



بسم الله الرحمن الرحيم

كلية نبتة
NAPATA COLLEGE

Medicine Program

Community Medicine Department

Post Traumatic Stress Disorder Among Sudanese Refugees In Saudi Arabia After Sudan war 2023_2025

Submitted By:

_Mai hashim ahmed idris

_Roman abbas hamza

_Abdelmohsen saif eldin adam ebrahim

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Supervisor:

D. Hadeel Ahmed

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DEDICATION

It is our genuine gratefulness and warmest regard that we dedicate this dissertation to our families for all of their continued love and support throughout our lives, to our fathers who taught us the meaning of life, to our mothers the origin of our success.

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The success of this thesis would not have been possible without Allah's endless support and then extensive support, assistance and encouragement from many people. We would like to express our appreciation for:

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Abstract

Background: Refugees face multifaceted challenges resulting from pre-migration trauma and ongoing post-migration stressors. This study examines PTSD symptoms, trauma exposure, displacement experiences, adaptation challenges, daily stressors, and coping mechanisms among Sudanese refugees in Saudi Arabia, following the Sudan War (2023–2025).

Methods: A cross-sectional survey was conducted with 213 Sudanese refugees residing in Saudi Arabia. Data were collected using a structured questionnaire that included demographic details, standardized PTSD symptom checklists (assessing intrusive memories, avoidance behaviors, hyper alertness, and emotional numbness), and items evaluating exposure to violence, loss, displacement, adaptation challenges, daily stressors, and coping strategies. Responses were quantified using appropriate Likert scales, and results were tabulated to capture frequency and percentages.

Results: The study sample was predominantly young (48.8% aged 18–25 years) with a majority of female respondents (60.1%). A high proportion of participants reported direct exposure to violence (53.5%) and displacement (90.1%), with 68.5% experiencing significant loss. PTSD symptom frequency varied: intrusive memories were reported as “always” by 24.9% of respondents, while avoidance behaviors, hyper alertness, and emotional numbness were also commonly experienced. Daily stressors related to language barriers, discrimination, and economic insecurity were prevalent. Coping strategies were mainly based on family support and religious/spiritual practices, which were perceived as highly effective. Social support was primarily moderate to strong, whereas cultural influences played a significant role in managing traumatic stress.

Conclusion: The findings reveal that Sudanese refugees in Saudi Arabia endure high levels of trauma-related distress compounded by post-migration stressors. Social, cultural, and familial supports are integral to mitigating PTSD symptoms. These results highlight the need for targeted mental health interventions and comprehensive support policies tailored to this vulnerable group.

Keywords: PTSD, refugees, Sudanese, Saudi Arabia, trauma exposure, displacement, coping mechanisms, mental health, post-migration stressors, cultural influences

المستخلص

خلفية الدراسة: يواجه اللاجئون تحديات متعددة الأوجه ناتجة عن الصدمات التي يتعرضون لها قبل الهجرة والضغط المستمرة بعد الهجرة. تبحث هذه الدراسة في أعراض اضطراب ما بعد الصدمة، والتعرض للصدمات، وتجارب النزوح، وتحديات التكيف، والضغط اليومية، وآليات التأقلم بين اللاجئين السودانيين في المملكة العربية السعودية، عقب حرب السودان (2023) - (2025).

طرق البحث: تم إجراء دراسة مسحية مقطعية شملت 213 لاجئاً سودانياً مقيماً في المملكة العربية السعودية. جمعت البيانات باستخدام استبيان منظم شمل تفاصيل ديموغرافية، وقوائم فحص أعراض اضطراب ما بعد الصدمة الموحدة (لتقييم الذكريات المتطفلة، وسلوك التجنب، وفرط التأهب، والتبذل العاطفي)، وبنوداً تقييم التعرض لأعمال العنف، والفقد، والنزوح، وتحديات التكيف، والضغط اليومية، واستراتيجيات التأقلم. وتم تقدير الإجابات باستخدام مقياس ليكرت المناسب، وتبويب النتائج لعرض التكرار والنسب المئوية.

النتائج: كانت عينة الدراسة في الغالب من الشباب (48.8% من الفئة العمرية 18-25 سنة)، مع أغلبية من الإناث (60.1%). أشار عدد كبير من المشاركين إلى تعرض مباشر للعنف (53.5%) وتجارب نزوح (90.1%)، حيث عانى 68.5% منهم من فقدان كبير لأفراد الأسرة أو الأصدقاء أو أفراد المجتمع. تنوعت وتيرة أعراض اضطراب ما بعد الصدمة؛ حيث أبلغ 24.9% من المشاركين عن حدوث الذكريات المتطفلة "دائماً"، فيما كانت سلوكيات التجنب وفرط التأهب والتبذل العاطفي أيضاً من الأعراض الشائعة. كانت الضغوط اليومية المرتبطة بحواجز اللغة، والتمييز، وعدم الأمان الاقتصادي منتشرة. استندت استراتيجيات التأقلم بشكل رئيسي إلى الدعم الأسري والممارسات الدينية/الروحية، والتي اعتُبرت ذات فعالية عالية. وقد كان الدعم الاجتماعي في المتوسط إلى القوي، بينما لعبت التأثيرات الثقافية دوراً كبيراً في إدارة الضغوط الناجمة عن الصدمات.

الاستنتاج: تكشف النتائج أن اللاجئين السودانيين في السعودية يعانون من مستويات عالية من الضغوط النفسية المرتبطة بالصدمات، والتي تزداد مع الضغوط بعد الهجرة. كما أن الدعم الاجتماعي والثقافي والأسري يعد أساسياً للتخفيف من أعراض اضطراب ما بعد الصدمة. وتشير

هذه النتائج إلى ضرورة التدخلات المستهدفة في مجال الصحة النفسية واعتماد سياسات دعم شاملة مصممة خصيصاً لهذه الفئة الضعيفة

الكلمات المفتاحية: اضطراب ما بعد الصدمة، اللاجئين، السودانيين، السعودية، التعرض للصدمات، النزوح، آليات التأقلم، الصحة النفسية، الضغوط بعد الهجرة، التأثيرات الثقافية.

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Chapter One

Introduction

1.1 Background

The mental health consequences of armed conflict, particularly post-traumatic stress disorder (PTSD), have been widely documented among displaced populations globally. The 2023–2025 Sudan war, characterized by widespread violence, displacement, and human rights violations, has precipitated a severe humanitarian crisis, displacing over 8.6 million individuals within and beyond Sudan’s borders as of 2024 [1]. Among those affected, Sudanese refugees in Saudi Arabia represent a vulnerable subgroup facing compounded stressors, including trauma exposure, displacement, and acculturative challenges in host environments. Research underscores that refugees from conflict zones exhibit elevated rates of PTSD, with prevalence estimates ranging from 30% to 40% in populations exposed to prolonged violence [2].

Sudan’s history of protracted conflict has long-term psychosocial impacts, with studies highlighting intergenerational trauma and limited access to mental health resources in the region [3]. However, the mental health burden of Sudanese refugees in Saudi Arabia remains understudied, despite the country hosting over 250,000 Sudanese migrants and asylum-seekers as of 2023 [4]. Saudi Arabia’s non-signatory status to the 1951 Refugee Convention exacerbates systemic barriers to healthcare access, leaving refugees reliant on fragmented humanitarian services [5]. Cultural stigma surrounding mental health and

a lack of trauma-informed care further hinder recovery, perpetuating chronic PTSD symptoms [6].

Emerging evidence suggests that post-migration stressors, such as legal insecurity and socioeconomic marginalization, significantly predict PTSD severity among refugees [7]. For Sudanese refugees in Saudi Arabia, these factors intersect with pre-migration trauma, creating a unique risk profile. This study seeks to address critical gaps in literature by examining PTSD prevalence, correlates, and intervention needs within this population, contributing to tailored mental health policies and cross-cultural trauma recovery frameworks.

