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Transformative Resilience: Harnessing ICT for Trauma Recovery and Community Empowerment among Eritrean Refugees

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Abstract

This study investigates the effectiveness of the TRUST intervention, delivered through Information and Communication Technology (ICT), in addressing trauma and enhancing resilience among Eritrean refugees in impoverished camps. The research aims to explore whether the comprehensive TRUST program, compared to a shorter psycho-education session, can reduce traumatic stress levels and improve social and economic resilience and social capital, indicating a reduction in collective trauma. Ethical approval was obtained, and participants were randomly assigned to intervention groups. Livelihood support availability was assessed, and psychometric tests were administered before and after the intervention. Results indicate a significant decrease in traumatic stress levels and improvements in social and economic resilience among participants receiving the full TRUST intervention. Interestingly, the availability of livelihood support did not significantly impact trauma levels or associated improvements. Challenges in delivering therapy via ICT, such as connectivity issues, were identified. This study underscores the potential of ICT-enabled interventions in addressing mental health challenges in resource-constrained environments but highlights the importance of addressing connectivity issues for effective implementation.

1. Introduction

Civil wars and intra-state conflicts as well as political violence and extreme repression are traumatising experiences that impact on refugees and lead to pushing them out of their countries often leaving behind everything of value to them. Our era is replete with the litany of dislocated people forced to desperately flee their homes in search for security and prospects following upheavals with tragic consequences in their homelands [1]. The recent history of conflicts in Eritrea, the genocide in Rwanda, the wars in Afghanistan, Kosovo, Darfur, and Syria, retell the same unfortunate story of devastation caused by displacement, which is often far greater than the total number of those killed and injured [2]. Moreover, as the nature of many conflicts become such that they tend to rage longer, the refugee crises that ensue also tend to drag for tens of years, leaving many victims traumatised and without an opportunity for a permanent home [3].

Despite the clear correlation between conflicts, trauma, and refugee outflows, there remains a significant gap in our understanding, particularly regarding the long-term prospects of refugees. Unfortunately, trauma support is rarely offered to refugees upon their initial arrival, as highlighted by Murray [4]. This knowledge gap persists despite ongoing discussions about refugee flows for many years, as seen in works by Teitelbaum (1984) and Grandi [5]. Mental health support is often not prioritized in disaster response efforts, with some considering it impractical or too expensive to implement [6]. Consequently, the provision of integrated mental health support in post-disaster scenarios remains an underdeveloped area of service, as noted by Everly [7].

The absence of this crucial therapeutic support forces traumatised refugees to continue to live with overwhelmed mental status and feel unsafe as a result and this might cause them to embark on dangerous (and more traumatic) secondary migration in search of safety (Luci, 2020). Meanwhile conflict-induced migration of refugees is often discussed through the prisms of economic consequences, including poverty, inequality, economic restructuring and pressures on development, these are often assumed to be the ‘root causes’ of such migration rather than traumatisation and traumatic stress [8]. The situation leads to a total failure of developing and delivering effective support for the individuals and groups suffering from traumatic stress and presenting with symptoms of PTSD hampering their recovery and rehabilitation including their efforts to rebuild the resources they lost [6].

Even in areas where mental health services have been made available there are challenges emanated from the fact that the provision is not contextualised to account for the historical and socio-cultural context of the population the intervention is targeting [9]. This can become harmful practice that exacerbates the problem, such inappropriate services in emergency contexts have been shown to result in detrimental impacts. Wessells outlined how a group of Kosovar survivors of gender-based violence in Albania were made to publicly disclose their predicament resulting in honour killings [10]. In Sri Lanka women participants of a therapeutic programs experienced ostracization [11]. Therefore, exploring capacity to develop and deliver a culturally appropriate trauma support at crucial points during the refugee trajectory such as refugee camps and Internally Displaced People's (IDP) Centres should be a pertinent area that transcends policy development as well as service provision.

This research focused on trauma in recognition of the fact that the devastation that triggers the refugee-making process, the individual experiences of harassment, extreme persecution, torture, violence and inhuman treatment as well as collective experiences such as terrorism and mass killings, are known to cause persistent symptoms that damage victims in many ways including damaging their self-esteem, and ability to trust others, often resulting in changes to their identity [12,13]. Baingana, found high prevalence of depression and post-traumatic stress disorder (PTSD) in refugee communities affecting 40 to 70% of the refugee population in consideration [14]. Systematic searches by De Silva et al. identified 15 studies, of which 10 examined treatment-seeking samples and remaining five focusing on wider population samples [15]. Complex Post Traumatic Stress Disorder (CPTSD) prevalence was between 16 and 38, and between 2.2 and 9.3% for the two sample groups respectively. The analysis also revealed that a fifth of the people under consideration reported a much higher estimate (50.9%). This review highlighted the high prevalence of CPTSD in refugee and asylum-seeking populations in line with previous findings that identified, how war and political violence cause mental illnesses such as PTSD, with debilitating effects for the refugees that flee them [16].

