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Review

The impact of trauma and PTSD on social functioning in refugees and asylum seekers post-migration: systematic review

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Background

Refugees and asylum seekers often experience trauma, leading to high rates of post-traumatic stress disorder (PTSD). However, the extent to which trauma and PTSD impacts social functioning, such as social relationships or engaging with community activities in new environments, remains unclear.

Aims

This systematic review aims to identify key areas of social functioning influenced by trauma and PTSD, with additional analyses stratified by trauma type.

Method

A comprehensive search of five databases, grey literature sources, and reference lists was conducted in February 2025. Included papers explored the impact of trauma or PTSD on social functioning in adult displaced populations post-migration, within the last 30 years. Studies' risk of bias was assessed using the Mixed Methods Appraisal Tool and the Authority, Accuracy, Coverage, Objectivity, Date, Significance checklist. Data were extracted on associations between trauma, PTSD and social functioning outcomes.

Results

Of the studies, encompassing 15 394 participants, 38 met the inclusion criteria. Our analysis indicated that trauma and PTSD have an impact on multiple domains of social functioning, including post-migration living difficulties, everyday functioning, acculturation and integration, social relationships, and employment and education. War-related trauma predominantly affected psychosocial functioning and integration, whereas interpersonal trauma had a greater impact on social relationships. While most findings indicated a negative influence of trauma and PTSD on these areas, some evidence suggested the potential for post-traumatic growth.

Conclusions

The findings underscore the challenges displaced groups face, alongside the possibility of post-traumatic growth. Future research should focus on identifying factors that facilitate positive adaptation, informing interventions to support social integration in these vulnerable groups.

Keywords

Trauma and stressor-related disorders; social functioning; systematic review; evidence-based mental health; psychosocial interventions.

Worldwide, 117.3 million people were displaced at the end of 2023, comprising 68.3 million internally displaced people, 43.5 million refugees and 6.9 million asylum seekers.[1] A thinktank has further projected that these figures could reach up to 1.2 billion people in 2050, a number compounded by climate change.[2] Specifically, a refugee is defined as a person who has escaped their country and cannot return because it is too dangerous.[3] An asylum seeker is an individual who has left their country and formally applied for international protection in another country, but whose claim has not yet been processed or decided. Displacement is caused by many factors including conflicts, systemic violence, human rights violations, individual and group identities, and forced conscription among others,[4,5] and while official routes are available for some when seeking sanctuary (e.g. resettlement schemes in the UK), many displaced people flee their countries through unofficial routes.[6]

Trauma is a common experience of those who are displaced and can arise from: (a) the displacement process and (b) the resettlement process itself.[7] Three distinct periods of displacement associated with trauma have been further defined as: (a) pre-migration, a time before deciding to leave a home country; (b) peri-migration, the period spent getting to a place of safety; and (c) post-migration, the time of resettlement into a new country.[8] Each stage comes with its own challenges and potentially traumatic experiences. During these different periods, research has found that individuals experience traumatic events that include war, violence, a lack of basic needs, family separation and poor living conditions.[9–12]

Such trauma is reflected in high rates of mental health problems, specifically high levels of post-traumatic stress disorder (PTSD) (31.5–43%).[13,14] In the general population, trauma can have a significant impact on people's quality of life,[15] their functional and emotional behaviours,[16] their physical health[17,18] and mental health.[18] In displaced individuals, trauma presents with similar outcomes, such as increased rates of PTSD, depression, anxiety[19] as well as through a reduced capacity to integrate into host communities.[20] Some studies also report cognitive impairments affecting memory and executive function,[21] as well as an increased risk of developing other psychiatric conditions like psychosis.[22]

Social functioning

Social functioning can be further impacted by trauma and PTSD in the general population.[23] Social functioning is defined as how individuals interact in society and their own personal environment.[24] More specifically, social functioning has been described as an individual's engagement with their environment and capacity to fulfil roles in work, social activities and relationships with partners and family.[24] This capability is crucial to the successful integration of displaced groups into a host country.[25] Consequently, those who integrate better will thrive, contributing to a healthy society.[25]

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Recommendations on how to enhance integration for displaced people include improving housing options, employment, language assistance and education, social inclusion, avoiding detention and a proactive approach to managing physical and mental health issues.[25] Trauma, however, has a profound impact on an individual's ability to function in a new society.[26]

Given the high prevalence of trauma in this population, it is essential to understand integration and social functioning within the context of displacement, and while there is research on the impacts of trauma or PTSD on social functioning, the results are mixed. Some studies highlight the profound negative impact of trauma on various aspects of functioning in displaced groups, while others suggest the potential for improvement post-trauma.[27,28] Although individual studies have examined different elements of social functioning, no review to date has synthesised how trauma or PTSD influences different areas of social functioning post-migration.

