Treatment of Traumatized Refugees and Immigrants

22

Thomas Maier

22.1 Introduction

Since humankind's expulsion from paradise, murder, violence, and warfare have always been our haunting companions. The dark sides of our character seem to follow us across history and generate evil in different forms: rivalry, hatred, envy, rage, anger, and violence. Even the great humanistic projects of civilization such as religion, democracy, and universal human rights apparently cannot effectively and permanently repress these manifestations of our inner demons. When we look at certain regions of the world today, it even seems doubtful that humankind has made any progress at all since our earliest history. What has definitely changed, however, is the perception and acknowledgment of the damage that human aggression causes. Indeed, interpersonal violence, especially in its most cruel form of physical violence, has severe psychological consequences for the victims and detrimental effects at various levels: not only individuals but also the victim's social environment and the society as a whole are affected. Even for the perpetrators, committed violence is often eventually destructive. A study of the effects of human aggression, on the other hand, makes obvious the fact that most humans are equally capable of immense compassion and have the strong wish to repair and restore what evil destroys (Volkan 2004).

Migration—the intentional but often not voluntary dislocation of people from one place to another—is equally a constant in the history of humankind (Silove 2004). Since the earliest times, people have permanently moved and migrated in search of a better life. The motives for migration are as diverse as people themselves; however, escape from poverty, starvation, war, and persecution have always been important reasons for relinquishing a home and homeland. At this very

T. Maier (✉)
Psychiatric Services of St. Gallen North, Wil SG, Switzerland
e-mail: thomas.maier@psgn.ch

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moment, several million people are in flight, and many more millions already live in exile. The UN estimates that today some 3.5% of the world's population—i.e., more than 270 million people—are international migrants (United Nations 2019). Almost one-third of them, 79.5 million, are forcibly displaced persons (UNHCR 2020). Of these, however, more than a half are so-called internally displaced persons, i.e., people who migrate within the borders of their home countries. Also many of the internally displaced persons are refugees in the truest sense of the word, but the term "refugee" as defined by the UN refugee convention of 1951 does not apply to people migrating within their home country.

Some of those who emigrate find a new and fruitful home in their hosting country, but many are less lucky and live in despair and marginalization. Hundreds of thousands of poor and desperate exiles constantly try to find a way into the promised land, i.e., the wealthy countries of the northern hemisphere. As a consequence these countries tighten their immigration legislation and try to discourage people from immigration. Only well-educated and healthy individuals are welcome while moneyless and stranded exiles are kept out of the boat.

Case Report

The following case report aims to give the reader an illustration of the concepts presented later in this chapter. It is written in the therapist's first person perspective, a form that may appear unusual in a scientific publication. However, the eminent influence of the therapist's authentic personality on the therapeutic process is conveyed more accurately that way. When treating traumatized immigrants, authenticity, personal commitment, and appreciation are crucial, so the author requests that this uncommon form be allowed by the reader.

Ceylan was a 32-year-old married woman from Syria and was referred to our outpatient clinic by her GP. She lived with her husband and two daughters (2 and 6 years old) in a rural Swiss village, where the family was accommodated by the immigration authorities. Ceylan had arrived in Switzerland 2 years earlier and the family was still waiting for their case to be decided by the immigration authorities. Her husband Awar had escaped from the Kurdish areas of Syria some 2 years earlier, leaving his wife and two daughters with her parents in their remote home, a small village near the Turkish border. Awar later helped to organize the journey for his wife and daughters from Syria to Switzerland, a dangerous and confusing experience for Ceylan in the hands of facilitators.

At the time of referral, Ceylan could speak only a few words in German. Direct communication with her was hardly possible, and only the husband, who had learned a little more German in the meantime, could give me some information about her problem. As the GP had already mentioned in his referring letter, Ceylan was perceived as constantly sad, exhausted, uncommunicative, absentminded, forgetful, and confused. With her agreement—which was,

in spite of the nebulous situation, very clearly given—I arranged a second appointment with a female Kurdish interpreter. The presence of the husband at the second appointment was a matter of course to both of them (as it seemed to me).

