

Refugee Mental Health - A Review of Literature on Treatment, Practices and Recommendations

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Abstract

The paper provides a review of mental health treatment and practices targeting refugee populations in Western countries. The review finds there are two overarching disparities between what Western treatment models can provide, and what many refugee populations need: firstly, limited cultural acknowledgment and understanding among practitioners of non-Western populations, belief systems and healing methods; and secondly, a tendency among Western treatment models to prioritize past trauma over the current stressors that many refugee populations face. Cases that shed light on these disparities are examined, followed by expert recommendations and an examination of alternative treatment methods offered by practitioners.

Keywords: Refugee mental health; cultural competence; post-migration trauma; patient-practitioner relationship

Introduction

The growth of refugee movements and internally displaced populations worldwide means that community mental health workers must adapt their practices towards an increasingly diverse and multiethnic refugee population. Refugees arriving from various conflict-affected regions bring with them an array of experiences, memories, values, opinions, and priorities that vary across populations and individuals. In order for mental health practitioners to meet the needs of these groups, practitioners must possess the skills to understand the unique epistemological influences that guide individual behaviour and needs. This review seeks to shed light on the disparities that often exist between the mental health needs of refugee populations, and the treatment methods

used on these populations. It is hoped that the review provides insight as to how mental health practitioners can alter their practice to more adequately meet the mental health needs of refugees.

The paper provides a breakdown of expert observations and recommendations regarding refugee mental health treatment models and interventions over the last several decades, predominantly examining refugee populations or ethnic minority populations that have resettled in or are living in Western countries. The findings of the review will undoubtedly be of value to mental health practitioners who seek to gain an all-encompassing understanding of refugee populations, and meet their needs in culturally appropriate and accepted ways.

The paper will analyze various studies of refugee populations around the world to highlight two overarching ethical issues highlighted by experts regarding refugee challenges and mental health. Alongside this analysis, expert recommendations and critiques with regard to treatment methods will be examined. Following this, four distinct case studies where these recommendations have been implemented will be looked at, followed by further recommendations and conclusions.

Expert Findings and Perceptions on Refugee Challenges and Mental Health Practice

Refugee populations from conflict zones face a myriad of challenges before, during and after migration to a new country or region. Pre-migration experiences commonly noted by scholars include torture, death of family members, exposure to combat, survivor's guilt, arbitrary imprisonment and intimidation, forced relocation, and persecution based on ethnicity, gender and religion, among others (Nicholson, 1997). Post-migration, challenges include acculturation to a new country or region, learning a new language, finding employment and housing, accessing health services, rebuilding social networks and status, and the long-term effects of past traumatic experiences (Nicholson, 1997). While scholarship on the issue of refugee trauma (to be explored in detail below) points out numerous issues and recommendations for tackling refugee mental health and trauma, two overarching, related themes appear most prominent:

1. There is a lack of cultural competence and understanding between Western mental health frameworks and attitudes, and the non-Western refugee populations they usually serve.
2. The post-migration process has been found to be a better indicator of long-term mental health than pre-migration trauma; to improve long-term refugee mental health, treatment models may need to prioritize the post-migration process and the current stressors that refugees face.

