# Refugees and Asylum Seekers

# 2

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**Abstract**

According to the UNHCR, in the year 2018, more than 68.5 million people live in external or internal situation of displacement. The reasons are different and complex, including political, logistic, economic, and social factors. Women and girls make up around 50% of any refugee, internally displaced, or stateless people. It is highly likely that the stress factors before, during, and after migration will contribute to the development of psychiatric disorders in vulnerable individuals. In some cases, the onset of illness may occur soon after migration, whereas in other cases, mental health problems may develop over time as one result of the impact of social factors and changes related to the host society. Additionally, post-migration factors have a high impact on the development of psychiatric disorders. Therefore, healthcare services should prepare themselves to serve this group of refugee, asylum seeker, and ethnic minority patients in a better way. Furthermore, in all these issues, gender-specific factors also have to be taken into consideration. Individual, psychological resources, social support, a successful acculturation

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processes, cultural variations, and time since relocation are statistically significant protective factors against the development of common mental disorders among refugees, asylum seekers, and ethnic minorities.

**Keywords**
Refugees and asylum seekers · Mental health · Gender · Social support · Cultural competence

## Introduction

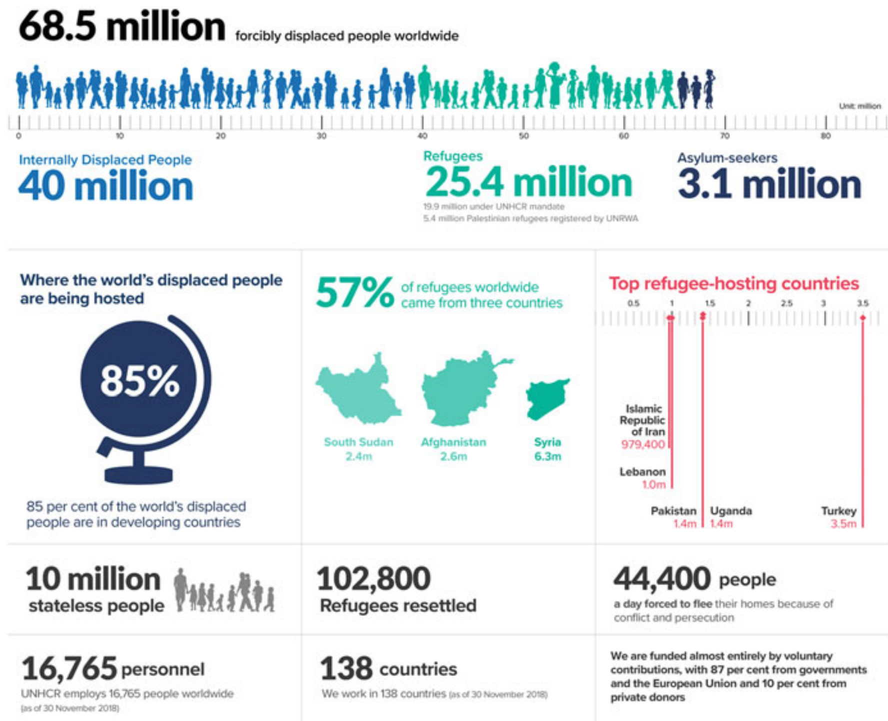
"People who move across borders in search of protection, but who may not fulfil the strict criteria laid down by the 1951 UN Convention. Asylum seeker describes someone who has applied for protection as a refugee and is awaiting the determination of his or her status. Refugee is the term used to describe a person who has already been granted protection. Asylum seekers can become refugees if the local immigration or refugee authority deems them as fitting the international UN definition of refugee" (UNESCO 2019).

According to the UNCHR (2015), "refugees include individuals recognised under the 1951 Convention relating to the Status of Refugees; its 1967 Protocol; the 1969 OAU Convention Governing the Specific Aspects of Refugee Problems in Africa; those recognised in accordance with the UNHCR Statutes; individuals granted complementary forms of protection; or those enjoying temporary protection. The refugees' population also includes people in a refugee – like situation" (UNHCR 2015, p. 56). Additionally, according to the UNCHR, "asylum seekers are individuals who have sought international protection and whose claims for refugee status have not yet been determined, irrespective of when they may have been lodged" (47, p. 56). An asylum seeker has to demonstrate that his or her fear of persecution in his or her home country is well-founded. When people flee their own country and seek sanctuary in another country, they apply for asylum – the right to be recognized as a refugee and receive legal protection and material assistance. A refugee has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion, or membership in a particular social group. Most likely, they cannot return home or are afraid to do so. War and ethnic, tribal, and religious violence are leading causes of refugees fleeing their countries (UNHCR 2019a).

