Trauma and Mental Health in Forcibly Displaced Populations

An International Society for Traumatic Stress Studies Briefing Paper

ISTSS
International Society
for Traumatic Stress Studies

Angela Nickerson, PhD
University of New South Wales, Australia

Belinda Liddell, PhD
University of New South Wales, Australia

Anu Asnaani, PhD
University of Pennsylvania, United States

Jessica Carlsson, MD, PhD
Competence Centre for Transcultural Psychiatry, Denmark

Mina Fazel, DM, MRC Psych
University of Oxford, United Kingdom

Christine Knaevelsrud, PhD
Free University of Berlin, Germany

Naser Morina, PhD
Zurich University Hospital, Switzerland

Frank Neuner, PhD
Bielefeld University, Germany

Elizabeth Newnham, PhD
Curtin University, Australia

Andrew Rasmussen, PhD
Fordham University, United States

We gratefully acknowledge the valuable contribution of Dr. Peter Ventevogel, Senior Mental Health Officer at the United Nations High Commissioner for Refugees in Geneva, Switzerland. We also greatly appreciate the input of Dr. Ulrich Schnyder, Dr. Stuart Turner, and the ISTSS Public Health and Policy Committee. In addition, we thank Savannah Minihan and Shraddha Kashyap for their assistance in the preparation of this document.

Key points

- Adult and child refugees and asylum-seekers evidence elevated rates of psychological disorders including posttraumatic stress disorder (PTSD) and depression.
- Exposure to traumatic events and daily stressors contribute substantially to psychopathology in refugees and asylum-seekers.
- Trauma-focused interventions have the strongest evidence base to reduce PTSD symptoms in adult and child refugees and asylum-seekers.
- Culture impacts on conceptualization, expression and treatment of psychological distress in refugees and asylum-seekers.
- There exist numerous logistical, cultural and situational barriers to accessing treatment for psychological disorders for refugees and asylum-seekers.
- There is promising evidence regarding scalable interventions for refugees and asylum-seekers that overcome barriers to accessing treatment for psychological symptoms, however these require further evaluation.

<u>Recommendations</u>

- Evidence-based interventions should be made available for, and implemented where possible with, refugees with psychological disorders.
- Settlement policy and mental health and psychosocial support (MHPSS) programming should facilitate positive mental health outcomes amongst refugees via the provision of resources, enhancing the capacity of the individual for resilience, and strengthening family and community supports. Settlement policy should consider the potentially negative effects of restrictive immigration policies on mental health.
- Clinicians and support workers should take into account contextual factors (i.e., cultural background, daily stressors, living, family and school environments) when working with refugees and asylum-seekers.
- High-quality research should be undertaken in collaboration with refugee communities to increase understanding and treatment of psychological disorders amongst refugees and asylum-seekers. More research should be conducted in LMICs to enhance knowledge about the mental health needs of those in sustained displacement.
- Professional organizations can play an important role in facilitating, promoting and disseminating research on refugee mental health.

Executive Summary

As of the end of 2016, there were over 65 million people forcibly displaced worldwide as a result of conflict and persecution. The experiences of conflict, persecution and forced displacement have a pervasive negative impact on the mental health of refugees and asylum-seekers. There is global recognition of a growing need to understand and meet the mental health needs of refugees and asylum-seekers worldwide. The International Society for Traumatic Stress Studies (ISTSS) commissioned this briefing paper to inform its membership, policymakers and global stakeholders about the mental health impact of the refugee experience. This paper outlines the research evidence regarding (1) commonly-experienced traumatic events and daily stressors, (2) mental disorders experienced by adult and child refugees, (3) psychological and pharmacological interventions, (4) the role of culture in influencing mental health and (5) barriers to treatment following forcible displacement. Recommendations are also made across the areas of public health, immigration, settlement and mental health and psychosocial support (MHPSS) policy, and clinical practice and research.