In addition to the impacts on the lives of individual victims the above experiences have affect the wider community causing collective traumatisation. Collective trauma affects whole communities in the form of maladaptation with long term and even intergenerational consequences [17]. Boehnlein et al., conducted a study in post conflict Cambodia, after the civil war of the 1960s that led to the Khmer Rouge rule, that decimated the social fabric of the society [18]. The study found a high prevalence of psychiatric symptoms in refugees, 10 years following the events. Similar results were reported in earlier research too; a survey of 993 adult participants from the largest Cambodian IDP camp on the Thailand-Cambodia border, identified that 80% of the participants felt depressed, and suffered with somatic complaints [19]. In a Mayan village in Guatemala, among a population that suffered a genocidal campaign from 1981 to 1983, which resulted in the massacre of 600 people, Manz found that everyone suffered an overwhelming sense of guilt with a number of psychological difficulties including extreme fear, symptoms of depression, feelings of loss, abandonment and despair as well as a sense of humiliation, anger and solitude [20]. In addition to psychological symptoms many participants experienced a shattering of their faith in God [20].

One of the inevitabilities of the refugee making process is the loss of home with all its resources; conservation of resources (COR) theory (Hobfoll 1998), details how the loss of resources can be more stressful than the efforts entailed in gaining resources. Accordingly, PTSD is thought to occur when there is drastic, major, and irreparable loss of valuable personal, social, or material resources crucial to survival, and social attachments [21]. Here resources are defined as things that are valued by individuals including objects, states, and conditions [22]. Stress, is thus, conceptualised as occurring when individuals fail to gain resources despite investment or when resources are threatened and lost. Consequently, traumatic stress is said to occur when there is an unexpected and rapid loss of resources that attacks people's basic values, as well as the resource mobilisation strategies they are accustomed to, thus leaving a powerful imprint on their consciousness, that can get triggered easily by cues associated with the event [23]. In this sense trauma healing and building resilience in refugees can be closely related to the ability to rebuild capacity to regain social and economic resources in addition to alleviating collective and individual symptoms related to the mental imprint and triggers thereof. This understanding of the prevalence of PTSD and other disabling psychological disorders will have implications for the development of policies and services suitable for vulnerable refugees. [15].

This research is concerned with the delivery of cost-effective trauma support, that is culturally and linguistically appropriate for the target community of highly traumatised refugees in emergency situations in refugee camps. Specifically, the research considered the delivery of trauma support to Eritrean refugees in a refugee camp in Ethiopia. The fate of Eritrean refugees, particularly the large numbers leaving the small country as well as the enormous risks they have been taking in the process have been the subject of discussion for several years now [24,25]. The traumatic violence being perpetrated in Eritrea has been fully outlined in a UN Human Rights Commission report, that investigated human rights violations and concluded that, these crimes potentially amounted to 'crimes against humanity' [26].

The report called for accountability on behalf of the millions of Eritrean victims and their families who have suffered atrocities that were hitherto untold. Systematic use of extrajudicial killing, extensive torture, heinous rape, and the situation of indefinite national service and forced labour were outlined in extensive detail, concluding that "It is not law that rules Eritreans – it is fear" [26]. Reading through the hefty document cataloguing violations committed against groups and individuals in Eritrea, it is not

difficult to expect the devastative traumatic impact on victims.

According to the report the regime of President Isaias Afwerki perpetrated violations, including forced disappearances and extrajudicial imprisonments that are “on a scope and scale seldom witnessed elsewhere” [27]. In addition, the inquiry also found evidence of extreme surveillance and censorship aimed at curbing any form of descent. The extreme measures even extended to the level of thought resulting in a culture of traumatic fear affecting the entire population. The situation led the Commission to conclude that, due to constant spying and surveillance Eritreans were forced to live in perpetual fear of detention, arbitrary arrest, disappearances, torture, and even death. This surveillance culture has also resulted in a toxic atmosphere of mistrust and self-censorship dividing communities and even families [26].

