simple mourning), in challenging yet surmountable circumstances (complicated mourning), and in highly adverse conditions that are insurmountable (extreme mourning). In the case of refugees, their mental health conceptually aligns with extreme migratory mourning (Achotegui, 2002) due to the life experiences they undergo and the daunting conditions they must surmount. Consequently, this category of extreme migratory mourning encompasses clinical symptomatology linked to responses in the face of extreme migratory situations. Importantly, it does not constitute a mental disorder but rather resides within the domain of mental health, encompassing matters related to stress and non-pathological grieving (Achotegui, 2002).

Among the stressors that give rise to Ulysses syndrome, notably prevalent among the refugees in this study, are primarily enforced isolation, a dearth of opportunities, exclusion, vulnerability, and fear. In summary, these individuals have confronted profoundly challenging life experiences and have navigated through some of the psychological tribulations encompassed by Ulysses syndrome.

As a result, this study lends support to the perspective that regards diagnoses like Ulysses syndrome as a domain of mental distress intricately linked to the profound mourning inherent in extreme migration, particularly characteristic of refugees. This approach seeks to acknowledge the suffering without promoting victimization, all while recognizing the gravity of the ordeal (Achotegui, 2019; Bianucci et al., 2017; Bustamante et al., 2018).

It's essential to emphasize that the absence of a mental disorder resulting from psychological distress (such as that triggered by extreme mourning) does not negate the presence of genuine mental suffering. This suffering, though it may not meet diagnostic criteria, should still be acknowledged and primarily addressed through psychosocial and psychoeducational interventions. A clearer understanding of this distinction becomes particularly relevant in the context of recent increases in migration to Europe. Asylum seekers often present complex emotional needs that may not always align with formal psychiatric diagnoses. For instance, although studies have reported a high prevalence of PTSD among this population

(44%) (Rodolico et al., 2019), the lack of a PTSD diagnosis does not necessarily indicate the absence of psychological harm or emotional distress (Guarch-Rubio & Manzanero, 2020; Manzanero et al., 2025). This highlights the importance of adopting a broader, more inclusive approach to mental health care in these settings.

Post-migration factors and their effect on trauma and integration

Arrival in a host country often involves the institutionalization of migrants and their stay in refugee camps and official detention centers (Zimmerman et al., 2011). Under these circumstances, overcrowding, lack of resources, unsanitary conditions, and exposure to situations of violence are frequent, which has a cumulative effect on the mental health of refugees. In this sense, a clear association has been observed between the time that refugees are under these conditions and the severity of the psychological disorders they present, especially for those who have previously been exposed to traumatic situations (Keller et al., 2003; Steel et al., 2006). Katy Robjant et al.'s (2009) systematic review analyzed the mental health of asylum seekers in immigration detention centers and found anxiety, depression, PTSD, self-harm, and suicidal ideations, confirming a positive association between the time they spent in these spaces and the complex intensity of the disorders. Thus, the effects that the psychosocial and post-migration components have on the mental health of displaced persons are evidenced (Aragona et al., 2012, 2013; Giacco & Priebe, 2018; Lund et al., 2018; Manzanero et al., 2024, 2025).

In addition, the re-traumatization effect due to post-migration factors causes greater difficulties in managing daily stressors in the host society (Aragona et al., 2012) and increases the risk of substance abuse (Bogic et al., 2012). On a daily basis, displaced individuals face stressors related to the lack of rights, such as unequal opportunities and the possibilities of detention (Giacco & Priebe, 2018), as well as others related to the emotional spectrum, such as social isolation, discrimination, or family separation (Schick et al., 2018). Likewise, the integration-employment relationship has an effect on the mental health of the displaced (Aragona et al., 2012, 2013; Bogic et al., 2012, 2015; Craig et al., 2009; WHO, 2018). In this sense, economic independence, a residence permit, and an adequate command of the language facilitate integration in host countries (Schick et al., 2018).

Considering all of the above, and although the basic need for security tends to be covered, refugees have to overcome new difficulties in host environments, even without having the appropriate resources to do so (Achotegui, 2009). Therefore, it can be argued that the multiple psychosocial barriers that migrants and refugees encounter in host societies pose a risk to their mental health and can precipitate the symptoms of PTSD, depression, and other long-term psychological consequences (Aragona et al., 2012, 2013; Steel et al., 1999).