Refugees are typically exposed to multiple types of traumatic events in their countries of origin and during displacement. These events are often repeated, prolonged and interpersonal in nature, and have been demonstrated to have a deleterious effect on mental health. Child and adolescent refugees may be especially vulnerable to exploitation during migration, leading to poor mental health outcomes. In addition, refugees face numerous daily challenges in their home countries and during displacement, as well as in the post-migration environment, including those related to lack of resources, family separation, social isolation and discrimination, socioeconomic factors, and immigration and refugee policies. These stressors negatively impact mental health over and above the traumatic events experienced in the context of persecution. Accordingly, refugees and asylum-seekers experience elevated rates of psychological disorders compared to the broader community in host countries, with the majority of research to date focusing on posttraumatic stress disorder (PTSD) and depression. For child and adolescent refugees, factors related to the family of origin (i.e., loss of a parent or poor parental mental health) may have an especially pervasive impact on wellbeing.

There is a growing evidence base relating to psychological treatment for trauma-related disorders amongst refugees and asylum-seekers. Evidence to date points to trauma-focused interventions being the most efficacious in reducing PTSD symptoms amongst adult and child refugees. In contrast, there has been relatively little rigorous research investigating other approaches such as multimodal and pharmacological interventions. In recognition of the barriers to accessing evidence-based interventions for refugees in both high and low-resource settings, there is increasing evaluation of scalable approaches to addressing mental disorders in refugees, including low-intensity interventions, task-shifting approaches, school-based interventions and the online delivery of treatments. Promising findings are emerging from these studies, however more research is required to determine the feasibility and efficacy of these approaches amongst refugees and asylum-seekers.

Refugees often originate from cultural groups that are outside the western context where psychiatric nosologies have been developed. Culture has a profound impact on the conceptualization, expression and treatment of psychological distress. Knowledge regarding

cultural constructs of distress can aid the understanding of mental health symptoms amongst trauma-affected refugees, however few studies have systematically investigated these. Similarly, few interventions are specifically developed around cultural content, with treatments often relying on clinicians' cultural competence in delivery.

There are numerous barriers to the treatment of psychological symptoms amongst refugees and asylum-seekers, including lack of access to specialized care, the high cost of traditional clinical treatments, lack of financial and practical resources, and lack of access to interpreters. In addition, divergent conceptualizations of mental distress, lack of knowledge regarding mental health care in the host country, stigma related to mental illness and lack of trust arising from persecutory experiences may hamper the uptake of available treatment. Practical concerns may also overshadow the salience of psychological symptoms leading to de-prioritizing psychological treatments amongst forcibly displaced groups.

We recommend a number of actions to improve knowledge regarding refugee mental health, and to better address the mental health needs of those affected by persecution and displacement.

Public Health Policy. Evidence-based psychological therapies should be made available to refugees and asylum-seekers in need of treatment. To facilitate this, the following steps could be taken:

- Provision of evidence-based treatment at no cost (with interpreters if required)
- Increased competence in the culturally-informed delivery of evidence-based interventions in the healthcare systems of host countries
- The creation of complementary treatment, training and research facilities for refugees and asylum-seekers in settlement countries
- The involvement of individuals from a refugee background in mental health programming and implementation
- Provision of stigma-reduction programs.

Immigration, Settlement and MHPSS Policy. Immigration, settlement and MHPSS policy should:

- Provide critical resources to facilitate positive adaptation in refugees and asylum-seekers, including enhancing individual capacity for resilience and strengthening family and community supports
- Consider the negative mental health effects of restrictive immigration policy and how psychological symptoms may impact on legal processes related to immigration status resolution
- Prioritize the reunification of families to protect vulnerable children and adolescents.

Clinical Practice. Those providing treatment to forcibly-displaced groups should

- Implement evidence-based treatments (such as trauma-focused interventions for PTSD) where possible and via a trained interpreter if required
- Consider how the cultural background of the client, the context in which the client is living (i.e., refugee camp, settlement country) and daily stressors impact on psychopathology, and how clinical practice can be adapted to accommodate these factors

- Consider family and school contexts when working with forcibly displaced children and adolescents.