1.2 Problem Statement

Sudanese refugees arriving in Saudi Arabia due to the Sudan War (2023–2025) face multiple adversities. The abrupt disruption of their lives, including exposure to violence, loss of family, and the breakdown of community structures, places them at a heightened risk for developing PTSD. Current literature suggests that the refugee experience, compounded by war trauma, significantly increases vulnerability to mental health disorders; however, limited empirical data exists regarding this phenomenon within the specific context of Sudanese refugees in Saudi Arabia. The absence of contextualized assessments makes it difficult for practitioners and policymakers to design targeted mental health interventions. Consequently, there is a crucial need to investigate the mental health outcomes, particularly PTSD, in this vulnerable population, and to identify sociocultural and environmental risk factors inherent in their resettlement process.

1.3 Justifications

Studying PTSD among Sudanese refugees in Saudi Arabia is critical for several reasons:

- There is sparse literature on the psychological health of Sudanese refugees in the Middle Eastern context. This study will contribute to filling that gap by

providing localized data about PTSD prevalence and manifestations within this group.

- Understanding the specific dimensions of PTSD in the context of forced migration can help mental health professionals to design culturally appropriate and effective interventions.
- The findings can guide policymakers and humanitarian organizations in the allocation of resources, planning support services, and developing comprehensive rehabilitation programs for refugees.
- By identifying key risk factors associated with PTSD, community leaders and stakeholders can work towards improved mental health awareness, early diagnosis, and stigma reduction among refugees, leading to better integration and support systems.

1.4 Research Questions

What is the prevalence and severity of Post-Traumatic Stress Disorder (PTSD) among Sudanese refugees residing in Saudi Arabia after the Sudan War (2023–2025), and how do pre-migration traumatic experiences, post-migration stressors, coping mechanisms, and sociocultural factors contribute to these mental health outcomes?

1.5 Objectives

1.5.1 General Objective:

To investigate the prevalence and severity of PTSD among Sudanese refugees in Saudi Arabia following the Sudan War (2023–2025).

1.5.2 Specific Objectives:

1. To quantify how widespread PTSD symptoms are among Sudanese refugees in Saudi Arabia and determine the severity of these symptoms.

2. To identify and document the types, frequency, and intensity of traumatic experiences that refugees encountered during the Sudan War (2023–2025).
3. To investigate the challenges refugees face in adapting to life in Saudi Arabia, including social isolation, discrimination, or economic instability, that might exacerbate PTSD symptoms.
4. To explore the coping mechanisms refugees have adopted to deal with trauma and assess how effective these strategies are in mitigating PTSD symptoms.
5. To understand how cultural beliefs, community support, and family networks affect both the experience of trauma and recovery processes among refugees.
6. To gather insights that can be used to design culturally sensitive mental health interventions and policy recommendations to support this vulnerable group.

Chapter Two

Literature Review

INTRODUCTION

Refugees are formally defined as people who have a “fear of being persecuted for reasons of race, religion, nationality, or membership of a particular social group or political opinion that is outside the country of his/her nationality” (9). Asylum seekers are defined as people who state that they are a refugee but their claim for asylum has not been definitively evaluated (UNHCR 2014). Apart from these groups, many more people are displaced in their own countries because of war, civil conflict, or fear of persecution. As of May 2022, more than 100 million people worldwide have been forcibly displaced by war and conflict, of whom more than 27 million are formally registered refugees and many more who are not registered (10). The vast majority of these refugees live in community settlements, with ~2.5 million people living in refugee camps (10). Notably, as of 2019, fewer than 1% of identified refugees have been

permanently resettled, which means many millions have been waiting for lengthy periods in exile (10).

Much research attention has focused on posttraumatic stress disorder (PTSD) in refugees (and internally displaced people) because this population has been subjected to a disproportionate amount of trauma, as well as ongoing stressors during displacement.

PREVALENCE OF PTSD IN REFUGEES

Studies report widely variable PTSD prevalence among refugees—from 0% to 99% and 4.4% to 86.0% (11)—largely due to methodological differences. Factors such as sample size, timing of assessment, sampling methods, reliance on self-report versus clinical interviews, and differing diagnostic criteria contribute to these discrepancies. For instance, one meta-analysis found a 29% prevalence with clinical assessments versus 37% with self-reports, and methodological factors alone accounted for 12.9% of the variance (12). Despite these variations, meta-analyses converge on an overall estimate of about 30% for PTSD in refugees, which is substantially higher than the 3.9% observed in general community samples as well as rates in host populations and nonrefugee migrants (12). Additionally, studies focused on specific groups, like Syrian refugees, report a rate of around 31%.

A related concern is complex PTSD, characterized by the core PTSD symptoms plus additional difficulties in affect regulation, social relationships, and negative self-concepts. Although research on complex PTSD has traditionally centered on individuals exposed to prolonged childhood abuse, recent studies indicate that many refugees exhibit these additional disturbances after severe, prolonged trauma (13). However, estimating its prevalence remains challenging due to methodological issues, with reported rates varying from 3.0% to 85.5% (13).

RISK FACTORS FOR PTSD IN REFUGEES

Risk factors for PTSD in refugees fall into two main categories: trauma exposure and ongoing postmigration stressors. Refugees often endure high levels of traumatic experiences—such as war, interpersonal violence, and torture—that significantly increase the risk and severity of both standard and complex PTSD (11). They frequently face these traumas not only before fleeing but also during and after migration, contributing to an elevated risk compared to nonrefugee populations.

Once resettled, refugees encounter additional stressors that further compound PTSD risk. Legal and social challenges—such as prolonged detention, insecure temporary visa status, limited access to resources, poverty, inadequate housing, discrimination, and poor social integration—exacerbate mental health problems (14). In some cases, postmigration stressors may even fully mediate the relationship between premigration trauma and PTSD symptoms, a finding that has spurred debate on their relative contributions.

Additional factors such as the constant fear of being returned to a hostile environment play a key role—temporary visas that do not guarantee permanent protection are linked to poorer mental health outcomes, including elevated PTSD risk and impaired emotion regulation, especially in refugees with complex PTSD (15).

For refugee children and adolescents, cumulative trauma and ongoing stress—compounded by family separation, detention, and visa rejections—are significant predictors of PTSD. Although mental health may improve over time in supportive community settings, these young refugees are particularly vulnerable when exposed to persistent stressors. Moreover, the mental health challenges of refugee youth are often exacerbated by parental PTSD, which can lead to harsh parenting practices and subsequent psychological problems in children (16).

MECHANISMS OF PTSD IN REFUGEES

While research on PTSD mechanisms in refugees is limited compared to other populations, available studies suggest that neural, biological, and cognitive–social processes all play a role. Neuroimaging research indicates that although refugees share common PTSD-related neural networks with other groups, cumulative trauma and ongoing postmigration stress can uniquely influence neural reactivity. For example, studies have shown that trauma exposure and postmigration stress—not solely PTSD symptoms—can drive altered activity in regions such as the insula and perigenual anterior cingulate cortex (13), and that disrupted resting state connectivity in regions like the thalamo–precentral cortex, amygdala, hippocampus, and prefrontal areas correlates with both trauma load and PTSD severity. In addition, differences in white matter integrity between key limbic and prefrontal regions further highlight variations in neural processing associated with distinct PTSD symptom clusters (16).

Distinct refugee experiences, such as torture, can lead to specific structural and functional brain alterations. Such exposures are linked to hyperactivity in regions like the ventrolateral prefrontal and superior parietal areas (17) and may induce patterns of hyper- and hypoconnectivity between intrinsic brain networks. These adaptations, which may initially help regulate overwhelming emotions, can become maladaptive over time, contributing to social withdrawal and impaired self-regulation (13).

On the biological front, dysregulation of the stress response is evident in refugees. Cortisol measurements in displaced populations have yielded variable results—with both elevated and dampened responses depending on the context, such as higher morning cortisol linked to trauma exposure and PTSD symptoms and altered chronic cortisol levels observed in asylum seekers (17). Some refugees with PTSD also exhibit signs of enhanced glucocorticoid sensitivity, as indicated by increased receptor expression in relation to FKBP5 levels. Furthermore, immune system disruptions, such as heightened interleukin-6 levels and altered T cell representations, have been reported. Genetic vulnerabilities, including risk alleles for the SLC6A4 gene and the COMT Val158Met polymorphism, have been associated with heightened PTSD risk in trauma survivors (18).