The aim of the present study is to know to what extent some post-migration factors (asylum claim resolution status, professional and financial aid, housing support, health care…) affect the mental health of refugees and which of them contribute to Ulysses syndrome. The specific objectives included the evaluation of psychosocial needs (familial, cultural, adjustment, language barriers…), post-migration elements, and the prevalence of PTSD.

Method

Participants

The present study had a total of 56 participants, of which 36 were men (64.3%) and 20 were women (35.7%). The mean age for the entire sample was 33.69 years (*SD* = 11.15) with an age range of 18 to 72 years. The mean time exposed to the conflict was 30.5 months (*SD* = 52.47).

According to the sociodemographic characteristics (see Table 1), 39.28% of participants came from the Middle East, with a majority of Syrian people (26.8%) compared to other countries in the region. Next, 28.57% of participants came from Latin American countries, with the majority coming from Nicaragua (26.8%). A 21.42% of participants came from Sub-Saharan Africa (with 12.5% of participants from Zimbabwe) and the remaining 10.71% were from other countries in the north of Africa (Algeria), Eastern Europe or South Asia (Pakistan).

Table 1. Sociodemographic characteristics among refugees and asylum seekers settled in Spain and Ireland (N=56). Assessment, January 2018–November 2019

	N	*%*
Sex		
Men	36	64.3
Women	20	35.7
Origin		
Middle East	22	39.28
Latin America	16	28.57
Sub-Saharan Africa	12	21.42
Others	6	10.71
Phase (Application)		
Admission to transat	38	67.9
International Protection		
Status of refugee	9	16.1
Subsidary protection	7	12.5
Humanitarian reasons	2	3.6

All the individuals evaluated had been granted international protection, either through refugee status (16.1%), subsidiary protection (12.5%), for humanitarian reasons (3.6%), or because they were asylum seekers pending their asylum resolution (67.9%). Participants resided in Ireland (53.6%) and in Spain (46.4%) as host countries. The recruitment of participants took place in two ways: through the referral of local entities that worked with refugees and by snowball sampling by reference of other refugees or asylum seekers. Despite some of them being referred to having received psychological treatment along the migratory process, the population was not defined as clinical. Moreover, the rather small sample was due to the pandemic crisis that did not allow us to keep on with recruitment.

Instruments and procedure

In this study, a questionnaire designed to detect psychosocial needs in refugees and asylum seekers was applied. These needs could influence their mental state and the development of PTSD. Likewise, the Post Migration Living Difficulties (Silove et al., 1997) and the Harvard Trauma Questionnaire (Shoeb et al., 2007) were administered.

The psychosocial characteristics questionnaire contained 42 questions related to demographic and integration aspects associated with migration, such as place of residence and command of the language, among others. This questionnaire was specifically customized for this study, and for the data analysis, only the most relevant results have been highlighted.

The Postmigration Living Difficulties Scale (PMLD) included 24 questions on adverse experiences and difficulties associated with post-migration stress. This scale assessed the degree of problem posed by post-migration episodes for asylum seekers/refugees during the past 12 months. Answers were given through a Likert-type scale for each of the items, ranging from 1 to 5, where 1 represented no problem and 5 represented a very serious problem. For this study, the reliability analysis on the 24 elements of the PMLD showed a Cronbach's $\alpha = 0.86$.

Finally, the Harvard Trauma Questionnaire (HTQ) was administered to obtain the prevalence of PTSD diagnosis. According to this scale, participants must obtain mean scores of 2.5 or higher in the first 16 post-traumatic symptoms (Ibrahim & Hassan, 2017; Rasmussen et al., 2015). Reliability analyses showed that Cronbach's alphas reflected a value of 0.95 for the 42 elements of post-traumatic symptoms, 0.88 for the 45 elements of traumatic experiences, and 0.90 for the 26 torture experiences analyzed. The assessments were carried out between January 2018 and November 2019 in Spain and Ireland through individual, hetero-applied, and confidential interviews in safe spaces appropriate for this purpose. The interviews were conducted in English or in Spanish, prioritizing the mother tongue of the interviewee. In addition, the questionnaires were written both in English and in Arabic to promote understanding in those participants whose mother tongue was not English or Spanish. As such, they could also read the questions in both languages. All of the participants were literate. Similarly to Hawkar Ibrahim and Chiya Q. Hassan's (2017) study with Syrian-Kurdish refugees in Iraq, the informed consent of voluntary participation was collected in written or verbal form for cultural reasons. Verbal consent was obtained using the same standard written document that collected information about the voluntary, anonymous, and confidential nature of participation for research purposes without consequences for their asylum resolution. Likewise, the document informed the participants about their freedom to ask for information about the study, not to complete some questions, or to cease the assessment at any time without any consequences. After obtaining the informed consent, the assessment was carried out individually. This study is part of a research project regarding the assessment of memory and psychological trauma in refugees and victims of war and was approved by the Ethics Committee from Complutense University of Madrid (Spain), reference number 2016/17-023. It was endorsed by the UNHCR-Spain and declared of interest to the European Union.