Study aims

Given the inconsistent findings in the existing research, a systematic approach is needed to clarify the relationship between trauma, PTSD and social functioning in refugees and asylum seekers post-migration. Our aim was to systematically review the literature to determine how trauma and PTSD affect social functioning in adult displaced groups. Specifically, we identified the aspects of social functioning most affected by trauma and analysed how various types of traumatic events influence these key areas.

Method

We adhered to the PRISMA guidelines in this systematic review,[29] and submitted a protocol for the systematic review on to PROSPERO (CRD42024612834).

Search

The search strategy was developed using preliminary searches of the current literature and key terms identified were applied to the PICO (Participant, Intervention, Comparator, Outcome) framework (see Appendix A in the Supplementary material). Searches were then conducted between November 2024 and February 2025 in the following databases: EMBASE, MEDLINE, PsycINFO, Scopus and Web of Science. Grey literature was searched for on government websites, United Nations, the World Health Organization, Amnesty International, Freedom from Torture, Hestia and Helen Bamber. Within the grey literature search, only reports published by reputable organisations or peer-reviewed literature were included.

Eligibility criteria

We included studies that examined the impact of trauma, traumatic events or PTSD on social functioning in adult refugees and asylum seekers (aged 18 and above). We focused on both refugees and asylum seekers to understand trauma and social functioning within the context of displacement in a new host society. Papers were excluded if the participants lived in refugee camps as this setting is not within the post-migration context. Under 18s were excluded because often young people receive different support and may experience a different resettlement experience compared with adults. For example, it has been suggested that children and young people can better adapt to new environments, and school systems can promote resettlement.[30]

When it was unclear if the study was investigating the impact of trauma on social functioning (rather than the other way around) a detailed analysis of the full text was conducted. Studies were included if they used trauma-focused measures like the Harvard Trauma Questionnaire (HTQ), which assesses pre-migration traumas. However, if a PTSD measure was used the paper was assessed further to determine the directionality of the relationship. While PTSD can result from displacement experiences, research has shown it may also develop as a consequence of social functioning difficulties and acculturation challenges.[31] Given this bidirectional relationship we only included studies that investigated how PTSD symptoms predicted social functioning outcomes. However, we excluded studies that primarily examined how social functioning predicted PTSD outcomes, even if they initially presented correlational analyses between these variables.

A study was also excluded if it was published in any language other than English, or if it was not primary peer-reviewed research (e.g. dissertations, case studies or series, literature reviews and systematic reviews). Within the grey literature search, reports published by reputable organisations or peer-reviewed literature were included. We excluded dissertations, as although they undergo some level of review, the extent to which each chapter has been thoroughly assessed cannot be assured. Finally, we excluded studies published more than 30 years ago. This date limitation accounts for the impact of globalisation and digitalisation on integration patterns and social functioning in modern host societies.

Screening, data extraction and analysis

The screening process utilised a two-stage procedure. Title and abstracts were initially screened by the first author (A.P.) using Rayyan.[32] Two authors (A.P., J.M.) then independently screened the full-texts, and any discrepancies were discussed ($\kappa = 0.473$, moderate agreement). A third author (I.M.) was approached for papers where the two authors could not reach a consensus. All references were reviewed, and those meeting the inclusion criteria were incorporated. We applied the same process for the grey literature search. Following this, data were extracted on the study design, methodology, sample size and characteristics, measures (trauma, PTSD, social functioning), trauma type, social functioning factors and the results between trauma or PTSD and social functioning (19 December 2024). We contacted authors when data were missing or incongruent. One author (A.P.) completed this phase, with the second author (J.M.) checking the information. Microsoft Excel (version 16.99.2) was used to extract the data. The data was analysed to identify key themes using a narrative synthesis.[33] To further stratify by trauma type we identified and analysed studies which focused on specific trauma exposures, exploring associations with, or impacts on, differing social functioning outcomes.

