ANXIETY DISORDER AMONG WOMEN URBAN REFUGEES

BY

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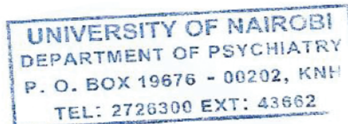

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DECLARATION

I, Hani Mohamed Shide do hereby declare that this is my original postgraduate diploma in clinical psychiatry work and that I have not presented the same to any other university

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Abbreviations

GAD: generalized anxiety disorder

UNHCR: United Nations high commission for refugees

PTSD: post traumatic stress disorder

LMIC: low and middle income countries

HIC: high income countries

WHO: world health organization

DSM: diagnostic and statistical manual

ICD: international classification of diseases

ANXIETY DISORDERS AMONG WOMEN URBAN REFUGEES: A REVIEW OF GLOBAL LITERATURE

Definition of Anxiety disorder

Anxiety is a normal reaction to stress and can be beneficial in some situations. It can alert us to dangers and help us prepare and pay attention. Anxiety disorders differ from normal feelings of nervousness or anxiousness, and involve excessive fear or anxiety. Anxiety disorders are the most common of mental disorders and affect nearly 30 percent of adults at some point in their lives. However, people with anxiety disorders frequently have intense, excessive and persistent worry and fear about everyday situations. Often, anxiety disorders involve repeated episodes of sudden feelings of intense anxiety and fear or terror that reach a peak within minutes (panic attacks). These feelings of anxiety and panic interfere with daily activities, are difficult to control, are out of proportion to the actual danger and can last a long time. Somebody may avoid places or situations to prevent these feelings.

SUMMARY

Anxiety symptoms may present differently between women and men as well as at different points in the female lifespan. The female lifespan includes distinct epochs of hormonal function, including puberty, the premenstruum, pregnancy or postpartum (in some women), and the menopausal transition. These stages give rise to important treatment considerations when treating anxiety among women.

The global increase in refugee migration to urban areas creates challenges pertaining to the promotion of refugee health, broadly conceived. Despite considerable attention to anxiety and forced migration, there is relatively little focus on how refugees cope with stressful situations, and on the determinants that facilitate and undermine resilience.

INTRODUCTION

Women experience markedly greater prevalence of anxiety disorders than men, including generalized anxiety disorder (GAD), panic disorder, and specific phobias. In a study of more than 20,000 individuals in the United States, the Collaborative Psychiatric Epidemiology Studies found higher rates of lifetime diagnosis for nearly all anxiety disorders among women [1]. Core features of the anxiety disorders include subjective anxiety or fear experience, physiologic reactivity, and, often, avoidance behavior [2]. Anxiety disorders are characterized by anxious apprehension or fear in response to a perceived threat [3,4]. Anxiety or anxious apprehension is a future-oriented state in which one is concerned about potential threats, whereas fear occurs in response to an immediate threat [5]. Anxiety disorders among women often precipitate or worsen at times of hormonal fluctuation, including puberty, the premenstruum, pregnancy or postpartum, and the menopausal transition. Female migrants comprise 48 per cent of all international migrants [6], with migrant and refugee pregnant women forming a highly vulnerable group to mental disorders, due to their unique needs during this period [7].

The United Nations High Commissioner for Refugees (UNHCR) considers that "*those women or girls who have protection problems particular to their gender, and lack effective protection normally provided by male family members*" ([8], are vulnerable to gender-related human rights

violations in addition to traumas often reported by other refugee groups. The vulnerability of these women and girls means their experience of the refugee journey will likely differ from that of their male or not at-risk female counterparts [8]. Consequently, the UNHCR created the 'Women-at-Risk' visa category to expedite suitable protection and support for identified refugee women through resettlement [9]. Applications for this visa are likely to rise since global numbers of forcibly displaced people appear to be growing, reaching 65.6 million by the end of 2016, representing an increase of 300,000 people over 1 year [10]. Increased numbers of forcibly displaced people underscore rises in UNHCR resettlement submissions, which increased from 92,915 in 2013 to 162,575 in 2016 [11]. Women have previously comprised approximately 10% of UNHCR submissions for resettlement in countries like Australia, Canada, and the United States [12].