Research. Research studies should

- Implement community participatory designs and be conducted in collaboration with service providers, clinicians and policymakers where possible
- Investigate the full breadth of psychological disorders and symptoms in refugees, focusing on cultural conceptions of distress
- Implement longitudinal, experimental, biological and neuroscience methods to identify mechanisms underlying refugee mental health and determine the temporal causal relationship between refugee experiences, mental health and other outcomes
- Be conducted in low- and middle- income countries (LMICs), to increase knowledge regarding the mental health of refugees in sustained displacement.

Further, treatment studies should

- Implement rigorous randomized controlled trial designs
- Investigate the efficacy of interventions in reducing psychological symptoms beyond PTSD and improving broader outcomes (e.g., functional impairment, quality of life)
- Evaluate interventions that improve access to mental health care (i.e., stepped care and on-line treatments) and have a broader community and societal focus
- Evaluate the efficacy of early intervention/ prevention programs, including Psychological First Aid
- Investigate treatment moderators to identify individuals who fail to benefit from best-practice interventions
- Include the development and evaluation of programs that support parental care and parenting practices in refugee families.

Professional Organizations. Relevant professional organizations should adopt an increased focus on refugee and asylum-seeker mental health.

Introduction

There are over 65 million people forcibly displaced worldwide due to conflict and persecution, with over 21 million of these being refugees (UNHCR, 2016). Approximately half of forcibly displaced people are children and adolescents, including a substantial proportion who are separated from their families (UNHCR, 2016). According to the 1951 Refugee Convention, a refugee is a person who is unable or unwilling to return to his or her country of origin due to a well-founded fear of persecution on the basis of race, religion, nationality, political affiliation or group membership. The United Nations High Commissioner for Refugees estimates that, in 2015, one in every 113 people globally was either an asylum-seeker, internally displaced person or a refugee (UNHCR, 2016). It is notable that, out of these, less than 1% of refugees worldwide in 2016 was resettled (UNHCR, 2016), with the majority of those being exposed to sustained displacement residing in LMICs. Refugees, asylum-seekers and other forcibly displaced persons are typically exposed to multiple traumatic events in the context of war, persecution and displacement. These experiences, which are often prolonged, repeated and interpersonal in nature, can have a profound impact on the individual's mental health. As an increasing number of people become forcibly displaced worldwide, there is a growing impetus amongst host countries to recognize and meet the mental health needs of refugees and asylum-seekers.

The overarching aim of this briefing paper is to inform ISTSS members, policymakers and global stakeholders about the mental health of individuals that have been forcibly displaced due to persecution and war. The following pages will review the extant evidence base on mental health related to psychological trauma in refugees and asylum-seekers. Over the past four decades, the field of refugee mental health research has grown exponentially, encompassing a broad array of research from epidemiological, qualitative, longitudinal and treatment evaluation modalities (Silove, Ventevogel & Rees, 2017). In recent years, theoretical models have been developed that provide comprehensive accounts of the impact of persecution, conflict and trauma, daily hardships, and social upheaval on the mental health of refugee and post-conflict populations (e.g., Hobfoll, 2014; Hou et al., 2017; Miller & Rasmussen, 2014; Silove, 2012; de Jong, 2002). While these models have created important frameworks to guide understanding and investigation of the psychological and social impact of the refugee experience, a theoretical review is outside the scope of this briefing paper. Instead, this paper will focus on empirical studies of refugee and asylum-seeker mental health. It is notable that the majority of empirical research reviewed in this paper has been conducted in high-income countries of settlement. In contrast, relatively less is known about the experiences of individuals living in contexts of sustained displacement in LMICs, which represents an important area for future research. This briefing paper will review studies that investigate common traumatic experiences and stressors, detail rates of psychological disorders amongst adult and child refugees and asylum-seekers, and evaluate psychological and pharmacological interventions for traumatic stress in these groups. The role of culture in influencing mental health will be considered, and barriers to treatment will be discussed. Finally, recommendations will be made for policy, research and clinical practice.