Analysis of bias

We assessed the quality of each paper using the Mixed Methods Appraisal Tool (MMAT)[34] (see Appendix B in the Supplementary material). Two authors independently rated each study against the criterion, with any discrepancies discussed. For any difficulties in reaching a consensus, another team member was consulted. We do not provide an overall risk of bias score, but instead present a qualitative description of the studies' quality in the results, as recommended.[34] For grey literature that did not fit into the MMAT grouping, we used the Authority, Accuracy, Coverage, Objectivity, Date, Significance (AACODS) risk of bias tool.[35]

Results

We identified 1388 references from the search, after removing duplicates. Following the title and abstract screening, 70 full texts were screened for eligibility, of which, 33 met the criteria. A further

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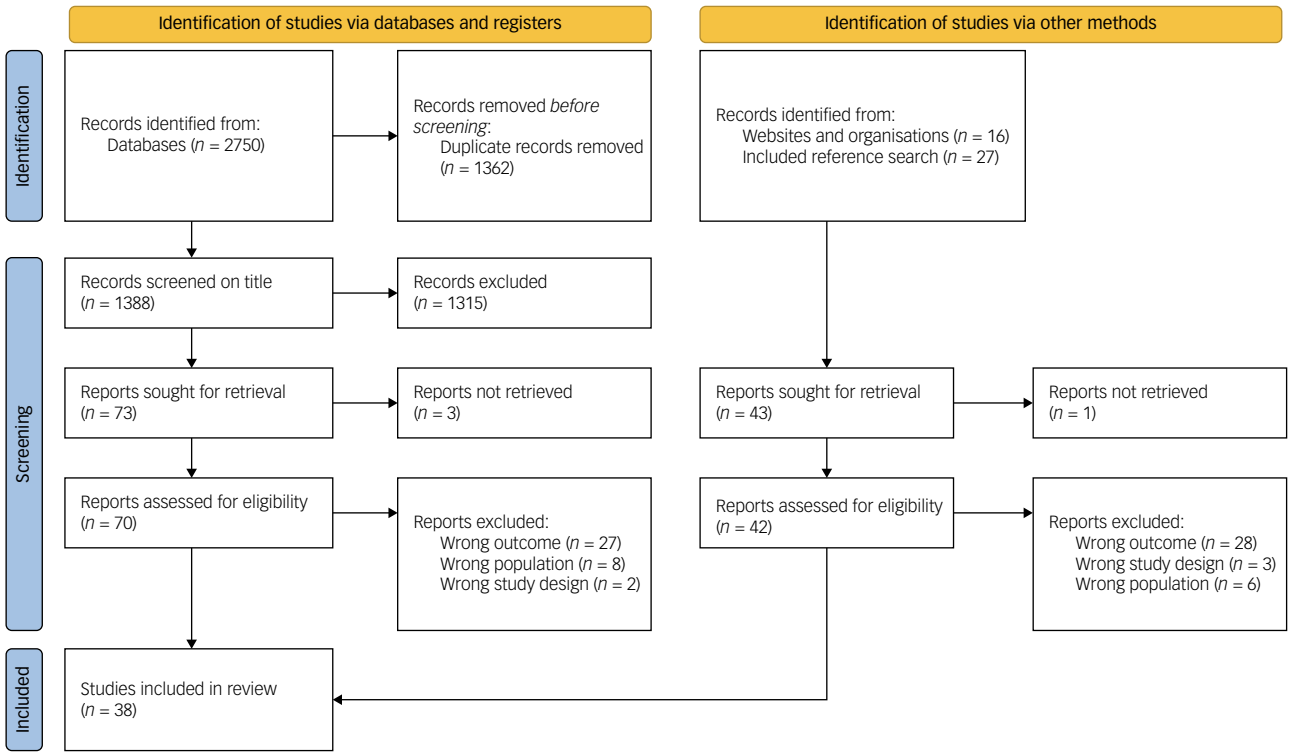

Fig. 1 PRISMA flow diagram.

five studies were identified from the references and grey literature, resulting in a total of 38 studies (see Fig. 1).