Collectively, these findings underscore the complex interplay between cumulative trauma, altered neural circuitry, dysregulated stress responses, and immune as well as genetic factors in contributing to PTSD among refugees. Further research with larger samples and replication studies is needed to refine our understanding and develop targeted interventions.

Social Factors

Refugees frequently experience separation from family and their established social networks, leading to isolation, loneliness, and a fragmentation of attachment systems that are crucial for buffering against adversity (19). These disruptions are compounded by repeated interpersonal losses due to war and trauma, which foster insecure attachment tendencies and increase comorbidity with adult separation anxiety disorder—factors that mediate the relationship between traumatic loss and PTSD (19). Moreover, the persistent worry about the safety of separated family members, rather than physical separation itself, exacerbates PTSD symptoms. In contrast, robust social support in the host country offers a protective effect. For refugee children, inconsistent or disrupted attachments—as a result of caregivers’ PTSD and its negative impact on parenting—predict higher PTSD symptoms and further undermine their emotional well-being (20).

TREATMENTS FOR PTSD

Trauma-focused psychotherapies are the frontline treatment for PTSD. These interventions—including prolonged exposure, eye-movement desensitization and reprocessing (EMDR), and cognitive processing therapy—employ cognitive behavioral strategies wherein patients repeatedly engage with their trauma memories while restructuring maladaptive beliefs. Meta-analyses indicate moderate-quality evidence for these treatments, showing reductions in PTSD, anxiety, and depression. For instance, one review reported a standardized mean difference of -1.03 (with a number-needed-to-

treat [NNT] of 4–5) in high-income settings, while another review across higher- and lower-income countries found an SMD of -1.08 (with an NNT between 6 and 7) (21).

Narrative Exposure Therapy (NET) is a trauma-focused approach tailored for refugees. NET helps individuals construct a coherent life narrative that integrates multiple traumatic events along with positive experiences. Although meta-analyses support NET's efficacy in reducing PTSD symptoms, some evidence suggests its effects may be less robust than those of mainstream trauma-focused therapies such as prolonged exposure and EMDR, particularly in low- and middle-income countries (LMICs) (22).

Because most refugees are hosted in LMICs where mental health resources are scarce, scalable, task-sharing approaches have been developed. These include programs that train nonspecialists using transdiagnostic treatment strategies. The World Health Organization's Problem Management Plus (PM+) is one such five-session program that teaches skills in arousal reduction, problem management, behavioral activation, and accessing social support. PM+ has shown promising results in resettled refugees in Europe, although a large trial in a camp setting did not find significant improvements in PTSD (23). Another scalable program, Self-Help Plus, is delivered in groups and has been effective both in reducing PTSD symptom severity and in preventing PTSD among refugees with subsyndromal distress (23). Moreover, the Common Elements Treatment Approach (CETA) uses a modular framework—including trauma exposure components—to personalize treatment. CETA has effectively reduced PTSD symptom, although its traditional 8–12 session format may limit scalability; a shortened 5-session version has shown comparable results (24).

For children and adolescents, trauma-focused psychotherapies—including adaptations such as KIDNET—have also demonstrated efficacy in reducing PTSD symptoms (25). School-based interventions, in particular, offer a practical delivery model and have shown significant reductions in PTSD among young refugees. However, more research is needed to optimize and scale these treatments in LMIC contexts, where evidence remains limited.

Barriers to Accessing Psychological Treatment for Refugees

Refugees face numerous obstacles in seeking psychological treatment for PTSD. Logistical challenges—including limited healthcare access, financial constraints, lack of interpreters, childcare responsibilities, and transportation difficulties—significantly reduce treatment-seeking behaviors [26]. Additionally, high levels of mental health stigma hinder help-seeking, with studies showing that refugees often exhibit more stigma than other immigrant groups and host community members. Cultural differences further complicate matters; refugees' understanding of mental health is typically grounded in their native cultural norms, which may not align with resettlement country models. This cultural mismatch, coupled with low mental health literacy, can impede recognition of psychological distress and discourage the uptake of interventions [26]. Finally, experiences of interpersonal or persecution-related trauma often erode trust in both people and institutional systems, leading to concerns over confidentiality and further discouraging treatment-seeking [27].

Previous studies

A substantial body of literature has investigated the mental health outcomes of refugees, with numerous studies highlighting a high prevalence of PTSD and associated psychological disorders. One of the seminal works by Fazel, Wheeler, and Danesh (2005) [28] conducted a systematic review and meta-analysis of refugee mental health. Their study found that refugees are at a significantly increased risk for PTSD and depression compared to the general population, largely due to exposure to multiple traumatic events before, during, and after displacement. The study emphasized that the cumulative effect of traumatic experiences plays a critical role in the onset and persistence of PTSD symptoms .

Steel et al. (2009) [28] extended these findings by analyzing the association between exposure to potentially traumatic events and mental health outcomes among conflict-

affected populations. Their meta-analysis indicated that not only does the intensity of trauma correlate with higher PTSD prevalence, but post-migration stressors—such as social isolation and economic uncertainty—also contribute substantially to psychological distress. The authors argued for the integration of interventions that address both historical trauma and current living difficulties, underscoring the need for comprehensive support services .

Silove, Ventevogel, and Rees (2017) [29] provided an in-depth review of mental health challenges among refugees, identifying both risk and protective factors related to PTSD. Their findings highlighted that while exposure to war-related trauma is a critical determinant of PTSD, the presence of robust social networks and culturally relevant community support can mitigate adverse psychological outcomes. This study underscored the complexity of the refugee experience, suggesting that effective mental health interventions must address not only individual trauma but also broader social and cultural dimensions .

In a study focusing specifically on Sudanese refugees resettled in Australia, Schweitzer et al. (2006) [30] explored the interplay between trauma exposure, post-migration living difficulties, and social support. Their research revealed that higher levels of traumatic exposure, compounded by ongoing post-migration stressors such as language barriers, discrimination, and financial instability, were significantly associated with increased PTSD symptoms. Importantly, their study illustrated that the availability of social support acted as a buffering factor, reducing the severity of PTSD symptoms among this vulnerable population .

Nickerson et al. (2014) [31] further contributed to this body of literature by qualitatively examining the lived experiences of refugees suffering from PTSD. Their findings pointed to the crucial role of narrative and communal sharing in processing trauma, with many refugees reporting that engagement in culturally endorsed healing practices and community activities significantly improved their mental health outcomes. This study highlighted the importance of culturally sensitive approaches to mental health treatment that not only address symptom reduction but also promote overall resilience

and recovery .

Chapter Three

Methodology

3.1 Research Design

Descriptive observational cross-sectional community-based study.

3.2 Study Population and Sampling

3.2.1 Target Population

The study focuses on Sudanese refugees currently residing in Saudi Arabia, who arrived

as a result of the Sudan War (2023–2025). This population is characterized by diverse backgrounds in terms of age, gender, educational levels, and the traumatic experiences encountered both before and after migration.

3.2.2 Inclusion Criteria

- Sudanese nationals who have been forced to flee due to the Sudan War (2023–2025).
- Individuals currently residing in Saudi Arabia for at least three months.
- Adults aged 18 years and above who are able to provide informed consent.

3.2.3 Sampling Strategy

A **convenient sampling** technique is employed. An effort will be made to include participants from various regions of origin in Sudan and different communities within Saudi Arabia to capture a broad range of experiences. Additionally, snowball sampling may be used to reach vulnerable populations who might not otherwise participate. The anticipated sample size is determined based on a total coverage over a 3 months period of data collection.

3.3 Data Collection Instruments

3.3.1 Structured Questionnaire

The primary data collection tool is a **structured questionnaire** divided into several sections designed to address each study objective. The questionnaire is available in both Arabic and English, ensuring linguistic accessibility. It is divided into the following sections:

- **Section 1: Demographic and Background Information**
Captures personal details and refugee-related background data. This section provides context for subsequent analyses and subgroup comparisons.
- **Section 2: Assessment of PTSD Prevalence and Severity**
Utilizes a set of standardized items based on validated PTSD scales (e.g., the

PTSD Checklist [PCL]) that assess intrusive memories, avoidance behavior, hyperarousal, and emotional numbing on a 5-point Likert scale (0=Never to 4=Always).

