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CHAPTER

138 Refugees and populations exposed to mass conflict

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Abstract

The mental health implications of forced migration because of conflict, leading to large populations of displaced and refugee adults and children, are the focus of this chapter. The factors leading to forced migration are discussed in light of their impacts on mental illness, both in the short and long term. Rates of mental illness, especially depression, anxiety disorders, and post-traumatic stress disorder, are raised in these populations, with exposure to torture and other forms of violence the strongest predictors for subsequent disorders. A framework for assessment is proposed, and a discussion of the cycles of violence that can impact on children and women raised. Specific populations of note are considered, including those in immigration detention, unaccompanied minors, and trafficked populations. The range of interventions that have been trialled to treat mental illness in refugee populations are presented.

Keywords: [refugee](#), [mental illness](#), [post-traumatic stress disorder](#), [PTSD](#), [depression](#), [violence](#), [conflict](#), [migration](#), [asylum seeker](#)

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Introduction

This chapter will consider the mental health needs of refugees and other populations forcibly displaced because of exposure to mass conflict. Migration has been a hallmark of humanity over millennia, the reasons leading individuals or groups to move being numerous and often multi-faceted. Migration can be forced or by choice or a combination of these factors; for example, poverty or natural disasters might lead a person or group to leave their home out of choice, but elements of compulsion can play a role such as severe food insecurity. This chapter will consider those obliged to leave their homelands for reasons of persecution and exposure to mass conflict, populations broadly referred to as refugees. The terms utilized to describe these populations are summarized in Box 138.1 [1], highlighting the different groups to consider; however, for the purposes of this chapter, *refugees* will be used to describe this population, unless reference is made to specifically defined groups.

Box 138.1 Definitions of migrant populations and subgroups

Migrant: A person who has moved across an international border or within a state away from their habitual place of residence, regardless of their legal status, whether the movement is voluntary or involuntary, what the causes for the movement are, or what the length of the stay is.

Refugee: A person who, owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group, or political opinions, is outside the country of his or her nationality and unable or, owing to such fear, is unwilling to avail themselves of the protection of that country; often strictly defined according to the 1951 UNHCR Refugee Convention.

Internally displaced person: A person who has been forced to leave their place of habitual residence as a result of armed conflict, generalized violence, violations of human rights, or natural or human-made disasters, and who has not crossed an internationally recognized state border.

Asylum seeker: A person who seeks safety from persecution or serious harm in a country other than their own and awaits a decision on the application for refugee status under relevant international and national instruments.

Stateless person: A person who is not considered as a national by any State under the operation of its law. As such, a stateless person lacks those rights attributable to protection of a State, no inherent right of sojourn in the State of residence, and no right of return in case he or she travels.

Irregular migrant: A person whose movement takes place outside the regulatory norms of the sending, transit, and receiving countries and increasingly used for a person who has been smuggled or trafficked.

Trafficked: A person who has been recruited, transported, transferred, harboured, by force or other forms of coercion, abduction, and deception, to achieve one person having control over another person, for the purpose of exploitation. Trafficking in persons can take place within the borders of one State or may have a transnational character.

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The mental health of refugees continues to be an important area of clinical work and research, and one that highlights the complex interplay among biological, psychological, social, and cultural processes in

determining how individuals vary on a spectrum of adaptation to frank mental illness. The psychological impact on a person, family, and groups forced to migrate because of conflict can be considerable, the effects generally being negative, but, in some aspects, potentially positive. To leave an environment of extreme insecurity in order to reach a new country of safety is likely to enhance the mental health and well-being for many; the focus of this chapter, however, will be on the varied mental health risks associated with forced migration and the factors preceding and following that major event. We will describe the mental health impacts of forced displacement and the essential role that both previous and ongoing exposures to traumatic events, ongoing stresses, and broader psychosocial influences play in generating or maintaining the psychopathology and the appropriate interventions that may assist in overcoming these adverse outcomes. Selective high-risk subpopulations will be described in more detail, including unaccompanied refugee minors, persons living in states of protracted insecurity, such as in refugee camps, women and their children, and those caught in cycles of violence, for example in situations where post-traumatic anger presents a risk to the individual, those close to them, and the wider community.