Study characteristics

Studies included were published between 1998 and 2024, with varied designs (see Supplementary Table 1 available at https://doi.org/10.1192/bjp.2025.10385): mixed methods ($n = 1$), cross-sectional ($n = 21$), longitudinal ($n = 8$), randomised control trial data ($n = 1$), secondary data analysis ($n = 1$) and qualitative studies ($n = 6$). The research spanned multiple countries: Australia ($n = 10$), Austria ($n = 3$), Germany ($n = 4$), Israel ($n = 2$), Jordan ($n = 1$), Norway ($n = 1$), Serbia ($n = 1$), Sweden ($n = 1$), Switzerland ($n = 2$), Turkey ($n = 2$), Uganda ($n = 1$), UK ($n = 2$), USA ($n = 7$) and a European collection of countries ($n = 1$). In total, 15 394 participants were included, representing diverse populations. Samples involved displaced populations who were Congolese ($n = 1$), Vietnamese ($n = 2$), Syrian ($n = 4$), Somali ($n = 1$), Eritrean ($n = 2$) Afghan ($n = 5$), Cambodian ($n = 2$), Bosnian ($n = 1$), Yugoslavian ($n = 1$) and of mixed nationalities ($n = 19$). Reasons for leaving their homes and specific traumatic events included: war and/or conflict ($n = 2$), persecution under oppressive systems targeting LGBTQIA + individuals ($n = 1$), violence and abuse ($n = 1$), a lack of basic needs ($n = 1$), being close to death ($n = 1$), individual ($n = 1$), family ($n = 1$) and collective trauma ($n = 1$), trafficking/torture ($n = 3$), separated and not separated from family ($n = 1$), genocide ($n = 1$), and others reported traumatic events more generally ($n = 24$).

Risk of bias

We carefully evaluated all papers for potential bias, using the MMAT for 37 papers and AACODS for one non-peer-reviewed paper (see Appendix B in the Supplementary material). The risk of bias highlights some key areas where the findings should be interpreted with caution. Many quantitative studies clearly defined their inclusion and exclusion criteria, but ten papers lacked clarity in this regard or failed to report these details. Thirty-three papers acknowledged the limited generalisability of their findings. This limitation was often due to the use of convenience or snowball sampling methods, or a focus on specific target populations – such as individuals who were from a particular country, highly educated, technology proficient or married. One research team conducted a structural equation model, while acknowledging their study did not have sufficient statistical power. Two other papers did not provide information on the validity of their measurement tools. Meanwhile, five papers had incomplete outcome data, or it was difficult to determine their completeness, although all papers did control for confounders. One descriptive paper appeared to be at risk for non-response bias.

All qualitative research studies showed minimal bias, while the sole mixed-methods paper fell short of certain criteria. It lacked a clear rationale for using mixed methods and failed to effectively integrate both quantitative and qualitative results. Lastly, the one grey literature paper[36] reviewed met all the AACODS grading criteria.

Themes

Five key social functioning themes arose out of the literature, these were: post-migration living difficulties, everyday functioning, acculturation and integration, social relationships, and employment and education (see Supplementary Table 1).

Post-migration living difficulties

Eight studies reported on the impact of trauma on post-displacement living difficulties (PMLDs), i.e. learning a new language, loneliness, discrimination and access to support).[37] The research consistently linked PTSD and traumatic experiences to heightened PMLDs.[38–44] Specifically, trauma significantly predicted worries about the future, including visa insecurity and emergency

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return concerns.[45] A latent class analysis (LCA) provided support for this result, showing that individuals facing severe PMLDs had experienced more traumatic events than those in moderate or low-PMLD groups.[44] Only one study found no association between the total number of traumatic events and the total number of PMLDs.[46,47]

Everyday functioning

Five studies explored how trauma affects everyday functioning, with mixed results. Ainamani et al[21] identified a significant positive correlation between PTSD and psychosocial dysfunction. Qualitative data highlighted several underlying mechanisms, including shame-induced low mood leading to self-neglect, post-trauma physical health challenges and a progressively negative self-perception.[48] Other studies failed to find a relationship between traumatic experiences and daily functioning[49,50] or between trauma and help-seeking.[51]

Acculturation and integration

Evidence of the impact of trauma on integration and acculturation in a host country was mixed. Nine studies demonstrated negative effects on integration. Trauma severity correlated with increased acculturation difficulties.[26] Trauma was further associated with reduced sociocultural adaptation,[52] as well as diminished ethnic and host cultural orientation and adoption,[19,53,54] and reduced cultural competency.[55] This relationship can be mediated by emotion-focused coping,[53] negative contacts with host country civilians[52] and acculturative stress.[54] Individuals with PTSD symptoms showed similar patterns – with reduced social integration[56] and difficulties with language acquisition in those with complex PTSD cluster.[57]