Globally

Responding to the growing numbers of forcibly displaced people, the number of countries offering resettlement has also grown, rising from 14 in 2005 to 37 in 2016 [11]. Resettlement countries often work with non-governmental organizations to assess the needs of newly arrived refugees, including their psychiatric needs, and then provide appropriate resettlement support, services, and referrals aimed towards facilitating refugee's wellbeing and local integration [13]. Consistent with UNHCR global resettlement priorities [8], Australia gives high priority to women-at-risk and their dependents. Women-at-risk occasionally enter Australia on other humanitarian visas, such as on Refugee (subclass 200) or Global Special Humanitarian (subclass 202) visas. Empirical investigation of the psychiatric symptoms experienced by women-at-risk is required to assist policy-makers and practitioners to respond effectively to this vulnerable group.

Research-informing policy and practice relating to refugee resettlement has often focused on anxiety and trauma [14]. Symptoms sometimes meet criteria for anxiety and post-traumatic stress disorder (PTSD). For example, research with 63 Sudanese [15] and 70 Burmese refugees [16] found that the number of trauma events experienced by participants predicted their anxiety symptoms. However, similarly to many studies in the field, samples included males and females and the gendered nature of the refugee journey was not fully addressed. The experiences of refugee women-at-risk, who are without male protection, are likely to be qualitatively different from other refugee groups, often involving gender-related violence such as rape or sexual bartering [17]. Such gender-based assaults are likely to have additional physical and social ramifications, including pregnancies and community ostracism [18].

In the context of the current "global refugee crisis"[19], promoting the health and well-being of forcibly displaced persons requires attention from public health practitioners and researchers. Refugees are particularly vulnerable to poor mental health outcomes as a result of exposure to physical and political violence [20], separation from families and loss of social and emotional support [21] and post-migration stressors such as employment insecurity, loss of meaningful social roles [22] uncertainty about immigration status [21] and social isolation [23]. Despite the advantages of migration to urban areas, refugees residing in cities are particularly vulnerable to harassment, police extortion and arrest, and social exclusion [24]. Despite high risk of poor mental health outcomes among those migrating to urban centers, some refugees do successfully mitigate social, emotional, and environmental stressors and exhibit positive psychosocial health in the face of great adversity [25].This study describes the range of coping mechanisms used by a

sample of urban Congolese refugees (N = 55) to navigate and negotiate personal, social, and environmental resources to promote psychosocial well-being.

There is an increasing number of displaced persons in the world with approximately 68.5 million people having been forced out of their homes; 25.4 million of these individuals are refugees [26]. Refugees are more likely to have experienced severe traumatic events in their home countries such as torture, rape, murder of family members, and have a higher incidence of post-traumatic stress disorder (PTSD) [27]. Most displaced persons and refugees are found in low and middle income settings, including sub-Saharan Africa which hosts more than 26% of the world's refugee population [26].

LMICs

Overview of Urban Refugees in Nairobi, Kenya The East and Horn of Africa is the third largest refugee-hosting region globally, and Kenya plays a significant role in receiving refugees from neighboring countries, hosting nearly 600,000 [28]. Although Kenya has generally followed a model of keeping displaced persons in refugee camps, 1 implementing the encampment policy has not been rigorous in practice and is often applied ad hoc [29]. Following a global trend of refugee movement to urban environments, many refugees in Kenya have sought livelihoods within the city of Nairobi, which is currently home to at least63,000 registered refugees (UNHCR, 2015a); however, the exact number of refugees in Nairobi is unknown, and has been estimated to be nearer to 100,000 [30]. According to the United Nations Refugee Agency (UNHCR, 2013), approximately7,000 Congolese refugees reside in Nairobi, making those from

the Democratic Republic of the Congo(DRC) the third largest refugee group in Nairobi (10%),behind Somalis (43%) and Ethiopians (26%), respectively [31]. Smaller refugee groups in Nairobi come from Eritrea, South Sudan, Uganda, Rwanda, and Burundi [31]. On March 26, 2014, the Government of Kenya issued a directive stating that all refugees living outside of an encampment area must relocate to one of the country's refugee camps. Urban refugees and their families, including many Congolese, were pushed deeper into the peripheral cracks of Nairobi [32]. The months following this directive were characterized by human rights abuses against refugees and police raids in sections of the city with large numbers of immigrants and refugees [33,34]. Deportations and forced relocation to camps resulted in the fragmentation of families and disruption of social support, overwhelming neighbors and community members who struggled to garner resources to care for children and elders who were separated from their families and left to fend for themselves [35].