In the second appointment—which was later followed by many more—I explored some parts of the family's story. Both Awar and Ceylan came from the same Kurdish village in Syria near the Turkish border. They lived a spare and rural life in the mountainous Kurdish area, cultivating their own land and raising some cattle and sheep. Awar and Ceylan were relatives and had known each other since they were children; however, the two of them had freely made the decision to marry, which they related with pride. Like most of the villagers, Awar was a supporter of the Kurdish party, which was antagonized by the Syrian police and army. Most probably, he was an active member of the party that worked mainly covertly. He was arrested several times by the police and experienced beatings and ill-treatment by state officials. To escape from further imminent detentions and even more violent treatment, he decided to immigrate to Switzerland, where some distant relatives already lived. For certain reasons, he was advised by friends to conceal his real identity when entering Switzerland and to register under a false name. This decision was a momentous mistake, as he realized later, because authorities refused at first to reunite him with his wife and children when they made it into Switzerland 2 years later. Only after the disclosure of his real identity was the family allowed to live together in an apartment assigned to them. This initial name deception, however, made Awar particularly suspicious to the immigration authorities and prolonged the procedure for granting the right for asylum. It was eventually decided only 4 years after his arrival in Switzerland, and Awar was not recognized as a refugee in legal terms.

Awar reported his wife to have started being altered in her mood and behavior only several months after her immigration. At first, he said, she was glad: happy to see her husband and joyful with her daughters. Only as time passed did she become increasingly peculiar, neglecting her housework, being erratic with her children and irritable, ill-humored, sad, and weepy. She could (or would) not explain the reasons for her behavior to her husband, but obviously she suffered from it and was looking for help.

Ceylan was a somewhat obese, pale woman, neatly dressed in western style, rather shy, but not completely uncommunicative. Initially, she merely answered questions I felt it was appropriate to ask and did not talk much spontaneously. But then, she gradually opened up, and it seemed to me that she started to like the kind of conversation we continued to have. From the very start of this therapy, I had ideas about what could have happened to her and what could have been her experiences. However, I did not at all urge her to talk about specific issues but left it completely up to her to choose the subjects of the sessions. I felt unsure about what was psychologically and culturally

appropriate for her to talk about and also realized that the situation—a male Swiss doctor and a Kurdish peasant woman sitting together in a room and having a conversation for 50 min—must be completely unfamiliar to her. Fortunately, our female interpreter was present, too, and helped to ease the situation.

During the first year of therapy in which I had appointments with her every 2 weeks, Ceylan mostly spoke about her feelings of insufficiency as a mother. Especially with her elder, now 7-year-old daughter, she had a lot of difficulties, because the girl (who was severely traumatized, as I guessed immediately and could confirm only much later from the story Ceylan told me) did not obey her and had severe learning problems in school. Ceylan felt responsible for her daughter's problems and asked me for advice. Together with the GP and a local social worker, I organized for her daughter to receive support from a child psychologist and for both of her children to visit with a neighboring Swiss family for lunch 3 days a week. She accepted these arrangements because they unburdened her somewhat and she realized that her children cheered up subsequently. Nevertheless, Ceylan's condition fluctuated considerably during the first year of treatment. Sometimes she was very depressed and desperate, and sometimes she seemed more self-confident and vigorous. Often, Ceylan proposed that her husband (and sometimes also the two daughters) join us for the last 5 or 10 min of the session.

Some 6 months after the beginning of our therapy, the family's claim for asylum was initially rejected. Not surprisingly, this decision caused a major relapse in Ceylan's condition. It took one more year to await the appeal court's decision, which assigned the family a temporary visa because of Ceylan's impaired mental health. The court argued that given her current impaired health condition, it would not be reasonable to send Ceylan back to her home country where no proper medical treatment was available. The court decision was mainly based on the description of Ceylan's health condition that I had communicated to the authorities in an expert report. So in Ceylan's view, I had saved the family by writing the "right" letter, but in fact, it was Ceylan who unintentionally saved her family from expulsion through her illness. Fortunately, she did not fully realize the paradoxical implication of the authority's decision, but I realized at once the imminent dead end of this situation: the very moment that I declared Ceylan to be cured, the immigration authority would send the whole family back to their home country.