1. The Cultural Gap

i) Medicalization of recovery and refugee resilience

The cultural mismatch between dominant Western treatment models and the refugees they are often applied to has been highlighted by a number of scholars. Derek Summerfield, a lecturer at the Institute of Psychiatry at King's College London, has been one of the foremost critics of the lack of cultural competence among health care professionals, and what he refers to as "the medicalization of recovery" (Summerfield, 2002, pg. 1105). Summerfield argues that Western mental health frameworks cannot be blindly and universally applied to refugee populations, and criticizes the assumption that refugees always need to confront and "work through" their experiences. For instance, while some refugees may be unwilling to discuss their pre-migration victimization, they may not necessarily be struggling with these experiences, and may in fact be coping well and progressing with their respective goals and ambitions. Summerfield criticizes the idea that since they are not discussing their experiences, their issues must be "under the surface," and that confronting them is the only way to true recovery (Summerfield, 1999). He states that this attitude exemplifies an inadequate understanding and appreciation of refugee populations' cultural influences and coping mechanisms, as well as an individual's resilience and ability to adapt. This medicalization of recovery also takes away agency from the individual, as it removes the issue from the individual's ownership and places it into a medical context where only medical professionals are qualified to discuss it (Summerfield, 1999). Summerfield goes on to say that grief does not always constitute a mental disorder, and that anger, resentment and wishes for revenge are normal, and are not necessarily grounds for psychological treatment. Instead of evaluating which groups are most at risk of mental health disorders, mental health professionals must consider the refugee's interpretation of themselves. He cites a 1995 survey of Rwandan adults as an example. The survey was taken by Rwandans who had witnessed or survived massacres during the Rwandan genocide, and lost family members. According to Summerfield, while many met measurements of PTSD such as poor sleep, poor concentration and sadness, many of them also answered positively to their outlook on their futures, and their ability to protect their families and themselves. Summerfield argues that this demonstrates the resilience of some traumatized individuals, and that their grief should not be blindly seen as a call for intervention.

Summerfield demonstrates how this mismatch of cultures can influence the success or failure of

psychiatric treatment in his 2003 treatment of a Bosnian refugee in London. Summerfield describes the story of Samir, a 45-year-old Bosnian refugee who attended treatment sessions with Summerfield over a three-year period. Summerfield describes that psychiatric medications did not have any impact on Samir's depression and sleep difficulties over the course of the treatment period (Summerfield, 2003). Summerfield states that medications did not work because Samir's worries were based in his outrage that he could have everything he had worked for and built taken from him, without anyone being held accountable for this injustice. Summerfield argues that psychiatric treatment could not possibly have worked on Samir, because in his mind, his issues were not psychiatric, but moral. Summerfield further states that psychiatric treatment is by design "politically and morally neutral," and since Samir's mental state was tied to the situation in Bosnia and the concepts of justice and morality, psychiatric treatment was not equipped to address it (Summerfield, 2003, pg. 267).

Summerfield's sessions with Samir highlight the importance of understanding the cultural aspects of trauma in mental health interventions; without understanding and appreciating the context of the war in Bosnia and its impact on victims, no extent of treatment could have helped Samir, because the root cause of his distress was the injustice he suffered. Summerfield contends that "psychiatry acknowledges that patients have social concerns but generally views them as secondary, and which the patient best addresses once his mental disorder has been treated" (Summerfield, 2003, pg. 267). In this case, the social concern itself was the cause of distress, and therefore had to be confronted first in order to treat Samir.

Other scholars have also debated the appropriateness of applying Western models of treatment on non-Western populations. In a study of 20 Sudanese refugees, immigrants and health care providers in Australia, Savic et. al. (2016) point to the effects of medicalizing recovery in non-Western populations. While many of the participants in this study had been exposed to violence in their home country, some did not consider themselves to have suffered trauma that would necessitate medical treatment. The term "depression" was unfamiliar to most participants, since there was no equivalent term in their native language, with one participant describing it as a "white man's sickness" (Savic et. al., 2016, pg. 79). To them, their "depression" was simply seen as sadness, a normal part of life that did not require seeing "a special person" for treatment (pg. 79). Some participants also stated that they had become conditioned to trauma due to generations of conflict in Sudan, and did not see the need to address their experiences at all, seeing it as ordinary.

This attitude highlights the use of what Summerfield describes as “PTSD checklists” (Summerfield, 1999, pg. 1452). Summerfield contends that “checking off” PTSD symptoms in refugee populations may lead to false diagnoses because, as the cases above show, symptoms alone cannot be viewed as being indicative of a mental disorder. Cultural nuances influence how individuals appraise their feelings and beliefs, and these appraisals need to be taken into account by practitioners; Western labels for suffering may not always be appropriate.

Savic’s case and Summerfield’s insights also demonstrate that refugees should not be seen as helpless victims in need of rescue. Kira and Tummala-Narra (2015) point out that the fact that refugees have survived and fought through the displacement and relocation process is, in itself, an indicator of their resilience. The wealth of experience and resilience that refugees bring with them must be appreciated and understood by health care providers for effective treatment.