Results

Table 2 highlights some of the salient psychosocial factors for the 56 asylum seekers/refugees.

Table 2. Elements related to integration among refugees and asylum seekers settled in Spain and Ireland (N=56). Assessment, January 2018-November 2019

	N	%
Accommodation		
Institutional (temporary reception center)	10	17.9
Institutional (long-term reception center)	15	26.8
Private	31	55.35
Language proficiency		
Very low or low	7	12.5
Medium or high	21	37.5
Very high or mother tongue	28	50
Feeling of acceptance		
Nothing / Lightly	9	16.1
Moderately	26	46.42
Quite / Completely	21	37.5

	N	%
Feeling of integration		
Nothing / Lightly	19	33.9
Moderately	19	33.9
Quite / Completely	18	32.14
Support		
Bad	19	33.9
Neither good nor bad	18	32.1
Good	19	33.9
Psychological treatment		
Yes	17	30.4
No	39	69.6

Regarding their place of residence, the majority lived in private homes (55.35%) compared to 44.7% who did so in detention centers for migrants and refugees and in temporary (17.9%) or long-term (26.8%) institutional reception centers. Other aspects related to integration showed that the command of the language was between medium and very high or mother tongue for the greater majority (87.5%). In addition, 46.42% felt moderately accepted by the host society, and 32.14% reported a lot of acceptance. In fact, 33.9% did not feel integrated at all, whereas 66.04% highlighted a moderate, fairly good, or full integration. However, the perception of support in the host society was distributed between bad (33.9%), fair (32.1%), and good (33.9%). Finally, 69.6% of the individuals evaluated had not received psychological treatment compared to 30.4% who had received such treatment in the host countries and for reasons related to forced migration.

Post-Migration Living Difficulties (PMLD)

In relation to the results obtained in the PMLD Scale, the frequencies are highlighted in Table 3. Among the set of responses, the concern for family members in the country of origin and the inability to return to their homes in case of emergency were the most prevalent problems for the entire sample, representing 58.9% and 62.5%, respectively. Loneliness and boredom were also elements highlighted by many of the participants (48.2%), as well as separation from family members and the feeling of isolation in 46.4% and 41.1%, respectively. Regarding employment-related issues, concerns were found associated with the lack of a work permit (42.9%) and the inability to find a job (64.2%). On the contrary, there was hardly any difficulty in accessing medical services, and no concerns were observed in relation to asylum interviews.

In relation to the above, poverty was a serious or very serious problem for more than half of the people evaluated. Regarding possible conflicts with migration

Table 3. Post-Migration Living Difficulties among refugees and asylum seekers settled in Spain and Ireland (N=56). Assessment, January 2018- November, 2019.

PMLD	No problem		Light problem		Moderate problem		Serious problem		Very serious problem	
	N	%	N	%	N	%	N	%	N	%
Worries about family back at home	2	3.6	4	7.1	5	8.9	12	21.4	33	58.9
Unable to return home in emergency	5	8.9	1	1.8	5	8.9	10	17.9	35	62.5
Loneliness and boredom	5	8.9	2	3.6	12	21.4	10	17.9	27	48.2
Separation from family	5	8.9	4	7.1	16	28.6	5	8.9	26	46.4
Isolation	7	12.5	5	8.9	11	19.6	10	17.9	23	41.1
Fears of being sent home	16	28.6	2	3.6	4	7.1	6	10.7	28	50
Not being able to find a job	12	21.4	3	5.4	5	8.9	18	32.1	18	32.1
Poverty	10	17.9	9	16.1	6	10.7	11	19.6	20	35.7
No work permit	19	33.9	2	3.6	3	5.4	8	14.3	24	42.9
Delays in processing your application	18	32.1	4	7.1	8	14.3	3	5.4	23	41.1
Bad job conditions	22	39.3	5	8.9	5	8.9	11	19.6	13	23.2
Poor access to the foods you like	21	37.5	4	7.1	11	19.6	7	12.5	13	23.2
Little government help with welfare	25	44.6	0	0	11	19.6	5	8.9	15	26.8
Poor access to counselling services	22	39.3	7	12.5	10	17.9	7	12.5	10	17.9
Little help with welfare from charities	27	48.2	3	5.4	8	14.3	3	5.4	15	26.8
Worries about not getting treatment for health problems	25	44.6	7	12.5	7	12.5	6	10.7	11	19.6
Poor access to dentistry care	28	50	3	5.4	9	16.1	6	10.7	10	17.9
Poor access to long term medical care	27	48.2	6	10.7	8	14.3	7	12.5	8	14.3
Conflict with immigration officials	32	57.1	6	10.7	4	7.1	5	8.9	9	16.1
Being in detention	33	58.9	6	10.7	3	5.4	5	8.9	9	16.1
Discrimination	29	51.8	8	41.3	10	17.9	3	5.4	6	10.7
Communication difficulties	29	51.8	11	19.6	7	12.5	3	5.4	6	10.7
Poor access to emergency medical care	37	66.1	4	7.1	6	10.7	7	12.5	2	3.6
Conflict with immigration officials	45	8.4	2	3.6	1	1.8	2	3.6	6	10.7