The Eritrean national service which has become indefinite forced military conscription has also trapped an entire generation of men and women and is subjecting their families to become destitute as result [28,29]. The UN report highlighted this situation as causing Eritreans including many underage children to flee their country in fear. In addition, at the various military installations, women were said to be facing gender-based violence: “Sexual violence against women and girls is widespread and indeed notorious in military training camps. […] Furthermore, the enforced domestic service of women and girls who are also sexually abused in these camps amounts to sexual slavery” [26]. The report also identified the prevalence of an atmosphere where Eritrean officials frequently use beatings and rape, inflicting physical and psychological pain, to extract confessions or information, or as a punishment, for defiance or to intimidate or coerce detainees and conscripts into compliance.

Linking these traumatic events to the mass exodus of refugees, the COI report states: “Faced with a seemingly hopeless situation they [Eritreans] feel powerless to change, hundreds of thousands of Eritreans are fleeing their country”, despite the fact that “Eritreans who attempt to leave the country are seen as traitors”, and that “the government has implemented a shoot-to-kill policy at border areas to prevent people from fleeing” (ibid., p. 6). Indeed, the situation has led tens of thousands of Eritreans to leave Eritrea taking enormous risks along the various routes to destinations they consider ‘safe’ [30-32]. Many of these young refugees are fleeing the abusive, national service, either deserting after they were forcefully recruited or to avoid impending conscription [28,33]. This situation in Eritrea has been ongoing for three decades since the country gained its independence from Ethiopia in 1993. The government’s extreme intolerance of any form of dissent has had an impact on the whole society and not just those who have become targeted for their activities or views, everyone knows someone in prison, often being tortured, or suffering rape or sexually assault, leading Eritreans to live in an atmosphere of total uncertainty, extreme repression, and hopelessness [31,34-36].

The difficulties are reflected in the number of Eritreans who flee their country placing Eritrea among the ranks of top refugee producing nations [37]. the United Nations Refugee Agency, UNHCR, reports for 2014 show that at the peak of the refugee crisis, the numbers arriving in Europe nearly tripled, from 13,000 the previous year to 37,000 [38]. In 2014 and 2015, roughly 40,000 Eritreans embarked on the extremely hazardous journey across the Mediterranean to arrive in Italy [39]. Every month some 5,000 Eritreans fled their country, this a figure represents a seismic population movement for a small country of 6 million. In 2016 UNHCR reported that, 52,000 Eritreans escaped their country and, by 2018, about 12% of the total population of Eritrea had been pushed out [40].

Those who flee include separated children, vulnerable women with their young children and many vulnerable young men often first fleeing to the nearest refugee camp but many end up moving further, arriving to Europe by boats having faced extremely traumatic experiences including many ship-wreck disasters [32,38,41]. The situation has been a cause of many discussions and reports with the central question being: why so many Eritreans are on such a move? [42-45]. Those who are familiar with the country’s history lament Eritrea’s decline and the fate of Eritreans [27,46,47].

The experiences mentioned above pose psychological risks including the risk of threat to the integrity of the self [48-50]. Many people exposed to such levels of traumatic stress go on to experience stress responses typical to PTSD, including avoidance, sleep disturbances, hyperarousal, and hypervigilance they may also engage in behaviour typical of those who anticipate further risks [51-54]. Constant activation of the stress response or allostatic load in post-traumatic stress, creates a state of hopelessness, fear, and horror including the risk of suicide [55-57]. A study of Eritrean refugees in an Ethiopian refugee camp found that there was a high prevalence of suicide ideation with previous history of trauma and traumatic stress disorder among the risk factors [58]. In a recent report Haynes was able to confirm, via Freedom of Information requests, that between 2018 and 2022 five Eritrean Unaccompanied Asylum-Seeking Children (UASC), aged 14 to 25 committed suicide in the UK [59]. Four out of the five were from the same friendship network of young Eritrean refugees [60]. Despite indicators of deteriorating mental health among the young people this deterioration was, unfortunately not matched by access services (Gal-dem, 2022).

When considering traumatisation in refugees or refugee communities one should exercise caution prior to conclusions regarding PTSD, to account for confounding set of variables in the chain of events resulting in disorders and suicides, painful and vivid past memories, can fall within the range that can be considered a normal responses to such adverse contexts nonetheless, we need to be mindful of all the evidence linking exposure of experiences resulting from conflict and atrocities and mental ill health including PTSD [61-65]. The reality for many refugees is a lack of adequate mental health support, both in initial displacement camps and in their final destinations. This deficiency

goes beyond mere policy or resource constraints but extends to issues encompassing challenges in comprehending the context of trauma that drives refugees from their homes. When working with traumatised refugees, understanding historical context is vital, alongside linguistic, and cultural adaptations crucial for tailoring therapeutic approaches [66,67]. As highlighted earlier, collective approach to conceptualising refugee trauma is an essential consideration. In addressing trauma healing for refugees, interventions must be contextualised at the collective level to acknowledge the potential for both individual and collective trauma resulting from experiences leading to refugee flight [68]. Moreover, many refugee cultures are collectivistic necessitating adaptation beyond language and cultural considerations [69]. This departure from the Eurocentric model of PTSD treatment, primarily focused on individual trauma, questions the applicability of universally developed psychological interventions, especially in non-Western contexts [2]. Therefore, trauma healing efforts should encompass not only addressing individual trauma and PTSD symptoms but also rehabilitating survivors and processing collective memories.

