41 Mental Health Problems and Risks in Refugees During Migration Processes and Experiences: Literature Overview and Interventions

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41.1 Introduction and Background

According to the United Nations High Commissioner for Refugees, the number of refugees and internally displaced people has reached its highest point since World War II; it could be over 65 million, and this figure is still rising (UNHCR's annual Global Trends Report, 2015). The figure is up from 37.5 millions 10 years ago. About 22 millions of these are asylum seekers. In the last year, 1 million asylum seekers came to Europe, and almost 4000 have died in the Mediterranean Sea (UNHCR's annual Global Trends Report 2015; Carta et al. 2015). Refugees are people fleeing conflict or persecution. They are defined and protected by international law and must not be expelled or returned to situations where their life and freedom are at risk (UNHCR's 2015). Such international legal protection started back in 1951, when the United Nations Convention relating to the status of refugees defined a refugee as someone who fears being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion. A refugee lives outside his/her country of origin and is unable or unwilling to be protected by that country. The term refugee is sometimes used to indicate persons forced to flee from their own countries. Actually a distinction should be made between those who have received official hospitality in the country of arrival and whose rights are guaranteed by the Geneva Convention and those who have not. Today most of the people who escape atrocities prefer to remain underground – i.e.,

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without official recognition – since an application for asylum might cause their exposure to the risk of retaliation by their country of origin. According to the rules of the European Union, if a person receives the status of refugee in one country, she/he cannot leave it for another EU country. Most refugees arrive in Italy but have relatives in other countries, particularly in Northern Europe. For this reason nobody wants to be recognized as a refugee upon their arrival.

Refugees have been often subjected to a range of traumatic experiences: human rights violations, persecution, war trauma, gender-based violence, significant family losses, and dangerous travels. Lack of information about immigration status, potential hostility, and undignified and protracted detention are all potential traumatic and stressful events. Not surprisingly, asylum seekers and refugees might have been exposed to events that have influenced their mental health (WHO/Europe 2015). According to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; *DSM-5*), the so-called trauma- and stressor-related disorder includes so-called disorders that arise from exposure to a traumatic or stressful events. These include so-called reactive attachment disorder, disinhibited social engagement disorder, post-traumatic stress disorder (PTSD), adjustment disorders, and acute stress disorder. Many individuals who have been exposed to a traumatic or stressful event exhibit anxiety, fear-based symptoms, and most prominent clinical characteristics as anhedonic and dysphoric symptoms, externalizing angry and aggressive symptoms, or dissociative symptoms (DSM-5); most of these symptoms evolve into a so-called structured disorder. Other frequent mental health problems and challenges among asylum seekers are depression and anxiety "disorders" (Naja et al. 2016). Two comprehensive systematic reviews and meta-analyses showed that these subjects are about ten times more likely than the general population to have post-traumatic stress disorder (PTSD), with a higher incidence rate in younger people (Fazel et al. 2005; Bogic et al. 2015). Similarly, a study on Bosnian refugees showed that after 3 years, 45% of the people suffering from post-traumatic stress disorder still presented significant symptoms; symptoms remained even after over 10 years since exposure to traumatic events (Mollica et al. 1999; Mollica et al. 2007). The Lebanese population has shown a high risk of psychiatric disorders documented 20 years after the Lebanese war, particularly among those who were children at that time (Karam et al. 2008). The results of a study made on Syrian refugees in Turkey are quite similar to the findings of the cited studies in Lebanon (Acarturk et al. 2015), thus supporting the need to consider the long-term consequences on these populations.

As a result, subsequent to a review of the relevant theoretical and empirical literature, the chapter highlights concepts, phenomena, and propositions that could serve as the basis for a theoretical framework of risk factors, mediation, and protective factors involved in the possible onset and development of mental health problems among refugee populations during their migration experience. The review will also take into account the risk factors attributable to the three phases (e.g., premigration, migration, post-migration) of the migration process according to a conventional time perspective. The potential protective factors on refugees' mental health will be identified on different levels: the personal level (i.e., skills, strategies,

demographic characteristics), the community level (i.e., support from the community or from family members on the territory), and the cultural level (i.e., cultural meaning systems and beliefs). We are assuming that this is a purely explicative distinction of dimensions that may depend one upon the others. Also clinical practices will be put in question as well as their probable ethnocentrism trend. Interventions treating symptoms of mental disorders among refugees population will be reviewed, and preventive measures will be discussed. The goal is to support and strengthen clinical knowledge on existing responses and treatments that could actually prove to be useful and effective response to the emergency to provide adequate care to a risk population as that of refugees and asylum seekers.

41.2 Risk Factors

Population movements expose migrants to a range of risk factors that may impact on various health issues: the reproductive system, drug and alcohol abuse, higher newborn mortality, and mental disease (Fazel et al. 2005; Bogic et al. 2015). Migration process can be conventionally explained in three stages, which can expose migrants to specific ranges of traumatic experiences. The first stage is called "premigration": it can be characterized by human rights violations, persecution, economic hardship, war trauma, and disruption of social support and of family and community networks. The second stage is called "migration," namely, physical relocation of individuals from one place to another which can be characterized by extremely dangerous journeys with an uncertain migration outcome, violent separation from the loved ones, and extremely precarious living conditions. Finally the "post-migration" stage may expose migrants to such factors as undignified and protracted detention, hostility, uncertainty about the outcome of the application for political asylum, difficulties in language learning, acculturation and adaptation, concern about family members left behind, and possibility of reunification (Bhugra 2004; Bhugra and Gupta 2011). Moreover once a mental health problem has become manifest, post-migration factors become critical in the process of development and potential chronicity of the problem (Carta et al. 2013; Mollica et al. 1999, Mollica et al. 2007; Lindert et al. 2009; Bogic et al. 2003, Bogic et al. 2015; Ginzburg 2010).