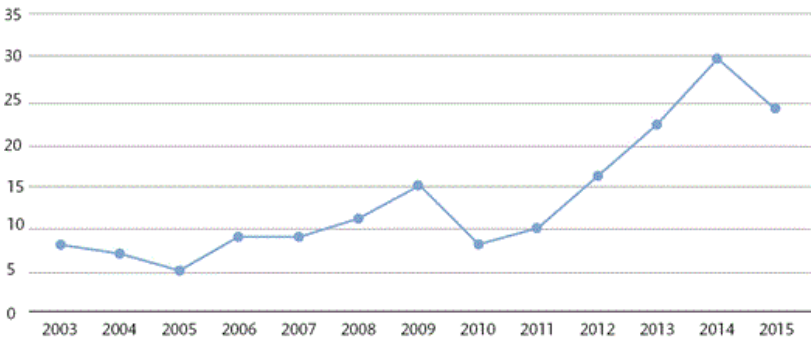
The global pressures causing forced displacement show no signs of abating, including the Syrian civil unrest which has caused a substantial movement of forcibly displaced populations. In 2015, the estimated number of people displaced by mass conflict reached 65 million worldwide [2]. A total of 12 million were displaced in 2015, with at least 40 million believed to be internally displaced. The majority of refugees live in protracted insecure situations, often in makeshift settlements in countries neighbouring the site of the conflict, almost all in low-income countries. Only a small portion are able to travel to high-income countries. Table 138.1 lists refugees and asylum seeker populations by country of origin and destination [2], and Fig. 138.1 is a graph showing the changes over the last 15 years in the numbers being displaced across the globe.

Table 138.1 Refugee data (2015) by country of origin and destination

Top ten source countries of refugees	Top ten refugee host countries	Highest number of refugees per 100 inhabitants in host country
Syria	Turkey (2.5 million)	Lebanon
Afghanistan	Pakistan (1.6 million)	Jordan
Somalia	Lebanon (1.1 million)	Nauru
Sudan	Iran (979,400)	Chad
South Sudan	Ethiopia (736,100)	Djibouti
Democratic Republic of Congo	Jordan	South Sudan
Myanmar	Kenya	Turkey
Central African Republic	Chad	Mauritania
Iraq	Uganda	Sweden
Eritrea	China	Malta

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Fig. 138.1

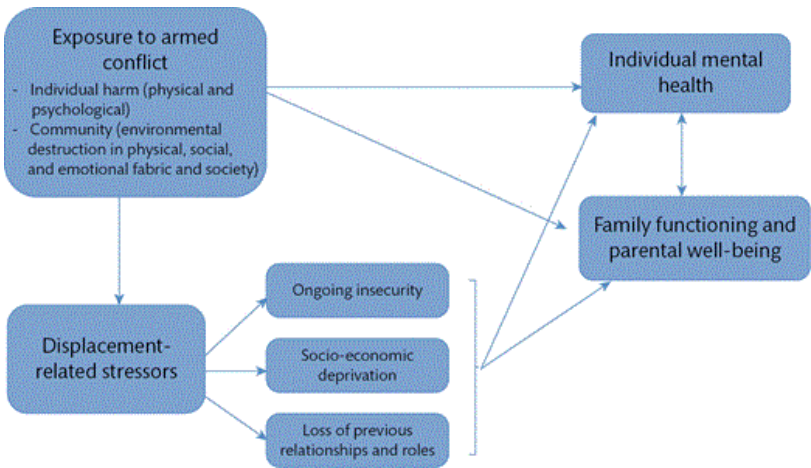


Graph to show rates of newly displaced persons from 2003 to 2015.

Mental health needs

Refugee populations are exposed to a number of stressors that may impact on mental health, many of these factors operating simultaneously or in sequence. Refugees commonly experience personal grief often complicated by the nature of the multiple losses they experience, including murders, disappearances, kidnapping, atrocities, and sex slavery, and more general potentially traumatic events such as violence, torture, sexual abuse, and arbitrary incarceration. As a group, refugees experience major psychosocial and cultural upheavals of having to leave their families, homes, communities, and work to seek personal security. Evidence suggests that two sets of factors are of key importance in impacting on the mental health of refugees: exposure to past and ongoing potentially traumatic events, and the complexities of navigating the post-migration environment as both individuals and groups [3, 4, 5]. These inter-relationships have been best described by Miller and Rasmussen (2016), from which Fig. 138.2 has been adapted [3].

Fig. 138.2



Relationship of armed conflict, displacement, and mental health.

Adapted from *Epidemiol Psychiatr Sci.*, 26(20), Miller K, Rasmussen A, The mental health of civilians displaced by armed conflict: an ecological model of refugee distress, pp. 129–138, Copyright (2017), with permission from Cambridge University Press.