HICs and Globally

Mental health problems are a serious barrier for the integration of immigrants into the host societies [36]. Refugees in particular are exposed to various risk factors for mental health problems before, during and after migration. Pre-migration risk factors for mental distress are persecution, exposure to potentially traumatic events in person or as a witness and exposure to, or involvement in, armed conflicts. Many refugees have to face economic hardships including having their basic needs not met. Peri-migration risk factors are exposure to physical harm and life-threatening conditions during migration. Separation from family members and from support

networks are additional stressors. Post-migration risk factors are manifold and include uncertainty about the asylum application, unmet health needs, fear for family members left behind, lack of close relationships, lack of social integration including difficulties in entering the labour market, recognition of degrees, loss of social status and difficult socioeconomic conditions including unsatisfactory housing conditions [37]. These particular risk factors for mental distress of refugees overlap with the general acculturative stress experienced by immigrants relating to loss, unfamiliarity with the tasks of daily living, unfamiliar (or very limited) occupational options, language barriers, discrimination and feeling marginalised in the new surroundings or social structure [36]. Although data on mental health problems of refugees having resettled in Europe in the years following 2014 is still scarce, it can be assumed that this population group shows high prevalence rates of mental disorders since they originated from war-affected countries like Afghanistan, Syria and Iraq. In general, refugee groups from countries with intense human rights violations show higher rates of mental health problems [38]. In the case of Germany, the prevalence of mental health disorders is reported to be significantly higher for refugees as compared to the host population [39]. Austria was an important receiver of asylum seekers in Europe in recent years. In the period 2014-2018, 197,000 asylum applications were filed in Austria [40], and roughly 109,000 individuals were officially granted asylum (including subsidiary protection and protection on humanitarian grounds). Between 2014 and 2018, six out of ten asylum applicants in Austria had Syrian, Afghan or Iraq nationality. In this paper, we examine the level of mental distress and thus the likelihood of mental disorders of adult refugees particularly from Afghanistan, Iraq and Syria who recently arrived in Austria.

Previous systematic reviews and meta-analyses evaluating mental health of refugees (including those recently resettled) have all indicated a reduction in risk for mental disorders as the length

of time since displacement increases [41, 42, 43]. However, these reviews did not specifically report findings for refugees with a longer duration of displacement [41, 42, 43, 44], mostly assessed studies of recently resettled refugees [41, 42, 43, 44] where rates would be expected to be higher, focused only on refugees in Western countries [11], and confined their findings to PTSD, depression or a generic effect size index of psychological distress derived from heterogeneous outcome measures across studies [41, 42, 43]. Thus, a systematic review focusing specifically on long-term mental health outcomes of war refugees worldwide is warranted. Understanding the long-term mental health of refugees is essential for guiding the health policies of recipient countries aimed at promoting long-term mental health of refugees [44].

In the literature on moderators of mental distress of refugees, the actual resident status of forced migrants' was found to have a significant impact on the prevalence of trauma-related mental-health disorders: For Switzerland [45], found that asylum seekers were more likely to suffer from anxiety and post-traumatic stress disorder (PTSD) than recognized refugees. The rate of depression among asylum seekers was nearly twice as high as compared to that of migrants with permanent residency claims (and hence access to the labor market, language courses and other activities). Lack of security and fear of deportation, connected to economic instability, substandard housing, and feelings of guilt and shame for having survived, tend to be the most relevant risk factors for developing mental health disorders, which can be exacerbated by a lengthy asylum process [46]. Systematic reviews on the prevalence of mental health disorders among refugees reveal a substantial variability in outcomes [47, 48], particularly when the specific, most common disorders (depression, general anxiety disorder, etc) are investigated. Variability in outcomes is due to the fact that refugee populations and their mental distress levels diverge between diverse countries of origin on the one hand and that reception conditions are

different in host countries on the other hand. More significantly, the differences in sample selection and methodological approaches result in strong variations in prevalence rates. Studies using a more representative sampling methodology were shown to result in lower prevalence rates than research applying convenience sampling [49]. While Priebe et al [48] found no systematic differences between total refugee populations and host country populations regarding short-term resettled people, [50], claimed in their review that prevalence rates of anxiety and depression disorders are as high as rates of PTSD. Reasons for the lack of differences in the cases of depression and general anxiety disorder in research applying population-based samples can be manifold. Refugees, and particularly those with mental distress, are a much more difficult group to survey in a representative way due to issues such as accessibility, mobility, trust and concerns about the stigma of health problems [51].