41.3 Resilience, Sense of Coherence, Coping Strategies, and Community Network Support as Mediating Factors

Overall the acculturation process can be mediated by economic, educational, social, psychological, physical, and cultural factors. Individual factors such as gender, age, language proficiency, and economic educational status contribute to the inclusion process, too, albeit in different ways (Hadgkiss and Renzaho 2014). Porter and Haslam (2005) in their meta-analysis found that individuals with higher levels of education who experienced significant decrease in their socioeconomic and professional status after migration had worse post-migration outcomes. The individual

coping strategies generate a response to stressors, influence the acculturation process outcome, and may therefore become a potential protection factor. The coping strategies developed after traumatic events are commonly described as a way to manage adverse or problematic conditions (Aldwin and Tracey 1987; Carver et al. 1989; Taylor and Stanton 2007). Action-oriented and intrapsychic efforts to manage stressful events can include:

- The cognitive ability to *process* and restore past and present stressful *events*
- Reframe the situation
- Focus on future wishes
- Relaxation and meditation
- Avoid any exposure to conditions that might recall the traumatic event

These strategies were discussed in different studies on refugee populations, showing their potential role in mediating the psychological burden following exposure to stressful events (Halcón et al. 2004; Goodman 2004; Khaawaja et al. 2008).

An individual's ability to recover quickly from "illness" and drastic changes and successfully adapt to adversity, trauma, tragedy, threats, or stressor – known as resilience (Davydov et al. 2010) – has emerged as a potential predictor of mental health outcomes among refugees (Schweitzer et al. 2007). Sense of coherence (SOC) (Antonovsky 1979) refers to an internal psychological mechanism that mediates the effects of external stressors. SOC refers how people see life and, in stressful situations, identify and use their resources to maintain and develop their health. SOC is a tripartite construct consisting in three dimensions: comprehensibility (the ability to understand processes and events), manageability (the ability to manage stressful events), and meaningfulness (the ability to assign and process meanings). Some studies have shown SOC can be an extremely powerful predictor of psychological coping and mediate the effects of external stressors among Southeast Asian refugees (Ying et al. 1997; Ying and Akutsu 1997).

Hofstede (2011) attempted to identify macrocultural dimensions in order to better define the acculturation phenomenon. He described cultural dimensions in terms of collectivism/individualism, feminine/masculine, orientation to power, and avoidance of uncertainty. Nevertheless not all the cultures have the same dimensions; furthermore, these characteristics may interact generating similar or different cultural outcomes than those of the host country (Bhugra 2014). In fact in some cultural contexts, religion, gender role expectations, and attitude toward the institutions and medical services can modulate the relationship between stressful events and mental health outcomes (Kamperman et al. 2007). A recent qualitative study of attributions in war survivors has underlined social attachment and support, coping strategies, personality hardiness, community involvement, and normalization of everyday life as the main helpful factors in recovery from posttraumatic symptoms (Ajdukovic et al. 2013). Lack of awareness and knowledge about mental health problems and medical care opportunities may ultimately increase the attribution ambiguity and foster more stigmatizing dynamics (Schomerus et al. 2012).

The post-migration process, and the procedure to be granted legal asylum in particular (in Italy) which lasts about 1 year, can expose refugees to a vast number of social stressors such as difficulty in participating in society, stigmatization, exclusion from welfare benefits and work, discrimination, racism, and stereotyping by the host community. Potential community intervention to protect from the overall burden of migration psychological distress includes family and community cohesion, support, and collective identity (Siriwardhana et al. 2014). Community approaches aim to achieve a strong social impact and social inclusion (Williams and Thompson 2011; Bolton et al. 2014); more specifically, some of these interventions are oriented to engage and empower local community groups to take an active part and true participation in diagnosing and solving their own health problems (Morgan 2001; Harpham and Few 2002). Resilience, SOC, and coping strategies, but also individual qualities, religious beliefs and culture, knowledge, social community, and family support, can all modulate the relationship between events, acculturation outcomes, and mental health. These dimensions can become potential protective factors reducing the overall burden of mental illnesses and levels of psychological distress (Siriwardhana et al. 2014). The interaction between these elements can have a decisive influence on the ability to seek help and support, use institutional and social resources, and access to health services.

41.4 From Ethnocentrism to Culturally Sensitive Practices

Modern medicine and health care, including mental health care, have been developed thanks to the contribution of scientists of different cultures. For example, despite the contemporary anti-Islamic sentiment that proliferates certain groups (see, e.g., many of the remarks and policies advance by candidate Donald Trump during the recent presidential elections in the USA or comments made during the "Brexit" campaign), Carta and Moro (2014) pointed out that:

> The great Greek and Roman medical tradition was saved thanks to the contribution of the doctors of the Arabic courts, who transcribed the Greek classics into Arab when Christian fundamentalism denied the science such as Ibn Rusd and Moshe ben Maimon.