agents and the fear of being detained, in general they were not a problem for the majority, although for more than 60% of the sample, repatriation would be a serious or very serious problem, and 41.1% considered the delays in the asylum resolution processes as an extremely serious problem.

A small majority reported no barriers in accessing healthcare and resources. Thus, 57.2% did not show any problems or concerns regarding not having access to medical care, either emergency (73.2%), long-term (58.9%), or dental health (55.4%) care. Similarly, access to counseling services (51.8%), satisfaction with state assistance received (44.6%), or access to food (44.6%) did not pose any problem or only slight problems to the tested sample. Finally, communication difficulties (10.7%) and other discrimination problems (10.7%) had a low prevalence.

Psychological effects

The HTQ analysis showed that 30.4% of the participants met the criteria for the diagnosis of PTSD according to the DSM-IV and presented a mean of 4.18 (*SD* = 1.7) post-traumatic symptoms that evidenced the presence of PTSD. The results showed that they had been exposed to a mean of 15.1 (*SD* = 7.0) traumatic situations in conflict contexts and that 32.1% had suffered at least one episode of torture (M = 5.8, *SD* = 4.9).

The factor analysis did not show any differences according to gender for the total of post-traumatic symptoms, $F(1,54) = 0.009$; $p = .927$; $\eta^2 = .000$ and no gender differences were found in the diagnosis of PTSD, $x^2(1, N = 56) = 40.422$, $p = .516$. As can be seen in Table 4, the number of trauma and torture episodes experienced was related to the presence of PTSD. Similarly, the participants with

Table 4. Results of the Harvard Trauma Questionnaire (HTQ) among refugees and asylum seekers settled in Spain and Ireland (N=56). Assessment, January 2018-November 2019

	PTSD		No PTSD		Total		F(1, 54)	p	η2
	N=17, 30.4%		N=39, 69.6%		N= 56, 100%				
	M	SD	M	SD	M	SD			
Trauma events	21	7.25	13.33	5.90	15.66	7.21	17.344	.000	.243
Torture events	8.76	4.49	3.49	4.22	5.08	4.91	17.792	.000	.248
Trauma symptoms	5.23	1.48	3.72	1.60	4.18	1.71	11.071	.002	.170
Length of exposition to conflict (months)	36.52	78.34	27.23	37.06	30.05	52.46	0.368	.547	.007

PTSD had a greater number of post-traumatic symptoms. Thus, the mean score for the total symptomatology in both groups was 4.18 (*SD* = 1.71, range [1-8]). No effects of time of exposure to conflict on the presence of PTSD were found.

Post-migration factors as protective factors

To analyze possible protective factors, the effect that some of the psychosocial needs had on the presence of PTSD was analyzed. No effects were found for the status of the asylum application (admitted for processing vs. granted), $x^2(1, N = 56) = 0.083$, $p = .773$; for the degree of perceived support, $x^2(2, N = 56) = 2.905$, $p = .234$; for the degree of acceptance, $x^2(1, N = 56) = 0.141$, $p = .708$; for the degree of integration, $x^2(2, N = 56) = 0.236$, $p = .889$; or for language, $x^2(1, N = 56) = 0.572$, $p = .449$. Receiving psychological treatment was also not a relevant element in the diagnosis of PTSD, $x^2(1, N = 56) = 3.221$, $p = .073$. Effects on the presence of PTSD were only observed as a function of place of residence, $x^2(1, N = 56) = 3.976$, $p = .046$. People residing in institutionalized settings were more predisposed to develop PTSD.