- **Section 3: Pre-Migration Traumatic Experiences**

Documents exposure to war-related events, including direct exposure to violence, loss of loved ones, and forced displacement. This section employs both yes/no items and scaled questions to quantify the intensity and impact of trauma.

- **Section 4: Post-Migration Stressors and Adaptation Challenges**

Explores challenges in adjusting to life in Saudi Arabia. Specific items include assessments of language barriers, discrimination, and economic hardship, again utilizing a Likert scale or multiple-choice format.

- **Section 5: Coping Mechanisms and Their Effectiveness**

Enumerates various coping strategies—such as social support, religious practices, and professional mental health intervention—and asks respondents to rate the perceived effectiveness of each approach on a scale from 1 (not effective) to 5 (highly effective).

- **Section 6: Sociocultural Influences on Mental Health**

Investigates the role of cultural beliefs, community support, and family networks by assessing agreement with culturally framed statements and the presence of stigma regarding mental health support.

3.4 Data Collection Procedures

Data collection will be conducted through a self-administered questionnaire.

3.5 Data Analysis Methods

Quantitative responses will be coded and entered into statistical analysis software (SPSS version 27) for descriptive and inferential analysis. The following steps will be taken:

- **Descriptive Statistics:** Calculation of frequencies, percentages, means, and standard deviations for demographic variables, PTSD symptom scores, trauma

exposure, and stressor frequency.

- **Inferential Statistics:**

- **Correlation analyses** to examine relationships between pre-migration trauma, post-migration stressors, and PTSD symptom severity.
- **Regression analyses** to identify significant predictors of PTSD severity and to assess the impact of coping strategies on mental health outcomes.
- **Subgroup comparisons** (e.g., by gender, age, duration of stay) using t-tests or ANOVAs to explore differences in PTSD prevalence and associated risk factors.

3.6 Ethical Considerations

3.6.1 Informed Consent

Prior to participation, all respondents will receive clear information about the study's purpose, procedures, potential risks, and benefits. Informed consent will be obtained in writing or verbally (as approved by the ethics board) with assurances that participation is voluntary and that respondents can withdraw at any time without consequence.

3.6.2 Confidentiality and Anonymity

Data will be collected and stored anonymously. Personal identifiers will be replaced with unique codes, ensuring that individual responses cannot be traced back to specific participants. Access to data will be limited to the research team, and electronic files will be secured on password-protected systems.

3.6.3 Psychological Support

Given the sensitive nature of the research, arrangements will be made to provide psychological support or referrals for professional counseling if any participant becomes distressed during the interview process. Information about available mental health resources will be provided to all participants.

3.6.4 Ethical Approval

Ethical approval for the study will be obtained from the Community Medicine Department at Napata College.

Chapter Four

Results

A total of 213 refugees participated in the study, providing a comprehensive data set regarding their demographic characteristics, experiences related to trauma and

displacement, PTSD symptomatology, daily stressors, coping mechanisms, and the influence of sociocultural factors.

Demographic Characteristics

The respondents were predominantly young, with nearly half (48.8%; $n = 104$) between 18 and 25 years of age. Those aged 26–35 years comprised 29.6% ($n = 63$), while participants aged 36–45, 46–55, and 55 years or over accounted for 10.8% ($n = 23$), 4.7% ($n = 10$), and 6.1% ($n = 13$), respectively. Gender distribution indicated that 60.1% ($n = 128$) of the sample were female, compared to 39.9% ($n = 85$) male.

Educational attainment among the participants was relatively high, with 59.2% ($n = 126$) having completed university education, 17.8% ($n = 38$) receiving secondary education, and 23.0% ($n = 49$) only achieving a basic level of education. When examining employment status, a significant majority were not working (80.8%; $n = 172$), while only 19.2% ($n = 41$) reported being employed at the time of the study.

Regarding their experience as refugees, 60.1% ($n = 128$) had resided in Saudi Arabia for 12 months or longer, whereas 39.9% ($n = 85$) had been in the country between 6 and 12 months. Participants originated from various regions of Sudan. The largest proportions came from Khartoum (39.0%) and Omdurman (24.4%), followed by Bahri (15.5%), Rabak (6.6%), Al-Hasahisa (6.1%), Darfur (8.0%), Elfasher (4.7%), and several other regions contributing smaller percentages.

PTSD Symptomatology

The study assessed PTSD-related symptoms using a standardized checklist with items rated on a 5-point Likert scale (0 = Never, 1 = Rarely, 2 = Sometimes, 3 = Often, 4 = Always).

- **Intrusive Memories:**

Respondents indicated that 13.1% ($n = 28$) never experienced recurring unwanted memories of traumatic events during the past month, while 16.4% ($n = 35$) reported experiencing them rarely. A further 30.5% ($n = 65$) experienced these memories

sometimes, 15.0% (n = 32) often, and 24.9% (n = 53) always experienced such intrusive recollections.

- **Avoidance Behavior:**

When asked about the avoidance of thoughts or feelings associated with traumatic events, 14.1% (n = 30) reported never engaging in this behavior, 20.7% (n = 44) rarely did so, 25.8% (n = 55) sometimes avoided such thoughts, 23.5% (n = 50) often did, and 16.0% (n = 34) always avoided them.

- **Hyper Alertness:**

For symptoms related to hyper alertness – including constant on-edge feelings, easy startle responses, and sleep disturbances – 15.5% (n = 33) of respondents indicated they never experienced these symptoms, 16.9% (n = 36) rarely did, 24.4% (n = 52) reported these symptoms sometimes, 18.8% (n = 40) often experienced them, and 24.4% (n = 52) always experienced such hyper alertness.

- **Emotional Numbness:**

In terms of emotional detachment, 19.7% (n = 42) of participants reported never feeling detached from their surroundings or others, 20.7% (n = 44) rarely did, 22.1% (n = 47) sometimes experienced emotional numbness, 19.2% (n = 41) often felt detached, and 18.3% (n = 39) always experienced such emotional numbness.

Trauma Exposure and Displacement Experiences

The data on participants' exposure to trauma during the conflict revealed that a slight majority (53.5%; n = 114) had been directly exposed to or had witnessed acts of violence (e.g., armed fighting, explosions, or violence against civilians), while 46.5% (n = 99) reported no direct exposure.

Regarding losses, a substantial 68.5% (n = 146) of respondents confirmed that they had lost a family member, friend, or community member as a result of the conflict, compared to 31.5% (n = 67) who had not experienced such losses.

The vast majority of participants (90.1%; n = 192) indicated that they had been forced to leave their home or community during the conflict, with only 9.9% (n = 21) reporting no displacement. When asked to rate the traumatic nature of their displacement experiences on a scale from 1 (least traumatic) to 10 (most traumatic), responses varied. Notably, 33.8% of respondents (n = 72) rated their experience as the most traumatic (a score of 10). Other ratings were as follows: 10.3% (n = 22) rated it as 1, 2.8% (n = 6) as 2, 6.1% (n = 13) as 3, 2.3% (n = 5) as 4, 7.0% (n = 15) as 5, 12.7% (n = 27) as 6, 7.0% (n = 15) as 7, 11.3% (n = 24) as 8, and 6.6% (n = 14) as 9.

Adaptation to Life in Saudi Arabia

The level of difficulty experienced in adapting to life in Saudi Arabia varied among the respondents. Approximately 20.7% (n = 44) reported no difficulty in adaptation. Meanwhile, 37.1% (n = 79) indicated low difficulty, 32.9% (n = 70) experienced moderate difficulty, and 9.4% (n = 20) reported very difficult adaptation.

Social Support and Daily Stressors

When assessing the level of social support available, 21.6% (n = 46) of participants perceived the support as very strong, 17.4% (n = 37) as strong, and 43.2% (n = 92) described it as moderate. In contrast, 12.2% (n = 26) reported weak support and 5.6% (n = 12) very weak support.