However, recent studies revealed more nuanced relationships between trauma and integration. Using structural equation modelling, Kurt et al[57] found that traumatic events negatively predict heritage culture maintenance while positively predicting destination culture adoption, even though initial bivariate correlations had suggested no relationship with host culture adoption.;[48] Limited effects were observed in relation to trauma on societal participation, except when individuals experienced violence and abuse, which significantly impaired participation.[58]

Conversely, eight studies reported minimal or no effects of trauma on acculturation outcomes. Traumatic events were found to have no association with acculturation,[55,59] integration in Norwegian culture[55] and orientation toward host or origin culture,[54] nor did they predict cultural identity or English language competency.[55] While Hunkler and Khourshed[60] reported an effect of traumatic events on cognitive-cultural integration, this effect was not significant. Regarding community engagement, PTSD symptoms at a first measurement timepoint did not predict later engagement.[61] Additionally, no differences were observed in socioeconomic conditions, discrimination, family concerns or residence insecurity in those with complex PTSD compared with those with standard PTSD.[57]

Social relationships

Eighteen studies presented mixed findings in relation to the impact of trauma on social relationships, with the majority of studies reporting a negative effect of trauma on positive social relationships. In one study, over 70% of participants with PTSD reported social withdrawal and inactivity.[27] Additionally, in an LCA, participants allocated to a social disconnection group had experienced a greater variety of traumatic events compared with other groups (i.e. fear of immigration, low/moderate difficulties classes).[44] Trauma was linked with weaker social networks[56] and predicted fewer contacts with the host society, through the impact on mental health symptoms.[58] Trauma further predicted more post-migration living difficulties related to isolation and loneliness, predicting subsequent depression, PTSD and disability.[43] Increased post-traumatic cognitions were associated with less social connectedness,[62] although more traumatised individuals still yearned for social contact.[63] Eritrean participants further reported the negative impacts of trauma on relationships with both fellow Eritreans and Israelis.[52]

The role of mistrust, leading to isolation and strained relationships was highlighted in the qualitative research.[48,64,65] Specifically, trafficking survivors reported that their perpetrators were often friends which compounded the loss of trust.[48] Others felt shame about their traumatic experiences, contributing to their isolation. Additionally, challenges in sharing their experiences arose due to a lack of empathy or understanding from others.[65] Injuries from torture caused shame in social settings while trauma-induced insomnia made social interactions more difficult. Other difficulties that arose as a result of the trauma included fear of commitment, heightened aggression and obsessive behaviours – all of which influenced their relationships with others.[65]

Our analysis indicated that trauma has a negative impact on family relationships. Over 50% of refugees and asylum seekers reported avoiding social contact due to unfulfilled family expectations following experiences of trauma.[27] Participants identifying as LGBTQIA+ distanced themselves from family members, viewing their family as part of the oppressive system.[66] Some respondents hesitated to share their experiences, both to protect their loved ones from hearing about their torture and out of fear of criticism.[65] In some cases, family members held participants responsible for their detention, contributing to a fractured relationship.[65] Traumatic events also predicted more worries for family members in their home country or in detention,[43] and others felt family life was unachievable.[48]

Nevertheless, some positive outcomes of trauma exposure were also reported, including greater family unity, stronger emotional bonds and enhanced interpersonal understanding.[65] Those who were survivors of a genocide found the trauma increased their compassion, with a greater sense of interconnectedness.[28] The positive effect of experiencing trauma extended to their family members where they had a new sense of appreciation. Other research found that trauma can have a positive impact on the support they received from their spouse.[59] This positive effect extended past family connections with analyses showing that group membership was 1.08 times higher for each point increase in trauma exposure.[50]

Notably, however, three studies found no relationship between trauma and social engagement[61,67] or social network size.[56] However, ongoing PTSD was associated with a weak social network.[56] Another study found that while traumatic events prior to resettlement were negatively associated with social support, adding trauma to their predictive model did not improve its explanatory power.[64]

Employment and education

Fifteen studies investigated the impact of trauma on employment or education. Although the majority of studies indicated the negative effects of trauma on employment, some results were mixed. In one study, over 50% described avoiding stressful situations such as searching for a job following rejection.[27] In addition, those experiencing PTSD often had lower employment opportunities[68] or trauma was associated with unemployment.[56,63] Participants expressed not feeling mentally well-enough to work,[36] and others felt they had lost hope and trauma had led to a negative view of the world, where employment did not seem possible.[48]