Marshall et. al. (2016) also highlight this resilience in their 2016 review of mental health practices. The authors cite a study by Angela Nickerson and colleagues on refugee PTSD and prolonged grief disorder (PGD). In this study, clinicians assessed 248 Mandaean refugees in Australia, and categorized them into four groups: a predominantly PTSD class, a predominantly PGD class, a class combining both PTSD and PGD, and a Resilient class. Results showed that 43% of participants fit the Resilient category, able to recover from their experiences on their own accord while not suffering from symptoms of either PTSD or PGD. Marshall et. al. cite further studies to argue that refugees, especially youth, possess resilience and adaptability to relocation, and that this adaptability must be harnessed to address refugee mental health. Imposing Western treatment models and definitions on refugee populations and not recognizing the refugees’ agency, according to the authors, can cause more harm than good. Instead, Marshall et. al. cite numerous scholars to suggest that clinicians use approaches that highlight the individual’s strengths, leadership skills and resilience, as well as cultural and community leadership, gender dynamics, the family unit, and work to establish trust between practitioners and clients.

ii) The nature of trauma

A theme that relates closely with the medicalization of suffering is the victim’s own perception of their trauma. In Summerfield’s earlier study, Samir’s perception of his victimization during the conflict in the former Yugoslavia as a moral injustice demonstrates that the nature of traumatic experiences varies between individuals. While Samir’s greatest concern was accountability and justice, not

everyone in his position would necessarily feel the same way, highlighting that an individual's self-perception is a crucial component of determining how to address his or her mental health.

The nuances of this fact are demonstrated by Martin et. al. (2013). In a study of 468 American college students, Martin et. al. argue that "the way in which trauma survivors assess their thoughts, feelings, and behaviours in response to trauma exposure is directly related to trauma-relevant symptomatology" (pg. 9). Martin points out that trauma is multidimensional, and that single-focus trauma models may be inadequate in addressing victims of cumulative or multiple forms of trauma. In analyzing surveys given to the study participants, the authors classify traumas into High, Medium and Low Betrayal Traumas. They found that trauma suffered at the hands of a friend, relative or otherwise trusted individual is more damaging than trauma suffered at the hands of strangers, and that increased levels of betrayal experienced correlated to increased symptoms of depression and dissociation. The key finding of the study, however, was that rather than level of betrayal or the type of trauma suffered, it was the manner in which victims of trauma perceived and appraised their own suffering that most accurately predicted mental health. These findings are indicative of the importance of considering refugee populations' appraisals of the trauma they have suffered; feelings of betrayal and trust, like Samir's moral outrage, have different meaning, significance and relevance from individual to individual. In order to address the variance in perceptions of trauma, socio-political and cultural context must be understood.

iii) The collective versus the individual

The fundamental role that cultural and community leadership plays in some societies raises another point of contention regarding the suitability of current Western treatment models toward non-Western refugee populations. Gozdzik (2004) argues that the primary subject of focus in Western mental health treatment models is predominantly the individual, which is often at odds with many cultures where family, religion and community play central roles in healing. She argues that Western treatment models often fail to take these influences into consideration, viewing mental health scientifically instead of socially. George (2012) also supports this view, arguing that cultural awareness is hindered by the tendency to see refugee clients as "singular and unitary," without considering the social, cultural, class and racial factors that influence their perspectives and values (George, 2012, pg. 433). In order to improve the efficacy and appropriateness of refugee mental health treatment, Gozdzik recommends using ethnography as a means to view refugee suffering as

a cultural challenge rather than a medical or psychiatric issue, to “learn from people [...] rather than study them” (Gozdziak, 2004, pg. 207).

The participants in Savic et. al.’s (2016) study point to the substantial relevance that community plays in Sudanese diaspora populations. Aside from questioning the relevance of Western notions of mental health to their community, many study participants reported that a community member’s mental health and wellbeing was not solely the responsibility of the individual, but of the community as a whole. Participants were open to the idea of psychological counselling, but were not receptive of the “Western mode” of it, believing that their community approach was more beneficial to them (Savic et. al., 2016, pg. 79). One participant described a community approach to addressing emotional challenges: members of the Sudanese community would consistently look for signs of distress (i.e. alcoholism, violence, family crises) among their members. If warning signs were noticed in an individual, members of the community would work together to observe this individual and check on them indirectly through consistent contact, in order to gather information. Subsequently, members would meet and delegate community members to offer assistance, based on relevant expertise and if needed, gender, age, etc. This community healing method is indicative of the need for mental health treatment models to be tailored to specific refugee populations, and the unique epistemologies that accompany them.