Exposure to traumatic events and mental health in forcibly displaced populations

Exposure to traumatic events and mental health in adult refugees and asylum-seekers

Refugees and asylum-seekers are vulnerable to the effects of traumatic events arising from persecution, conflict and displacement. Overall, forcibly displaced populations report exposure to a high number of potentially traumatic, repeated and prolonged adverse events. By definition, refugees are subject to persecution, which means that these events are often

interpersonal in nature. Potentially traumatic events commonly experienced by refugees and asylum-seekers in their home countries include interpersonal violence, sexual violence, life-threatening injuries, witnessing the murder of loved ones, and torture. People living in conflict-affected areas also report high levels of exposure to events such as injury, witnessing the deaths of others, terrorist attacks, and lack of food, water, shelter or medical care. As a function of persecution and conflict, refugees and asylum-seekers also often experience the death and/or disappearance of loved ones. While the extent of exposure to traumatic events may vary according to several factors including area/country of origin, characteristics of conflict and personal factors such as gender, age, ethnicity and sexual orientation, the dosage of exposure to traumatic events prior to displacement is commonly high amongst refugees and asylum-seekers.

For many individuals, displacement may involve several months or even years of travelling, living in conflict-affected areas or residing in refugee camps. In these contexts, the likelihood of experiencing a life-threatening situation is often high. For instance, refugees or asylum-seekers travelling by boat may be at risk of drowning at sea, with the number of people who have drowned in the Mediterranean sea while attempting to reach Europe exceeding 5000 in 2016 alone ("Migrant death toll passes 5,000 after two boats capsize off Italy," 2016). During displacement, additional potentially traumatic events related to the circumstances of the flight are common, such as limited access to clean water, food and medical assistance, extreme weather conditions and insecure means of travel. In addition, the physical safety of the individual or family may be compromised. Refugees, especially women, who are dependent on short-term accommodation and transportation, may be especially vulnerable to potentially traumatic events like oppression, sexual exploitation and violence, and forced marriage (Wells, Steel, Abo-Hilal, Hassan, & Lawsin, 2016).

Research indicates that there is a strong association between extent of exposure to traumatic events and symptoms of psychological disorders such as PTSD and depression; individuals who are exposed to more types of traumatic events, more frequently, and over a longer period of time report more severe psychological symptoms (Karunakara et al., 2004; Mollica, McInnes, Pham, et al., 1998; Mollica, McInnes, Poole, & Tor, 1998; Neuner et al., 2004; Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997). It is also notable that particular types of traumatic events appear to confer especially high risk for mental disorders. For example, rates of psychological disorders have been consistently found to be elevated amongst torture survivors compared to non-tortured groups (Basoglu et al., 1994; Shrestha et al., 1998; Van Ommeren et al., 2001), even after controlling for exposure to other types of traumatic events (Silove, Steel, McGorry, Miles, & Drobny, 2002). In a meta-analysis investigating predictors of mental health, torture emerged as the strongest risk factor associated with PTSD in conflict-affected and displaced populations (Steel et al., 2009). In addition, head injuries sustained during torture may also contribute to symptoms of PTSD and depression (Keatley, Ashman, Im, & Rasmussen, 2013).

Exposure to traumatic events and mental health in children and adolescents

The chronic and pervasive nature of war may be particularly harmful for children and adolescents. Exposure to harm may last weeks, months or years, often representing a significant proportion of their lifetime (Betancourt, Newnham, McBain, & Brennan, 2013; Fazel, Rees, & Silove, 2017). The range of exposures that children face during war and migration mirror those experienced by adults, and include witnessing violence and warfare, experiencing physical and sexual violence, deaths of or separation from family members and caregivers, deprivation of shelter, food and water, involuntary drug use, and in some cases

forced perpetration of violence against others (Betancourt et al., 2013; Hebebrand et al., 2016).

Children and youth are particularly vulnerable during migration, with significant risks of exploitation for those escaping from war zones (Digidiki & Bhabha, 2017; UNICEF, 2016). Many children and youth are vulnerable to trafficking, bonded labor, and sexual exploitation (Digidiki & Bhabha, 2017; Hebebrand et al., 2016), or die during migration (Fazel, Karunakara, & Newnham, 2014). While higher rates of sexual violence have been documented for females, both male and female refugee children and adolescents are at risk of sexual exploitation (Digidiki & Bhabha, 2017). Unaccompanied minors are particularly susceptible to harm (Devi, 2016).