## Statistical Data

The UNHCR reported that 2018 more than 68.5 million people around the world have been forced from home as forcibly displaced people (UNHCR 2018). Eighty-five percent of them were being hosted in developing countries, and only 15% were

able to be hosted in developed countries, e.g., in Europe and North America. According to UNHCR (2018), among forcibly displaced people around 25.4 million were refugees, over half of whom were under the age of 18 years. Only 3.1 million were asylum seekers. Fifty-seven percent of the refugees worldwide were from three countries: South Sudan 2.4 million, Afghanistan 2.4 million, and Syria 6.3 million. Top refugee-hosting countries were Turkey, Uganda, Pakistan, Lebanon, and Islamic Republic of Iran. Around 40 million of the forcibly displaced people worldwide were internally displaced. Additionally, the UNHCR reported that 10 million stateless people were estimated who have been denied a nationality and access to basic rights such as education, healthcare, employment, and freedom of movement. Furthermore, it was pointed out that nearly one person was forcibly displaced every 2 s as a result of conflict or persecution worldwide. Summing up, 1 in every 110 people globally is either an asylum seeker, internally displaced, or a refugee (UNHCR 2018).




Additionally, according to UNHCR, women and girls make up around 50% of any refugee, internally displaced, or stateless population, and those who are

unaccompanied, pregnant, head of households, disabled, or elderly are especially vulnerable. Furthermore, according to UNHCR, in some societies, women and girls face discrimination and violence every day, simply because of their gender (UNHCR 2019b).

## Mental Health of Refugees and Asylum Seekers

Immigration is politically controversial, and the need for continued immigration to Europe is still poorly recognized. Nevertheless, immigrants make up a growing share of European populations (Rechel et al. 2013). Bhugra et al. (2014) emphasized that refugees and asylum seekers constitute one of the groups at the highest risk of developing mental disorders and are among the most vulnerable groups in society. From a public mental health perspective, epidemiological evidence showed that exposure to extreme stressors, including major losses and potentially traumatic events such as torture and war exposure, are disproportionately experienced by refugees and asylum seekers before and during displacement (Bogic et al. 2012), Priebe et al. (2016). In addition, post-displacement traumatic events (Miller et al. 2006), perceived stigma, and discrimination as well as resettlement stress are important impacts for mental health (Miller and Rasmussen 2010). In various publications, it was emphasized that refugees and asylum seekers have been shown to experience higher prevalence rates of a range of disorders, including common mental disorders (e.g., depression, anxiety, somatoform disorders), severe mental disorders (e.g., psychosis), substance use disorders, and disorders specifically tied to stress, in comparison with the general population (Nosè et al. 2017; Fazel et al. 2005; Bogic et al. 2015, Winkler et al. 2018). Interestingly, the best-studied mental health outcome in refugees remains post-traumatic stress disorder (PTSD), despite the range of mental disorders of relevance to conflict-affected populations. According to several authors, PTSD is ten times more likely in refugees and asylum seekers compared to host populations (Fazel et al. 2005; Bogic et al. 2015). In a systematic review, Fazel et al. (2005) found that refugees who resettle in certain Western countries are around ten times more likely to have post-traumatic stress disorder than age-matched general populations in the same countries (USA, Australia, Canada, Italy, New Zealand, Norway, and UK). According to the authors, tens of thousands of refugees and former refugees who have resettled in Western countries are likely to have post-traumatic stress disorder worldwide (Fazel et al. 2005). A study in Switzerland aimed to describe, compare, and predict mental health outcomes among different migrant groups and native residents (Heeren et al. 2014). The authors found a high psychiatric morbidity in the group of asylum seekers, refugees, and illegal migrants. Significant percentages of asylum seekers (54.0%) and refugees (41.4%) fulfilled criteria of PTSD. The results showed clinically relevant symptoms of anxiety and depression by asylum seekers (84.6% and 63.1%, respectively) and illegal migrants (both 47.6%) (Heeren et al. 2014).

Pre-migration, during the migration, and after the migration, they have frequently been subjected to physical, sexual, and/or psychological violence and traumatic

bereavement due to war, social or political instability, or socioeconomic, familial, or administrative conflicts. Therefore, the proportion of traumatized people with a serious mental disorder is very high, and the healthcare systems of the receiving countries are not prepared for this specific group of traumatized immigrants (Bhugra et al. 2014; Schouler-Ocak et al. 2019). The published rates of post-traumatic disorders are often high, lying between at anything from 3% to 86% among refugees and asylum seekers who have experienced physical and sexual violence, torture, loss of family members, and persecution (Bhugra et al. 2014). The very large range is partly due to differences in methodology and study populations. Lindert et al. (2009) reported that the rates of common mental disorders (CMD) are twice as high in refugee populations in comparison with economic migrants (40% vs. 21%).