On the one hand, it is necessary to underline that modern medicine and mental health care are the products of the contribution of different cultures, whose merits and paternity ought to be acknowledged; on the other hand, many psychiatric clinical practices tend to ethnocentrism (REF). Ethnocentrism is the attitude to use practices and standards that are strongly related to mental health conceptions influenced only by western symbols and meanings (REF). Not surprisingly, the most recent edition of the DSM emphasizes the need to assess mental health needs and problems in a more interpretive culture framework:

> Diagnostic assessment must therefore consider whether an individual's experiences, symptoms, and behaviors differ from sociocultural norms and lead to difficulties in adaptation in the cultures of origin and in specific social or familial contexts. (DSM-5, p?)

In particular, as regards to the spectrum of trauma-related problems, DSM-5 specifies that:

> Cultural syndromes and idioms of distress influence the expression of PTSD and the range of comorbid disorders in different cultures by providing behavioral and cognitive templates that link traumatic exposures to specific symptoms. For example, panic attack symptoms may be salient in PTSD among Cambodians and Latin Americans because of the association of traumatic exposure with panic-like *khyâl* attacks and *ataque de nervios*. Comprehensive evaluation of local expressions of PTSD should include assessment of cultural concepts of distress.

The overall trend seems indeed to perceive refugees like a homogeneous population linked by traumatic experiences of human rights violations and physical abuse; accordingly it becomes necessary to consider the complexity of the cultural differences involved in a massive population movement. The limitations imposed by ethnocentricity are now recognized by many scientists and professionals, who underline how some aspects of trauma-related mental disorders are shaped by cultural determinants (Marsella 2010; Drožđek and Bolwerk 2010; Drozdek and Wilson 2007; Wilson and So-Kum Tang 2007).

The bias of imposing treatment without cultural appropriateness could generate a distorted picture of psychosocial disabilities and functioning, poor outcome, and ineffective treatment; it may as well increase distrust of nontraditional practices. Several efforts have been made to adapt clinical practices, as much as possible, to a more culturally sensitive approach. Tool validations in different languages (Mollica et al. 1999, 2007; Dinh et al. 2009), or support by a native language consultant or lay counselor (Neuner et al. 2008), have been implemented in the clinical practice, although the approach of mere linguistic adaptation of PTSD measurement and treatment was criticized (Myers 2011). Culturally sensitive approaches and treatments that pay higher attention to the varying social context have been explored and applied. In the case of Congolese and Somali men and women refugee groups in the USA, mental health concerns were often dealt in their community first, with the help of families or friends. The role of mental health professionals seems to be not well understood by all refugees, and this could have a strong effect on hesitancy to access medical services, thus in turn worsening the stigma dynamics (Piwowarczyk et al. 2014).

An analysis of the recorded and transcribed statements, beliefs, and knowledge about post-traumatic stress disorder among older Iranian refugees in the USA has shown a holistic approach to health care that views the mind, the body, and the spirit as inseparable (REF). These three elements are indicated with a unique word: *salamati*. This holistic view could contribute to their difficulties in describing symptoms that conform to western biomedical standards (Martin 2009). More culture-sensitive programs could favor the effective work with refugees within a social justice framework, but it requires potential modification of empirically supported screening and treatments and overall flexibility of clinicians.

41.5 Treating Mental Health Problems Among Refugee Populations

Some approaches and types of treatment of trauma among refugee populations have obtained more specific attention. Some of the major approaches will be illustrated, to provide an overview of what the scientific literature has underlined. Psychological, social, physical, biofeedback, and complementary and alternative medicine treatments shall be herein described. Some treatments use group techniques including community, family members, or individual session's therapy; in some cases these have been integrated and used in a multidisciplinary way (Slobodin and de Jong 2015).

41.5.1 Community-Based Interventions

The goal of community-based interventions is to involve communities and families as real healing agents through cohesion, support, and collective identity identification. This approach might also act as a potential protective factor that effectively reduces the overall burden of mental health problems (Siriwardhana et al. 2014). The local community has been empowered to take an active part and true participation in the diagnosis and care process (Morgan 2001; Harpham and Few 2002). Participation in health outcomes can be implemented in some steps of the process, e.g., the planning or implementation intervention phases. Community-based interventions mainly focus on outreach, workshops, train-the-trainer models, employment of refugees, and mentoring programs. All activities are generally aimed at achieving a strong social impact and social inclusion (Stone 1992; Williams and Thompson 2011; Bolton et al. 2014).

41.5.2 Complementary and Alternative Medicine

The National Center for Complementary and Alternative Medicine (NCCAM) divides complementary and alternative medicine (CAM) into four domains: mind/body medicine, biologically based practices, manipulative and body-based practices, and energy medicine (Pearson and Chesney 2007). Some of these promising approaches are emerging in the physical rehabilitation of torture survivors and include physical therapy; others focus on meditation, specific diet and exercise, and acupuncture (Mollica 2011). Several studies and reviews have documented the use of CAM among refugees, finding evidence of the use of CAM in combination with or without standard medicine on refugee populations (MacDuff et al. 2011). The conclusions were limited by some methodological problems in the included studies, namely, poor documentation of intervention methods and lack of randomized control trials. More evidence-based approaches and further investigation would be appropriate.