The actual rates of mental illness identified among refugees vary by population, their exposures to potentially traumatic events, their current living arrangements (where and with whom they are currently residing), and the long-term security of their place of residence. In general, rates of depression, post-traumatic stress disorder (PTSD), and anxiety disorders are high, compared to non-displaced populations,

with some suggestion that the prevalence of psychotic disorders is also increased [4, 6, 7]. Nevertheless, there is considerable heterogeneity in reported rates of mental disorder across studies, most likely because of variation in sampling, measurement, and the characteristics of the groups under inquiry. The sociodemographic profile of the population alone may influence the overall mental health status of individual groups. In a meta-analysis published in 2005 on pre- and post-displacement influences on mental health, refugees who were older, more educated, and female, those who had higher pre-displacement socio-economic status, and persons from a rural background had worse mental health outcomes [4]. Some studies have identified higher rates of somatization [5], and others have suggested an elevated suicide risk among refugees, especially when there are significant post-migration stressors [8]. Several factors have been shown to be associated with suicidal risk among refugees, including lack of employment, access to resettlement services and social support, distress related to separation from families, past trauma exposure, and integration difficulties in the resettlement country. Discrimination against ethnic minorities is also associated with poor mental health among refugees, a society-wide problem that is of particular relevance to contemporary resettlement environments. These factors, along with the stigma that often accompanies mental illness, can complicate efforts to seek treatment after resettlement [8] (Box 138.2).

Box 138.2 Assessment of refugees in mental health services

In addition to the usual assessment required of any person referred to mental health services, there are a number of areas that it might be of additional importance to question. These include those identified in the ADAPT formulation described in the text, but the core elements of assessment are detailed here.

Background history

- Description of previous life before difficulties that led to displacement.
- Sensitive enquiry of reasons as to why they had become displaced: any experience of incarceration, torture, abuse directed to themselves or family members and other close associates, including sexual abuse. Significant losses experienced of family members, friends, and colleagues.
- Enquiry as to how they arrived in their current place of residence: how did they travel, were they placed in hands of strangers or traffickers, did they spend time in a refugee camp, experiences and exposure to abuses in these environments.
- Their perceived roles in their families, previous occupation, and communities.

Physical health

- Review of physical health needs is important, as this can be overlooked. It should include chronic health conditions, oral health, and skin. The screening would need to include questions about previous health and exposure to any infectious diseases endemic in the countries of origin and transit, as well as previous injuries [9, 10, 11].
- Previous head injury, especially if associated with loss of consciousness, is an important question to ascertain, as studies have demonstrated that this is highly prevalent in torture survivors and can have significant long-term psychological effects, including depression and PTSD [12, 13, 14].

Current situation

- Living circumstances: where are they living; with whom; how many house moves have they had since arrival; are they able to afford food, clothing, other necessities; how do they spend their time (as those awaiting more permanent legal status are often not permitted to work); any new family stressors; any family members they are trying to find.
- Immigration status and understanding of the process: these processes can often be complex and hard to understand, as information might not be available in the desired languages; legal representation can be hard to access without financial assistance, and there might be the constant threat of immigration detention and deportation back to either a country of transit or the country of origin.
- Linguistic ability and access to interpreters: this is likely to be apparent in the interview. Mental illness can impact on a person's ability to learn the host language.

Long-term outcomes

The complexities of studying refugee populations are most evident when considering the array of long-term mental health implications associated with their experiences; although studies are limited, there is evidence that mental disorders, especially PTSD, tend to be highly prevalent in these populations, even years after resettlement [15]. As identified in a systematic review on studies of populations resettled for more than 5 years, this increased risk seems to be a consequence of exposure to both conflict-related trauma, post-migration socio-economic factors, and more general living difficulties [16]. The systematic review identified 29 studies, of which only 13 were deemed of high quality. Consistent with past findings, there was substantial heterogeneity across studies in the prevalence rates of depression (range 2.3–80%), PTSD (4.4–86%), and anxiety disorder (20.3–88%). Nevertheless, prevalence estimates were typically in the range of 20% and above for any disorder, the lowest rates being found in the higher-quality studies. Descriptive synthesis suggested that greater exposure to pre-migration traumatic experiences and post-migration stressors, the higher the rates of all three categories of mental disturbance (PTSD, depression, anxiety), while a poor post-migration socio-economic status was particularly associated with depression.