Laban et al. (2004) pointed out that the risk of PTSD and CMD in asylum groups increases with the length of time the person is in a waiting position after their application for asylum. Furthermore, Porter and Haslam (2005) reported in a meta-analysis that refugees had worse outcome if they were older, better educated, and female and had a higher socioeconomic status and rural residence prior to displacement. Laban et al. (2008) documented unemployment, absence of family support, and complicated asylum processes as other risk factors. As compared with the general population, refugees have been shown to experience considerably higher levels of psychological distress and higher levels of social distress in different domains (i.e., demographic, economic, neighborhood, environmental events, and social and cultural domains) (Lund et al. 2018). These findings are not consistent across studies (Turrini et al. 2017). In comparison with the general population, psychosis has also been shown to be more frequent in people exposed to trauma and displacement (Close et al. 2016; Dapunt et al. 2017). According to Bourque et al. (2011), data from studies on risk for psychosis showed that stress factors in the post-migratory stage over all have more impact on mental health than those in the pre-migratory stage. Giacco et al. (2018) pointed out that exposure to traumatic events before or during migration may explain high rates of PTSD. Additionally, the authors underlined that, in the first years of resettlement, only post-traumatic stress disorder (PTSD) rates are clearly higher in refugees than in host countries' populations. Five years after resettlement rates of depressive and anxiety disorders are also increased. In this line, Mladovsky et al. (2012) pointed out that a lack of familiarity with rights, entitlements, gaps in health literacy, social exclusion, and direct and indirect discrimination are risk factors for bad mental health outcomes of immigrants.

## Social Support, Social Conflict, and Mental Health Service Use

Guruge et al. (2015) reported that the literature is limited about the role of social conflict and reciprocity within informal social networks, which play an important role in shaping the access and use of mental health services among refugee, asylum seeker, and ethnic minority patients. It has been also underlined that refugees, asylum seekers, and ethnic minorities are more likely to underutilize the sources of social support. The main reasons are unawareness of these services or inability

to access them (Bhugra et al. 2014), transportation problems or mobility issues (Stewart et al. 2011), and a lack of culturally safe (Lai and Surood 2010) as well as linguistically appropriate services (Schouler-Ocak et al. 2015). Furthermore, staff may be faced with significant language difficulties, negative stereotypes, and expectations of treatment that cannot be fulfilled. Additionally, stigma, which plays an important role, is associated with seeking help, particularly for mental health issues (Küey 2015). In this context, intercultural and institutional barriers – as described under cultural competence below in more detail – should be underlined (Schouler-Ocak et al. 2015). Moreover, De Jong and van Ommeren (2005) used the term "interculturalization" and defined it as the adaptation of mental health services to suit patients from different cultures. Therefore, they developed a model to promote and assess interculturalization of mental healthcare services in Western multicultural societies. According to them, changes are necessary in four contexts:

1. The relationships between the refugee, asylum seeker and ethnic minority patients, and the healthcare workers and the treatment team
2. The organizational adaptations required in the treatment context of the mental health care facility
3. The relationships between the mental health facility and the ethnic communities
4. The relationships between the mental healthcare system, other facilities, and society at large (De Jong and van Ommeren 2005)

This model can help to negotiate the barriers mentioned above and increase the usage of the healthcare services.

## Access of Mental Healthcare

Refugee and asylum seeker patients often have difficulties in the new host society. As Kluge et al. (2012) reported, immigrants and refugees, especially those who are newly settled, often have poor knowledge about how the healthcare system works, what help they can obtain, or how to communicate their suffering and need for help in an understandable way. The aim of the study of Winkler et al. (2018) was to assess asylum seekers' views on their legal situations, asylum procedures and living conditions, and the relationship of these factors toward psychological stress. The authors found that according to psychological test criteria, 74.6% of the respondents indicated symptoms of mental disorders. Significant correlations between insecure residency status and these symptoms were not found. Interestingly, the respondents with higher symptom load took less advantage of support, participated less in measures designed to assist integration, and described more difficulties in their hearing. Additionally, the authors pointed out that only 11.6% of the asylum seekers with mental illness indicating symptoms were under psychiatric treatment. Thus, Winkler et al. (2018) found a big gap between the proportion with high symptom burden and the proportion of treatment required.

Therefore, Schouler-Ocak et al. (2015) recommended that it is necessary for all mental health professionals to be sensitive to cultural and contextual aspects of communication. Therein, cultural sensitivity and culturally competent services are some of the key concepts in mental healthcare services for refugee, asylum seeker, and ethnic minority patient (Schouler-Ocak et al. 2015).

Fenta et al. (2007) reported that in cases of psychiatric illness, the first consultation that takes place is often more of a general medical consultation rather than a consultation with trained psychiatric/psychological professionals. Only in case of emergency will the costs be covered by health insurances. This difficulty in accessing healthcare often contributes to the further exacerbation of existing mental disorders (Laban et al. 2004). Access to the healthcare system significantly impeded by language and cultural communication problems. Qualified language and cultural mediators are not widely available. Moreover, they not regularly asked to attend (Kluge et al. 2012). This can lead to misunderstandings, misdiagnosis, and incorrect treatment, with serious consequences for the afflicted. Language barrier represents one of the main barriers to access to the healthcare system for people who do not speak the local language; indeed, language is the main working tool of psychiatry and psychotherapy, without which successful communication is impossible (Schouler-Ocak 2015).

According to Rechel et al. (2012), there is less data about mental health services for refugees and asylum seekers, which makes it difficult to monitor and improve their health. The authors underlined that one of the most fundamental barriers for refugees and asylum seekers in accessing health services is inadequate legal entitlement. Pace (2011) pointed out that where entitlement exists, mechanisms for ensuring them were well-known and respected in practice. Karl-Trummer (2010) reported that the problems are greatest for asylum seekers and undocumented migrants. By 2009, only 11 European countries had established national policies to improve migrant health that go beyond migrants' statutory or legal entitlement to care (Mladovsky et al. 2012). In this context, evidence suggests that poor social integration and difficulties in accessing care contribute to higher rates of mental disorders in the long-term (Giacco et al. 2018).