Daily stressors were evaluated using a Likert scale (0 = never, 1 = rarely, 2 = sometimes, 3 = often, 4 = always) for three key dimensions: language or communication challenges, discrimination or social exclusion, and economic insecurity. For language or communication challenges, 27.7% (n = 59) of participants reported rarely experiencing these issues, 20.7% (n = 44) sometimes, 28.2% (n = 60) indicated these challenges occurred at a moderate frequency, while 15.0% (n = 32) reported experiencing them both often and always. Discrimination or social exclusion was reported as “never” by 38.5% (n = 82), “rarely” by 19.7% (n = 42), “sometimes” by 23.0% (n = 49), “often” by 13.6% (n = 29), and “always” by 5.2% (n = 11). With respect to economic insecurity, 27.2% (n = 58) reported never encountering such issues, 18.3% (n = 39) rarely, 22.1% (n

= 47) sometimes, 12.7% (n = 27) often, and 19.7% (n = 42) reported always experiencing economic difficulties.

Coping Strategies and Their Effectiveness

Participants reported various coping strategies to manage stress and traumatic memories. The most prevalent strategy was talking with family or friends, utilized by 64.6% (n = 137) of respondents. Other methods included engaging in religious or spiritual practices (31.0%; n = 66), using distractions (media/hobbies) (29.2%; n = 62), seeking professional mental health support (8.0%; n = 17), participation in community or social activities (8.8%; n = 19), and, to a minimal extent, drug addiction (1.8%; n = 4). Additionally, 8.0% (n = 17) reported using other methods.

The perceived effectiveness of these coping strategies was also evaluated on a scale from 1 (ineffective) to 5 (very effective). In the case of talking with family or friends, 34.3% of respondents assigned a rating of 3, 28.6% rated it as 5, while smaller proportions rated it as 1 (11.7%), 2 (14.1%), and 4 (11.3%). Professional support was viewed as less effective, with 39.9% rating it as 1, 15.0% as 2, 22.1% as 3, 9.9% as 4, and 13.1% as 5. In contrast, religious/spiritual practices received predominantly high effectiveness ratings, with 55.4% of participants rating them as very effective (score 5), and the remaining ratings distributed across lower scores. For community participation, 35.7% rated its effectiveness as 3, with 19.7% rating it as 1, 15.0% as 2, 10.8% as 4, and 18.8% as 5.

Sociocultural Influences

The influence of cultural beliefs on coping with traumatic experiences was examined using a statement with graded agreement responses. The responses indicated that 33.3% of participants strongly agreed, and 32.4% agreed that their cultural beliefs assist them in dealing with traumatic experiences; 27.2% remained neutral, while a small minority disagreed (5.6%) or strongly disagreed (1.4%).

Moreover, the role of family and community support in mental health was deemed highly significant by the respondents. An overwhelming 73.2% considered the support

from their community and family to be very important, 22.5% rated it as important, and only 4.2% found it unimportant. In relation to cultural stigma associated with seeking mental health support, 22.1% of respondents reported experiencing such stigma, whereas 77.9% denied any stigma within their cultural community.

Table 1 Age distribution among participants

		Frequency	Percent
Age	18-25	104	48.8
	26-35	63	29.6
	36-45	23	10.8
	46-55	10	4.7
	55 and over	13	6.1
	Total	213	100.0

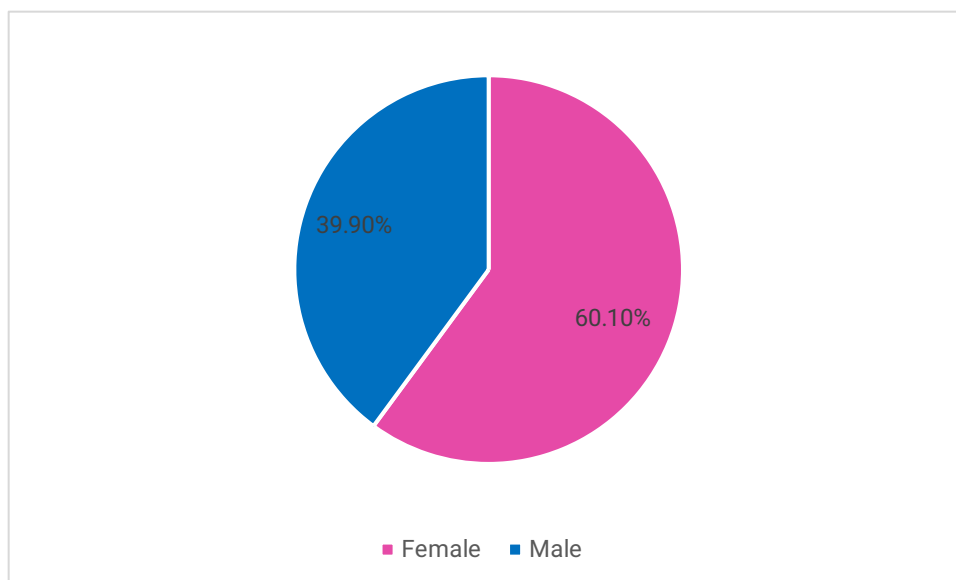


Figure 1 Gender distribution among participants

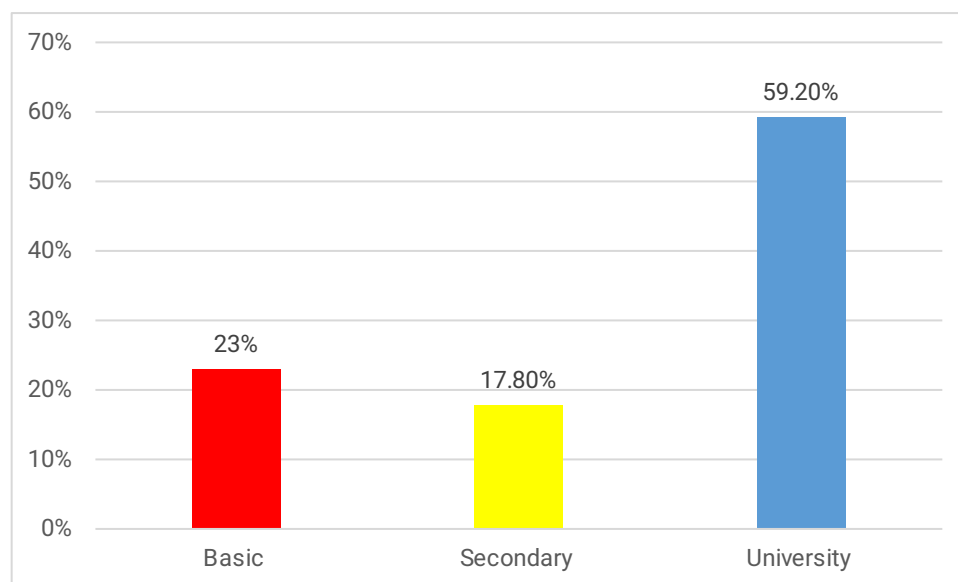


Figure 2 Highest level of education obtained by participants

Table 2 Employment status of participants

		Frequency	Percent
Employment status	Working	41	19.2
	Not working	172	80.8
	Total	213	100.0

Table 3 Length of stay in KSA as refugees

	Frequency	Percent
12 months or older	128	60.1
6-12 months	85	39.9
Total	213	100.0