Impact of exposure to previous and ongoing traumatic events

Impact of other post-migration stressors

p. 1403 Specific post-migration displacement stressors that have been shown to influence mental health include social isolation resulting from the loss of social networks [17], unemployment (either due to limited rights to work or because of local employment demands [17, 18]), poverty [19, 20], perceived discrimination [21], increased violence against women [22, 23, 24, 25, 26], and a lack of safety when living in refugee camps [20, 27]. These post-migration living difficulties prolong pre-existing feelings of insecurity and deplete the capacity of displaced persons to manage ongoing challenges, a compounding of prior conflict-related experiences and ongoing stressors, a combination of factors that increase the vulnerability to disorders such as PTSD [28].

A conceptual model for understanding the refugee experience

When attempting to understand the full range of experiences of refugees, it is important to consider a number of interacting domains: early developmental experiences; the context and culture of origin; and the sequence of changes that have occurred through the phases of mass conflict, displacement, transition, and final resettlement [29]. There are multiple levels of influences (political, social, cultural, familial, and physical/biological) that impact at each phase on the adaptive capacity of refugees, their families, and the wider community; the outcome of these attempts to adapt may be positive or, in conditions of overwhelming stress, may result in severe distress and ultimately mental disorder. The Adaption and Development After Persecution and Trauma (ADAPT) model identifies five core psychosocial pillars challenged by the sequence of experiences that refugees encounter [30]. These pillars, which form the foundations of stable societies, maintain social cohesion, as well as individual mental health. Specifically, the pillar of *safety* and its maintenance are vital to the person's sense of security and protection, with conditions of pervasive or recurrent threat generating anxiety and fear, the extreme outcome being disorders such as PTSD. Maintaining *interpersonal bonds* (nuclear and extended family, networks) is essential to mental well-being. Multiple threats to attachments and repeated traumatic losses can lead to severe distress, including symptoms of complicated grief and separation anxiety. The maintenance of *roles and identities* (cultural, social, family, personal, work-related) is vital to prevent alienation, isolation, and marginalization, a state referred to in sociology as anomie. Finally, the sense of *meaning and coherence* in life is critical to forming a positive view of the present and future, the existential domain which may be expressed in political values, religious beliefs, social and cultural affiliations, and/or spirituality. All five domains, and the institutions and social rules that support them, tend to be undermined by the refugee experience, ↪ impacting at every level on the displaced community and exerting reciprocal effects on the individual capacity to adapt. The extent to which these disruptions can be repaired or accommodated will determine where individuals and their collectives are located on the continuum of adaptation and functional impairment, a failure of adaptation expressing itself in the individual as mental disorder. The ADAPT system can be used as a framework for undertaking a comprehensive assessment of the experiences and psychosocial responses of individual refugees in clinical and other service settings. The model can also provide a framework for assessing the overall needs of refugee families and communities as a first step in formulating effective programmes of psychosocial and mental health interventions.

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Specific populations of note

There are a number of subpopulations requiring special attention among the heterogenous population of refugees.

Unaccompanied minors

An unprecedented number of children and adolescents worldwide are forced to migrate on their own to escape war and persecution [31]. As minors, these individuals face extreme risks to their physical and psychological well-being at an important developmental period [27, 32]. The trauma and hardships that accompany these experiences have potential to create prolonged mental health difficulties [33].

War exposures and ongoing social hardships can be complex and severe in nature for unaccompanied refugee minors. In contrast to single-incident trauma, war-affected youth can experience chronic exposure to traumatic events for weeks, months, or even years, often representing a significant proportion of their life [34]. Among the range of traumatic incidents common in war, children may witness violence, lose family members and friends, experience physical, sexual, and psychological harm, be exploited in various ways (involvement in criminality, prostitution, sex slavery), deprived of food, water, or shelter, or be

compelled to inflict harm on others. These exposures have varying impacts for each child, but some experiences are particularly harmful [35]. For example, it is not uncommon for long-term shame and guilt to be experienced by some of these children, responses that are intensified by being forced to serve as ‘child soldiers’ and either witnessing or participating in breaking cultural taboos such as injuring family members. Managing the social stigmatization and isolation that can follow these experiences adds to the complexities of rehabilitation of these populations.

Studies support the high-risk status of unaccompanied minors. For example, the prevalence of PTSD was increased among unaccompanied minors resettled in Belgium, Norway, and the Netherlands [33, 36, 37, 38]. War exposure was positively associated with depression among unaccompanied minors on arrival in Belgium [37] and 6 months post-arrival in Norway [36]. In a follow-up study, unaccompanied minors continued to exhibit high scores on anxiety, depression, and PTSD over an 18-month period, with negative outcomes predicted by the number of traumatic experiences and daily stressors experienced [33].