The granting of a regular, although only temporary, visa to the family had a remarkable effect on them: Awar was now entitled to work legally and to have his driver's license, and Ceylan felt visibly relieved. After a short time, Awar found a job as a handyman in a nearby spa resort, and Ceylan now was able to function much more on her own as a housewife. Even after 2 years of treatment, she still felt unable to travel alone the 50 km from her home to my office. She would have to take a bus, then to change to a train, and finally to

walk five blocks. She felt uneasy traveling on her own for several reasons; however, I knew one particular reason for her reluctance: Ceylan was illiterate. Only when her daughters went to school in Switzerland did she pick up the Roman alphabet and slowly learn to read and write in German. Because her husband now had to work when she had appointments with me, she simply had to jump into the cold water, as it were, and come to my office on her own. She also had learned to ride a bicycle in the meantime (something she never had the chance to practice in her home country), joined the local women's gymnastic club, and even attended the (mixed!) swimming lessons we organized in our treatment center. Around that time, she came to the appointment 1 day and proposed to me to continue the sessions without the interpreter. Indeed, she had learned to speak German fairly well now and communication was possible in a sufficient manner. Not surprisingly, the conversation changed in many ways after that. The subjects became much more personal, and she addressed different topics we had never discussed before: Ceylan wanted to talk about life in Switzerland, asking me about local traditions, family values, and religious practices, and even wanted to learn about delicate issues like contraception, dating and sex in adolescence, and marriage customs. I felt that by talking about all of these issues, she was in fact exploring *me,* and I prepared for something more to come.

Finally, after more than 3 years of continuous therapy, she started to tell me about traumatic and haunting experiences she had had in her home country before she left. After her husband had escaped to Switzerland, Ceylan lived with her small children (then a newborn baby and a 4-year-old daughter) with her parents in their farmhouse. One day, when her parents were away for work in the fields, three unknown men—civil officials of the military police—arrived suddenly at her door. They immediately entered the house and rudely asked for her husband. She said that he was abroad and that she hadn't seen him for some time. The policemen laughed at her and started beating and groping her. While both of her children were in the room, they forced her to undress, and they raped her brutally. They left her humiliated and injured, but not without threatening her and her family with further troubles in case the family did not comply with the police. Ceylan was deeply frightened and scared, not only by the horror she had just experienced but also by the imminent danger she was in now. If her father or husband were to find out what had happened to her, she would probably be outlawed and expelled by her own family. Ceylan confided in her mother and told her everything. Together, they managed to conceal the crime from the rest of the family. Ceylan was sick for several weeks; she had suffered from gynecological injuries and had to be treated at home. Fortunately, she recovered passably and could endure the adventurous escape together with her two children to Switzerland.

When Ceylan started to talk about these traumatizing experiences, she seemed to be determined that she wanted to tell it all. I did not have to

persuade or urge her to do so. I was the witness, and she was the actor. When she was recalling her trauma over the next three sessions, she experienced deep pain, shame, and disgust and suffered from flashbacks and intensified nightmares between the sessions. However, it was doable, and she regained self-control and felt relief by the end. We could subsequently address some related issues such as sexual problems she had with her husband and her general anxiety towards male officials. She still did not want to tell her husband about her trauma. In my opinion, he already knew everything but did not want to embarrass her, and so they both remained silent about her secret.

Based on an amendment to the immigration law, the family could apply for a permanent visa after they had lived in the country for 5 years and were independent from welfare for more than 1 year. Proudly, Ceylan presented me a folder full of testimonials and letters of support written by dozens of neighbors, supporters, and friends from her new home village. This was a remarkable achievement because the village where they used to live was known as a rather conservative and close-minded area. Awar had gained a good reputation as a hard-working man, and Ceylan was well known among the women in the village because she had joined the local gymnastic club. After almost 5 years of treatment, Ceylan's family was given a permanent resident status. Her mental health condition was almost completely normalized. I ended our therapy and continued to see her once or twice a year for a follow-up.

22.2 Clinical Challenges

In the case vignette above, different specific problems linked to the treatment of traumatized immigrants are presented. Health professionals in hosting countries must identify and address these problems to effectively improve the victims' condition.

22.2.1 Severity of Trauma, Shattered Assumptions, Loss of Self-Sameness

The severity of traumatic experiences in victims of war and torture often surpasses the levels of trauma that clinicians are used to treating in civil resident patients. The duration of traumatizing conditions, the number of traumatic events, the cruelty of the experienced trauma, the unsettling character of interpersonal violence, and the magnitude of loss are often extraordinary. In consequence, these patients not only suffer from "regular, classical" posttraumatic stress symptoms but also from a deep and fundamental blow to what could be called self-sameness or identity as a person (Bettelheim 1943; Mollica et al. 2001; Wilson 2004). Severe depression, identity confusion, loss of meaning, and deep feelings of shame are challenges for clinicians

working with traumatized refugees. In the WHO's outdated ICD-10, the diagnosis of *enduring personality change after catastrophic experience* as well as the ICD-11's *Complex PTSD* cover some of this severe and often persistent psychopathology (Chap. 6). For clinicians, it is important to realize that severely traumatized patients:

- Do not suffer only from intrusive memories and associated symptoms (i.e., hyperarousal, avoidance, dissociation). Although these "classical" features of posttraumatic stress disorder are often amenable to specific—and definitely successful—trauma-focused treatment (Başoğlu 1998; Lustig et al. 2004; Neuner et al. 2008; Nicholl and Thompson 2004; Nickerson et al. 2011; Schauer et al. 2005; van Dijk et al. 2003; Varvin 1998), some patients nevertheless continue experiencing suffering and despair. Many severely traumatized immigrants remain deeply depressed about their losses and cannot find a way to cope with helpless anger or recover from paralyzing shame (cf. Haagen et al. 2017).
- Have experienced a fundamental shattering of their assumptions about the trustworthiness of the world (Janoff-Bulman 1992). Ordinary human life in the community with other people has lost meaning, and basic social values such as trust, respect, and compassion are mere words to these patients. Many have abandoned their faith in fairness and ethical values, and in consequence, some even abstain from any kind of religious practice. This feature is particularly dramatic for people who formerly were deeply rooted in religiosity. Matters of faith are rarely addressed in psychotherapy; however, in the treatment of traumatized immigrants, the dimensions of faith, religion, and spirituality need to be explored (Boehnlein 2006). In some cases, advice from religious leaders may be helpful for therapists.
- Are deeply isolated in the world because they cannot share their experiences with anybody. Even if they live together with family members, they feel fundamentally alienated. "Whoever has succumbed to torture can no longer feel at home in the world" (Améry 1980).

22.2.2 Physical Disabilities and Complaints

Together with their psychological traumatization, most of these patients experienced significant physical injuries, too. Usually, physical injuries are healed in time; however, chronic pain or other residual consequences of earlier injuries often haunt patients and are intimately linked with altered psychological conditions (Amris and Prip 2000a; Buhmann 2014; Otis et al. 2003; Thomsen et al. 1997) (Chap. 19). Physical complaints and symptoms often function as triggers for intrusions, and sometimes they *are* bodily flashbacks of traumatizing experiences (Salomons et al. 2004). When treating victims of war and torture, support from an experienced physician is very helpful. In an ideal treatment setting, the psychotherapist and physician collaborate closely, and the patient knows that these two health experts are coordinating their efforts. Often, a physiotherapist also can contribute to a favorable outcome (Amris and Prip 2000b). However, physiotherapists must be informed

about the exact trauma history of a patient because they work directly with the body of a patient and must understand specific vulnerabilities in tortured patients. Intrusions and flashbacks can be provoked by physical contact or even when taking certain positions or performing certain motor actions (De Winter and Drožđek 2004). However, working with the body can be a clue to recovery for torture survivors (Karcher 2004). Experienced physiotherapists or body therapists are therefore welcome in the efforts to rehabilitate victims of war and torture.

Although survivors of torture prove to be physically strong and tough having survived unthinkable maltreatment, they often feel particularly sensitive and damageable in the posttraumatic situation. Many patients have irrational fears about supposed physical illnesses, sometimes to the level of hypochondriasis. Survivors of torture are focused on the body in a highly ambivalent manner: The body was the gateway for the torturers to break their minds; it was the weak link, the source of pain and suffering. At the same time, the body was their means of survival, the inseparable companion carrying them through danger and despair. So victims of torture feel shame and disgust about their body simultaneously with feelings of pride and gratitude. Psychotherapy should aim at a reconciliation of these ambivalent feelings and contribute to an acceptance of one's own body (Karcher 2004).