According to Priebe et al. (2016), challenges for the Member States of the WHO European Region are to facilitate the social integration of refugees, asylum seekers, and irregular migrants within the host countries and to adopt good practices that improve access to and outcomes of mental healthcare. The authors underlined also that strategies for implementing policies to achieve this include providing resources for social integration programs, outreach services, appropriate information, and staff training; promoting organizational flexibility to provide the best possible coordination between services; routine data collection on service use and outcomes of this use; and the formal evaluation of implemented initiatives (Priebe et al. 2016).

## Mental Health of Female Refugees and Asylum Seekers

According to UNHCR (2019b), in some societies, women and girls face discrimination and violence every day, simply because of their gender. An ordinary task like collecting water or going to the toilet can put them at risk of rape or abuse.

Therefore, while fleeing and living as a refugee can be traumatic events for everyone, gender differences can significantly affect the experience. Women and men as well as girls and boys embody different roles within their societies of origin and assigned different roles. Women are more frequently less educated than men in their countries of origin and more frequently tend to family and care duties rather than working outside of the home (Breslau 2002). According to Freedman (2016), women are also more vulnerable to all forms of violence in their home countries and during flight leading to physical abuse and psychological traumatization. Stempel et al. (2016) reported that the gendered expectations toward their roles might be questioned once they reach their country of destination, where gender roles could strikingly differ leading to conflict and self-questioning.

The Female Refugee Study was the largest study to date documenting the specific situation of refugee women arriving in Germany during the years 2015–2016 (Jesuthasan et al. 2018), in which they reported a multitude of reasons for flight and experienced traumas in their home countries and during the journey. The reasons for fleeing were mostly war, terror, and fear for one's life or the life of family members, demonstrating a high degree of stressors and a perceived unavoidability of migration in many cases (Jesuthasan et al. 2018). In this study, about 25% of the women reported personally witnessing unnatural death or killing of a family member or close friend. Gender-specific reasons for fleeing primarily are expressed by women from Afghanistan and Somalia, who most frequently mentioned fear of forced marriage and honor killings (Jesuthasan et al. 2018). Furthermore, women of all countries of origin expressed fear of sexual violence as reason for fleeing, yet fear of genital mutilation was mentioned by 10% of the women from Somalia, which was surprisingly low in comparison with the widely spread practice of female genital mutilation (FGM) in the region (Mitike and Deressa 2009). The study did not address whether FGM is a taboo topic or not considered a relevant reason for fleeing due to either social acceptance or resignation (Johnson-Agbakwu et al. 2014). According to the Jesuthasan et al. (2018), 12% of the women reported sexual contacts as minors. The authors pointed out that this might reflect a high incidence of child marriages but could also include experiences of sexual coercion. In fact, having had sexual contacts as a minor negatively correlated with self-satisfaction in the sample. According to Kessler et al. (1995), there is a negative impact of non-consensual sexual actions, especially in minors, on self-respect and self-image as described before. This could be at the root of the observations of Jesuthasan et al. (2018). Prevalence of PTSD is elevated among women and the previously married. The traumas most commonly associated with PTSD are combat exposure and witnessing among men and rape and sexual molestation among women (Kessler et al. 1995).

Additionally, according to Jesuthasan et al. (2018), refugee women experience multiple traumatic experiences before and/or during their journey, some of which are gender-specific. These experiences affect the quality of life in their current country of residence and have an impact on the integration process. Early investigations

would be able to identify rapidly women at higher risk and to improve healthcare for somatic and mental illness.

The most important aspects are summarized in the following tables:

## Cultural Competence

Working with refugee, asylum seeker, and ethnic minority patients requires cultural competence of the mental health staff, so that mental health workers should be familiar with the patient's cultural context as well as their own cultural values and prejudices (Bhugra et al. 2011). Thus, cultural competence should be a main issue in the daily work of mental health workers (Bhugra et al. 2014; Schouler-Ocak et al. 2015), because cultural competence is one of the concepts used with the ambition of grasping the need of knowledge, skills, and efforts to work with culture and context

**Table 1** Gender-specific risk factors for psychosocial distress among women refugees and asylum seekers

| Risk factor | Source |
|---|---|
| Discrimination and violence every day, simply because of their gender and risk of rape or abuse | UNHCR 2019b |
| Women are more frequently less educated; women more frequently tend to family and care duties | Breslau 2002 |
| Gender roles could strikingly differ leading to conflict and self-questioning | Stempel et al. 2016 |
| High degree of stressors and a perceived unavoidability of migration | Jesuthasan et al. 2018 |
| Fear of forced marriage and honor killings | |
| Child marriages | |
| Sexual coercion | |
| Refugee women experience multiple traumatic experiences before and/or during their journey, some of which are gender-specific | |
| Fear of sexual violence | Mitike and Deressa 2009 |
| Fear of genital mutilation | |
| Sexual contacts as minors, negatively correlated with self-satisfaction | Jesuthasan et al. 2018; Kessler et al. 1995 |
| Non-consensual sexual actions, especially in minors, negative impact on self-respect and self-image | |
| Violation of human rights and in some cases a crime against humanity | UNHCR 2003 |
| Sexual violence | |
| Emotional-psychological violence | |
| Physical violence | |
| Harmful cultural practices and socioeconomic violence | |
| Sexual- and gender-based violence may have significant consequences on sexual, reproductive, physical, and psychological health | Hynes and Lopes 2000; Tavara 2006 |