The challenges in providing adequate trauma support for refugees are multifaceted and extend beyond merely having a trained workforce and resources. Even in well-resourced settings, the availability of appropriately trained professionals who can deliver therapy in accessible languages while understanding the cultural, social, and political contexts remains limited [2]. Furthermore, delivering effective trauma support is hindered by practicalities such as the refugees' legal status and the transient nature of their settlements. Many refugees are constantly on the move due to safety concerns, contributing to a sense of instability and making it difficult to access traditional trauma support modalities that often require settled living conditions (Gruner et al., 2000). Paradoxically, the lack of access to trauma support exacerbates refugees' feelings of insecurity, prompting them to continue seeking safety elsewhere. Despite advancements in practice, research, and policies, the complex needs of traumatised refugees often go unmet due to limited resources and the challenges inherent in providing appropriate care [70]. Considering the high levels of trauma among refugees and their mobility, the societal challenge, particularly for advocates of equity, lies in effectively delivering the much-needed assistance within the realistic constraints of available resources.

Recognising the challenges of resource scarcity in providing trauma therapy to refugees, organizations like the World Health Organization (WHO) have explored alternative, less resource-intensive approaches, such as self-help interventions. WHO developed Self-Help Plus (SH+), a self-help guide based on third-wave cognitive behavioural therapy, specifically Acceptance and Commitment Therapy (ACT), aiming to address the shortage of adequately trained professionals to deliver trauma support to refugees [71]. SH+ consists of audio recordings of adapted ACT sessions accompanied by a manual. Trials conducted with Ugandan refugees in South Sudan revealed the intervention's efficacy in reducing psychological distress [72].

While self-help guides like SH+ hold promise in addressing the human resource challenges in trauma therapy delivery to refugees, concerns persist regarding the high mobility of the target population. Despite the adaptability of delivering interventions through analogue audio, this method still falls short in matching the mobility of the target communities. To mitigate these challenges, leveraging information and communication technology (ICT) can enhance intervention effectiveness. This approach is particularly appealing given the widespread use of smartphones among refugees, including Eritrean refugees who utilize these devices to access valuable information from fellow refugees and official sources such as media outlets [73].

This research focuses on the development and implementation of trauma support for refugees, specifically emphasising the delivery of such support via mobile phones, which have become essential tools in the lives of many refugees. As detailed in Kidane, a six-session self-help trauma support program, named Trauma Recovery Understanding Self-Help Therapy (TRUST), was developed to address the expertise and logistical challenges in delivering trauma support to refugees [2]. TRUST, designed to address both individual and collective trauma concurrently, draws from self-help techniques derived from Eye Movement Desensitization and Reprocessing therapy (EMDR), which has been noted for its effectiveness in integrating traumatic memories in survivors of traumatic experiences, including refugees [74,75]. Recognizing EMDR's efficacy, the World Health Organization (WHO) has endorsed it as a top-level evidence-based therapy [76].

The initial two sessions of TRUST focus on psychoeducation, providing participants with a comprehensive understanding of trauma and its effects on brain functioning. This is followed by three sessions aimed at equipping participants with coping skills to manage traumatic stress symptoms. Additionally, participants are provided with opportunities for reintegration and encouraged to contribute to addressing trauma within their communities. TRUST's framework is adapted from Shapiro's self-help book, which is organized into similar categories, with the incorporation of collective healing sessions to address the significance of collective trauma and healing [77]. Notably, TRUST is delivered through information and communication technology (ICT) to overcome challenges associated with the high mobility of the target community and the scarcity of qualified therapists proficient in the refugees' language. Each session is facilitated through pre-recorded videos featuring a therapist who provides guidance on session content and demonstrates techniques. These videos are uploaded to a password-protected platform, accessible only to registered participants who follow the sessions sequentially. Participants also have the opportunity to submit text-based questions and remarks.

This paper aims to investigate the effectiveness of TRUST in reducing levels of traumatic stress and collective trauma among Eritrean refugees residing in refugee camps in Tigray, Northern

Ethiopia.