22.2.3 Insecure Residency Permit Status

Unfortunately, in traumatized immigrants, legal problems about residence often interfere with therapeutic interventions. Many traumatized immigrants live in chronic insecurity as asylum seekers awaiting their cases to be decided or even as undocumented immigrants. Some hosting countries barrack asylum seekers in run-down buildings, others put them in confinement, and still others virtually relinquish them to a social no-man's-land (Silove et al. 2001). Undocumented immigrants, the poorest of the poor, are in fact the invisible legions of victims traveling incognito through our orderly societies. They are helplessly at the mercy of slave traders, panderers, indifferent officials, and other doubtful characters. Only a few of them will ever appear in our services, and only a few of them will ever tell us their stories. Also, asylum seekers—who have a regular legal status—frequently remain with only minimal social, legal, and medical support. In many countries, only accepted refugees have access to professional treatment, although the need for treatment would be much more exigent in the earlier stages of immigration. The general stress of life for asylum seekers or even more for undocumented residents already affects the mental health condition of these individuals to a degree that is comparable to other extremely stressful life events (Hauff and Vaglum 1994; Heeren et al. 2012; Laban et al. 2004; Steel et al. 2002, 2004). For therapists, it is important to realize that legal problems of residence are paramount for most asylum seekers. Even those who have successfully endured long periods of insecurity as applicants for asylum and end up as recognized refugees often remain obsessed with fears of sudden expulsion, withdrawal of documents, nightly detention, and similar official orders. The very basic precondition of any trauma-specific treatment—safety—is not

provided to many traumatized migrants. Even officially recognized refugees often do not feel secure enough to engage in psychotherapy. This hesitancy sets limits on the possibilities of psychological treatment, and health professionals must first of all support their patients in the regulation of their legal situation. There is an undeniable responsibility for authorities, officials, and political leaders who are defining the legal frameworks of immigration policies.

22.2.4 Cultural and Social Uprooting

Immigrants who suffer from posttraumatic stress symptoms are often culturally and socially uprooted. Many lack social support and are distant from their families, their cultural background, and their traditional means of coping. This isolation is particularly distressing for traumatized individuals because the process of coping with extremely stressful experiences is always embedded in a cultural perspective (Aroche and Coello 2004; Charuvastra and Cloitre 2008). Ethnocultural beliefs, religious practices, and social behaviors are intimately linked to the process of how individuals integrate traumatic experiences into their lives and how they recover to a higher level of functioning. When treating victims of war and torture, clinicians must try to enter into the cultural and historical reality of their patients and evaluate the collectivistic dimension of individual traumata (Eisenbruch et al. 2004). In recent research, the social ecology of posttraumatic symptoms has been increasingly highlighted (Kohrt 2013). Not only do PTSD symptoms lead to relational difficulties in the family and society, but the reverse is also true: Lack of social support leads to more severe PTSD symptoms. Factors like family acceptance, stigma, education, economic perspective, prosecution of perpetrators, and political development are intimately related to the course of posttraumatic stress symptoms. Despite the importance of societal and collective factors, however, most evidence-based treatment modalities for trauma victims focus on the individual.

> *From a cross-cultural perspective, the social and relational aspects of trauma also can be more distressing than individual symptoms of PTSD. There is often a connection between social distress and post-traumatic psychosomatic complaints that resolve through community processes rather than solely through individual treatment* (Kohrt 2013).

Therapists treating traumatized immigrants should always carefully explore the patient's social environment. Also, some knowledge about the patient's cultural background is very helpful for evaluating the context of the therapy. Even if a patient is reluctant to involve family members or friends in treatment, the significance of others for the patient's recovery has to be clarified before initiating therapy. If a patient feels like an outcast from his community or disregarded by the family patriarch because of his posttraumatic stress symptoms, the patient will not even be able to enter into therapy. In some cases, the involvement of cultural brokers facilitating the dialogue between patient and health professionals can be useful.

In addition to that, the language barrier is often a particularly complex issue in the treatment of traumatized refugees. The use of professional interpreters is highly recommended in various medical settings in order to assure sufficient communication and to achieve good treatment adherence (Karliner et al. 2007). However, the presence of a third person—the interpreter—is an irritating factor for both therapist and patient, especially when it comes to the recounting of traumatic experiences. Not only that the interpreter could be a member of the patient's local community, but also age/gender discordance, cultural, religious, ethnical, tribal or character differences may significantly interfere with the development of a therapeutic alliance. Therefore it is important for clinicians to collaborate with trained interpreters only and to establish a professional relationship with the interpreter (Crosby 2013). There are professional and ethical standards for medical interpreters (e.g., International Medical Interpreters Association 2007) as well as particular recommendations for the use of interpreters in psychotherapies with traumatized refugees (e.g., Tribe and Raval 2002; Miller et al. 2005).