**Table 2** Women who are at risk

| Women, especially the impoverished and those living in shelters, in remote areas, or in detention centers | Wenzel et al. 2004 |
|---|---|
| Adolescent girls, particularly if they live alone or with only one parent and are of low socioeconomic status | Tavara 2006 |
| Displaced and refugee communities | Hynes and Lopes 2000; UNHCR 2003; Ward and Vann 2002 |
| People with heightened risk perception and people who were personally victimized or witnessed sexual- and gender-based violence during childhood are prone to subsequent victimization or perpetration of SGBV themselves | Browm et al. 2005 |
| Refugees, homeless, or impoverished people and young men are often victimized by strangers, persons in authority, and those assigned to their protection | Hynes and Lopes 2000 |

**Table 3** Aspects of gender- and culture-sensitive interventions for women refugees and asylum seekers

| Specific health promotion and violence prevention interventions are urgently needed to correct the unequal health conditions in refugee and asylum seeker population | Keygnaert et al. 2012 |
|---|---|
| At an individual level, behavioral change, sensitization to sexual- and gender-based violence and its risk and protective factors, and the enhancement of objective and subjective social status are of major importance | |
| At the interpersonal level, it is paramount to empower our research population to build social networks that improve social capital and enhance the exchange of transferable knowledge and skills through social learning, the creation of social support, and community resilience | |
| At the organizational level, it is crucial that healthcare and other services are made accessible to everyone, regardless of residence status | |
| At the societal level, structural changes in asylum policies to enable everyone to enjoy and fulfil their human rights are urgently required | |
| The participation of refugees and asylum seekers in all these levels is crucial | Keygnaert et al. 2012 |
| Prevention of gender- and culture-sensitive interventions should be based on culturally competent interventions, empowerment, the enhancement of structural elements | Bhuyan and Senturia 2005 |
| The adoption of comprehensive prevention approaches in which community resilience is integrated | Krieger et al. 2002 |
| Culture-specific intervention tailored to the target group reaches the target group | Schouler-Ocak et al. 2014 |
| Interventions should be gender-sensitive | |

in clinical care. Alternative concepts are cultural sensitivity, humility, and responsiveness (Bhugra et al. 2014; Schouler-Ocak et al. 2019). Additionally, mental health workers should also be aware of their own cultural biases and knowledge on the use of interpreters or culture brokers, culturally different family structures, the effects of

discrimination, exclusion, unemployment, intergenerational differences in acculturation, different explanations of illness, symptom presentations and treatment expectations, and idioms of distress (Bhugra et al. 2014). In this line, they should also be knowledgeable of training in the use of cultural mediation, culture brokers, or other models, including interpreters, working with family members or relatives. Furthermore, they should be trained in intercultural psychotherapy, including issues of transference and countertransference and somatization (Qureshi and Collazos 2011). In this line, Schouler-Ocak et al. (2019) underlined that there have to be knowledge on how the professional's own cultural background and limitations could influence working relationships with and the effectiveness of treatment they provide for refugee, asylum seeker, and ethnic minority patients. Therefore, cultural competence should be a part implemented at both the individual and clinical level as well as at the institutional level (Schouler-Ocak et al. 2015). A growing number of publications emphasized that cultural competence requires knowledge, skills, and attitudes, which can improve the effectiveness of psychiatric treatment. It is precisely for this reason that it provides a comprehensive response to the mental healthcare needs of refugee, asylum seeker, and ethnic minority patients. In this context, cultural knowledge means cognitive cultural competence, which is known as "knowledge" about the various ways in which culture, immigration status, and race influence psychosocial development, psychopathology, and therapeutic transactions (Bhugra et al. 2011), so that mental health workers should be mindful of the risks of stereotyping (Bhugra et al. 2014; Schouler-Ocak et al. 2015). Working with refugee, asylum seeker, and ethnic minority patients requires cultural skills and technical competence, which are essential in applying the knowledge in the clinical context. The main skills are the intercultural communication, the capacity to develop a therapeutic relationship with a culturally different patient, and the ability to adapt diagnosis and treatment in response to cultural differences between the psychiatrist and the patient (Schouler-Ocak et al. 2015). According to the authors, these skills explore the awareness of differences and similarities between cultures and their role in the expression and explanation of mental distress. Lie et al. (2011) reported that cultural attitudes and beliefs, which include personal prejudices, will be affected by knowledge and will impact behaviors. Therefore, intercultural work requires mental health workers to challenge their own perceptions of "reality"; to explore their own cultural identity, prejudices, and biases; and to be willing to adapt and to distinct cultural practices (Schouler-Ocak et al. 2015). Additionally, it should be emphasized that cultural competence is not an end product, a kind of technical expertise that confers on the individual a resolved accreditation which will enable them to work with patients from all cultures (Kirmayer 2012). Bhugra et al. (2011) and Qureshi et al. (2008) described cultural competence as an ongoing process of learning by training.