41.5.3 Trauma-Focused Cognitive Behavioral Therapy

As an adapted form of cognitive behavioral therapy, trauma-focused cognitive behavioral therapy (TF-CBT) is a component-based psychosocial treatment model that integrates also attachment, humanistic, empowerment, and caregiver therapy elements. In the first part of the therapy, psychoeducation is provided to patients and their caregivers concerning the impact of trauma and common reactions. With the aim of helping identify and cope with a range of emotions and behavioral adjustments, relaxation and stress training skills are provided. Cognitive processing is enhanced by illustrating the relationships among thoughts, behaviors, and feelings, while the trauma is gone through narration, with patients' describing their personal traumatic experiences (Buhmann et al. 2015; Lambert and Alhassoon 2015).

41.5.4 Narrative Exposure Therapy

NET (Narrative Exposure Therapy) is a narrative approach, a short, pragmatic, and cross-cultural application mainly used as PTSD treatment (REF). It can be applied across cultures and easily fits into the social and setting backgrounds (Gwozdziewycz and Mehl-Madrona 2013). In NET the patient constructs a narrative of his whole life, from birth to present day, recording a new biography with the therapist support instead of defining a single traumatic event as the only target of therapy. Patients are encouraged to reconstruct a narration of their lives and contextualize their experiences in a more social justice and emotionally aware framework (Gwozdziewycz and Mehl-Madrona 2013; Buhmann 2014).

41.5.5 Interpersonal Psychotherapy (IPT)

Interpersonal psychotherapy (IPT) is a short psychotherapy focus on interpersonal issues, which are considered fundamental in the genesis and maintenance of psychological distress. The targets of IPT are symptom resolution, improving interpersonal functioning, and increasing social support. Social functioning is assessed and discussed with consequent benefits on the quality of life and mood symptom experience. The patient's interpersonal functioning problems are previously analyzed and structured in four areas, interpersonal disputes, role transitions, grief, and interpersonal deficits (Stuart and Robertson 2012), in order to generate the interpersonal inventory assessment that is an important starting point of therapy. Therapy works by identifying dispute, role transition, or grief and linking them with emotional and interpersonal accomplishments occurring during the final part of the treatment. Despite the growing body of evidence concerning the effectiveness of this therapy (Swartz et al. 2014), few studies have addressed its effectiveness among refugees (Meffert et al. 2014).

41.5.6 Basic Body Awareness Therapy

Basic Body Awareness Therapy (BBAT) is a recommended form of physiotherapy that combines a number of different movements from the Western and Eastern traditions. The Body Awareness Therapy was developed and taken from Swedish physiotherapy and implemented in the treatment of psychiatric disorders. BBAT has somatic, biological, physiotherapy bases and includes other professional practices, such as psychiatry and psychotherapy. Since the spectrum of trauma disorders often includes a strong psychosomatic base as an important part of the pathology, therapy is focused on body awareness exercises aimed at total coordination and nonverbal therapeutic process. The therapist guides the patient's movements to empower confidence in their own resources (Gyllensten et al. 2009). Chronic pain is very common among traumatized refugees, and it is believed to maintain the mental symptoms of trauma. The literature reports only a very limited amount of scientific trials about physical activity as part of the treatment of traumatized refugee populations (Stade et al. 2015; Gyllensten et al. 2009).

41.5.7 Biofeedback Treatments

Biofeedback has already been performed in a few preliminary studies on traumatized refugees (Muller et al. 2009) in combination with cognitive behavioral intervention treatment and physical activity for pain management. The intervention is performed by integrating various biofeedback technologies and physical activity tasks to make specific body movements (Schwartz and Andrasik 2015). While the patient performs tasks that stimulate images of a stressful situation or relaxation, the biofeedback technology can detect the patient's internal bodily functions with far greater precision than a person alone could. This information is evaluated by the patient and the therapist, in order to direct the progress of treatment. Trauma-related symptoms such as muscle tension due to hyperarousal can produce pain and more stress (Vlaeyen and Linton 2000). In this sense, movement task activity with biofeedback can help patients become more aware and learn new coping strategies to manage their physiological reactivity and somatic and psychological symptoms.

41.5.8 Physical Activity

Physical activity has already been performed within a cognitive behavior therapy (CBT) intervention with the aim of helping traumatized refugees cope with pain. This has suggested that physical activity adds value to pain management intervention outcomes (Liedl et al. 2011). The effectiveness of interventions that use physical activity – with or without integration of conventional therapies – has already been amply demonstrated in a wide range of mental disorders, including depression, anxiety, and PTSD (Manger and Motta 2005; Carta et al. 2008; Mura and Carta 2013).