When in work, task-oriented performance was affected in individuals suffering from PTSD (i.e. work that demonstrates

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problem solving, coping with stress and learning).[69] Longitudinally, traumatic experiences negatively predicted employment status, labour income, labour force participation, permanent job status, skilled occupation, hours worked a week and work in agriculture.[70] Traumatic events additionally predicted economic post-migration living difficulties, which were then related to increased depressive symptoms.[43] Additional results[65] supported the findings of negative impacts.[71] Trauma following torture led to difficulties in committing to work. For others, it motivated them to engage in activism for their home country, shifting priorities away from employment in the host country. However, in some cases post-traumatic growth is possible, with a direct effect on adaptive performance: handling stress and emergencies, creative problem-solving, interpersonal adaptability, coping with unpredictable work environments and learning new tasks.[69] For instance, Cambodian leaders who were displaced in the USA used their trauma as a strength.[28] Participants felt that trauma shifted their priorities and goals, inspiring a new dedication to higher education or career advancement. Being in the USA provided additional opportunities, fostering a belief that nothing is impossible and giving participants a renewed sense of purpose. Some embraced new missions, pursuing meaning through political activism, community engagement or helping others. In trafficked survivors, trauma resulted in a drive to create a better future, with a focus on education and careers which help others.[48] Despite this, five studies found that traumatic events had no effect on employment[40,55,56,60,62] or education.[60,62]

Stratification by traumatic events

Eleven papers focused on specific traumatic events which can be grouped into interpersonal and war-based trauma.

Interpersonal trauma

Eight studies explored the impact of interpersonal trauma on social functioning, with many focusing specifically on the link with social relationships. Survivors of abuse, trafficking or torture experienced greater integration issues and impaired participation. Participation challenges were specifically related to a lack of engagement in community activities.[49] Integration was further limited, measured by a subsection of the PMLD checklist encompassing difficulties around communication, social participation, access to services, everyday living and discrimination.[38] Trauma resulted in isolation, loneliness and struggles with trust, shame, aggression and strained relationships.[48,65] LGBTQIA+ individuals viewed family as part of an oppressive system, affecting their relationships,[72] though some trauma survivors reported stronger family bonds and a greater emotional understanding.[28,65]

Interpersonal trauma also affected additional areas of social functioning. Collective trauma symptoms were linked to post-migration difficulties,[42] and family separation was associated with increased social, economic and future-related challenges.[43] However, growth was evident in some, with a desire for educational and employment opportunities.[48] Cambodian genocide survivors, for example, reshaped their life goals towards education, careers or activism, finding renewed purpose in the USA.[28] Having been close to death or experiencing a lack of basic needs was not related to participation.[49]

War-based trauma

Three papers focused on conflict-based trauma. One study found that a model including gender, age and education predicted 7% of the variance in psychosocial dysfunction. However, when war- or conflict-related PTSD was added, the model's predictive value increased to 48%.[21] Higher levels of PTSD following war were also associated with greater self-reported integration difficulties,[38] yet the experience of war-related trauma and probable PTSD symptoms did not predict help-seeking.[51]

Discussion

We identified five key themes relating to social functioning among trauma-affected displaced populations: post-migration living difficulties, everyday functioning, acculturation and integration, social relationships, and employment and education. While the existing literature offers a nuanced understanding of these themes, our review highlights that trauma predominately has a negative impact on social functioning. However, positive outcomes in relation to social functioning following trauma are possible.

Social functioning factors affected by trauma

The reviewed studies consistently showed a strong link between trauma and post-migration living difficulties. Most studies utilised the PMLD questionnaire, which encompasses factors such as communication barriers, discrimination, family separation, employment challenges, access to support, financial strain and social connectedness.[37] Such difficulties are well-documented, with displaced individuals commonly experiencing many challenges throughout the post-migration period.[12] Recent recommendations have suggested that clinicians and policy-makers should consider providing multifaceted, integrated support. This should involve practical aid with housing, employment, the asylum process and skills-based training.[12,25] Given that trauma can exacerbate these difficulties further, clinicians should also consider broader factors in relation to supporting trauma recovery.[73] Services must further ensure that displaced individuals, especially those with trauma histories, are not further disadvantaged and that barriers (i.e. language) to access are mitigated.[74]