There has been an unprecedented upsurge in the number of refugees worldwide, the majority being located in low-income countries with limited resources in mental health care. If current trends continue, one in a hundred persons will be a refugee in the near future [52]. At present, responsibility for mental health support to refugees is shared by a network of agencies, including the United Nations High Commissioner for Refugees (UNHCR) and the World Health Organization (WHO), government and non-for profit organizations, mainstream mental health and specialist refugee services and voluntary organizations. Yet, the ineluctable reality is that most refugees with mental health problems will never receive appropriate services.

The chief reason for this is the scarcity and inequitable distribution of services, but other factors contribute to the situation, including difficulties in coordinating national and international efforts, barriers to accessing care even when services are available, and persisting stigma

associated with being both a refugee and mentally ill [53]. Notwithstanding, advances have been made in research, theory, policy and models of treatment. Importantly, there is evidence of growing convergence in these areas, a consensus that is likely to gradually build to the more effective use of scarce resources to achieve better mental health outcomes for this population.

The present paper focuses on issues of general concern amongst adult refugees. The reader is referred to the specialized literature on vulnerable sub-populations (child soldiers, unaccompanied minors, children and youth, single or widowed women) and specific geographical situations around the world [54].

The United Nations estimate that over 65 million persons worldwide are currently displaced by war, armed conflict or persecution. In total, 16.5 million fall under the mandate of the UNHCR. Although the flow has slowed somewhat, 3.2 million persons were displaced in 2016 alone, the leading source countries being Syria and South Sudan [52]. More than 80% of refugees are displaced internally or have fled across national border to neighboring countries, the majority being located in low- and lower middle-income countries.

Half of the world's refugees remain in “protracted situations”, unstable and insecure locations, most commonly in dense urban areas, but also in refugee camps. For example, 314,000 persons remain displaced from Darfur in Eastern Chad, and more than a million Somalis live as displaced persons in Kenya, Ethiopia, Djibouti and Yemen. Dadaab, a vast refugee camp in Kenya, houses families that have been sequestrated in this remote and insecure location for more than three generations.

In 2016, Europe confronted the largest single inflow of refugees since the World War II, with over a million Syrians and others from the Middle East entering the region [52]. Oscillations in

public opinion and government policies resulted at times in chaotic responses in which authorities attempted to halt or divert the influx, indicating the lack of preparedness of even advanced nations to deal with this humanitarian crisis.

To place the European situation in perspective, a total of 13 million Syrians have been displaced by the war, the majority to neighboring countries. Lebanon, a small country of 4.5 million persons, now accommodates as many Syrian refugees as the whole of Europe [52]. The wars in the Middle East also tend to overshadow lesser known refugee crises around the world, for example in West Papua, Myanmar and Western Sahara [55].

Throughout history, recipient societies have responded in ambivalent ways to refugees, at times greeting them as heroes, and at others as interlopers who threaten the peace, integrity, cultural identity and economic stability of the host country [56].

The policies applied to refugees by host countries are crucial to the mental health of that population. The United Nations Refugee Convention (1951) and later Protocol (1967) ushered in a progressive era in the international response to this problem. The essential principles established by these instruments include: a) that persons with "a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion" have an inalienable right to seek asylum in signatory countries; b) that refugees are protected from *refoulement* or forced return to places of danger in their homeland; and c) that host countries have a responsibility to provide "favorable" conditions for refugees, including, *inter alia*, the right to work, to freedom of association and movement, and to appropriate services.

The Convention proved effective in the early decades following the World War II, when refugee flows were small, newcomers were mainly of European origin, and recipient societies resonated positively with their reasons for fleeing, usually based on their opposition to the ideology of totalitarian regimes in the countries of origin. The popular campaign against torture in the 1970s further strengthened public compassion for survivors who in most instances were refugees.

The large exodus of Southeast Asian refugees in the 1970s and 1980s created a new challenge for the Convention [57], but after a period of inertia and dissension, leading Western nations finally accepted most of the displaced persons for resettlement. Nevertheless, the crisis underscored a pattern that has been repeated in Europe in contemporary times, that is, that the willingness of recipient countries to accept refugees is inversely related to the rate of influx and ethnic difference of the incoming group [58].