41.5.9 Mindfulness

The definition of mindfulness is based on Buddhist and psychological literature, and it refers to a set of meditation and awareness practices, defined "mindful," to the focus on present-oriented experience with a certain emotional attitude, and to mind-sets designed to achieve body-set acceptance perceptions. The patient doing meditation is instructed to watch thoughts and feelings come and go on their own, without judging them. Mindfulness focuses on relaxation and gentleness and leads the person to watch thoughts and emotional reactions from a completely different perspective. Some trial has already illustrated how to utilize acceptance and mindfulness techniques in integrated treatments (culturally adapted CBT, or CA-CBT) for traumatized refugees and ethnic minority populations (Hinton et al. 2013).

41.5.9.1 Eye Movement Desensitization and Reprocessing

Eye movement desensitization and reprocessing (EMDR) is known particularly for treating PTSD after traumatic experiences. EMDR aims to alleviate the distress associated with traumatic memories, by facilitating the access to and the processing of traumatic experience in order to get to an adaptive resolution. The therapeutic goal is to relieve distress, reformulate negative beliefs, and reduce physiological arousal. During EMDR therapy, the patient remembers emotionally disturbing materials while simultaneously focusing on an external stimulus – like hand tapping or audio stimulation – and performing lateral eye movements. Information processing is enhanced through new associations forged between the traumatic memory and more adaptive emotions and information (Shapiro and Maxfield 2002). Since EMDR seems to be an easily implementable technique in specific contexts, among Traumatized Refugees, it is receiving a lot of attention (Bower et al. 2004; Regel and Berliner 2007; Jackie June ter Heide et al. 2011).

41.5.9.2 The Effectiveness of Cultural Sensitivity Practices and the Role of Community Support

Some kinds of treatment are receiving more attention than others. Narrative Exposure Therapy seems to be the most implemented and evaluated approach among refugees (Robjant and Fazel 2010). A recent meta-analysis concerning RCT of NET revealed that it shows a total average effect size of 0.53 (Cohen's d). The effect size found in a trial that actively involved refugees in the care process as counselors was of 1.02 (Gwozdziewycz and Mehl-Madrona 2013). This may suggest that NET can be actually more effective on refugee clinical populations. The common cultural background between counselors and treated refugees could be the key. If it were true, then a culturally sensitive approach could really serve as a key component in the therapeutic process among refugee populations. So far a limited number of studies have included a refugee community member as a therapist or a counselor (Neuner et al. 2008; Meffert et al. 2014). Other studies have included a native speaker or a certified translator in the NET therapeutic process, but these were not from the same refugees' cultural community (Stenmark et al. 2013; Hijazi

et al. 2014). Family support is often recognized as a key context for refugees and their mental health, serving as a resource for adjustment and coping (Voulgaridou et al. 2006). Multiple-family group intervention can be effective in increasing access to mental health services, while family support can mediate the intervention effect in depression symptoms among refugees (Weine et al. 2008).

41.6 Preventing Mental Health Problems Among Refugees

Refugees' exposition may span generations with significant negative impacts on public health and socioeconomic development (World Health Organization 2015). Despite this, few studies have verified the effectiveness of prevention programs on refugees' well-being (Kirmayer et al. 2011). Preventive efforts to reduce the onset of mental disorders among migrants should focus on mental health education and on emotional, social, and economic support; and they should address the barriers against traditional western mental health services and human rights (Porter 2007). Considering the factors that have proved crucial for refugees' quality of life, post-migration interventions should provide an integrated approach including trauma therapy, work orientation, language training, and support for bureaucratic and political awareness, while facilitating the creation of a supportive refugees' network in the host community. Preventive activities aimed at facilitating and speeding up the integration process have already proved a protective factor against experiences of discrimination and mental disease, in a perspective of long-term health benefits (Beiser 2006). Community-oriented intervention in the early stages of refugee resettlement has been performed among young refugees in the USA, with the aim to prevent or detect the initial stages of mental illness. Results showed how community-based mental health services seem more effective than the traditional primary care model (Weine et al. 2006; Weine 2008; Weine 2011; Dura-Vila et al. 2013). Community collaboration opposes the feeling of being isolated, alone, and discriminated; it is also a great facilitator in the access to information and resources by refugee community members, especially by the younger ones, thus supporting the successful adaptation to host countries (Birman et al. 2008; Tyrer and Fazel 2014). Preventive interventions have often been conducted with minimum methodological quality standards; therefore, more studies are required on its application and on the effect it might have on public health.

References

Acarturk C, Konuk E, Cetinkaya M, Senay I, Sijbrandij M, Cuijpers P, Aker T (2015) EMDR for Syrian refugees with posttraumatic stress disorder symptoms: results of a pilot randomized controlled trial. Eur J Psychotraumatol 18(6):27414

Ajdukovic D, Ajdukovic D, Bogic M, Franciskovic T, Galeazzi GM, Kucukalic A, Lecic-Tosevski D, Schützwohl M, Priebe S (2013) Recovery from posttraumatic stress symptoms: a qualitative study of attributions in survivors of war. PLoS One 8(8):e70579

Aldwin CM, Tracey R (1987) Does coping help? A re-examination of the relation between coping and mental health. J Pers Soc Psychol 53(2):337–348

