Refugees’ mental health—a call for a public health approach with focus on resilience and cultural sensitivity

Sweden, as the rest of Europe, faces the humanitarian responsibility of welcoming and providing a safe space for refugees from war zones and conflict areas. This is an urgent task with the current humanitarian catastrophe in Syria, which has caused the largest refugee crisis since World War II. It is estimated that around 470,000 persons in Syria has been killed since the start of the war, 11.2% of the Syrian population is killed or badly injured, and 50% of the population on flight. Lindert and colleagues point out that the current situation requires a timely and effective response in particularly within the mental health domain. They emphasize that many refugees, asylum seekers and internally displaced are vulnerable and at risk of mental health problems. They discuss possible individual and social interventions, and argue for an expansive intervention approach that includes both contextual factors and, whenever needed, trauma-focused interventions.

I agree with Lindert and colleagues that we need to overcome the dichotomy between individual and social interventions and the importance of better knowledge on how to treat and manage persons who suffer from posttraumatic stress. To this I want to add the importance of seeing the strengths and resilience of most refugees and their potential of contributing to the social and economic development of the society in which they settle. Resilience refers to the ability to cope and manage stress and trauma.

Including resilience-oriented perspective implies strengthening individual as well collective and societal resources for promoting mental health, and translating knowledge about mental health promotion for refugees into social and political action, which basically is a public health approach. There are several points on which there is good evidence: (i) Detention and temporary protection, like temporary permits, appear to be detrimental for the long-term mental health of refugees; (ii) Families that are not reunified may be of greater risk of prolonged mental disorder; (iii) A long asylum seeking process has a negative impact on mental health; (iv) A majority of those who develop acute stress reactions or Posttraumatic stress disorder (PTSD) will improve when they feel they are in safe conditions, although for some persons symptoms may remain for a long time. Thus, from a public health perspective, to promote a safe and smooth reception system, short asylum processes, reunification of families, and permanent residencies instead of temporary permits should lead to better mental health.

The profound effects on mental health and psychosocial wellbeing among Syrian refugees is documented in a comprehensive report commissioned by UNHCR. For the Syrians the experiences of conflict-related violence are added to the daily severe stressors of displacement, including poverty, lack of basic needs and services, and uncertainty about the future. The report shows that psychological distress is manifested in a wide range of emotional, cognitive, physical, behavioural and social problems. A wide range of mental disorders is documented: depression, prolonged grief disorders, post-traumatic stress disorder, anxiety disorders and also a certain increase of severe mental disorders (psychosis, severe depression and anxiety disorders). Yet, normal psychological stress reactions are the most common.

In ordinary health services, clinicians need to be able to differentiate between normal stress reactions and mental disorders. In situations of cross-cultural assessments clinicians may find this more difficult, since there are cultural differences in expressing symptoms, explanatory models, expectations of help and coping strategies. The UNHCR report argues for the importance of contextualizing appropriate services for mental health and psychological support. This includes a clinical interest for patients’ way of expressing distress, their idioms of distress, and their explanatory models of illness. A useful tool in the evaluation of cultural and contextual factors is the Cultural Formulation Interview (CFI) which is included in the diagnostic manual DSM-5.

With a sets of 16 questions the CFI facilitate understanding of the individual patients’ cultural context, cultural idioms of distress, explanatory models, coping strategies, identity and also vulnerability and resilience.

To strengthen resilience among asylum seekers and refugees with mental distress there are novel approaches such as ‘resilience-oriented treatment of traumatized asylum seekers and refugees’ (ROT). The ROT model brings together the concepts of vulnerability and stress with two aspects of resilience, personal strengths and social support. Adaption of services can be complemented by conveying knowledge to refugees about how the health care system of the new host society works and by strengthening their understanding of health promoting strategies. One example is a model using ‘health communicators’ that has been implemented in some parts of Sweden. The health communicators meet groups of newly arrived refugees in the communities. They maintain an interactive communication in the language of the refugees, informing, about general health and mental health promoting strategies and about the Swedish health care system. They discuss on topics such as migration experiences, stress reactions, trauma and what types of support and help are available.

References


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To respond to the mental health needs of refugees is an urgent social and humanitarian priority. For Europe the current refugee crisis imply the challenge of promoting effective mental health strategies including cultural sensitive mental health services responding to the psychological needs of the refugees. The response needs a public health approach, and there is already plenty of knowledge on what can and should be done.

References


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