The distinction made in the 1980s onwards between asylum seekers (persons arriving without prior authorization) and "Convention" refugees (those granted residency visas prior to arrival, further put to test the viability of existing international procedures. Australia implemented stringent policies of deterrence to asylum seekers, and other countries of Europe and North America instituted similar policies and practices [59].

The spirit of the Convention was further eroded by the phenomenon of terrorism. Several factors, including the ethnic and religious stereotyping of terrorists, increased communal resistance to immigration, the distinction between refugees and voluntary migrants becoming blurred in the process [60]. For all these reasons, although the Refugee Convention is still in force, there are unprecedented pressures to dilute if not to dismantle the key provisions for protecting the rights of refugees, irrespective of their backgrounds or countries of origin2Y [61].

Prior to the 1970s, the field lacked robust scientific data detailing the nature, prevalence and determinants of mental health problems amongst refugees. Pioneering studies undertaken in the US, Canada, Norway and Southeast Asia identified what appeared to be substantial symptom levels of anxiety and depression amongst Indochinese refugees, but the absence of closely matched comparison groups limited interpretation of the findings.

In the following two decades, there was a burgeoning of epidemiological studies in the refugee mental health field, prompting two systematic reviews of the cumulative findings in 2005 [62]. The first, which was limited to studies of refugees in Western countries, yielded an average prevalence of 9% for anxiety and 5% for depression, noting that lower rates were found amongst the larger, more rigorously conducted studies. These findings provided a corrective to the tendency to regard all refugees as "traumatized" and in need of counselling. The second review, based on studies that included comparison groups, showed that refugees had a modestly elevated risk (effect size of 0.41) of a range of adverse mental health outcomes. Factors associated with poor mental health amongst refugees included socio-demographic characteristics (being older, a woman, from rural background, well educated, and coming from a higher socio-economic status), and stressors in the post-displacement environment (living in institutions, restrictions in economic opportunities, being internally displaced or involuntarily repatriated, and coming from a country that remained in conflict).

The largest review of its kind, published in 2009, identified 181 surveys undertaken amongst 81,866 refugees and other conflict-affected populations from 40 countries [63]. The prevalences of anxiety and depression were similar, approximating 30%, although there was substantial

heterogeneity in rates across studies. Exposure to torture and the total number of trauma events experienced emerged as the strongest predictors of anxiety and depression, respectively.

The body of research focusing on asylum seekers served to highlight the impact of the post-migration environment on the mental health of displaced populations [64]. A growing number of studies in recipient countries found that imposed conditions of adversity, including prolonged detention, insecure residency status, challenging refugee determination procedures, restricted access to services, and lack of opportunities to work or study, combined in a way that compounded the effects of past traumas in exacerbating symptoms of anxiety and depression [65, 66, 67]. Yet, in spite of widespread concerns, these practices continue. As a corollary, mental health professionals keep on confronting ethical challenges when working within detention centre hierarchies, and practical questions persist regarding the effectiveness of offering counselling to persons forced to live under such restrictive conditions [66].

Translating epidemiological data into estimates of service needs requires careful consideration. As indicated, prevalence rates of common mental disorders such as depression and anxiety have shown wide variation across the body of refugee studies reported. Methodological factors are partly responsible, including transcultural measurement error, biases related to non-probabilistic sampling, and the use of screening measures which tend to overestimate the prevalence of disorder [66]. In addition, populations from some regions of the world (East Asia, Sub-Saharan Africa and the Pacific) tend to record lower symptom levels compared to high-income countries [67].

The greatest obstacle in translating epidemiological data into service needs arises from the difficulty in differentiating, in cross-sectional surveys, between reactions which may be

commensurate with the level of anxiety being encountered and frank mental disorder that risks becoming chronic and disabling, in part independent of the context [68]. Longitudinal studies assist to some extent in addressing this anxiety, in that they are capable of distinguishing between symptom trajectories that indicate recovery as opposed to chronicity, pathways that may be predicted to some extent by the profile of baseline risk and protective factors [69]. Short-term follow-up studies (1-3 years) may not distinguish these trajectories with any accuracy, particularly if the follow-up extends through a period of ongoing instability, for example, in the immediate post-displacement phase [70]

Only a small number of studies have followed up refugees for 10 years or longer, in all instances being limited to the measurement of general symptoms of anxiety and depression using screening instruments [70, 71]. Broadly interpreted, these studies suggest a common pattern of outcome: most refugees continue to show low or no symptoms; a significant minority show a pattern of gradual recovery; and a small group remain chronic. This picture was supported by a large cross-sectional study using a retrospective quasi-longitudinal analysis [72]. A similar set of trajectories has been found in a six-year follow-up study amongst a post-conflict population in Timor-Leste [73]. This tripartite pattern of low or no symptoms, gradual recovery and chronicity, although tentative, has important implications from a public health perspective in judging which populations will benefit from programs of social reconstruction and which might require more intensive psychotherapeutic interventions, as discussed hereunder.