Daily stressors and mental health in forcibly displaced populations

Daily stressors and mental health in adult refugees and asylum-seekers

Refugees typically encounter significant daily stressors following displacement – whether it be in a refugee camp, some form of temporary accommodation or upon settlement in a high-income host country. Post-migration or displacement-related stressors have been observed to adversely impact on the mental health of resettled refugees, over and above the effects of past trauma (Chu, Keller, & Rasmussen, 2013; Li, Liddell, & Nickerson, 2016; Schweitzer, Brough, Vromans, & Asic-Kobe, 2011). In addition, these stressors compound the dose-response association between past trauma and PTSD symptoms (Chen, Hall, Ling, & Renzaho, 2017; Gorst-Unsworth & Goldenberg, 1998; Miller & Rasmussen, 2017; Porter & Haslam, 2005; Rasmussen et al., 2010). Meta-analytic research has shown that post-migration stressors may also be associated with depression (Bogic, Njoku, & Priebe, 2015). Increasing recognition of the association between perceived post-migration/displacement stress and mental health has led to research uncovering the characteristics of these stressors and their specific impacts. These can be conceptualized as falling into three core categories:

Social isolation and discrimination: One of the most powerful classes of stressors experienced by refugees is social isolation, which may be caused by ongoing family separation, and a breakdown in familiar social and community structures (Miller & Rasmussen, 2017). Loneliness and social integration stressors emerged as major predictors of PTSD and other psychiatric diagnoses in a large cohort study of refugees with permanent settlement status in Australia (Chen et al., 2017). Importantly, restoration of family links via reunion programs (Nickerson, Bryant, Steel, Silove, & Brooks, 2010) and increased emotional social support provided to refugees (Gorst-Unsworth & Goldenberg, 1998) were associated with lower PTSD symptom severity. There is evidence to suggest that host country-refugee intercultural exchanges designed to facilitate social support also decreased psychological distress and improved self-reported quality of life among refugees in the United States (Goodkind et al., 2014). Negative public attitudes towards refugees and perceived discrimination are also major risk factors for PTSD and depression (Correa-Velez, Gifford, & Barnett, 2010; Ellis, MacDonald, Lincoln, & Cabral, 2008; Noh, Beiser, Kaspar, Hou, & Rummens, 1999). This is of significant concern in the current political climate. For example, recent analyses have shown that European media outlets frequently perpetuate polarizing views of refugees and migrants as threatening to culture and economic stability (Berry, Garcia-Blanco, & Moore, 2015).

Socioeconomic factors: Refugees face significant socioeconomic challenges – whether in temporary camps in which it is not possible to earn a living, or upon settlement, where achieving financial stability may be hampered by housing insecurity, poor language skills, and difficulties finding suitable employment (Beiser & Hou, 2001). Unemployment is high

amongst forcibly displaced groups, and refugees are frequently underemployed, as their skills and qualifications are often not recognized in host or settlement countries (Krahn, Derwing, Mulder, & Wilkinson, 2000). Many refugees also face restrictions on their right to work (Hocking, Kennedy, & Sundram, 2015). Unemployment (Beiser & Hou, 2001) and residing in temporary or insecure housing (Porter & Haslam, 2005) have been shown to adversely affect mental health, and particularly to contribute to risk of depression and anxiety. Pressure to support family members who remain in situations of ongoing conflict or poverty via remittances is high, which also has a deleterious effect on wellbeing (Savic, Chur-Hansen, Mahmood, & Moore, 2013). In addition, refugees are often highly reliant on welfare and support from government agencies, non-government organizations and charities.