Another notable theme under the community banner is religion. Ellis et. al. (2010) point out that religious leaders are an important tool of guidance for religiously devout individuals. Individuals who identify religion as an important aspect of their identity may naturally seek guidance from religious leaders in confronting various issues they encounter, including mental health, which will in turn lead to religious solutions. Kira and Tummala-Narra (2015) stress that family support is an important source of resiliency for refugees as they often come from traditional family settings, and agree that religious leaders wield significant influence in refugee communities. Consequently, these leaders play important roles in community healing and mediating conflicts. However, while religion can clearly help refugees come to terms with traumatic experiences, Gozdzia (2004) states that the prominence of individualization in Western treatment models means that religiously motivated behavioural differences are often seen as undesirable. Instead of rejecting an individual’s religious and spiritual beliefs, or their unique methods of adapting to trauma, mental health practitioners need to incorporate these facts into their treatment approaches. Community dynamics, religion and refugees’ unique beliefs and values need to be viewed as viable pathways to healing.

iv) Stigma

Stigma has been noted by a number of scholars as a barrier to refugees' willingness to seek help with their mental health issues. Perceptions and misunderstandings of mental health within a community can often dissuade an individual from seeking the help they require, even if the result is worsening health. Several of the Sudanese refugees studied by Savic et. al. (2016) stated that they would be unwilling to seek professional assistance, due to fears of being judged as "crazy" or suffering a "madness" (pg. 79). Aside from these considerations, having mental health issues and being in need of professional help was associated with low social status, which in turn would lead to their community questioning their stability, usefulness, ability to contribute to society, suitability for marriage, and opinion. Furthermore, these doubts would spread quickly throughout the Sudanese community, further throwing into question their ability to be accepted by their peers.

A study of 111 Bhutanese, Somali, Burmese and Ethiopian refugees in the United States by Shannon et. al. (2015) also supports these misconceptions. Some of the Somali and Ethiopian participants of this study reported that there was a fear of being labeled as "crazy" and consequently becoming isolated or shunned from their respective communities. Ethiopian participants stated that this fear often led individuals to hide their symptoms from doctors as well, labeling them as sleep issues or headaches. The nature of stigma is also complex; Bhutanese interviewees reported that individuals seen as "crazy" were viewed with sympathy rather than disapproval, but that it was nevertheless a taboo subject to discuss mental health publicly due to ramifications within the community. Ethiopian participants reported that troubled individuals often became isolated because the community did not want to add to their burden with further issues, or self-isolated as to not burden the community with their struggles. It was also voiced by one Ethiopian participant that since those struggling were seen as unhealthy, it was believed that giving them advice or information would simply not work, because they would not have the capacity to understand it.

Somali participants also voiced concerns that they could lose housing or jobs if the community found out about their challenges, while some felt that talking would simply not help. According to participants, shame and stigma were particularly prevalent around victims of sexual assault, as it was feared by victims that they would be blamed for their own victimization. The authors suggest that health care providers who inquire about cultural norms for communicating with victims of sexual assault may be more successful in connecting with these individuals.

It is undeniable that cultural stigma is a significant barrier in refugees' willingness to seek

assistance from mental health workers. The fear of community repercussions expressed by the participants in these studies demonstrates that mental health practitioners must understand the cultural perceptions that influence these beliefs. Marshall et. al. (2016), in reference to female refugees victimized by sexual violence, suggest that “identify[ing] refugee girls’ and women’s needs in the context of their existing abilities and strengths” is necessary to give these women a sense of self-worth and agency (pg. 310). The authors reference Rousseau et. al. (2004), who suggest that “embedding mental health services in other acceptable forms of support,” such as making youth services available at schools, will be more positively received by some refugee communities (Marshall et. al., 2016, pg. 312); this would put mental health treatment under the banner of “education” rather than a mental health organization. It is also suggested that community cultural organizations can incorporate mental health awareness and discourse in their activities, and that community leaders can spread awareness about the importance of addressing mental health challenges through culturally accepted channels.