Estimating service needs also depends on a range of other factors, including help-seeking behavior. Stigma, mistrust and lack of knowledge of services may limit the extent to which refugees access mental health services, even if available. Taking all factors into account,

modelling based on the Global Burden of Disease Study has illustrated how large the gap is between the existing number of mental health professionals and the service needs of low-income countries and regions that have large populations exposed to mass conflict and displacement [74]. There is no realistic prospect, therefore, of formal mental health services, whether generic or specialized, meeting the mental health needs of refugees, noting that the majority reside in low-income countries. Creative solutions are thus necessary, including networking of all agencies to ensure the sharing of responsibility of care for refugees with mental disorder, and task-shifting, i.e., the transfer of skills to primary care and lay workers in order to undertake specific mental health interventions of various types under supervision.

In a research in the refugee field has widened the scope of interest to disorders and reactions that extend beyond the conventional focus on anxiety and depression, and to a lesser extent anxiety and somatic symptoms. There is a resurgence of interest in the construct of prolonged or complicated grief, given the importance of this reaction to refugees, the majority of whom have experienced multiple losses and separations in the context of gross human rights violations [75]. In addition, the long-debated category of complex anxiety , comprising elements of disrupted self-organization (negative self-concept, affective dysregulation, interpersonal difficulties) will be included for the first time in the forthcoming ICD-11 [76], early evidence suggesting that the diagnosis can be identified amongst refugees.

There is also a growing body of studies documenting cases in which anxiety and PTSD are associated with psychotic-like symptoms or frank psychosis amongst refugees and post-conflict populations [77]. Recognition of the prevalence and salience of these symptom constellations

adds further complexity to the field, particularly in relation to the need to tailor interventions to individual patterns of comorbidity and disability.

The massive disruptions to family and social networks in the context of extreme human rights violations undermines the fundamental sense of coherence of refugees, many becoming isolated and losing trust in authority structures. Chronic anger is one potential outcome that has important social implications. For example, amongst West Papuan refugees, a constellation of mistrust, resentment and anger is embodied in an idiom of distress, *Sakit Hati*, literally meaning "sick heart" [77].

A focus on states of chronic and uncontrollable anger in survivors of extreme trauma creates an important bridge that links individual reactions to the stability of the family and the wider social network. A cycle of violence model posits that, in some instances, aggressive outbursts amongst survivors may be implicated in family conflict, generating a multiplier effect of mental health problems in intimate partners and potentially children, a cycle of violence that may have profound trans-generational effects [78]. Recent applications of multilevel statistical techniques allow examination of these transactional effects both within conjugal couples and families, thereby broadening the scope of epidemiology to increase its ecological and contextual significance [38, 79].

The refugee mental health field overlaps considerably with the larger movement of Global Mental Health, both focusing on the mental health needs of deprived populations from low-income countries (noting that one of several distinctions is the substantial number of refugees relocated to high-income countries, where they confront special conditions).

There has been a tendency in the refugee field to limit interest in severe mental illnesses such as anxiety and related psychoses, bipolar disorder, melancholic forms of depression, drug and alcohol problems, and organic brain disorders. Persons with psychosis in particular are at risk of neglect, exploitation and abuse in acute humanitarian settings and other situations of mass displacement. During these periods, psychiatric hospitals and clinics often close, leaving patients without protection or medication.

The reality for psychiatrists and other mental health professionals working in clinics in Africa and other refugee situations is that a large proportion of the patients they consult manifest one or more of these forms of severe mental disorder. There is now compelling evidence that schizophrenia and other psychotic disorders are more prevalent amongst refugees resettled in high-income countries compared to other immigrants and host populations [80]. Therefore, the field of refugee mental health should include consideration of this subpopulation in mounting comprehensive programs of mental health care, an issue that is now more widely recognized and acknowledged in policy and planning exercises [81].