Immigration and refugee policies: Research clearly indicates that stressors associated with the process of seeking asylum contribute to elevated psychological distress, including PTSD symptoms (Laban, Gernaat, Komproe, Schreuders, & De Jong, 2004; Silove et al., 1997; Silove, Steel, McGorry, & Mohan, 1998). Long waiting periods involved in the refugee status determination process (Steel, Liddell, Bateman Steel, & Zwi, 2011), extended periods of time in immigration detention (Keller et al., 2003; Robjant, Hassan, & Katona, 2009; Steel et al., 2004) and ongoing uncertain or temporary visa status (Steel, Momartin, et al., 2011) have each been linked to poor mental health outcomes. These include elevated rates of psychological disorders and increased suicidality, as well as poorer mental health outcomes over time (Coffey et al., 2010; Ichikawa, Nakahara, & Wakai, 2006; Keller et al., 2003; Procter, Kenny, Eaton, & Grech, 2017; Steel et al., 2004; Steel et al., 2006). In the context of refugee status claims, it is also likely that psychological symptoms impact on reporting of traumatic events experienced in the country of origin, potentially reducing the perceived credibility of the asylum-seeker and impacting negatively on the asylum decision (Herlihy, Jobson, & Turner, 2012; Herlihy, Scragg, & Turner, 2002; Herlihy & Turner, 2007). Alongside increased risk for psychological distress, studies have observed that insecure visa status is associated with impaired interpersonal functioning (Coffey et al., 2010) and persistent worry and social withdrawal (Steel, Momartin, et al., 2011), which in turn can exacerbate PTSD and depression symptoms regardless of pre-migration trauma (Schick, Zumwaki, et al., 2016). Resolution of insecure visa status has been linked to improved mental health, including PTSD symptoms (Raghavan, Rasmussen, Rosenfeld, & Keller, 2013), with longitudinal research suggesting that these effects may be explained by the reduction in post-migration stressors associated with insecure visa status (Nickerson, Steel, Bryant, Brooks, & Silove, 2011).

Daily stressors and mental health in children and adolescents

The long-term effects of exposure to trauma are mediated by ongoing risk and protective factors at the individual, family and community level (Miller & Rasmussen, 2017; Montgomery, 2008). Childhood and adolescence are developmental periods often reserved for the development of life-skills, nurturing relationships and access to education. For those forced to migrate at a young age, these opportunities are often lost (UNICEF, 2014). Disruptions to schooling and education can compound the detrimental effects of displacement (Sirin & Rogers-Sirin, 2015) and young people are often acutely aware of the cost of this interruption to future livelihoods and opportunities (Betancourt & Khan, 2008; UNICEF, 2016). Upon settlement in safer environments, acculturation stressors, economic insecurity, community violence and stigma can be important risk factors in child adjustment (Betancourt et al., 2017; Ellis et al., 2010).

At a family level, the loss of parents, siblings and relatives can have devastating effects for children and youth (Fazel, Reed, Panter-Brick, & Stein, 2012). Traumatic grief has

significant impacts for child and adolescent mental health and adjustment, and the death of a parent can create further adversity when economic stability and interpersonal security are threatened. In some families, parents' experience of trauma and torture can be a powerful predictor of child mental health (Almqvist & Broberg, 1999; Daud, af Klinteberg, & Rydelius, 2008), and it is well established that parental distress mediates the relationship between war trauma and psychosocial adjustment in children (Khamis, 2016). However, the role of parental exposure to trauma and child adjustment is complex and dynamic, and the effect on child mental health can fluctuate over time (Rousseau, Drapeau, & Rahimi, 2003).

Migration policy plays a critical role in child mental health. The detention of child refugees and forced migrants in purpose-built detention centers, jails and makeshift holding facilities is a global practice that defies the Convention on the Rights of the Child (Fazel, Karunakara, et al., 2014; International Detention Coalition, 2012). The majority of children in these conditions have been shown to meet diagnostic criteria for at least one psychiatric illness (Lorek et al., 2009; Steel et al., 2004). Contributing factors to the dire mental health status of this group include pervasive stress associated with prolonged and indefinite detention, separation from parents and family members, squalid and unsanitary living conditions, risk of abuse and assault, ongoing uncertainty about the future, disruptions to schooling, and poor access to medical care (Fazel et al., 2012; Killedar & Harris, 2017; The Australian Human Rights Commission, 2014). Similarly, insecure visa status can have detrimental effects on child mental health and limit opportunities for growth (Tozer, Khawaja, & Schweitzer, 2017).