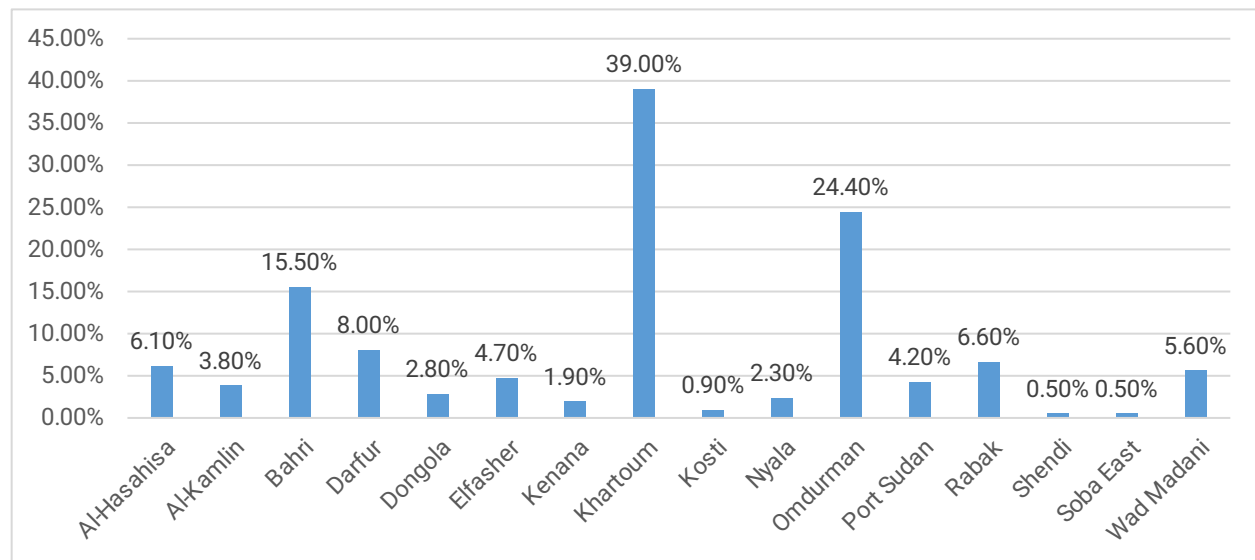


Figure 3 Place of origin in Sudan

Table 4 PTSD Symptomatology

	0 (Never)		1 (Rarely)		2 (Sometimes)		3 (Often)		4 (Never)	
	N	%	N	%	N	%	N	%	N	%
Intrusive Memories: During the past month, how often have you experienced recurring, unwanted memories of traumatic events?	28	13.1	35	16.4	65	30.5	32	15.0	53	24.9
Avoidance behavior: How often do you avoid thoughts or feelings associated with traumatic events?	30	14.1	44	20.7	55	25.8	50	23.5	34	16.0
Hyper alertness: How often do you feel like you're constantly on alert, startled easily, or have trouble sleeping?	33	15.5	36	16.9	52	24.4	40	18.8	52	24.4
Emotional numbness: How detached do you feel from your surroundings or emotionally detached from others?	42	19.7	44	20.7	47	22.1	41	19.2	39	18.3

Table 5 Exposure to or witnessing acts of violence during the conflict (e.g., armed fighting, explosions, violence against civilians)

		Frequency	Percent
Valid	no	99	46.5
	Yes	114	53.5
	Total	213	100.0

Table 6 Loss of a family member, friend, or community member as a result of the conflict

		Frequency	Percent
Valid	no	67	31.5
	Yes	146	68.5

	Total	213	100.0
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Table 7 Leaving home or community during the conflict

		Frequency	Percent
Valid	no	21	9.9
	Yes	192	90.1
	Total	213	100.0

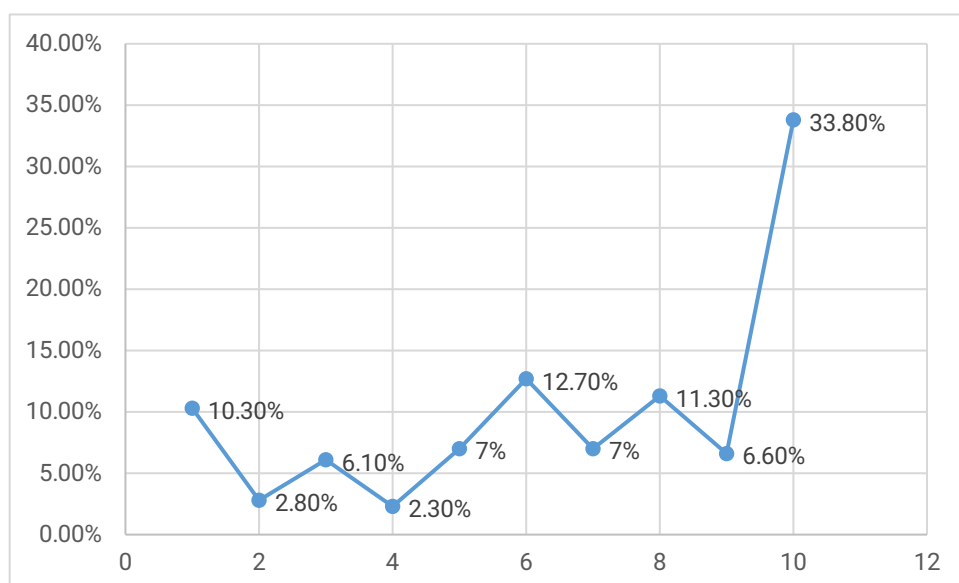


Figure 4 Rating the traumatic experience of displacement (1 = Least traumatic, 10 = Most traumatic)

Table 8 Difficulty adapting to life in Saudi Arabia

		Frequency	Percent
Valid	low difficulty	79	37.1
	Not difficult at all	44	20.7
	somewhat difficult	70	32.9
	very difficult	20	9.4
	Total	213	100.0

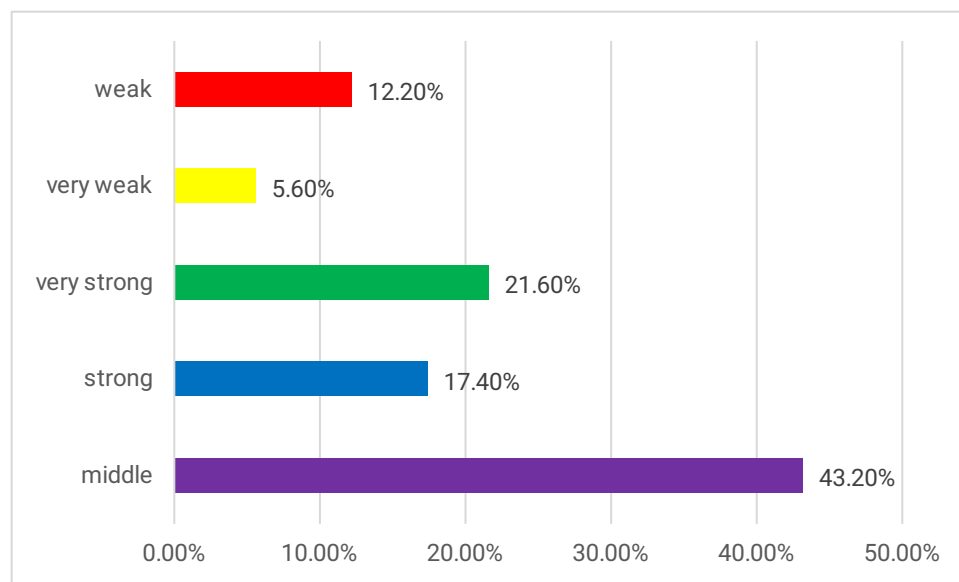


Figure 5 The level of social support (from family, community, or organizations) available in Saudi Arabia

Table 9 Daily Stressors: Indicate how often you experience stressors such as language barriers, discrimination, or economic difficulties in your daily life (use a Likert scale: 0 = never to 4 = always for each item)

	0 (Never)		1 (Rarely)		2 (Sometimes)		3 (Often)		4 (Never)	
	N	%	N	%	N	%	N	%	N	%
Language or communication challenges	59	27.7	44	20.7	60	28.2	32	15.0	32	15.0

Discrimination or social slavery	82	38.5	42	19.7	49	23.0	29	13.6	11	5.2
Economic insecurity	58	27.2	39	18.3	47	22.1	27	12.7	42	19.7

Table 10 Inventory of Coping Strategies: methods you have used to deal with stress and traumatic memories.

		Frequency	Percent
Valid	drug addiction	4	1.8
	Engaging in other religious or spiritual practices	66	31.0
	Other	17	8.0
	Participation in community or social activities	19	8.8
	Seeking professional support for mental health	17	8.0
	Talking to family or friends	137	64.6
	Use of distractions (media hobbies)	62	29.2

Table 11 The effectiveness of coping mechanisms

	1 (Ineffective)		2		3		4		5 (Very effective)	
	N	%	N	%	N	%	N	%	N	%
Talking with family or friends	25	11.7	30	14.1	73	34.3	24	11.3	61	28.6
Professional support	85	39.9	32	15.0	47	22.1	21	9.9	28	13.1
religious/spiritual practices	28	13.1	15	7.0	21	9.9	31	14.6	118	55.4
Community participation	42	19.7	32	15.0	76	35.7	23	10.8	40	18.8

Table 12 My cultural beliefs help me deal with traumatic experiences.