v) Building rapport between worker and client

While not falling strictly under the theme of cultural competence, several scholars have noted the importance of establishing trust between clinicians and refugee clients, and have highlighted the socio-cultural influences that may hinder this process. Shannon et. al. (2015) state that refugees who have suffered from years of political repression, and have survived by staying silent and obedient may not feel comfortable speaking, as they are accustomed to feelings of helplessness and suspicion. With regard to victims of ethnic persecution, the authors state that acknowledging these individuals’ struggles and recognizing and accepting their ethnic self-identities is an important step towards their empowerment. They further state that refugees who have family in their country of origin may be unwilling to trust health workers and interpreters for fear that spies in the community may inform authorities there, thereby putting their families in danger. This fear can be confronted by building trust between refugees and interpreters, by maintaining consistent interpreters over time and demonstrating to refugees that confidentiality is not simply stated, but will truly be ensured (Shannon et. al., 2015). This establishment of trust will in turn allow refugee clients to discuss their challenges without fear.

Summerfield (2003) also alludes to the establishment of trust in his intervention with Samir, discussed above: despite the seeming ineffectiveness of psychiatric treatment that Summerfield

describes, Samir nevertheless continued to attend treatment sessions with Summerfield for a three-year period. Summerfield attributes this to the fact that he was able to build rapport with Samir, and connect with him on a personal level by discussing and exchanging opinions on the political situation in Bosnia. He established a relationship with Samir which undoubtedly gave Samir a sense of comfort and solidarity, demonstrated by their continued communication.

These studies indicate that establishing trust between clinicians and clients can go a long way in giving refugees the peace of mind to discuss their concerns, as well as the belief that their concerns are being understood and appreciated. George (2012) states that clinicians need also be aware of the power dynamic between themselves and the refugee clients they interact with. She elaborates that clinicians may consciously or subconsciously use information, expertise, “perception of expertise” or their legitimacy as service providers to exert power over refugee clients (pg. 433). As Marshall et. al. (2016) highlight, refugees who have been persecuted by the very authority figures who they had once depended on for protection, may be very mistrustful of authority figures, including mental health workers. Marshall et. al. emphasize that refugees have an inherent need to feel safe, and that community input and support from other refugee families is needed to build trust between clients and clinicians. George (2012) suggests that clinicians use “intervention negotiation” to build trust and dialogue with refugee clients instead of using persuasion or pressure (pg. 433). George states this will empower refugee clients and allow clinicians to become more culturally competent. George also suggests that group intervention models and cultural rituals can be used to build rapport between clients and clinicians, and to show refugees that they are not alone by connecting them with individuals of shared cultural context and experience. Marshall et. al. (2016) stress that mental health workers need to prioritize building this therapeutic relationship with clients, and need to empathize and express hope for the client’s progress and recovery.

2. Primacy of Post-Migration Stressors

A second theme that has emerged prominently in scholarly literature is the significance that many refugee populations place on their post-migration experiences, ahead of their experiences before migration. Savic et. al. (2016) state that traditional mental health treatment models tend to focus on pre-migration experiences, perpetuating the perspective that refugees suffer from pre-migration trauma that must be treated in order for them to succeed after resettlement. Savic and colleagues, however, reference Derek Summerfield to argue that healing is more a “social process than a

biomedical one”, and highlight that many of the participants in their study did not see addressing their past experiences as important as addressing their post-migration stressors (pg. 77). One of the twenty Sudanese participants in his study, a community health worker, reported that the extent to which past traumas affected refugees post-migration was conditional upon the refugees’ resilience, and ability to rebuild their social networks and community.

The prominence of the post-migration experience has been noted by other scholars as well. In a study of 12 Yugoslav mixed-marriage refugees living in Australia, Keel and Drew (2004) demonstrate that the refugees’ sense of community and fitting in with Australian society surpassed any need to discuss their pre-migration experiences. Being in a mixed marriage made many of the participants in this study unwelcome in all parts of the former Yugoslavia, due to the war separating the population along ethnic lines. Consequently, Keel and Drew argue that the participants were forced to build strong social networks in Australia. They state that the participants’ search for social integration is indicative of the self-esteem and support offered by community and social networks. Participants voiced concerns over financial security and disappointment that their children were losing their ethnic identities, further demonstrating that the refugees’ stressors and concerns were overwhelmingly rooted in the present, and were future-focused. Keel and Drew suggest that future research in this area should explore barriers to networking.