Antonovsky A (1979) Health, stress and coping. Jossey-Bass, San Francisco
Beiser M (2006) Longitudinal research to promote effective refugee resettlement. Transcult Psychiatry 43(1):56–71
Bhugra D (2004) Migration and mental health. Acta Psychiatr Scand 109(4):243–258
Bhugra D (2014) All medicine is social. J R Soc Med 107(5):183–186
Bhugra D, Gupta S (2011) Migration in mental health. Cambridge University Press, Cambridge
Birman D, Beehler S, Harris EM, Everson ML, Batia K, Liautaud J, Frazier S, Atkins M, Blanton S, Buwalda J, Fogg L, Cappella E (2008) International family, adult, and child enhancement services (FACES): a community-based comprehensive services model for refugee children in resettlement. Am J Orthopsychiatry 78(1):121–132
Bogic M, Ajdukovic D, Bremner S, Franciskovic T, Galeazzi GM, Kucukalic A, Lecic-Tosevski D, Morina N, Popovski M, Schützwohl M, Wang D, Priebe S (2003) Factors associated with mental disorders in long-settled war refugees: refugees from the former Yugoslavia in Germany, Italy and the UK. Br J Psychiatry 200(3):216–223
Bogic M, Njoku A, Priebe S (2015) Long-term mental health of war-refugees: a systematic literature review. BMC 15:29
Bolton P, Lee C, Haroz EE, Murray L, Dorsey S, Robinson C, Ugueto AM, Bass J (2014) A transdiagnostic community-based mental health treatment for comorbid disorders: development and outcomes of a randomized controlled trial among Burmese refugees in Thailand. PLoS Med 11(11):e1001757
Bower RD, Pahl L, Bernstein MA (2004) Case presentation of a tattoo-mutilated, Bosnian torture survivor. Torture 14(1):16–24
Buhmann CB (2014) Traumatized refugees: morbidity, treatment and predictors of outcome. Dan Med J 61(8):B4871
Buhmann C, Andersen I, Mortensen EL, Ryberg J, Nordentoft M, Ekstrøm M (2015) Cognitive behavioral psychotherapeutic treatment at a psychiatric trauma clinic for refugees: description and evaluation. Torture 25(1):17–32
Carta, M.G. & Moro, M.F. (2014) Conflicts and mental health in the Mediterranean, Conference: XVI World Congress of Psychiatry. Madrid 2014, At Madrid, Volume 2. Abstracts Regular Symposia, Conference Paper January 2014
Carta MG, Hardoy MC, Pilu A, Sorba M, Floris AL, Mannu FA, Baum A, Cappai A, Velluti C, Salvi M (2008) Improving physical quality of life with group physical activity in the adjunctive treatment of major depressive disorder. Clin Pract Epidemiol Ment Health 26(4):1
Carta MG, Wallet Oumar F, Moro MF, Moro D, Preti A, Mereu A, Bhugra D (2013) Trauma and stressor related disorders in the tuareg refugees of a camp in Burkina Faso. Clin Pract EpidemiolMental Health 9:189–195
Carta MG, Moro MF, Bass J (2015) War traumas in the Mediterranean area. Int J Soc Psychiatry 61(1):33–38
Carver CS, Scheier MF, Weintraub JK (1989) Assessing coping strategies: a theoretically based approach. J Pers Soc Psychol 56(2):267–283
Davydov DM, Stewart R, Ritchie K, Chaudieu I (2010) Resilience and mental health. Clin Psychol Rev 30(5):479–495
Dinh TQ, Yamada AM, Yee BW (2009) A culturally relevant conceptualization of depression: an empirical examination of the factorial structure of the Vietnamese depression scale. Int J Soc Psychiatry 55(6):496–505
Drožđek B, Bolwerk N (2010) Group therapy with traumatized asylum seekers and refugees: for whom it works and for whom it does not? Traumatology 16(4):160–167
Drozdek B, Wilson JP (2007) Voices of trauma: treating psychological across cultures. Springer
Dura-Vila G, Klasen H, Makatini Z, Rahimi Z, Hodes M (2013) Mental health problems of young refugees: duration of settlement, risk factors and community-based interventions. Clin Child Psychol Psychiatry 18:604–623
Fazel M, Wheeler J, Danesh J (2005) Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. Lancet 365:1309–1314