Recommendations to policy makers, service providers, and clinicians are offered in the WPA guidance on mental health and mental healthcare in migrants (Bhugra et al. 2011), the EPA guidance on mental healthcare of migrants (Bhugra et al. 2014), and the EPA guidance on cultural competence (Schouler-Ocak et al. 2015).

## Conclusion

According to UNHCR (2018), millions of refugees, asylum seekers, and ethnic minorities live somewhere other than their regions of origin. More than 68 million people are currently in the process of fleeing their homes, and the number of refugees, asylum seekers, and ethnic minorities will continue to rise. Therefore, worldwide, healthcare systems have to be prepared for this very heterogeneous population. In this context, it should be taken into consideration that both concepts of health and disease and expectations about treatment depend on cultural background, including their traditional values, personal experiences, and social worlds, which are in a constant state of flux (Bhugra et al. 2011, 2014; Kirmayer 2012). Discussed factors as placing a burden on the health of refugee, asylum seeker, and ethnic minority patients include social exclusion, low education, low economic status, and low ethnic density. They are associated with a higher risk of developing certain disorders (Veling et al. 2014).

The very heterogeneous group referred to here is growing dramatically, and the developed countries are likely to receive increasing numbers of them. Among this population the proportion of people with a serious mental disorder such as PTSD is high. Therefore, healthcare services should prepare themselves to serve this group of refugee, asylum seeker, and ethnic minority patients in a better way. According to Lewis-Fernandez et al. (2016), in order to achieve this, on an individual level, the Cultural Formulation Interview (CFI) can usefully be employed during a mental health assessment to obtain information about the impact of culture on key aspects of a patient's clinical presentation and care. The key aspects include also their concepts of health and disease and expectations of treatment as well as stress factors. Additionally, training could profit greatly from the inclusion of teaching on the factors influencing the clinical assessment, treatment, and cultural integration of refugee, asylum seeker, and ethnic minority patients. In this line, cultural competence training for all professional staff and the regular use of language and culture mediators could be very helpful in minimizing some of the key barriers to service access and use, as well as in reducing undertreatment and inappropriate treatment. Furthermore, in all these issues, gender-specific factors have to be taken into consideration. On the one hand, it is well-known that social support, social conflicts, social exclusion, a lack of familiarity with rights, entitlements, gaps in health literacy, and direct and indirect discrimination are risk factors for poor mental health outcomes. On the other hand, individual psychological resources, social support, successful acculturation processes, cultural variations, and time since relocation are identified as statistically significant protective factors against the development of common mental disorders among refugees, asylum seekers, ethnic minorities, men, and women (Guruge et al. 2015).

## Cross-References

► Challenges in Women's Mental Health: Care in Conflict and Post-Conflict Situations
► Culture and Women's Mental Health

► Mental Health Consequences of Sexual Assault
► Suicide and Suicidal Behavior in Women

## References

Bhugra D, Gupta S, Bhui K, Craig T, Dogra N, Ingleby JD et al (2011) WPA guidance on mental health and mental health care in migrants. World Psychiatry 10(1):2–10

Bhugra D, Gupta S, Schouler-Ocak M, Graeff-Calliess I, Deakin NA, Qureshi A, Dales J, Moussaoui D, Kastrup M, Tarricone I, Till A, Bassi M, Carta M (2014) EPA guidance mental health care of migrants. Eur Psychiatry 29(2):107–115

Bhuyan R, Senturia K (2005) Understanding domestic violence resource utilization and survivor solutions among immigrant and refugee women. Introduction to the special issue. J Interpers Violence 20(8):895–901

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 (2012) 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 Int Health Hum Rights 15:29

Bourque F, van der Ven E, Malla A (2011) A meta-analysis of the risk for psychotic disorders among first- and second-generation immigrants. Psychol Med 41(5):897–910

Breslau N (2002) Gender differences in trauma and posttraumatic stress disorder. J Gend Specif Med 5(1):34–40

Brown AL, Messman-Moore TL, Miller AG, Stasser G (2005) Sexual victimization in relation to perceptions of risk: mediation, generalization and temporal stability. Pers Soc Psycholy Bull 31(7):963–976

Close C, Kouvonen A, Bosqui T, Patel K, O'Reilly D, Donnelly M (2016) The mental health and wellbeing of first generation migrants: a systematic-narrative review of reviews. Glob Health 12:47

Dapunt J, Kluge U, Heinz A (2017) Risk of psychosis in refugees: a literature review. Transl Psychiatry 7:e1149

De J, Van Ommeren M (2005) Mental health services in a multicultural society: interculturalization and its quality surveillance. Transcult Psychiatry 42(3):437–456