A study by Shedlin et. al. (2014) examining 75 Colombian refugees and key informants living in Ecuador supports the notion that post-migration stressors are more effective indicators of mental health than pre-migration trauma. Although participants in this study reported suffering violence, threats and forced recruitment into paramilitary groups in Colombia, the study shows that social isolation, financial instability, and housing insecurity in Ecuador contributed substantially to the prolongation of stress among participants. Participants reported facing discrimination from Ecuadorians, who perpetuated stereotypes of Colombians as being gang members, guerrillas, and generally violent. This was found to inhibit refugees from accessing food, housing, education and employment, thereby increasing their isolation and prolonging suffering long after they had left Colombia. Many participants turned to alcohol and drugs as a means to cope with their difficulties. Shedlin et. al. (2014) state that more research is needed on the “geopolitical, historical and cultural factors that influence health and well-being,” and stress that structural violence targeting refugees must be understood in order to create effective intervention strategies (pg. 123).

Beiser and Hou (2016), in reference to Canada’s refugee system, report that governments often

take in victims of persecution with little thought of what happens to them afterwards, and that refugee trauma can continue to grow post-migration unless addressed. In their study of refugee youth in Canada, Beiser and Hou found that post-migration stressors were significant indicators of youth emotional problems and aggressive behaviour; specifically, they highlight that feeling welcome in school was a powerful indicator of whether youth displayed aggressive behaviour. This undoubtedly demonstrates that the post-migration resettlement process should be considered as equally important as pre-migration trauma when addressing refugee mental health.

These findings are also corroborated by other scholars. In a meta-analysis of 22 studies, seven of which were designed in collaboration with the refugee populations they targeted, Murray, Davidson and Schweitzer (2010) state that the success of mental health intervention programs was most likely dependent upon “the extent to which those interventions relate[d] directly to the educational, socioeconomic, and sociopolitical stresses” that the refugee populations in question faced (pg. 582). The authors indicate that these interventions must also be able to address “lingering symptoms of traumatic stress,” but make it very clear that the priority must be placed on post-migration stressors (pg. 582). It is recommended that mental health workers promote personal growth rather than focus exclusively on past traumas. In order to achieve this, Murray, Davidson and Schweitzer recommend that clinicians engage not only with the individual, but with the individual’s family and community, and acknowledge “community leaders and indigenous wisdom, help build community capacity, ensure cultural salience and significance, and work to minimize power differentials between health professionals and local healing and support systems” (pg. 582). According to the authors, taking these steps and listening to refugees’ testimonies of their experiences can assist in the healing process, and increase the utilization of psychological services by refugees.

The present-focus treatment model is also supported by Nicholson (1997). Nicholson presents a study of 447 refugees living in the United States, split evenly among Cambodian, Vietnamese, Laotian, and Hmong ethnic backgrounds. All participants were above the age of 35, and split evenly among working vs. non-working. Nicholson screened for three factors: PTSD, depression and anxiety. The study found that while the exposure-level to pre-migration trauma did impact the three measures and how refugees dealt with current stress, current stressors were the most significant overall indicators of mental health outcome. Among the most significant indicators of mental health, Nicholson identifies one pre-migration factor (“traumatic events experienced”), and two post-migration factors (“perception of own health” and “income”). Nicholson suggests that somatization of

symptoms due to cultural restraints was a common theme as well, and may need to be viewed as an indicator of mental health on its own, along with PTSD, depression and anxiety. The participants' perception of their own health and income as indicators of mental health are indicative of the need to consider refugees' appraisals of their own experiences, as well as the importance of acknowledging current stressors ahead of past trauma.