Counselling and psychotherapy of Anxiety disorder and other disorders

Counselling and psychotherapy remains the mainstay of treatment for common mental disorders such as anxiety, depression and even PTSD or combinations of these symptom profiles – in refugees. Most commonly, workers apply a flexible combination of supportive counselling and cognitive behavioral therapies. In spite of variability in the quality of existing studies, the overall evidence suggests that various forms of psychotherapy are relatively effective in ameliorating symptoms of depression and anxiety [82].

Over the past two decades, a series of brief, structured, manualized psychotherapeutic packages have been devised for use amongst refugee and post-conflict populations. Most models draw on evidence from Western contexts supporting trauma-focused cognitive behavioral therapies [83]. The strengths of these newer programs include that: a) they can be adapted to local cultures; b) they allow rapid training of front-line personnel; and c) they facilitate task-shifting, that is, the transfer of skills from professionals such as psychologists to lay or community workers, a vital provision to allow uptake and dissemination in settings where there is a severe lack of mental health specialists. The time-limited nature and low cost of these interventions increase the potential for dissemination (or scalability) and for integrating the procedures within routine public health or community centre settings.

Most approaches use standard cognitive behavioral components including stress management, prolonged exposure, cognitive restructuring, behavioral strategies, and mindfulness or related de-arousal techniques. Increasingly, activation therapies are used for depression. The most widely tested method, narrative exposure therapy, draws on the principles of testimony therapy in tracing the person's chronological life course, embedding imaginal exposure to trauma memories in the natural course of this sequence [84]. A common elements treatment approach is designed to accommodate common patterns of comorbidity, allowing the therapist flexibility in selecting modules (for example, for traumatic stress, depression, anxiety) to match the particular symptom constellation of each patient. Trials in several settings attest to the efficacy of this method [85]. More recently, the WHO has established a brief intervention, Problem Management Plus (PM+), drawing once again on the core principles and strategies of cognitive behavioral therapy. The first studies examining this method have yielded positive findings [86].

An important next step is to establish that these brief packaged interventions can be embedded in routine primary care services in low-income countries in a manner that is supported by local structures and hence sustainable. Apart from securing resources and the commitment of the hierarchy to these mental health initiatives, there is a major challenge in providing ongoing supervision and mentoring of workers, an essential provision to avert attrition of skills and motivation and to avoid burnout. The increasingly wide reach of the Internet and telecommunication systems improves opportunities to provide supervision from afar to remote locations where many refugee populations are located.

A further concern is whether brief or even extended interventions based on contemporary approaches to psychotherapy are effective for the significant minority of refugees with complex traumatic stress presentations. A controlled trial from Denmark [87] offering a comprehensive array of interventions (medical and psychiatric assessment and consultation, psychopharmacology, social worker assistance, and individualized psychotherapy) found no change in baseline high levels of anxiety and PTSD symptoms over a one-year course of follow-up, and only modest reductions in symptoms of depression. The most likely reason is that the majority of participants came from the poor prognostic subpopulation provisionally identified in epidemiological studies. Participants had extensive exposure to torture and other forms of abuse; high rates of head injury, chronic pain and physical disability; a chronic pattern of persisting symptoms; and a history of failed response to past treatments. Most were socially isolated, marginalized and unemployed.

Patients with these complex characteristics may not have the motivation, resilience or cognitive capacity to engage in exposure therapies or to implement the techniques of cognitive behavioral

therapy which require active practice to be effective. Questions remain, therefore, as to the best strategies to assist these complex cases. It may be that more graduated rehabilitation approaches are needed to encourage what may be a slow recovery trajectory in this subpopulation.

Psychosocial interventions

As indicated, research findings are consistent with contemporary ecological models in demonstrating the powerful impact that ongoing social conditions exert on the mental health and psychosocial well-being of refugees. In addition to the effects of past trauma, anxiety, refugees commonly confront important challenges and stressors in their new environments, including ongoing insecurity, restricted access to essential services (health, mental health, education), lack of opportunities for employment, and more generally, host society attitudes of racism and xenophobia [88]. Death, disappearances and separations result in persisting grief and loss. The ongoing consequence of these losses is that refugees commonly lack the support of nuclear and extended families and other traditional networks, a profound challenge for communities with strong collectivist values. Even in intact families, relationships can be undermined by the cumulative effects of past trauma and ongoing stressors, resulting in conflict and, at worst, intimate partner violence [89].