Ginzburg ES (2010) Comorbidity of posttraumatic stress disorder, anxiety and depression: a 20-years longitudinal study of war veterans. J Affect Disord 123(1-3):249–257
Goodman JH (2004) Coping with trauma and hardship among unaccompanied refugee youths from Sudan. Quant Health Res 14(9):1177–1196
Gwozdziewycz N, Mehl-Madrona L (2013) Meta-analysis of the use of narrative exposure therapy for the effects of trauma among refugee populations. Perm J 17(1):70–76
Gyllensten AL, Ekdahl C, Hansson L (2009) Long-term effectiveness of basic body awareness therapy in psychiatric outpatient care. A randomized controlled study. Adv Physiother 11(1):2–12
Hadgkiss EJ, Renzaho AM (2014) The physical health status, service utilisation and barriers to accessing care for asylum seekers residing in the community: a systematic review of the literature. Aust Health Rev 38(2):142–159
Halcón LL, Robertson CL, Savik K, Johnson DR, Spring MA, Butcher JN, Westermeyer JJ, Jaranson JM (2004) Trauma and coping in Somali and Oromo refugee youth. J Adolesc Health 35(1):17–25
Harpham T, Few R (2002) The Dar Es Salaam urban health project, Tanzania: a multi-dimensional evaluation. J Public Health Med 24(2):112–119
Hijazi AM, Lumley MA, Ziadni MS, Haddad L, Rapport LJ, Arnetz BB (2014) Brief narrative exposure therapy for post-traumatic stress in Iraqi refugees: a preliminary randomized clinical trial. J Trauam Stress 27(3):314–322
Hinton DE, Pich VH, Stefan G, Otto MW (2013) Acceptance and mindfulness techniques as applied to refugee and ethnic minority populations with PTSD: examples from "culturally adapted CBT". Cogn Behav Pract 20(1):33–46
Hofstede G (2011) Dimensionalizing cultures: the hofstede model in context. Online Read Psychol Culture 2(1):8
Jackie June ter Heide F, Mooren GTM, Kleijn W, de Jongh A, Kleber RJ (2011) EMDR versus stabilisation in traumatised asylum seekers and refugees: results of a pilot RCT. Eur J Psychotraumatol 2:5881
Kamperman AM, Komproe IH, de Jong JT (2007) Migrant mental health: a model for indicators of mental health and health care consumption. Health Psychol 26(1):96–104
Karam EG, Fayyad J, Nasser Karam A, Cordahi TC, Melhem N, Mneimneh Z, Dimassi H (2008) Effectiveness and specificity of a classroom-based group intervention in children and adolescents exposed to war in Lebanon. World Psychiatry 7:103–109
Khaawaja NG, White KM, Schweiter R, Greenslade J (2008) Difficulties and coping strategies of Sudanese refugees: a qualitative approach. Transcult Psychaitry 45(3):489–512
Kirmayer LJ, Narasiah L, Munoz M, Rashid M, Ryder AG, Guzder J, Hassan G, Rousseau C, Pottie K (2011) Canadian collaboration for immigrant and refugee health (CCIRH): common mental health problems in immigrants and refugees: general approach in primary care. CMAJ 183(12):E959–E967
Lambert JE, Alhassoon OM (2015) Trauma-focused therapy for refugees: meta-analytic findings. J Couns Psychol 62(1):28–37
Liedl A, Müller J, Morina N, Karl A, Denke C, Knaevelsrud C (2011) Physical activity within a CBT intervention improves coping with pain in traumatized refugees: results of a randomized controlled design. Pain Med 12(2):234–245
Lindert J, Ehrenstein OS, Priebe S, Mielck A, Brähler E (2009) Depression and anxiety in labor migrants and refugees--a systematic review and meta-analysis. Soc Sci Med 69(2):246–257
MacDuff S, Grodin MA, Gardiner P (2011) The use of complementary and alternative medicine among refugees: a systematic review. J Immigr Minor Health 13(3):585–599
Manger TA, Motta RW (2005) The impact of an exercise program on posttraumatic stress disorder, anxiety, and depression. Int J Emerg Ment Health 7(1):49–57
Marsella AJ (2010) Ethnocultural aspects of PTSD: an overview of concepts, issues, and treatments. Traumatology 16(4):17–26
Martin SS (2009) Illness of the mind or illness of the spirit? Mental health-related conceptualization and practices of older Iranian immigrants. Health Soc Work 34(2):17–26

Meffert SM, Abdo AO, Alla OA, Elmakki YO, Omer AA, Yousif S, Metzler TJ, Marmar CR (2014) Pilot randomized controlled trial of interpersonal psychotherapy for Sudanese refugees in Cairo, Egypt. Psychol Trauma 6(3):240–249

Mollica RF (2011) Medical best practices for the treatment of torture survivors. Torture 21(1):8–17

Mollica RF, McInnes K, Sarajlic N, Lavelle J, Sarajlic I, Massagli MP (1999) Disability associated with psychiatric comorbidity and health status in Bosnian refugees living in Croatia. JAMA 282(5):433–439

Mollica RF, Caridad KR, Massagli MP (2007) Longitudinal study of posttraumatic stress disorder, depression, and changes in traumatic memories over time in Bosnian refugees. J Nerv Ment Dis 195(7):572–579

Morgan LM (2001) Community participation in health: perpetual allure, persistent challenge. Health Policy Plan 16(3):221–230

Muller J, Karl A, Denke C, Mathier F, Dittmann J, Rohleder N, Knaevelsrud C (2009) Biofeedback for pain management in traumatised refugees. Cogn Behav Ther 38(3):184–190

Mura G, Carta MG (2013) Physical activity in depressed elderly. A systematic review. Clin Pract Epidemiol Ment Health 12(9):125–135

Myers SJ (2011) Cross-cultural measurement of posttraumatic stress disorder in post-conflict settings. Am J Public Health 101(4):581–582

Naja WJ, Aoun MP, El Khoury EL, Abdallah FJ, Haddad RS (2016) Prevalence of depression in Syrian refugees and the influence of religiosity. Compr Psychiatry 68:78–85

Neuner F, Onyut PL, Ertl V, Odenwald M, Schauer E, Elbert T (2008) Treatment of post-traumatic stress disorder by trained lay counselors in an African refugee settlement: a randomized controlled trial. J Consult Clin Psychol 76(4):868–694

Pearson NJ, Chesney MA (2007) The national center for complementary and alternative medicine. Acad Med 82(10):967