		Frequency	Percent
Valid	I agree	69	32.4

	I disagree	12	5.6
	I strongly agree	71	33.3
	neutral	58	27.2
	strongly disagree	3	1.4
	Total	213	100.0

Table 13 Family and community support: How important is the role of your community and family in your current mental health?

		Frequency	Percent
Valid	important	48	22.5
	unimportant	9	4.2
	Very important	156	73.2
	Total	213	100.0

Table 14 Cultural Stigma: Have you experienced any stigma associated with seeking mental health support within your cultural community?

		Frequency	Percent
Valid	no	166	77.9
	Yes	47	22.1
	Total	213	100.0

Chapter Five

Discussion

This study aimed to examine the prevalence and severity of PTSD symptoms, traumatic exposure, displacement experiences, adaptation challenges, coping strategies, and the role of sociocultural factors among Sudanese refugees in Saudi Arabia following the Sudan War (2023–2025).

Demographic Characteristics and Trauma Exposure

The demographic data indicate a predominantly young sample, with nearly half (48.8%) of respondents between 18 and 25 years. This youthfulness is consistent with migration patterns reported among refugee populations, where younger individuals often constitute a substantial segment (32). The gender distribution in our study (60.1% female, 39.9% male) also aligns with other studies that have noted a higher representation of females among displaced populations, which can influence the

observed prevalence of PTSD symptoms given gender differences in trauma processing (33).

Furthermore, 53.5% of the respondents reported direct exposure to violence during the conflict, and an overwhelming 90.1% experienced displacement. These figures reinforce the cumulative nature of trauma in conflict settings. Similar rates of exposure to violence and high displacement experiences have been documented by Schweitzer et al. (34) among Sudanese refugees resettled in Australia, underscoring the pervasive impact of conflict-induced displacement across different host countries. The high prevalence of loss (68.5% experiencing the death of a family member, friend, or community member) mirrors findings from meta-analyses which show that cumulative traumatic events strongly predict PTSD symptoms (33).

PTSD Symptomatology

The study's PTSD checklist results revealed a wide distribution in the frequency of symptoms. Notably, approximately one-quarter of the participants reported experiencing intrusive memories "always" (24.9%) or "often" (15.0%), while similar patterns emerged for avoidance behaviors and hyper alertness. These findings are consistent with those reported by Silove et al. (35), who noted that persistent and pervasive PTSD symptoms are common among refugees due to both pre-migration trauma and post-migration stressors. Emotional numbness was reported with a somewhat lower frequency; however, nearly 40% of the participants experienced this symptom "often" or "always," echoing previous research that highlights emotional dysregulation in post-traumatic settings (36).

Adaptation and Daily Stressors

While 20.7% of respondents reported no difficulty adapting to life in Saudi Arabia, a substantial proportion still experienced low to moderate levels of adaptation challenges. This finding is in line with other studies that demonstrate the significant impact of post-migration stressors—such as language barriers, discrimination, and economic hardships—on refugees' mental health (36). Our data regarding daily stressors indicate

that issues related to language and communication, discrimination, and economic insecurity persist, which likely exacerbate PTSD symptoms. These ongoing stressors have been similarly observed in studies among displaced populations in diverse settings, underscoring the importance of post-migration factors in shaping mental health outcomes (33).

Coping Mechanisms and Social Support

The predominant coping strategy reported was talking with family or friends (64.6%), a finding that underscores the critical role of social and familial networks in mitigating psychological distress. This reliance on interpersonal relationships for stress management corroborates previous research, which has found that social support often serves as a buffer against the adverse mental health effects of trauma (34,36). In contrast, the low utilization of professional mental health services (8.0%) is concerning but not unexpected, given that many refugees face barriers such as stigma, limited access, and cultural incongruence with formal mental health systems (35).

The effectiveness ratings for coping strategies revealed that religious or spiritual practices were rated highly effective by over half of the participants (55.4% rated as very effective). This supports findings from previous studies where culturally grounded spiritual practices were shown to enhance resilience and promote psychological well-being among refugees (36).

Sociocultural Influences

Our findings also highlight the significant role of cultural beliefs in coping with traumatic experiences. With 66% of respondents either agreeing or strongly agreeing that their cultural beliefs help them deal with trauma, our results are consistent with Silove et al. (35), who emphasized the protective effects of culturally rooted coping mechanisms. Furthermore, the overwhelming importance placed on family and community support (73.2% rating it as very important) aligns with the literature indicating that a strong social network is crucial for mental health recovery in displaced populations (34).

Interestingly, only 22.1% reported experiencing cultural stigma associated with seeking mental health support, suggesting a potential area for intervention to improve professional mental health service utilization without fear of stigma—a finding that requires further exploration in the context of culturally sensitive practices (32).

Conclusion

A significant proportion of participants reported direct exposure to violence, high rates of displacement, and substantial loss, all contributing to pervasive PTSD symptoms such as intrusive memories, avoidance behaviors, hyper alertness, and emotional numbness. In addition, daily stressors—including language barriers, discrimination, and economic insecurity—compound the psychological toll, while social support (especially from family and community) and culturally congruent coping mechanisms (e.g., religious practices) serve as critical buffers against mental health deterioration.

Limitations

Several limitations of the current study warrant consideration:

1. **Sampling Method:** The use of purposive and snowball sampling may limit the generalizability of findings, as the sample might not be fully representative of the entire population of Sudanese refugees in Saudi Arabia.
2. **Self-Report Bias:** Data were obtained via self-report measures, which may introduce recall bias or social desirability bias, especially in discussions of traumatic experiences and mental health symptoms.
3. **Cross-Sectional Design:** The study's cross-sectional nature precludes establishing causal relationships between traumatic exposures, post-migration stressors, and PTSD outcomes.

4. **Cultural Nuances:** While efforts were made to adapt the questionnaire culturally and linguistically, subtle cultural differences might have influenced participants' understanding of the questions and self-reporting of symptoms.

Recommendations

Based on the findings, the following recommendations are proposed:

1. Develop and implement culturally sensitive mental health programs that emphasize both trauma-informed care and practical interventions to address post-migration stressors.
2. Encourage community-based initiatives and family support programs that leverage existing cultural and social structures, given their significant protective role.
3. Conduct longitudinal studies to monitor the evolving mental health status of refugees over time and to determine the long-term effectiveness of various coping strategies.
4. Advocate for policy changes that improve access to employment, education, and social services for refugees to alleviate daily stressors that exacerbate PTSD symptoms.
5. Offer specialized training for mental health professionals and social service providers to increase cultural competency and improve the delivery of mental health services to refugee populations.

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Appendix

Study Questionnaire

Section 1: Demographic and Background Information

1. Basic Demographic Information:

- Age: _____
 - Gender: _____
 - Marital Status: _____
 - Educational Level: _____
 - Employment Status: _____
2. Refugee Background:
- Duration of Stay in Saudi Arabia (in months): _____
 - Region of Origin in Sudan: _____

Section 2: Assessment of PTSD Prevalence and Severity

Objective: Directly measure PTSD symptoms using standardized items.

Using a 5-point Likert scale (0=Never, 1=Rarely, 2=Sometimes, 3=Often, 4=Always):

3. PTSD Symptom Checklist:
- **Intrusive Memories:**
 - “In the past month, how frequently have you experienced recurrent, unwanted memories of traumatic events?”
 - **Avoidance Behavior:**
 - “How often do you find yourself avoiding thoughts or feelings associated with the traumatic events?”
 - **Hyperarousal:**
 - “How frequently do you feel constantly on edge, easily startled, or struggle with sleep difficulties?”
 - **Emotional Numbing:**
 - “How often do you feel detached from your surroundings or emotionally disconnected from others?”