Similarly, the role of post-migratory problems (assessed using the PMLD) on the presence of PTSD was analyzed, finding significant effects based on communication difficulties, $F(1,54) = 6.508$; $p = .014$; $\eta^2 = .108$; discrimination, $F(1,54) = 4.230$; $p = .045$; $\eta^2 = .073$; family separation, $F(1,54) = 4.925$; $p = .031$; $\eta^2 = .084$; not being able to find a job, $F(1,54) = 7.767$; $p = .007$; $\eta^2 = .126$; poor working conditions, $F(1,54) = 5.210$; $p = .026$; $\eta^2 = .088$; not getting treatment for health problems, $F(1,54) = 14.384$; $p = .000$; $\eta^2 = .210$; loneliness, $F(1,54) = 4.581$; $p = .037$; $\eta^2 = .078$; and isolation, $F(1,54) = 6.389$; $p = .014$; $\eta^2 = .106$. In all cases, the best conditions in these areas were related to a lower presence of PTSD. Thus, it seems that factors related to work, physical health, and social relationships could play a resilient role.

Apart from the PTSD diagnosis, and considering the mental health of the refugees more globally from the amount of post-traumatic symptoms they present, a positive correlation was found with discrimination ($r = .279$, $p = .037$), family separation ($r = .319$, $p = .017$), fear of being detained ($r = .276$, $p = .040$), interviews with immigration agents ($r = .308$, $p = .021$), fear of being repatriated ($r = .436$, $p = .001$), poor counseling ($r = .326$, $p = .014$), and poor social assistance from the state ($r = .309$, $p = .020$). In all cases, better conditions implied fewer post-traumatic symptoms.

Discussion

The heterogeneous nature of the participants in this study showed the wide variability of origins of refugees and asylum seekers in Europe in the 21st century.

Regarding the data on asylum resolutions, the present study confirmed the prevalence of granting refugee status (16.1%) compared to other forms of protection, in line with the data of the European Commission (2022). However, the vast majority of the participants were pending the resolution of their asylum application. Inherently to the refugee condition, the interviewees expressed concern for their family in their place of origin and for not being able to return to the country from which they fled in a hypothetical emergency situation. Likewise, it was observed that the situation of poverty, loneliness, boredom, and isolation were frequent and serious problems for the participants, which suggests the need to promote psychosocial resources aimed at covering these aspects. Another frequent element was the concern regarding the time delay in asylum processes, while the command of the language remained at a level of medium to mother tongue for the vast majority, and less than half resided in institutionalized environments, aspects that favored acceptance, integration, and the perception of support.

Regarding the presence of PTSD, 30.4% of the participants met diagnostic criteria, and a positive relationship was observed between the number of traumatic and torture events and post-traumatic symptoms. In this way, people who experienced greater situations of violence presented greater symptoms and were more likely to develop PTSD, which was congruent with those who had received or were receiving psychological treatment (30.4%). However, no greater presence of PTSD was found in relation to gender, acceptance and integration in host countries, or support or status of asylum application. Thus, having or not having received international protection was not a predisposing or protective factor for PTSD, although it was observed that living in institutionalized settings had worse consequences for mental health. Thus, this study confirms that residence settings have an effect on the mental health of refugees. Similarly, language proficiency was found to have effects on symptomatology, which can be interpreted as a lower ability to master the expression of signs and symptoms, in addition to hindering access to health resources.

Ultimately, the data review suggests that the prevalence of PTSD (30.4%) was not a widely spread disorder among the refugees, despite the fact that the vast majority of the participants had experienced traumatic situations and 32.1% had experienced torture situations. However, although most of the studied refugees did not present the aforementioned mental disorder (69.6%), this fact does not mean that their mental health status was good. In relation to this situation, the Ulysses syndrome (Achotegui, 2002, 2005) reflects the suffering of immigrants in extreme situations, who experience extreme mourning but who do not develop mental disorders. Thus, it is important to ask about the mental state of almost

70% of the sample that does not present PTSD. The Ulysses syndrome approach considers that there is a continuum between the pathological state of suffering from PTSD or another mental disorder and the state of health. It is important to conceptualize and name this psychological suffering that does not constitute a mental disorder but is recognizable as discomfort and suffering in many cases. In addition, it is important to contain this discomfort because if it is not resolved, it may develop into a mental disorder, as indicated by the data associated with post-migratory conditions, where the presence of mental disorders is enhanced (Bogic et al., 2012, 2015; Craig et al., 2009; Schick et al., 2016, 2018).