Living in prolonged insecurity such as refugee camp settings

Refugee camps are settlements, usually built with the intention of being temporary, to receive forcibly displaced populations. However, many settlements have grown and become semi-permanent, requiring the development of systems of governance and civic institutions [39]. Approximately one-third of refugees in protracted situations live in camps, some of which have been in existence for over 20 years. In 2015, the largest camps were in Kenya, with occupants primarily from South Sudan and Somalia (for example, the population of Kakuma exceeds 180,000 and that of Hagadera more than 100,000); other large camps have also been established in Jordan for Syrian occupants [40].

p. 1405 Studies have highlighted the mental health risks of living in refugee camps [41, 42]. For example, among Rwandan and Burundese ↵ refugees in a Tanzanian refugee camp, the prevalence of serious mental health problems was estimated to be 50% [43]. Children and young people living in camps (for example, in Central America, the Middle East, and the Former Yugoslavia) have higher rates of mental illness, compared to young people living in other transitional settings [27]. Refugee camps are often unsafe situations, placing children at risk of violence and abuse and consequent negative mental health outcomes. Neglect of basic needs, such as sanitation, parental distress, high levels of poverty, and lack of access to education increase the risk of mental disorder—even though humanitarian organizations and international bodies, such as UNICEF, provide substantial assistance in these settings [44]. Not surprisingly, therefore, a systematic review of 20 mental health studies of refugee/displaced youth residing in camps highlighted high rates of maladjustment, a large number of these young persons experiencing anxiety, somatic symptoms, depression, and aggression [45].

Women and families

Violence against women is a global public health problem. There is a clear association between exposure to gender-based violence, including intimate partner violence, rape, and sexual assault, and mental disorders including PTSD, depression, and anxiety, as well as adverse psychosocial outcomes such as increased suicidal ideation [46]. Social and cultural factors influence the risk of violence against women. In particular, violence is higher in societies that are patriarchal, that is where authority in the household is reserved for men, and many contemporary settings of mass conflict involve populations with these traditional customs. In these contexts, women are at risk because of the prevailing culture of patriarchy and the disruptive and traumatic effects of mass violence [47]. The sequence of factors that increase the risk of intimate partner violence is complex, commencing with the increased risk among those exposed to early childhood abuse and violence (involving both sexes), experiences of war-related trauma, and conditions of extreme deprivation and poverty in the post-conflict environment, stressors that are common among displaced populations in low-income countries [48, 49]. Laws and customs that promote and protect women's rights and entitlements may also be regressive or undermined by war and conflict. The society as a whole may have lost its regulatory capacity, for example to intervene in situations of family conflict, and the exigencies of survival and the stresses arising from these pressures may reinforce traditional roles, including gender-inequitable practices.

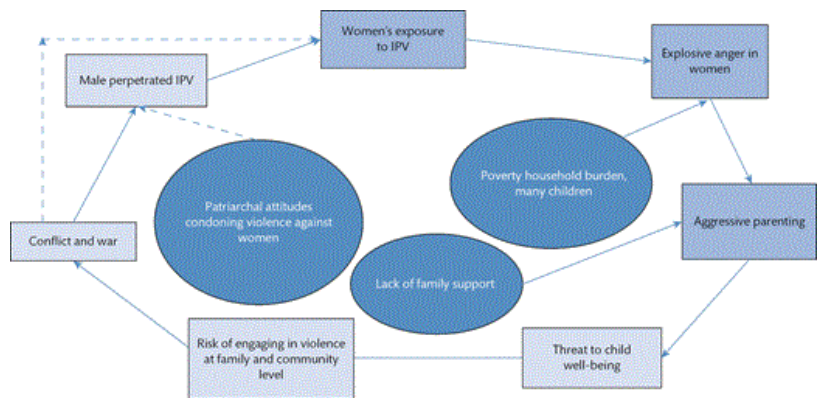
War-specific factors can directly endanger women. The militaristic culture associated with war, for example, can intensify women's subordination and increase the risk of gender-based violence [50]. Rape is commonly used as a weapon of war and intimidation, leading to demoralization, humiliation, and isolation of women survivors and impacting more widely on men, families, and communities [25]. A recent meta-analysis of studies found that one in five refugee or displaced women in complex humanitarian settings have experienced sexual violence [51]. This is likely to be an underestimate, given the multiple barriers associated with disclosure, particularly in such unsafe settings. As indicated, gender-based violence is associated with a range of mental disorders, including PTSD, outcomes that further undermine women's functioning and capacity to manage the immediate demands of the post-displacement environment [46].