Section 3: Pre-Migration Traumatic Experiences

4. Trauma Exposure Inventory:
- **Conflict Exposure:**
 - “Did you directly experience or witness violent events during the conflict? (e.g., armed combat, explosions, violence against civilians)”
 - Yes ☐ No
 - If yes, please briefly describe the events: _____
 - **Loss and Bereavement:**
 - “Have you lost a family member, friend, or community member as a result of the conflict?”
 - Yes ☐ No

- Rate the impact of these losses on a scale from 1 (minimal impact) to 10 (extreme impact): _____
- **Displacement Experiences:**
 - “Were you forced to flee your home or community during the conflict?”
 - Yes ☐ No
 - “How traumatic was the displacement experience for you?” (Scale: 1 to 10): _____

Section 4: Post-Migration Stressors and Adaptation Challenges

5. **Adjustment Challenges:**
 - “How challenging has it been for you to adjust to life in Saudi Arabia?”
 - Extremely challenging
 - Moderately challenging
 - Slightly challenging
 - Not at all challenging
6. **Social Support and Isolation:**
 - “How would you describe the level of social support (from family, community, or organizations) available to you in Saudi Arabia?”
 - Very strong
 - Strong
 - Moderate
 - Weak
 - Very weak
7. **Daily Stressors:**
 - “Indicate the frequency with which you experience stressors such as language barriers, discrimination, or economic hardship in your daily life.”
(Use a Likert scale: 0=Never to 4=Always for each item)
 - “Language or Communication Challenges: _____”
 - “Discrimination or Social Exclusion: _____”
 - “Economic Insecurity: _____”

Section 5: Coping Mechanisms and Their Effectiveness

8. **Coping Strategies Inventory:**
 - “Which of the following methods have you used to cope with stress and traumatic memories? (Select all that apply)”
 - Speaking with family or friends
 - Seeking professional mental health support

- Engaging in religious or spiritual practices
 - Participation in community or social activities
 - Using distractions (e.g., hobbies, media)
 - Substance use
 - Other (please specify): _____
9. **Evaluation of Coping Effectiveness:**
- “On a scale from 1 (not effective) to 5 (highly effective), rate how effective each strategy has been in helping you manage your stress and traumatic symptoms.”
 - Talking to Family/Friends: _____
 - Professional Support: _____
 - Religious/Spiritual Practices: _____
 - Community Engagement: _____
 - Other (please specify): _____

Section 6: Sociocultural Influences on Mental Health

10. **Cultural Influences:**
- “To what extent do you agree with the following statement: ‘My cultural beliefs help me to cope with traumatic experiences.’”
 - Strongly agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly disagree
11. **Community and Family Support:**
- “How significant is the role of your community and family in your current mental well-being?”
 - Extremely significant
 - Moderately significant
 - Slightly significant
 - Not significant
12. **Cultural Stigma:**
- “Have you experienced any stigma related to seeking mental health support within your cultural community?”
 - Yes ☐ No
 - If yes, please briefly describe: _____

استبيان الدراسة

القسم 1: المعلومات الديموغرافية وخلفية الدراسة

1. المعلومات الديموغرافية الأساسية:

- العمر: _____
- الجنس: _____
- الحالة الاجتماعية: _____
- المستوى التعليمي: _____
- حالة التوظيف: _____

2. خلفية اللاجئ:

- مدة الإقامة في المملكة العربية السعودية (بالأشهر): _____
- منطقة المنشأ في السودان: _____

القسم 2: تقييم انتشار وشدة اضطراب ما بعد الصدمة

الهدف: قياس أعراض اضطراب ما بعد الصدمة مباشرة باستخدام بنود موحدة.
(باستخدام مقياس ليكرت ذو 5 نقاط: 0 = أبداً، 1 = نادراً، 2 = أحياناً، 3 = غالباً، 4 = دائماً)

3. قائمة فحص أعراض اضطراب ما بعد الصدمة:

- **الذكريات المتطفلة:**
"خلال الشهر الماضي، إلى أي مدى واجهت ذكريات متكررة وغير مرغوبة لأحداث صادمة؟"
- **سلوك التجنب:**
"ما مدى تكرار تجنبك للأفكار أو المشاعر المرتبطة بالأحداث الصادمة؟"
- **فرط التأهب:**
"ما مدى شعورك بأنك في حالة تأهب دائم، تتفاجأ بسهولة، أو تواجه صعوبة في النوم؟"
- **التبدل العاطفي:**
"ما مدى شعورك بانفصال عن محيطك أو بالانفصال العاطفي عن الآخرين؟"

القسم 3: تجارب ما قبل الهجرة الصادمة

4. مخزون التعرض للصدمة:

- **التعرض للصراع:**
"هل تعرضت مباشرة أو شهدت أحداث عنف خلال الصراع؟ (على سبيل المثال: قتال مسلح، انفجارات، عنف ضد المدنيين)"
نعم [] لا []
- إذا كانت الإجابة نعم، يرجى وصف الأحداث بإيجاز:

○ **الفقد والحداد:**

"هل فقدت فرداً من العائلة، صديقاً، أو عضواً من المجتمع نتيجة للصراع؟"
نعم [] لا
"قيم تأثير هذه الخسائر بمقياس من 1 (تأثير ضئيل) إلى 10 (تأثير شديد):"

تجارب النزوح:
"هل اضطررت إلى مغادرة منزلك أو مجتمعك خلال الصراع؟"
نعم [] لا
"ما مدى صدمة تجربة النزوح بالنسبة لك؟" (مقياس: من 1 إلى 10): _____

القسم 4: الضغوط بعد الهجرة وتحديات التكيف

5. تحديات التكيف: "ما مدى صعوبة التكيف مع الحياة في المملكة العربية السعودية بالنسبة لك؟"

- صعبة جداً
 - صعبة إلى حد ما
 - قليلة الصعوبة
 - غير صعبة على الإطلاق
6. الدعم الاجتماعي والعزلة: "كيف تصف مستوى الدعم الاجتماعي (من العائلة، المجتمع، أو المنظمات) المتاح لك في المملكة العربية السعودية؟"

- قوي جداً
 - قوي
 - متوسط
 - ضعيف
 - ضعيف جداً
7. الضغوط اليومية: "حدد مدى تكرار مواجهتك لضغوط مثل حواجز اللغة، التمييز، أو الصعوبات الاقتصادية في حياتك اليومية."

(استخدم مقياس ليكرت: 0 = أبداً إلى 4 = دائماً لكل بند)

- تحديات اللغة أو التواصل: _____
- التمييز أو الاستبعاد الاجتماعي: _____
- عدم الأمان الاقتصادي: _____

القسم 5: آليات التأقلم وفعاليتها

8. جرد استراتيجيات التأقلم: "ما هي الطرق التالية التي استخدمتها للتعامل مع التوتر و

- الذكريات الصادمة؟ (اختر كل ما ينطبق)"
- التحدث مع العائلة أو الأصدقاء
- البحث عن دعم مهني للصحة النفسية

- o الانخراط في ممارسات دينية أو روحية
 - o المشاركة في الأنشطة المجتمعية أو الاجتماعية
 - o استخدام وسائل الإلهاء (مثل: الهوايات، وسائل الإعلام)
 - o تعاطي المخدرات
 - o أخرى (يرجى التحديد): _____
9. **تقييم فعالية آليات التأقلم:** "على مقياس من 1 (غير فعالة) إلى 5 (فعالة جداً)، قيم مدى فعالية كل استراتيجية في مساعدتك على إدارة التوتر وأعراض الصدمة."
- o التحدث مع العائلة/الأصدقاء: _____
 - o الدعم المهني: _____
 - o الممارسات الدينية/الروحية: _____
 - o المشاركة المجتمعية: _____
 - o أخرى (يرجى التحديد): _____

القسم 6: التأثيرات الثقافية والاجتماعية على الصحة النفسية

10. **التأثيرات الثقافية:** "إلى أي مدى توافق على العبارة التالية: 'تساعدني معتقداتي الثقافية في التعامل مع التجارب الصادمة.'"
- o أوافق بشدة []
 - o أوافق []
 - o محايد []
 - o لا أوافق []
 - o لا أوافق بشدة []
11. **الدعم الأسري والمجتمعي:** "ما مدى أهمية دور مجتمعك وعائلتك في صحتك النفسية الحالية؟"
- o مهم جداً
 - o مهم
 - o قليل الأهمية
 - o غير مهم
12. **الوصمة الثقافية:** "هل واجهت أي وصمة عار مرتبطة بطلب الدعم للصحة النفسية داخل مجتمعك الثقافي؟"
- o نعم [] لا
- إذا كانت الإجابة نعم، يرجى وصف الأمر بإيجاز:
-