Piwowarczyk L, Bishop H, Yusuf A, Mudymba F, Raj A (2014) Congolese and Somali beliefs about mental health services. J Nerv Ment Dis 202(3):209–216

Porter M (2007) Global evidence for a biopsychosocial understanding of refugee adaptation. Transcult Psychiatry 44(3):418–439

Porter M, Haslam N (2005) Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: a meta-analysis. JAMA 294(5):602–612

Regel S, Berliner P (2007) Current perspectives on assessment and therapy with survivors of torture: the use of a cognitive behavioural approach. Eur J Psychother Counsel 9(3):289–299

Robjant K, Fazel M (2010) The emerging evidence for narrative exposure therapy: a review. Clin Psychol Rev 30(8):1030–1039

Schomerus G, Auer C, Rhode D, Luppa M, Freyberger HJ, Schmidt S (2012) Personal stigma, problem appraisal and perceived need for professional help in currently untreated depressed persons. J Affect Disord 139(1):94–97

Schwartz MS, Andrasik F (2015) Biofeedback: a practitioner's guide, 4th edn. The Guilford press, London

Schweitzer R, Greenslade J, Kagee A (2007) Coping and resilience in refugees from the Sudan: a narrative account. Aust N Z J Psychiatry 41(3):282–288

Shapiro F, Maxfield L (2002) Eye movement desensitization and reprocessing (EMDR): information processing in the treatment of trauma. J Clin Psychol 58(8):933–946

Siriwardhana C, Shirwa SA, Roberts B, Stewart R (2014) A systematic review of resilience and mental health outcomes of conflict-driven adult forced migrants. Confl Heal 8:13

Slobodin O, de Jong JT (2015) Mental health interventions for traumatized asylum seekers and refugees: what do we know about their efficacy? Int J Soc Psychiatry 61(1):17–26

Stade K, Skammeritz S, Hjortkjær C, Carlsson J (2015) "after all the traumas my body has been through, I feel good that it is still working."--basic body awareness therapy for traumatised refugees. Torture 25(1):33–50

Stenmark H, Catani C, Neuner F, Elbert T, Holen A (2013) Treating PTSD in refugees and asylum seekers within the general health care system: a randomized controlled multi-center study. Beh Res Ther 51(10):641–647

Stone L (1992) Cultural influences in community participation in health. Soc Sci Med 35(4):409–417
Stuart S, Robertson M (2012) Interpersonal psychotherapy: a clinician's guide, 2nd edn. Edward Arnold, London
Swartz HA, Grote NK, Graham P (2014) Brief interpersonal psychotherapy (IPT-B): overview and review of evidence. Am J Psychother 68(4):443–462
Taylor SE, Stanton AL (2007) Coping resources, coping processes and mental health. Annu Rev. Clin Psychol 3:377–401
Tyrer RA, Fazel M (2014) School and community-based interventions for refugee and asylum seeking children: a systematic review. PLoS One 9(2):e89359
UNHCR's annual Global Trends Report (2015), 20 JUNE 2016
Vlaeyen JW, Linton SJ (2000) Fear-avoidance and its consequences in chronic musculoskeletal pain: a state of the art. Pain 85(3):317–332
Voulgaridou M, Papadopoulos R, Tomaras V (2006) Working with refugee families in Greece: systemic considerations. J Fam Ther 28:200–220
Weine S (2008) Family roles in refugee youth resettlement from a prevention perspective. Child Adolesc Psychiatr Clin N Am 17(3):515–518
Weine S (2011) Developing preventive mental health interventions for refugee families in resettlement. Fam Process 50(3):410–430
Weine SM, Kulauzovic Y, Besic S, Lezic A, Mujagic A, Muzurovic J et al (2006) A family beliefs framework for developing socially and culturally specific preventive interventions for refugee families and youth. Am J Orthopsychiatry 76:1–9
Weine S, Kulauzovic Y, Klebic A, Besic S, Mujagic A, Muzurovic J, Spahovic D, Sclove S, Pavkovic I, Feetham S, Rolland J (2008) Evaluating a multiple-family group access intervention for refugees with PTSD. J Marital Fam Ther 34(2):149–164
WHO/Europe (2015) Mental health and psychological support for refugees, asylum seekers and migrants on the move in Europe: a multi-agency guidance note
Williams ME, Thompson SC (2011) The use of community-based interventions in reducing morbidity from the psychological impact of conflict-related trauma among refugee populations: a systematic review of the literature. J Immigr Minor Health 13(4):780–794
Wilson JP, So-Kum Tang C (2007) Cross-cultural assessment of psychological trauma and PTSD. Springer, New York
World Health Organization (2015) Policy brief on migration and health: mental health care for refugees. http://www.euro.who.int/__data/assets/pdf_file/0006/293271/Policy-Brief-Migration-Health-Mental-Health-Care-Refugees.pdf?4a=1
Ying YW, Akutsu PD (1997) Psychological adjustment of southeast Asian refugees: the contribution of sense of coherence. J Commun Phychol 25(2):125–139
Ying YW, Akutsu PD, Zhang X et al (1997) Psychological dysfunction in southeast Asian refugees as mediated by sense of coherence. Am J Community Psychol 25:839