Women are critically important to ensuring social stability and recovery after conflict, both in the roles they play within the family and in guiding societies towards a return to peace and security [26]. Yet, qualitative studies confirm that women are often under-represented in decision-making in situations where they could provide a significant contribution to recovery and development. For example, women's voices concerning the violent episodes in refugee camps are often muted and left unheard [50]. It is crucially important therefore to raise awareness of aid personnel and camp authorities to ensure that priority is given to promoting gender equality and to recognizing and addressing factors that may undermine women's participation such as the presence of mental health-related disabilities as a consequence of gender-based violence. Gender equity promotion programmes and an explicit social and legal infrastructure that promotes gender equality should be prioritized to reduce violence against women and promote gender equality [47].

Cycles of violence and human rights abuses that can be perpetuated in peri- and post-migration settings

There is emerging evidence indicating that under certain circumstances, a post-conflict cycle of violence can occur within families and communities in displaced societies. The proposed cycle of violence, partly supported by a growing body of research, proposes that there is a sequence of events in which adults exposed to trauma related to human rights violations are prone to outbursts of excessive anger in the post-conflict period, a sense of enduring injustice playing an important role in engendering this tendency. As a consequence, there can be inappropriate acts of anger and aggression within the family, triggered by relatively minor frustrations and conflict. Post-migration conditions of poverty and insecurity can exacerbate this tendency (see Fig. 138.3) for a conceptual model to describe these cycles of violence. In affected families, aggression may manifest as family conflict or in the form of intimate partner violence targeting women, and/or in harsh parenting in the upbringing of children. The long-term outcome may be the initiation of pathways in which the effects of trauma are transmitted to the next generation, impacting on their mental health and their tendency towards aggression and violence. A recent study identified a key pathway in this sequence in which male and female partners of survivors of trauma were more likely to exhibit high levels of grief and anger symptoms. Only women partners of men with high levels of trauma, however, showed an increase in PTSD, an important reason appearing to be that women tended to identify with the injustices experienced by their husbands [52].

Fig. 138.3



The conflict-related cycle of violence model.

Reproduced from *Soc Sci Med*, 132, Tay AK, Rees S, Chan J, *et al.*, Examining the broader psychosocial effects of mass conflict on PTSD symptoms and functional impairment amongst West Papuan refugees resettled in Papua New Guinea (PNG), pp. 70–8, Copyright (2015), with permission from Elsevier Ltd.

Societal factors

Detention

In over 60 countries worldwide, including high-, middle-, and low-income nations, immigration detention is used in inconsistent ways to incarcerate some of the persons who have been forcibly displaced. In high-income countries, these practices are applied to selective groups of refugees such as those who arrive without an entry visa and others who are deemed not to have proved their claim for protection. Existing studies suggested that immigration detention is associated with poor mental health outcomes that can last for many years after release, the overall body of evidence indicating that the relationship is likely to be causal [53, 54, 55, 56]. Several studies from the UK and Australia showed that the majority (if not all) children surveyed in detention centres meet criteria for at least one psychiatric illness [54, 57]. The prevalence of disorder in these settings is remarkably high, with some studies showing a 10-fold increase in PTSD, anxiety disorders, depression, and sleep disturbances following detention [54, 58]. Factors such as ongoing uncertainty and stress associated with prolonged and indefinite detention, parental psychological distress, disrupted peer and family relationships, exposure to further traumatic events, human rights abuses, and witnessing attempts at self-harm all increase the risk of mental disorder in detained children and adolescents [53]. In a study of adults who had been detained, both previous detention and ongoing temporary protection after release contributed to the risk of ongoing PTSD, depression, and mental health-related disability [55].

Providing mental health care in immigration detention facilities is associated with major challenges, with the compromise of human rights in these facilities serving as an 'invalidating environment' that potentially undermines the therapist's attempts to provide psychological assistance [59, 60].

Trafficking

Human trafficking represents a further risk for refugees, with the lack of protection many experience making them prey to both forced labour and sexual exploitation [61, 62]. Studies indicate that trafficked women, men, and children experience high levels of violence and consequent physical health symptoms, including headaches, stomach pain, and back pain. The most commonly reported mental health problems include depression, anxiety, and PTSD [62, 63]. Self-harm among these populations is prevalent. There is a greater need therefore for professionals working with refugees to focus on these high-risk groups [64, 65].