The study aims to test the effectiveness of the TRUST program delivered via ICT by comparing the shorter version (focusing on psychoeducation) with the full program. The hypotheses to be tested are as follows:

Hypothesis 1: Results will reveal a negative correlation between post-traumatic stress (measured using IES-Short) and the following components:
• Social and economic resilience (excluding worriedness, as higher values indicate more worry)
• Social capital (measured by ISCS scores, both online and offline)

Hypothesis 2: The full TRUST program will yield superior outcomes compared to the shorter version focusing solely on psychoeducation. Specifically, the full program is expected to result in:
• Reductions in post-traumatic stress
• Increase in scores for social and economic resilience
• Increase in social capital (both online and offline)

Hypothesis 3: Participation in livelihood support activities will lead to the following outcomes:
• Decreased levels of post-traumatic stress
• Increased social and economic resilience (excluding worriedness)
• Increased components of social capital (both online and offline)

2. Research Design

This study revolves around the delivery of TRUST, the conceptual framework depicted in Figure 1 illustrates the relationships among traumatic stress (an indicator of individual trauma), social capital (representing collective trauma), and socio-economic resilience (indicative of perceptions of social and economic resilience) during both the pre - and post-intervention phases. Pre-intervention, these variables are considered independent of each other. However, following the trauma intervention, levels of trauma serve as a mediating variable affecting both social capital (collective trauma) and social and economic resilience. This impact is attributed to changes in self-efficacy and agency resulting from the intervention.

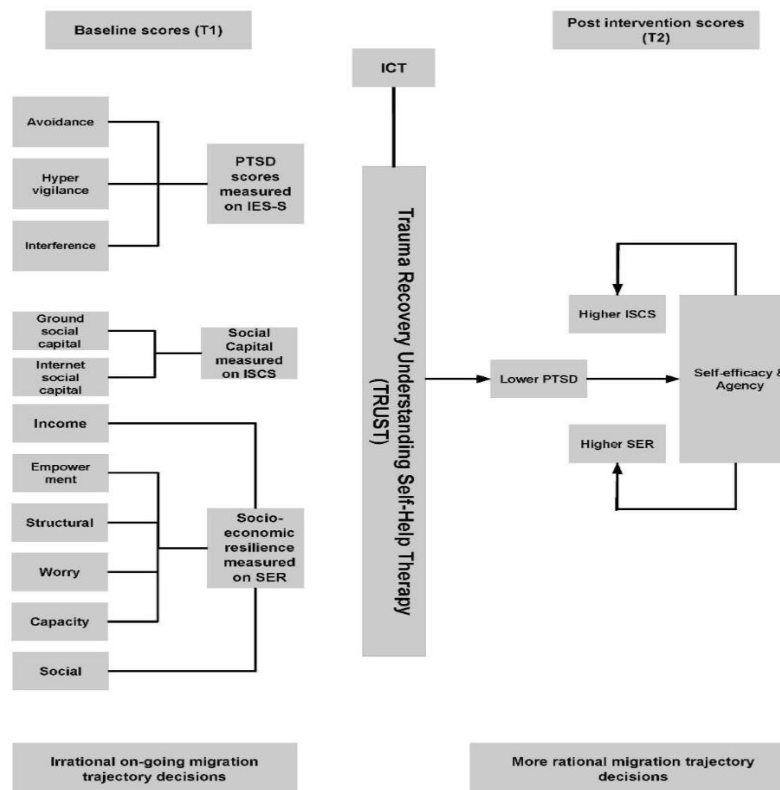

Figure 1: Conceptual Framework [2]

The research design adopted for this study was experimental, aiming to assess the effectiveness of TRUST as an intervention within the real-life context of two refugee camps in the Tigray region of northern Ethiopia. Given the constraints of this real-life setting, not all variables could be controlled, necessitating responsiveness to the environment and meticulous documentation of contextual specificities [78]. One significant consideration was the absence of a control group receiving "no intervention." Ethical concerns precluded the withholding of assistance from individuals identified as having experienced traumatic events, especially in an environment where support options were scarce. As a result, the study included two intervention groups: one receiving a short intervention and the other receiving the full intervention.

Another instance of adaptive adjustment was the shift in delivery platform from an application requiring reliable internet access to one (SHAREit) facilitated through Bluetooth. This change was prompted by the practical effectiveness of the latter platform, which was introduced to researchers by refugees utilising it for material sharing among themselves. Furthermore, phone cards were provided to all participants initially intended to reimburse the cost of accessing videos and downloading the application. However, since downloads were primarily unnecessary due to the use of the Bluetooth application, the reimbursement remained unchanged. Consequently, the phone cards served as an incentive to encourage continued participant engagement.