The effects of trauma on everyday psychosocial functioning, acculturation and integration were mixed, with reports of varying to no effects. Regarding everyday functioning, these findings both align with and contradict the broader literature on PTSD in the general population, which consistently reports significant impairments in daily functioning with large effect sizes.[75] In terms of acculturation, the wider literature suggests psychological acculturation (i.e. identification with the host culture) is multifaceted and impacted by social support, education, school-based factors in host countries, and academic achievement.[76] The mixed findings therefore underscore the complexity of some social functioning factors. These contradictory findings may also be explained by the convenience samples used in the majority of the reviewed studies that are effective at targeting hard-to-reach populations,[77] but may consist of participants who function better in everyday life. Future research is needed to examine the effects of trauma on everyday functioning in displaced groups further.

Social relationships were predominately negatively impacted by trauma, particularly through mechanisms of social withdrawal, perceived stigma, mistrust, and isolation. These findings are reflected in the broader scope of literature exploring social connectedness within displaced populations. For example, a systematic review found the loneliness (15.9–47.7%) and social isolation (9.8–61.2%) rates in refugee populations are higher than in the general population.[78] Trauma's role in disconnection extends beyond refugee contexts, as childhood trauma has been linked to social exclusion in adulthood,[79] and PTSD symptoms are shown to have a bidirectional relationship with loneliness.[80]

Trust was an additional mechanism that is disrupted as a result of trauma, leading to subsequent issues with relationships. This theme is prominent in the literature, where refugees face distinct

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trust challenges,[81] and those who have experienced interpersonal trauma demonstrate a reduced capacity to trust others[82] – with a need to rebuild trust following resettlement.[83] Therefore strategies fostering trust could play a critical role in breaking the cycle of trauma and social disconnection. This aligns with the socio-interpersonal view of PTSD.[84] The framework proposes that trauma affects three layers: (a) social affects (i.e. guilt, shame, social withdrawal), (b) social connection (i.e. social support), and (c) culture and society (i.e. cultural values).[85] The impacts on such areas can perpetuate PTSD severity, in line with a previous meta-analysis which found that social support is negatively related to PTSD severity.[86] Drawing on existing theoretical frameworks, prior research, and the present findings, clinicians and intervention programmes should prioritise social factors and actively facilitate the rebuilding of social connections.

Notably, some participants displayed a newfound appreciation for their family, and increased compassion and interconnectedness following trauma. This may represent a growing phenomenon recognised in the literature as 'post-traumatic growth', the idea that there is potential for growth following adversity,[87] and that some find benefit in stressful events.[88] Post-traumatic growth has also been reported in displaced populations during resettlement, with factors such as high educational attainment and religious commitment being associated with more post-traumatic growth.[89] Sultani, Heinsch[89] further reported on increased post-traumatic growth in those with a drive to help and serve the community which could explain why Cambodian leaders demonstrated a positive response to trauma.

Growth was also present within the context of employment. For some displaced people, trauma catalysed positive shifts in goals and values, fostering a renewed sense of purpose. This emphasises the importance of post-traumatic growth and the need to promote hope, resilience and empowerment during recovery and in seeking sanctuary.[85,90] Clinicians therefore need to support resilience building as suggested by the socio-interpersonal framework, focusing on both trauma and broader social factors in intervention. Future research should explore how interventions can be tailored to enhance post-traumatic growth, particularly in displaced populations.

Trauma stratification

We identified two trauma-focused themes: interpersonal trauma and war-related trauma. While these events may not be mutually exclusive, the results suggested differing outcomes for those primarily affected by war, and those affected by torture. War-based trauma predominantly affected psychosocial functioning and integration, while interpersonal trauma was more disruptive of social relationships. Both themes shared a common impact on social factors, but the influence was notably more pronounced in individuals who experienced interpersonal trauma.

Additional research has found social cooperation and trust to be diminished in individuals who have experienced interpersonal trauma.[83] Therefore, interpersonal trauma may fragment attachment systems[91] and have a more deep-rooted impact on individuals' ability to engage in, and maintain, positive social interactions. This may be because experiences of torture, trafficking, abuse, or ostracism often involve betrayal, which fundamentally undermines trust[92] and can result in avoidant attachment styles.[93] Models of PTSD in displaced populations have suggested such changes to attachment can perpetuate PTSD symptoms.[94] This underscores the importance of addressing social factors in clinical interventions and policy planning. On the other hand, war-related trauma, while similarly affecting social factors, tends to manifest more in broader societal concerns, as supported by studies on veterans.[95] This highlights the importance of considering trauma type when providing interventions and support plans to displaced groups.