Social programs for refugees have the potential to revive a sense of connectedness, re-establish social networks, and promote self-help activities. Strategies that foster community initiatives encourage a sense of control and engagement in the task of self-directed recovery, counteracting the inertia, dependency, and inter-group divisions that characterize many transitional refugee settings. There are compelling theoretical, economic, and strategic reasons, therefore, to give

priority to social interventions in the array of strategies aimed at relieving distress and promoting well-being amongst refugees.

At the most general level, psychosocial programs focus on the population as a whole, examples being community-wide truth and reconciliation programs, income generation activities, and the development of participatory processes to foster democratic decision-making and self-governance. Practical programs include setting aside child friendly spaces, developing teams of refugee outreach volunteers to assist families confronting a range of economic or social problems, and establishing community centres where individuals can obtain assistance in relation to housing, other basic needs, education, and referral to other services [90].

Special populations or vulnerable groups such as former child soldiers and survivors of gender-based violence may require specifically designed programs. In some instances, however, social programs may have paradoxical effects. For example, participation in truth and reconciliation processes can improve community cohesion, but result in worsening of mental health. These findings reinforce the need for rigorous research to test both the benefits and disadvantages of various psychosocial programs.

Sociotherapy is one of the few well researched group psychosocial interventions [91], the primary focus being the fostering of connections between people. The method was developed in the post-genocidal context of Rwanda and has since been applied in other settings including amongst refugees [92]. Groups share and discuss daily problems ranging from interpersonal disputes, feelings of marginalization, and strategies to deal with gender-based violence and poverty at the community level. Trained facilitators create a safe therapeutic environment which nurtures trust, mutual care and community-wide respect. The restorative experience of

participating in the group itself may assist in repairing disrupted social relationships, although in all groups of this kind there should be agreed limits to disclosure, for example, discussing and revealing specific instances of intimate partner violence is contraindicated in the group setting. In general, however, the process may foster supportive peer relationships that endure beyond the life of the group program. Preliminary research suggests that socio-therapy has the dual effect of increasing civic participation (and hence social capital) and improving participants' mental health [93].

In relation to future developments, a stepped care model in which refugees first attend social programs which address general levels of distress, while at the same time those with more severe mental health problems such as anxiety are identified, offers an integrated approach to maximizing resources and a non-stigmatizing referral pathway to specialist services.

Conclusions

The prevalence of anxiety disorders is high in population subgroups across the globe. Recent research has expanded its focus to Asian countries, an increasingly greater number of physical and psychiatric conditions, and traumatic events associated with anxiety. Further research on illness trajectories and anxiety levels pre- and post-treatment is needed. Few studies have been conducted in developing and under-developed parts of the world and have little representation in the global literature.

An important direction for research is to distinguish the needs of the various subpopulations of interest: those with distress reactions that are responsive to environmental factors, for whom broader social programs as well as more targeted non-clinical group interventions may be of assistance; those whose traumatic stress reactions are severe, disabling and unlikely to resolve

spontaneously and who may benefit from brief structured psychotherapies; more complex trauma-related cases who may benefit from longer-term rehabilitation; the severely mentally ill who need an array of mainstream interventions; persons with drug and alcohol problems requiring specific attention; and special groups such as women exposed to domestic violence who may require a gender-sensitive approach to care.

In relation to advocacy, awareness-raising and embedding mental health programs within the existing institutional structure, the refugee field can learn a great deal from the general field of Global Mental Health [94, 95]. Without establishing a firm foothold for refugee mental health in existing primary care and other public health services, issues of sustainability will persist. Showing that treatments work under controlled research conditions is only the first step in ensuring that effective interventions actually reach the majority of populations in need.

A major challenge that the field confronts at a global level is that most refugee populations reside in locations where the resource base in mental health is extremely low. Theoretical debates aside, the reality is that, in these contexts, no single agency or program can provide for all the inter-related psychosocial and mental health needs of refugees. The success of the overall program will be gauged not by the accomplishments of one component but by the extent to which all contributors coordinate to establish the most comprehensive, inclusive, and integrated response, which includes networking of mental health agencies with social, community, and general health services.

Within the mix, the voice of the refugee communities is vital. Mental health cannot be conferred, it must be regained by the communities that have temporarily lost their equilibrium as a consequence of overwhelming circumstances.

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