2.1 Participants and Interventions

The 103 participants were purposively sampled, leveraging the research team's deep understanding of the population and their circumstances within the refugee camps. They were then randomly assigned to either the short or full version of the TRUST intervention. Additionally, some participants received livelihood support, which is additional aid given to particularly vulnerable groups, either in-kind or in cash, often aimed at building resilience by enhancing income and income generation. This led to the formation of four distinct groups as detailed in table 1:

1. Participants receiving the short version of TRUST and livelihood support.
2. Participants receiving the full version of TRUST and livelihood support.
3. Participants receiving only the short version of TRUST.
4. Participants receiving only the full version of TRUST.

Intervention	2-videos group	7-videos group	Total
With livelihood support	14	18	32
Without livelihood support	36	35	71
Total	50	53	103

Table 1: Below Illustrates the Distribution of Participants Across these four Groups

3. Research Instruments

Three psychometric tests were utilized in this study: the Impact of Events Scale (IES), the Social and Economic Resilience Scale (SER), and the Internet Social Capital Scale. All three scales were adapted for use within the specific context of the study, as outlined in, and demonstrated a high level of internal consistency, indicating their reliability for research purposes [2]. The IES is recognised as one of the most commonly used self-reported measures of Post-Traumatic Stress Disorder (PTSD). Initially developed in 1979 by Horowitz, Wilmer, and Alvarez, the scale was designed to assess the degree of symptomatic response to a particular traumatic experience occurring within the previous seven days [79]. In order to better suit the needs of highly mobile communities, a shorter version of the scale, known as the IES-S, was developed for this study. The IES-S retains the three main constructs of the original IES—namely, intrusion, avoidance, and hyperarousal—following the suggestion of Thoresen et al. [80]. This adapted version of the scale exhibited strong internal consistency, as detailed in Table 2 below.

	Mean		Standard deviation	
	Pre-test	Post-test	Pre-test	Post-test
Other things kept making me think about it.	3.58	3.09	1.50	1.44
I had waves of strong feelings about it.	3.36	2.94	1.53	1.41
I stayed away from reminders of it.	3.83	2.57	1.35	1.40
I tried not to talk about it.	3.42	2.65	1.52	1.44
I had trouble falling asleep.	2.78	2.52	1.41	1.44
I had trouble concentrating.	3.07	2.40	1.50	1.42
Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.	3.00	2.63	1.58	1.59

Table 2: Mean and Standard Deviation of IES-Short Items

The Social and Economic Resilience (SER) scale was originally developed and employed in a previous study conducted in Uganda by van Reisen et al. in 2019 [81]. To make it suitable for the current research context, adaptations were made by Kidane in 2021 [2]. These adaptations aimed to ensure the scale's effectiveness and relevance in the new setting. Additionally, Kidane conducted statistical analyses to verify the internal consistency of the scale, as outlined in Kidane (2021) [2]. Table 3 provides a summary of the key statistics derived from this analysis.

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		Number of items included	Mean	Standard deviation	Skewness	Kurtosis
Income	Pre-test	4	2.05	0.98	0.86	-0.12
	Post-test	4	2.16	0.99	0.62	-0.48
Empowerment	Pre-test	3	3.05	0.88	-0.27	-0.64
	Post-test	3	3.54	1.11	-0.37	-0.91
Trust in the system	Pre-test	3	3.15	0.88	-0.37	-0.40
	Post-test	3	3.64	1.04	-0.50	-0.45
Worriedness	Pre-test	4	3.53	0.77	-0.34	-0.13
	Post-test	4	3.30	1.05	-0.07	-0.91
Capacity	Pre-test	3	2.93	0.98	-0.22	-0.69
	Post-test	3	3.51	1.21	-0.29	-1.06

Table 3: Summary of SER-S Statistics [2]

The Internet Social Capital Scale (ISCS), chosen for its ability to assess social capital both offline and online, was adopted based on the work of Williams (2006). Given the consistent findings across studies indicating that prolonged civil conflict can erode social capital, measuring social capital was deemed crucial, especially considering its parallels with collective trauma. In fact, the depletion of social capital has been utilised as a measure of collective trauma [82-84].

Like the approach with the SER scale mentioned earlier, ensured the ISCS's reliability for use in the current research context by assessing its internal consistency [2]. Table 4 summarizes some of the key findings related to the ISCS from this analysis.