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

Fenta H, Hyman I, Noh S (2007) Health service utilization by Ethiopian immigrants and refugees in Toronto. J Immigr Minor Health 9(4):349–357

Freedman J (2016) Sexual and gender-based violence against refugee women: a hidden aspect of the refugee "crisis". Reprod Health Matters 24(47):18–26

Giacco D, Laxhman N, Priebe S (2018) Prevalence of and risk factors for mental disorders in refugees. Semin Cell Dev Biol 77:144–152

Guruge S, Thomson MS, George U, Chaze F (2015) Social support, social conflict, and immigrant women's mental health in a Canadian context: a scoping review. J Psychiatr Ment Health Nurs 22(9):655–667

Heeren M, Wittmann L, Ehlert U, Schnyder U, Maier T, Müller J (2014) Psychopathology and resident status – comparing asylum seekers, refugees, illegal migrants, labor migrants, and residents. Compr Psychiatry 55(4):818–825

Hynes M, Lopes CB (2000) Sexual violence against refugee women. J Wom Health Gend Based Med 9(8):819–823

Jesuthasan J, Sönmez E, Abels I, Kurmeyer C, Gutermann J, Kimbel R, Krüger A, Niklewski G, Richter K, Stangier U, Wollny A, Zier U, Oertelt-Prigione S, Schouler-Ocak M (2018) Near-death experiences, attacks by family members, and absence of health care in their home

countries affect the quality of life of refugee women in Germany: a multi-region, cross-sectional, gender-sensitive study. BMC Med 16(1):15
Johnson-Agbakwu CE, Helm T, Killawi A, Padela AI (2014) Perceptions of obstetrical interventions and female genital cutting: insights of men in a Somali refugee community. Ethn Health 19(4):440–457
Karl-Trummer U, Novak-Zezula S, Metzler B (2010) Access to health care for undocumented migrants in the EU: a first landscape of now hereland. Eur Secur 16:13–16
Kessler RC, Sonnega A, Bromet E, Hughes M, Nelson CB (1995) Posttraumatic stress disorder in the national comorbidity survey. Arch Gen Psychiatry 52(12):1048–1060
Keygnaert I, Vettenburg N, Temmerman M (2012) Hidden violence is silent rape: sexual and gender-based violence in refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. Cult Health Sex 14(5):505–520
Kirmayer LJ (2012) Rethinking cultural competence. Transcult Psychiatry 49(2):149–164
Kluge U, Bogic M, Devillé W, Greacen T, Dauvrin M, Dias S, Gaddini A et al (2012) Health services and the treatment of immigrants: data on service use, interpreting services and immigrant staff members in services across Europe. Eur Psychiatry 27(Suppl 2):S56–S62
Krieger J, Allen C, Cheadle A, Ciske S, Schier JK, Senturia K, Sullivan M (2002) Using community-based participatory research to address social determinants of health: lessons learned from Seattle Partners for Healthy Communities. Health Educ Behav 29(3):361–382
Küey L (2015) Trauma and migration: the role of stigma. In: Schouler-Ocak M (ed) Trauma and migration. Switzerland: Springer, pp 57–69
Laban CJ et al (2004) Impact of a long asylum procedure on the prevalence of psychiatric disorders in Iraqi asylum seekers in the Netherlands. J Nerv Ment Dis 192(12):843–851
Laban CJ, et al. The impact of a long asylum procedure on quality of life, disability and physical health in Iraqi asylum seekers in the Netherlands. Social psychiatry and psychiatric epidemiology 2008;43(7):507–515.
Lai DWL, Surood S (2010) Types and factor structure of barriers to utilization of health services among aging south Asians in Calgary, Canada. Can J Aging 29:249–258
Lewis-Fernández R, Aggarwal NK, Kirmayer LJ (2016) Introduction (xxvii-xxiv). In: Lewis-Fernandez R, Aggarwal N, Hinton L, Hinton D, Kirmayer LJ (eds) DSM-5 handbook on the cultural formulation interview. American Psychiatric Publishing, Washington, DC, pp 173–181
Lie DA, Lee-Rey E, Gomez A, Bereknyei S, Braddock CH 3rd (2011) Does cultural competency training of health professionals improve patient outcomes? A systematic review and proposed algorithm for future research. J Gen Intern Med 26(3):317–325
Lindert J et al (2009) Depression and anxiety in labour migrants and refugees. Soc Sci Med 69:246–257
Lund C, Brooke-Sumner C, Baingana F, Baron EC, Breuer E, Chandra P, Haushofer J, Herrman H, Jordans M, Kieling C, Medina-Mora ME, Morgan E, Omigbodun O, Tol W, Patel V, Saxena S (2018) Social determinants of mental disorders and the sustainable development goals: a systematic review of reviews. Lancet Psychiatry 5:357–369
Miller K, Rasmussen A (2010) War exposure, daily stressors, and mental health in conflict and post-conflict settings: bridging the divide between trauma-focused and psychosocial frameworks. Soc Sci Med 70:7–16
Miller K, Kulkarni M, Kushner H (2006) Beyond trauma-focused psychiatric epidemiology: bridging research and practice with war-affected populations. Am J Orthopsychiatry 76:409–422
Mitike G, Deressa W (2009) Prevalence and associated factors of female genital mutilation among Somali refugees in eastern Ethiopia: a cross-sectional study. BMC Public Health 9:264
Mladovsky P, Ingleby D, McKee M, Rechel B (2012) Responding to diversity: an exploratory study of migrant health policies in Europe. Health Policy 105:1–9
Nosè M, Ballette F, Bighelli I, Turrini G, Purgato M, Tol W, Priebe S, Barbui C (2017) Psychosocial interventions for post-traumatic stress disorder in refugees and asylum seekers resettled in high-income countries: systematic review and meta-analysis. PLoS One 12(2):e0171030
Pace P (2011) The right to health of migrants in Europe. In: Rechel B, Mladovsky P, Devillé W, Rijks B, Petrova-Benedict R, McKee M (eds) Migration and health in the European Union. Open University Press, Maidenhead, pp 55–66