In the present study, the Ulysses syndrome is reflected in the answers collected in the Post-Migration Living Difficulties questionnaire, where reference is made to the current status of the refugees. Thus, the participants of this study showed three mournings that are very relevant in Ulysses syndrome. On the one hand, family and forced separations (48.2% report loneliness, 46.4% manifest suffering because of family separations); on the other, social status (42.9% report lack of work permit, 64.2% report inability to find a job, poverty in half of the sample, and difficulties in having their own home), and, finally, physical risks (60% report fear of being returned to their country of origin because their life would be at risk).

However, despite the fact that any mourning experienced in an extreme situation is a risk factor, it does not have to lead to a mental disorder, as this study shows in relation to PTSD with a prevalence of 30.4%. The only downside is the small size of the sample, which limits authors ability to interpret the lack of differences found based on gender, nationality, or host country. Nevertheless, the high point of this study is that it contains very interesting results to pay attention to Ulysses syndrome and that the participants in the majority did not develop criteria for PTSD. It would be well worth following up on a longitudinal study to detect possible changes in migrants' mental health over time. As Morton Beiser and Kandauda Wickrama (2004) noted employment and relational stability contributed to better mental health as a consequence of temporal reintegration.

Conclusions

It can be concluded that despite the fact that the mental health of the displaced has traditionally been examined from a pathogenic perspective (Arnetz et al., 2013), in most cases, trauma management is resolved without psychopathologies (Bonanno, 2004; Craig et al., 2009; Guarch-Rubio, 2023; Levine et al., 2009; Manzanero et al., 2021). Thus, the present study supports the need for further research to add to the existing ones (Aitcheson et al., 2017; Arnetz et al., 2013; Chan et al., 2016; Uy & Okubo, 2018) and to examine protective factors and the role they play in the well-being of refugees. Coming back to Morton Beiser and Ilene Hyman (1997), mental health stability is not just a product of migrants' traumatic exposition to stressors but of their circumstances and the success they deal with them. However, taking refugees' spontaneous resilience for granted can become an obstacle if host countries delegate their obligation to offer psychological care services for trauma (Guarch-Rubio et al., 2025).

The presented work highlights the need to study the mental health issues of the 69% of the sample who do not have a mental disorder. The Ulysses syndrome helps explain many of these cases, where cultural issues play a fundamental role. It should be noted that most of the post-migration factors that could act as protective factors have cultural connotations, such as communication difficulties, discrimination, family separation, loneliness, isolation, etc.

In this way, the mental health and well-being of refugees and asylum seekers could be influenced by cultural variables through various factors, including:

a) Cultural Responses to Stress: The way people from different cultures cope with and express stress and trauma can vary significantly. Understanding these cultural differences is essential for providing effective support. For example, some cultures may emphasize open emotional expression, while others may encourage emotional restraint.

b) Impact of Cultural Loss: Many refugees and asylum seekers have lost their homes, families, and cultural connections due to conflict and forced migration. This cultural loss can lead to profound grief and a sense of displacement that affects their mental health.

c) Acculturation and Acculturative Stress: The process of adapting to a new culture and society can be stressful and challenging. Refugees often face discrimination, language barriers, and difficulties in understanding and adopting the norms and values of the host society. This acculturative stress can negatively impact their mental health.

d) Cultural Support Systems: The presence of cultural communities and support groups among people who share the same culture can have a positive impact on the mental health of refugees. These groups provide a space where individuals can maintain their cultural traditions, language, and mutual support.

e) Religious Beliefs and Practices: For many refugees, religion plays a crucial role in their lives and can be an important source of emotional and spiritual support. Understanding and respecting these beliefs is essential for providing culturally sensitive mental health care.

f) Reconstruction of Cultural Identity: Rebuilding cultural identity after migration can be a complex process. Refugees often strive to maintain their cultural identity while adapting to their new reality. This process can influence their emotional well-being.

In summary, culture is a key factor in the mental health of refugees and asylum seekers, and mental health professionals must be aware of its importance when providing support and treatment. Culturally sensitive care can significantly enhance the effectiveness of care and help address the unique needs of this population. They emphasize the complexity of the issue and highlight the need for further research in this area.

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