		Number of Items	Mean	Standard deviation	Skewedness	Kurtosis
Social capital online	Pre-test	11	2.64	1.01	-0.12	-0.99
	Post-test	11	3.07	1.35	-0.27	-1.26
Social capital offline	Pre-test	11	2.75	0.72	-0.30	-0.36
	Post-test	11	3.30	1.09	-0.30	-0.92

Table 4: Key Statistics of ISCS (Online and Offline) [2]

4. Procedures

Ethical approval was obtained from Tilburg University's ethics board. Participants were briefed collectively and provided explicit consent before being randomly assigned to one of two main groups. Livelihood support availability was determined during individual interviews covering demographic information and traumatic experiences. Participants were then guided through the completion of three psychometric tests for baseline pre-test scores, with the lead researcher conducting all assessments to ensure consistency and assess any vulnerabilities. Participants identified with active mental health distress were referred to camp clinics for additional support. Research assistants distributed videos to the remaining participants based on their assigned groups, ensuring completion of all tasks within each session.

Six weeks post-intervention, all participants were invited for a second interview using the same psychometric tests as in the initial interview. Additionally, participants were encouraged to engage in group discussions to share their experiences and were thanked for their participation.

5. Results

The correlation between individual traumatic stress, collective trauma, and social and economic resilience in the pre-test was analyzed. The data indicated a negative correlation between post-traumatic stress and all components of social and economic resilience, except worriedness, aligning with the hypothesis. Furthermore, there was a negative correlation between post-traumatic stress and social capital, particularly with regard to social capital in offline contexts compared to online social capital.

		Correlation	Significance
SER	Income	-0.280**	< 0.01
	Empowerment	-0.343**	< 0.01
	Worriedness	0.487**	< 0.01
	Trust in the system	-0.192	0.052
	Capability	-0.269**	< 0.01
	Social embeddedness	-0.252*	0.010
ISCS	Offline	-0.187	0.058
	Online	-0.068	0.495

Table 5: Correlation Between PTSD, SER and ISCS Scores

5.1 Effectiveness of Trust

The effectiveness of TRUST was examined by comparing the two sets of results, as well as the impact on each of the livelihood support using MANOVA (multivariant analysis of variance). The first and second measurements gave a within factor while the livelihood support category 2x2x2 MANOVA gave us a between factor analysis.

5.2 Is Trust Effective at Reducing Traumatic Stress?

The results of the IES-S scores are indicative that post-traumatic stress levels changed between the first and second measurement (F (1.90) = 64.594, p<0.01). Moreover, the interaction time*TRUST was significant (F (1.90) = 91.80, p<0.01), indicating that TRUST did bring down the levels of trauma, as measured on the IES-S.

Inspection of the estimated means show that those who received seven videos of TRUST (i.e., the full programme) reported less post-traumatic stress during the second measurement, than those who received the shorter version with two videos.

5.3 Can Trust Enhance Social and Economic Resilience?

The study employed 2x2x2 repeated-measure MANOVAs to analyse the impact of TRUST on various aspects of the SER-S subscales. Results indicated that the perception of income remained stable over time (F(1.91) = 0.358, p<0.551), but there was a significant interaction between time and TRUST (F(1.91) = 15.084, p<0.01), suggesting differing perceptions of income between the two TRUST intervention groups.

Similarly, TRUST demonstrated a significant positive influence on empowerment, trust in the system, worry reduction, capability, and social embeddedness, as evidenced by significant interactions with time (empowerment: F(1.91) = 42.344, p<0.01; trust in the system: F(1.91) = 23.480, p<0.01; worriedness: F(1.91) = 13.438, p<0.01; capability: F(1.91) = 69.565, p<0.01; social embeddedness: F(1.91) = 22.474, p<0.01).

However, livelihood support did not lead to significant differences in any of the SER scores (income: F(1.91) = 1.112, p=0.294; empowerment: F(1.91) = 0.069, p=0.793; trust in the system: F(1.91) = 1.983, p=0.162; worriedness: F(1.91) = 0.368, p=0.545; capability: F(1.91) = 0.644, p=0.424; social embeddedness: F(1.91) = 0.808, p=0.371).

Overall, participants who received the full TRUST intervention demonstrated positive outcomes across all components of the social and economic resilience scale, while livelihood support did not significantly impact participants' perceptions of their social and economic resilience.

5.4 Can Trust Improve Social Capital (Reduce Collective Trauma)?

The 2x2x2 repeated measure MANOVA analysis revealed a significant main effect of time for both online and offline social capital scores, indicating changes over the research period. TRUST was found to enhance social capital scores, indicating a reduction in collective trauma, both within the refugee camps and across online networks accessed by participants.

For online social capital scores, there was a significant main effect of time (F(1.90) = 14.859, p<0.01), and the interaction time*TRUST was significant (F(1.90) = 32.203, p<0.01). Participants receiving the full seven videos of TRUST reported higher social capital scores online. However, the interactions time*livelihood support and time*TRUST*livelihood were not significant (F(1.90) = 0.675, p=0.413; F(1.90) = 2.719, p=0.103), suggesting livelihood support did not impact online social capital.