Parenting difficulties and second-generation psychopathology

The culture of the refugee parenting experience may be characterized by disruption and alterations to family structure and organization; cultural values and norms; and gender roles [66]. Trauma-exposed parents and children may also have problems with attachment and related parenting dysfunction [67]. Difficulties can arise in communication because of language barriers which can place children with greater access to learning the new language in a premature adult role in the family. Further, differing beliefs and behaviours concerning child-rearing practices can lead to claims of child maltreatment, as well as inter-familial conflict [68]. The situation can become more complex when older children and parents adjust to differing degrees to western cultural mores and norms regarding freedoms and rights [69]. It is important to affirm the positive parenting practices of families in post-migration environments and ensure child safeguarding needs are addressed using culturally sensitive and engaging methods. Therefore, there needs to be specific attention to promoting the welfare of children within pre- and post-resettlement contexts [32, 66, 70].

Interventions

The study of interventions for refugee and forcibly displaced populations has grown substantially over the last decade, although only a few have been rigorously evaluated in randomized controlled trials [71, 72, 73]. This reflects many of the difficulties inherent in studying forcibly displaced populations where cultural, linguistic, financial, and practical problems abound [27, 74, 75, 76].

Refugees have diverse mental health needs, and in the ideal setting, there should be a range of networked services and agencies providing assessments and interventions for common mental disorders (depression, PTSD, anxiety), severe mental disorders (psychosis, schizophrenia, bipolar disorder) which are often neglected, 'complex cases' who may not respond to brief therapies, drug and alcohol problems, and organic disorders (often, by default, including epilepsy in low-income settings). The heterogeneity of needs makes it difficult to draw general conclusions about the effects of various interventions on a range of symptomatic and functional outcomes. The difficulty is to combine specific therapeutic components, for example, derived from cognitive behavioural therapy, in a broader and multi-level approach to psychosocial interventions, for example based on the principles of the ADAPT model [77, 78]. Specific clinical interventions at the individual level include treatments for PTSD following multiple traumatic events, commonly applied approaches being narrative exposure therapy (NET), eye movement desensitization and reprocessing (EMDR), and trauma-focused cognitive behavioural therapy (TF-CBT) [79, 80, 81, 82]. At a more general psychosocial level, several approaches are used focusing on groups, the community as a whole, the school, and the family [83, 84, 85, 86] (Table 138.2).

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Table 138.2 Examples of mental health interventions for refugee populations

Intervention	How delivered	Study example	Findings
Narrative exposure therapy (NET)	Individual sessions provided by lay counsellors (6–10 sessions)	Rwandan and Somali refugees in a Ugandan camp [79, 87]	Significant reduction in PTSD symptoms for NET and trauma counselling groups. Remission of 70% following NET
Common elements treatment approach	Individual sessions provided by lay counsellors	Burmese refugees in Thailand [85]	Significant reduction in depression, post-traumatic stress, anxiety, and aggression scores
Cognitive behavioural therapy (CBT)	Individual sessions (with or without interpreter)	Mixed refugee group receiving CBT in a London outpatient service [88]	Positive PTSD outcomes in both groups (interpreter or not)
Multiple-family group access intervention for PTSD	Multiple-family group (nine sessions)	Families from Bosnia-Herzegovina in Chicago [89]	Improved access to mental health services
Parenting intervention	Parenting programme (eight sessions)	African migrants and refugee families in Australia [90]	Positive change in all parenting domains tested
School-based theatre intervention to improve mental health and academic outcomes	Classroom-based drama workshop	Multi-ethnic high schools [91]	Significant decrease in impairment score for first-generation migrants and increase for second-generation
Classroom-based intervention (CBI)	CBI for aftermath of exposure to potentially traumatic events (15 sessions)	Trials in conflict-affected settings (Burundi, Sri Lanka, Indonesia, Nepal) [44]	Positive change in coping, hope, pro-social behaviour, and functional impairment

Studies of specific interventions usually targeting culturally homogenous client samples tend to demonstrate moderate to large outcome effects in relation to traumatic stress and anxiety reduction [72]. Further work is needed to ensure that these interventions can be embedded and sustained within primary health care facilities, that workers receive adequate supervision to maintain skills and prevent burnout, and that the long-term effects of treatment are maintained.