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):606–612
Priebe S, Giacco D, El-Nagib R. Public Health Aspects of Mental Health Among Migrants and Refugees: A Review of the Evidence on Mental Health Care for Refugees, Asylum Seekers and Irregular Migrants in the WHO European Region [Internet]. Copenhagen: WHO Regional Office for Europe; 2016.
Qureshi A, Collazos F (2011) The intercultural and interracial therapeutic relationship: challenges and recommendations. Int Rev Psychiatry 23(1):10–19
Rechel B, Mladovsky P, Devillé W (2012) Monitoring migrant health in Europe: a narrative review of data collection practices. Health Policy 105:10–16
Rechel IB, Mladovsky P, Ingleby D, Mackenbach JP, McKee M (2013) Migration and health in an increasingly diverse Europe. Lancet 381:1235–1245
Schouler-Ocak M (2015) Psychiatrische Versorgung von Menschen mit Migrationshintergrund in Deutschland. Nervenarzt 86:1320–1325
Schouler-Ocak M, Heredia Montesinos A, Aichberger MC (2014) Suicide prevention for women with a Turkish migrant background. Ärztl Psychother Psychosom Med 9(2):68–73
Schouler-Ocak M, Graef-Calliess IT, Tarricone I, Qureshi A, Kastrup M, Bhugra D (2015) EPA guidance on cultural competence training. Eur Psychiatry 30(3):431–440
Schouler-Ocak M, Laban CJ, Bäärnhielm S, Kastrup MC, Dein S, Wintrob R (2019) WPA-TPS – Refugee, asylum seeker and immigrant patients over the globe. In: Fountoulakis KN, Javed A (eds) Advances in Psychiatry, Springer International Publishing AG, part of Springer Nature, pp 637–655
Stempel C, Sami N, Koga PM, Alemi Q, Smith V, Shirazi A (2016) Gendered sources of distress and resilience among Afghan refugees in Northern California: a cross-sectional study. Int J Environ Res Public Health 14(1):25
Stewart M, Shizha E, Makwarimba E et al (2011) Challenges and barriers to services for immigrant seniors in Canada: 'you are among others but you feel alone'. Int J Migr Health Soc Care 7:16–32
Tavara L (2006) Sexual violence. Best Pract Res Clin Obstet Gynaecol 20(3):395–408
Turrini G, Purgato M, Ballette F, Nosè M, Ostuzzi G, Barbui C (2017) Common mental disorders in asylum seekers and refugees: umbrella review of prevalence and intervention studies. Int J Ment Heal Syst 11:51
UNCHR (2015) Global trends 2014. http://www.unhcr.de/service/zahlen-und-statistiken.html. Downloaded 01 July 2015
UNESCO (2019). http://www.unesco.org/new/en/social-and-human-sciences/themes/international-migration/glossary/asylum-seeker/. 23 Mar 2019
UNHCR (2003) Sexual and gender-based violence against refugees, returnees and internally displaced persons: guidelines for prevention and response. UNHCR, New York
UNHCR (2018). http://www.unhcr.org/figures-at-a-glance; June 2018. 23 Mar 2019
UNHCR (2019a). https://www.unrefugees.org/refugee-facts/what-is-a-refugee/. 23 Mar 2019
UNHCR (2019b). http://www.unhcr.org/women.html. 23 Mar 2019
Veling W, Susser E, Selten JP, Hoek HW (2014) Social disorganization of neighborhoods and incidence of psychotic disorders: a 7-year first-contact incidence study. Psychol Med 17:1–10
Ward J, Vann B (2002) Gender-based violence in refugee settings. Lancet 360(Suppl):13–14
Wenzel SL, Tucker JS, Elliott MN, Marshall GN, Williamson SL (2004) Physical violence against impoverished women: a longitudinal analysis of risk and protective factors. Womens Health Issues 14(5):144–154
Winkler J, Brandl EJ, Bretz J, Heinz A, Schouler-Ocak M (2018). Psychische Symptombelastung bei Asylsuchenden in Abhängigkeit vom Aufenthaltsstatus. Psychiatr Prax. 2018 Dec 12. https://doi.org/10.1055/a-0806-3568