Similarly, for offline social capital, there was a significant main effect of time (F(1.90) = 55.409, p<0.01), and the interaction time*TRUST was significant (F(1.90) = 82.733, p<0.01). Participants receiving seven videos of TRUST reported higher social capital offline. Again, the interactions time*livelihood support and time*TRUST*livelihood were not significant (F(1.90) = 0.359, p=0.551; F(1.91) = 1.109, p=0.295), indicating no impact of livelihood support on offline social capital.

Table 6 provides a summary of the impact of TRUST on traumatic stress (measured by IES-Short), various dimensions of social and economic resilience (SER), and social capital (measured by ISCS). The partial eta-square results indicate the percentage of variance in the change between pre-TRUST and post-TRUST measurements,

including associated error variance (Pierce, Block & Aguinis, 2004).

The findings suggest that TRUST had a notably strong effect on reducing post-traumatic stress, enhancing capability (specifically self-efficacy and agency as indicated by SER), and increasing offline social capital (as indicated by ISCS). Consequently, it can be concluded that TRUST intervention effectively mitigated trauma, thereby improving participants' perceptions of their capability and social capital.

		F value	Partial eta-square
IES-Short		F (1.90) = 91.80, p < 0.01	0.51
SER	Income	F (1.91) = 15.084, p < 0.01	0.14
	Empowerment	F (1.91) = 42.344, p < 0.01	0.32
	Worriedness	F (1.91) = 13.438, p < 0.01	0.13
	System	F (1.91) = 38.632, p < 0.01	0.30
	Capability	F (1.91) = 69.565, p < 0.01	0.43
	Social embeddedness	F (1.91) = 22.474, p < 0.01	0.20
Social capital (ISCS)	Offline	F (1.90) = 82.733, p < 0.01	0.48
	Online	F (1.90) = 32.203, p < 0.01	0.26

Table 6: Summary of Results for the Effect of Trust

6. Discussion

The primary objective of this study was to evaluate the effectiveness of the TRUST intervention delivered via ICT in highly mobile and traumatized communities, such as Eritrean refugees residing in impoverished refugee camps with limited support infrastructure. Additionally, the study aimed to investigate whether different components of TRUST, particularly the full intervention versus a shorter psychoeducation session, could effectively reduce trauma levels and enhance social and economic resilience, as well as social capital, indicating a reduction in collective trauma. Despite the brevity of the TRUST intervention and the inherent challenges associated with delivering therapy through ICT, the results suggest a reduction in traumatic stress levels, alongside improvements in social and economic resilience and decreased indicators of collective trauma. Treating post-traumatic stress disorder (PTSD) appears to positively impact mental health, perceptions of social and economic status, and community-wide relationships (social capital). By addressing symptoms of traumatic stress, TRUST seems to have bolstered participants' self-efficacy in coping, which is fundamental for resilience to trauma.

TRUST aimed to equip survivors with an understanding of their symptoms and basic coping skills, facilitating their reconnection to their communities as resourceful members with heightened self-efficacy. Furthermore, the full 7-video intervention was found to be more effective than the 2-video psycho-education session. This comprehensive approach incorporated phases focused on educating participants about trauma, coping with symptoms, and reintegration into their communities. The efficacy of this phased approach aligns with existing literature on trauma treatment, particularly in addressing complex trauma. Surprisingly, the availability of livelihood support in the camps did not significantly affect trauma levels or associated improvements in social and economic well-being or social capital. This finding contrasts with the Conservation of Resources (COR) theory, which predicts stress following resource loss or failure to gain resources. The limited impact of livelihood support may stem from its inadequate nature and the lack of integration with mental health support, highlighting the need for holistic approaches to refugee support.

However, delivering TRUST via ICT was not without challenges, particularly concerning infrastructure limitations and connectivity issues, which impacted the delivery and effectiveness of the intervention. Future research should address the implications of inadequate connectivity on delivering interactive support and coaching, especially when addressing highly traumatic memories through self-help techniques. In conclusion, the use of ICT has made therapy accessible to highly traumatized refugees with complex needs related to mobility, language barriers, and cultural differences. The TRUST intervention has demonstrated promising results in reducing traumatic stress levels and enhancing psychosocial well-being, underscoring its potential to address mental health challenges in resource-constrained environments. Nonetheless, addressing connectivity issues and ensuring adequate support infrastructure are critical for optimizing the delivery and effectiveness of ICT-based interventions in similar contexts [85-99].

Declarations

Availability of Data and Materials

The data that support the findings of this study are available upon request by contacting the author.
The author declares no competing interests.

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