In designing intervention programmes, beliefs held by refugees about health care—its role, how to access it, and whether it can help—need to be a primary consideration. For example, a study among Somali women demonstrated how their beliefs focused on situational factors as determinants of mental health, in contrast to biological models that tend to drive interventions in Western medicine [92, 93]. These discordant health beliefs resulted in divergent expectations regarding the process and outcomes of treatment and health care interactions. Experiencing unmet and varying expectations, Somali women and their health care providers reported multiple frustrations, which often diminished the perceived quality of health care. Moreover, during the process, previously silent worries about mental health and reproductive decision-making surfaced. To provide high-quality, transcultural health care, providers must encourage patients to voice their own health explanations, expectations, and worries.

There is a consensus that in the resettlement environment, positive psychosocial outcomes for youth and adults depend to a great extent on the integrity and functioning of families. Yet few intervention programmes in mental health focus specifically on families in the refugee field. There is a pressing need

therefore to devise and test mental health interventions that aim to prevent or lessen the effects of family dysfunction on individual mental health. Weine (2011) described eight characteristics that preventive mental health interventions should address to meet the needs of refugee families, including: feasibility, acceptability, culturally tailored, multi-level, time-focused, prosaicism, effectiveness, and adaptability [94]. To address these eight characteristics in the complex environment of refugee resettlement programmes requires modifying the process of research to introduce innovative strategies that build these principles into mental health services. Important principles are adopting a resilience (rather than an illness) framework; promoting community collaboration, participation, and leadership; and utilization of mixed-methods approaches, including focused ethnography. At a wider systems level, promoting preventive mental health programmes for refugee families requires appropriate supporting policy directives, multi-systemic partnerships, and training in flexible implementation research designs that ensure that innovative programmes are rigorously evaluated and the positive findings are captured and disseminated.

In general, controlled studies among refugees and asylum seekers have reported positive intervention outcomes in reducing trauma-related symptoms [84]. For example, there is evidence to support TF-CBT and NET in certain refugee populations. Findings from other intervention studies are limited by methodological constraints such as lack of randomization, absence of control groups, and small samples. Further evaluations of the array of psychotherapeutic, psychosocial, pharmacological, and other therapeutic approaches, including psychoeducational and community-based interventions that facilitate personal and community growth and change, are needed [72]. In addition, there is a need to test the effectiveness of rehabilitation strategies for more complex cases and interventions for refugees with severe mental disorders such as psychosis. There is a need for increased awareness, training, and funding to implement and assess broader psychosocial programmes (working in synchrony with clinical services) that collaborate with refugee communities in promoting adaptation during the stages of resettlement, programmes that require an innovative approach to ensuring that both the host and refugee communities actively contribute in reciprocal ways to ensure successful integration.

Notwithstanding the documented risks to mental health that the refugee experience generates, these adverse outcomes must be balanced against the potential positive adaptive outcomes among many displaced populations [95]. There is growing interest in issues of youth resilience and post-traumatic growth in the face of adversity; for example, many war-affected adolescents from Uganda did not display psychosocial distress 4 years after the war had ended, despite witnessing various atrocities [96, 97]. Nevertheless, although the relevance of a resilience-oriented approach is broadly recognized, there is little consensus about the definition of resilience and substantial variation in the operationalization and measurement of that construct, a challenge that is increased in relation to ensuring the cross-cultural equivalence of relevant concepts [95]. A study of 26 qualitative studies exploring resilience in young refugees identified six sources of resilience: (1) social support; (2) acculturation strategies; (3) education; (4) religion; (5) avoidance; and (6) hope [95]. These sources indicated that both social as well as personal factors confer resilience in young refugees. Nevertheless, several fundamental issues need to be clarified, including whether resilience is a latent capacity of the individual or is invested in the social sphere in which the person is embedded; and whether resilience is a unique positive characteristic of active adaptation and maximizing the person's potential, independent of mental disorder or simply the absence of the latter.

Conclusions

Refugee communities and people displaced by mass conflict have been increasing in numbers over the last few decades. They can experience a potent mix of biological, psychological, and social stressors that can lead to increased rates of mental health problems, especially depression, anxiety, and PTSD. Furthermore, these populations have increased exposures to a sequence of experiences of violence and abuse, both in their countries of origin, situations of transition such as refugee camps and even when reaching host countries, within their own families and self-induced, in the form of suicidal acts. Refining a suite of broad psychosocial and more specific clinical interventions to address the varied needs of this population requires much further work, the focus being both on mitigating specific mental health problems and preventing adverse society-wide outcomes, including potential cycles of violence in the family and the community.

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