Implementing Expert Recommendations – Case Studies

The literature discussed above draws attention to the cultural limitations of current treatment models, and the greater significance of post-migration stressors for long-term mental health. Multiple scholars have integrated the various cultural considerations and recommendations outlined into treatment models and studies, in order to address the numerous limitations discussed in the literature. Some of these cases will be examined below. These cases were selected in order to illustrate the complex themes found in the literature, and to provide a variety of examples of culturally adapted treatment methods targeting different refugee populations.

Möhlen et. al. (2005) present a group intervention approach in a study of ten Kosovan refugees living in a German refugee shelter, all between the ages of 10 and 16. This 12-week intervention included trauma-focused sessions, relaxation techniques, "creative techniques" such as "painting, playing, acting, and fantasy journeys," among other techniques (pg. 83). Each session also had a specific focus or topic, such as "grief and sorrow about lost ones" (pg. 83). Fundamental to the intervention, however, was its focus on current stressors, such as the resettlement process, family, and future goals. While the intervention was targeted at youth, family sessions were also held, along with sessions solely with the individual's parents, and group sessions where all study participants met together. The study found that nine of the ten participants showed various forms of functional improvement, such as improved sleep, anxiety, and social interactions post-intervention. The group sessions were found to be very beneficial for the participants, who stated that group treatment gave them a feeling of "togetherness," mutual care and protection (pg. 85). The fantasy journey approach further allowed the participants an escape from their difficult conditions. The authors state that the intervention was found to be beneficial overall, but question its effectiveness for severely traumatized children.

Ellis et. al. (2010) present a community-based youth intervention called the Gateway Provider Model. Ellis and colleagues report that the ability of youth to access health services is determined by

key individuals termed “gateway providers,” who have knowledge with regard to the availability of resources, and influence youths’ decisions and access to these resources. Community leaders, religious leaders and family members can all act as gateway providers. 144 Somali refugees and immigrants living in the United States participated in this study, all between the ages of 11 and 19. The participants were questioned about friends, family, culture, discrimination, and attitudes towards mental health. Through the interviews, community and religion emerged as two prominent themes among the participants. Community members sharing information and observations with one another often motivated youths to stay out of trouble, but could also lead to youths earning negative reputations in the community. Speaking to family members about their issues was not a viable option for some participants, due to the fear of burdening their parents and the reported custom in Somali culture of keeping problems to oneself. Ellis et. al. found that there was also stigma associated with speaking about personal issues, and a belief within Somali culture that you should not have issues so severe that professional help is needed. Study participants noted that speaking to their friends and school counsellors was a viable option, since the probability of their community finding out was diminished; speaking to counsellors outside of school, however, was more of a challenge.

Ellis et. al. go on to state that while Western treatment methods were not valued by many participants, prayer, religious leaders, family and friends were shown as essential pathways to healing. The authors recommend that more communication is needed between gateway providers (parents and religious/community leaders) and mental health experts, in order to raise awareness, mutual respect and understanding; due to the important role parents play in giving their children access to services, parents need education to address their own stigma that may cloud their perspectives on treatment. Due to the significant utilization of school-based mental health systems by youth, the authors further recommend “supporting the presence of mental health services within schools, and bolstering the language and cultural capacity of school-based mental health programs through training and partnerships with community organizations” (pg. 806).

Griner and Smith (2006) demonstrate the improved treatment that can result from culturally modified treatment. They present a meta-analysis of 76 culturally adapted mental health studies, totaling 25225 participants; “31% African Americans, 31% Hispanic/Latino(a) Americans, 19% Asian Americans, 11% Native Americans, 5% European Americans, and 3% not specified” (pg. 535). The methods of cultural adaption in the studies varied, such as consultations with cultural experts,

cultural competency training for clinicians, and providing clients access to therapists of similar language or ethnic background, among others. The most commonly used cultural adaptation was the incorporation of concepts unique to the client's cultural background, such as folklore and culturally significant characters. The authors make two overarching conclusions: "Interventions provided with groups of same-race participants were four times more effective than interventions provided to groups consisting of mixed-race participants," and "studies in which the client was matched with a therapist based on language (if other than English) had outcomes that were twice as effective as studies that did not." (pg. 541). While the authors caution against the generalization of these findings due to the inability of measuring the quality of the numerous studies analyzed, they state that it is clear that interventions conducted in a client's native language will more adequately meet the client's needs. The findings are also indicative of the sense of community and security, as described earlier, that victims of trauma gain by connecting with individuals of shared experience and mutual understanding.