22.2.5 Survivor's Guilt, Perpetrator's Guilt, Moral Injury

Traumatized immigrants have to cope not only with feelings of fear, helplessness, and horror but also with shame, guilt, hatred, and anger. This mixture of different emotions is sometimes hard to disentangle and unsettles patients and therapists, as well. Survivors of war and torture often believe they survived only because they could hide behind others who died. To survive is indeed sometimes the result of mere chance, and sometimes it is the result of the survivor's alert action. To survive in situations where reliable rules and moral values are annulled inevitably carries ethical dilemmas. The individual is challenged with the how to remain fair and honest in situations where the will to survive becomes a mere biological drive. Especially in contexts of war and torture some experiences inevitably transgress deeply held moral beliefs. Transgressions that lead to serious inner conflict because the experience is at odds with core ethical and moral beliefs is called *moral injury* (Litz et al. 2009; Nickerson et al. 2014). From the comfortable armchair of the doctor's office, it is easy to moralize and to argue about right or wrong. Nevertheless, survivors of war and torture often rigorously apply moral reasoning to their acts and omissions, aggrieving themselves with reproaches and accusations. Feelings of guilt and persistence in self-reproach or even self-harm are, of course, symptoms of major depression; however, they also can be understood as re-enactment of torture. In fact, torturers purposefully entangle their victims in moral dilemmas and inflict on them feelings of guilt (Modvig and Jaranson 2004). For therapists, the treatment of victims of war and torture always holds the potential for confusion, anguish, and pain as in countertransference, the patient's horrors are re-experienced. In fact, patients' experiences can also involve acts of cruelty or even crime. Some severely traumatized patients desperately seeking help are, in fact, perpetrators at the same time. It is rare, however, that patients expose themselves as perpetrators and want to focus their therapies on committed acts of violence. The example of child soldiers or war

veterans show, though, that even committed violence is potentially traumatizing and has detrimental effects on perpetrators, too. The crucial problem in these therapies is often the handling of actual guilt and moral injury, which is obviously not a psychotherapeutic issue. The therapist must wrestle with what to advise to a patient who believes he is guilty, probably not only morally but also legally. From a therapeutic perspective, the involvement of societal, religious, or legal authorities can pave the way to eventual recovery. When working in this field, clinicians must be prepared to enter into the most complex realities of patients, where truth, certainty, and clarity are not easy to recognize. They must find a way to address issues of morality, guilt, responsibility, and compensation without falling into a moralizing or condemning attitude.

22.2.6 Peer-Based Approaches

Obviously, even high-performance healthcare systems still face manifold obstacles when trying to treat traumatized immigrants: language barriers, mutual cultural biases, mistrust, limited funding, lacking identification of affected individuals, limited availability of service providers, etc. Given these difficulties, more and more peer-based approaches are applied and seem to add new perspectives in the support of traumatized refugees. While in resource-poor settings the deployment of locally recruited counselors and ad hoc trained lay therapists in the treatment of traumatized refugees is widespread, this type of support is far less common in high-income countries. Of course the World Health Organization recommends a taskshifting approach from academic professionals to trained lay health workers mainly for countries with an insufficient health sector (Jordans and Tol 2012), still it could be a useful complement in high-income countries as well. Often peer support may be limited to basic interventions like problem solving (Sijbrandij et al. 2017), psychosocial support (Ayoughi et al. 2012), or mentoring (Paloma et al. 2020), but also specific interventions like Narrative Exposure Therapy (NET) have been successfully applied by trained lay therapists who do not have any medical or psychological background (Neuner et al. 2008). The use of lay therapists in high-income countries, however, might be impeded by legal restrictions and professional organizations' interventions. Still there are large areas of employment of peers, mainly in the preclinical support of affected individuals and families (Chap. 6).

22.2.7 Summary and Recommendations

The treatment of traumatized refugees and immigrants poses major challenges to healthcare professionals. Given the high and increasing number of affected individuals, healthcare providers should step up their efforts in providing effective treatments to these patients. As several studies have demonstrated recently, also in refugees and immigrants trauma-focused psychotherapies are applicable and effective (e.g., Adenauer et al. 2011; Crumlish and O'Rourke 2010; Haagen et al. 2017;

Hinton et al. 2005; McFarlane and Kaplan 2012; Neuner et al. 2004, 2008; Nickerson et al. 2011; Paunovic and Ost 2001). Owing to legal and language barriers, however, many affected individuals have no access to adequate treatment and remain untreated. Treatment should be made accessible to all individuals in need regardless their legal status, their ethnical and cultural background, and their financial potency. The use of professional interpreters in mental health service provision should become part of the standard procedure. Also the deployment of trained peers in the support of traumatized refugees offers additional benefit to standard medical treatment and should be implemented.

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