Critical appraisal

A key strength of our review is that it is the first to systematically synthesise the literature on trauma and its impact on social functioning in displaced groups who have resettled. By consolidating the evidence across studies, it provides a comprehensive framework for understanding the intersection of trauma and social functioning. Furthermore, by combining insights from a diverse range of studies, including cross-sectional, longitudinal, mixed-methods, and qualitative, our review paints a nuanced picture of how trauma can impact social functioning in displaced groups. This included grey literature and one report, aiming to provide a broader representation of the literature and reduce the reliance on Western or Global North sources. However, we acknowledge that the exclusion of dissertations or non-English papers may have limited the representativeness of the sample.

We note some further methodological limitations. First, only one author screened the titles and abstracts. Given the full-text screening showed only moderate agreement between two authors, the breadth of the initial screening stage may have been limited. Of the studies included, several relied on snowball or convenience sampling. While some authors stated that these samples were representative of the target population, such approaches may overlook individuals at the pointiest end of trauma exposure and those who may experience more profound functional impairment. Such populations are often hard to engage, even under optimal conditions, and their exclusion likely limits the scope and generalisability of the findings. Consequently, this sampling bias may partially explain instances where the relationship between trauma and social functioning was inconsistent.

We also did not explore the differences between complex PTSD and PTSD which may have differential social functioning outcomes, especially given complex PTSD often presents following an interpersonal trauma.[96] For example, non-displaced populations with complex PTSD show pronounced difficulties with interpersonal relationships compared with their PTSD counterparts.[97] Therefore, future research should consider focusing on complex PTSD or distinguishing between the two conditions, as this may reveal important differences in social outcomes and inform more targeted interventions.

Another limitation is that only eight longitudinal studies were included. While these studies provide valuable insights into causality and the long-term impacts of trauma, more longitudinal research is needed to capture the evolving nature of post-migration living difficulties over time. Most studies further relied on semi-structured interviews or questionnaires. Future research could explore alternative design, such as experimental or creative visual methods, to examine aspects of social functioning affected by trauma that may be overlooked in standard surveys.[46] Despite these limitations, our review highlights several critical implications. It underscores the pressing need for trauma-informed interventions tailored to address the compounded challenges faced by displaced populations, alongside emphasising the importance of societal efforts to promote integration, reduce systemic barriers, and foster post-traumatic growth in displaced groups.

Implications and future directions

In summary, while trauma often leads to social functioning challenges, the literature also highlights instances of resilience and post-traumatic growth. However, additional research is needed to better understand the effects of specific trauma types and to adopt

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alternative research methods, such as visual creative approaches, which may better capture lived experiences. Furthermore, cultural, social (e.g. refugee status), and personal factors (e.g. age, gender) require deeper exploration to understand how they interact with trauma in shaping social functioning and overall well-being in displaced populations. These intersecting influences are crucial for developing context-sensitive interventions.

Nevertheless, our findings suggest that the effects of trauma are not homogeneous, and interventions should be tailored to the individual's experiences, while facilitating post-traumatic growth. Policy makers should recognise the importance of social systems which has been extensively supported across the literature and with a range of perspectives.[12,25,84] Clinicians should further consider broader social factors when supporting trauma. Overall, the review calls for more holistic support in relation to trauma in refugees and asylum seekers. In doing so, interventions can promote growth and improve social functioning at an individual level but can more broadly improve integration and cohesion in society.

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Supplementary material

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Data availability

Data availability is not applicable to this article as no new data were created or analysed in this study.

Author contributions

A.P.: conceptualisation; research design and methodology; data acquisition; data analysis and interpretation; writing original draft; drafting; final approval. J.M.: research design and methodology; data analysis and interpretation; drafting; final approval. S.S.: conceptualisation; research design and methodology; drafting; final approval. L.D.: conceptualisation; research design and methodology; drafting; final approval. I.M.: conceptualisation; research design; data analysis and interpretation; drafting; final approval.

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Declaration of interest

None.

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