Sundel (1999) presents an interesting case study examining the creation of a mental health framework within an ethnically divided community. His 1999 study analyzes his efforts, in partnership with the UNHCR, to create a bi-communal mental health unit in Cyprus, where ethnic tensions continue between Greek Cypriots and Turkish Cypriots. The purpose of the proposed unit, in simple terms, was "to improve ethnic relations and collaboration" between the two sides, by having them work together to tackle mental health in their respective communities (Sundel, 1999, pg. 463). The author identified a five-step process to the establishment of the feasibility study (pg. 467):

1. "Preliminary meetings with mental health administrators and government officials";
2. "Data gathering, fact finding and literature review";
3. "Preparation of a program survey form for use in interviews and site visits to mental health facilities";
4. "Site visits to mental health facilities" in both communities, "interviews with service providers and administrators, and observations of programs and services";
5. "Meetings with volunteers and mental health professionals from non-governmental organizations."

The author highlights that the project was influenced by various factors. Suspicion and mistrust between the two sides was strong, and the wishes of both Turkish Cypriots and Greek Cypriots were

largely aligned with those of Turkey and Greece respectively; minority Turkish Cypriots ideally wanted partition from Cyprus and closer ties with Turkey due to the benefits this would bring in terms of security and living amongst people of the same language and ethnicity, while the majority Greek Cypriots preferred a return to the pre-conflict system. Both sides were willing to work together due to the increased resources and mobility this would bring, but were still cautious. The availability of resources was also a concern, as predominantly Turkish Cypriot areas lacked qualified personnel. Sundel states that preliminary work that brought together experts and government officials from both sides was successful, but that political tensions eventually forced the cancellation of the project. He concludes that the preliminary work demonstrates that interethnic collaboration can help to improve ethnic relations between the two sides, but that humanitarian efforts cannot be used to solve a political issue. Sundel notes that the implementation of the mental health unit depended on political stability in Cyprus, which was heavily influenced by Turkish, Greek, British and American political interests. Sundel's study demonstrates the wide variety of factors that can influence intervention efforts. Geopolitics, and a history of hostility and ethnic tensions heavily influenced the above initiative, and made it clear how vital it is to fully comprehend and appreciate the complexity and power of the socio-cultural circumstances that influence individual behaviours and decisions.

Discussion

This review aimed to provide an overview of disparities between mental health treatment methods and refugee needs, and highlight ways in which practitioners can adapt their practices. The two overarching themes analyzed thus far, cultural competence and the post-migration process, highlight key limitations, as noted by scholars, that exist with regard to refugee mental health treatment approaches. The medicalization of recovery, refugee resilience and self-appraisals, role of community in healing, stigma, and power dynamics bring attention to the appropriateness and limitations of using Western treatment models to assist refugees who are unfamiliar with the concepts they present. Mental health treatment must take an epistemologically sensitive approach and be adaptable to acknowledge the experiences, priorities, value systems and social codes of varying refugee groups; in many cases, these factors do not fall neatly in line with established treatment frameworks, which can have ethical implications for practitioners and recipients.

The studies conducted by Möhlen et. al. (2005), Ellis et. al. (2010), and Griner and Smith (2006) are indicative of the successes that can be achieved with culturally adapted treatment methods, and

also demonstrate the variety of ways in which practices can be modified. Sundel (1999) brings light to the scope and complexity that can accompany interventions, reaffirming the importance of contextual understanding.

Conclusion

The themes discussed above provide a general picture of the various challenges faced by refugee populations and the health care professionals who seek to provide assistance. Refugee mental health is influenced by numerous internal and external factors: refugees' own perceptions of their health, their perceptions of Western treatment models, fears and suspicions associated with their past victimization, religious and communal beliefs, associated stigma, and the misperceptions of health care workers towards refugees are factors that need to be understood and considered when determining how to approach mental health practice. These findings provide useful insight to mental health practitioners who seek to gain greater cultural understanding of those they serve, and seek to adapt their approaches to refugee mental health treatment.

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