Trauma-related disorders amongst forcibly displaced populations

Trauma-related disorders in adult refugees and asylum-seekers

Displaced and resettled refugees and asylum-seekers report elevated rates of psychological disorders in comparison to host populations in many settlement countries. The vast majority of research investigating the prevalence of psychological disorders in these groups has focused on PTSD and depression, with rates varying widely between studies. A comprehensive meta-analysis of rates of PTSD and depression in adult refugee and conflict-affected populations reported a point prevalence of 30.6% for PTSD (ranging from 0-99%) and 30.8% for depression (with individual study rates ranging from 3-86%; Steel et al., 2009). A re-analysis of this data using representative samples and full diagnostic assessment yielded rates of 15.4% for PTSD and 17.3% for depression (World Health Organization, 2013). There is evidence that these elevated rates of psychological disorders persist several years after displacement, both in countries of settlement and refugee camp contexts. For example, a review of mental disorders in adult refugees five years or longer after displacement reported prevalence rates of 4.4% to 86% for PTSD, and 2.3% to 80% for depression, with two-thirds and three-quarters of studies respectively reporting prevalence rates greater than 20% (Bogic et al., 2015). It is also notable that comorbid PTSD and depression is highly prevalent amongst refugees (Bogic et al., 2015), and meeting criteria for both of these disorders simultaneously is associated with greater functional impairment than either disorder alone (Mollica et al., 1999; Momartin, Silove, Manicavasagar, & Steel, 2004; Nickerson, Schick, Schnyder, Bryant, & Morina, In press).

While relatively less research has been conducted investigating the prevalence of other mental disorders in refugees and asylum-seekers, there is growing evidence that anxiety disorders such as panic disorder and obsessive compulsive disorder are elevated in these groups (Bogic et al., 2015). In addition, individuals who have lost loved ones, or are uncertain of the fate of those close to them may experience complicated bereavement or prolonged grief reactions (Boss, 2009; Nickerson et al., 2014; Tay, Rees, Chen, Kareth, &

Silove, 2016). In addition, numerous studies have identified high rates of somatic symptom disorders amongst refugees, particularly those who have experienced torture (Hondius, van Willigen, Kleijn, & van der Ploeg, 2000; Moisander & Edston, 2003; Olsen, Montgomery, Bojholm, & Foldspang, 2007). In contrast, findings regarding substance use disorders are mixed, with studies suggesting that there are elevated rates of alcohol and drug use amongst some displaced populations, but not others (Ezard, 2012; Kazour et al., 2017). There is also emerging evidence that psychotic symptoms are elevated in forcibly displaced populations (Dapunt et al., 2017; Hollander et al., 2016). It is important to note that, while rates of PTSD and depression are high in forcibly displaced groups, most studies conducted to date have found that the majority of participants did not meet criteria for a mental disorder, highlighting the resilience inherent in refugee and asylum-seeking populations.

Trauma-related disorders in children and adolescents

There are currently more than 10.8 million child refugees globally (UNHCR, 2016). While many child and adolescent refugees demonstrate tremendous resilience in the aftermath of war and forced migration (Sleijpen, Haagen, Mooren, & Kleber, 2016; Tozer et al., 2017; see Vindevogel, 2017 for a discussion of resilience in war-affected children), a sizeable proportion of this group report high rates of emotional and behavioural difficulties compared with community baseline estimates (Fazel & Stein, 2003; Jakobsen, Dermott, & Heir, 2014; Thommessen, Laghi, Cerrone, Baiocco, & Todd, 2013) and matched clinical samples (Betancourt et al., 2017). As in adult studies, prevalence rates vary considerably across study sites and populations. For example, reports of PTSD span rates of 10.5% reported among Yazidi youth in Turkey (Ceri et al., 2016) to 87% among Iraqi Kurdistan children living in refugee camps (Ahmad, Sofi, Sundelin-Wahlsten, & Von Knorring, 2000). For children and youth resettled in high-income nations, rates of PTSD, anxiety disorders and depression remain high (Ellis et al., 2008; Papageorgiou et al., 2000), even years after settlement (Vervliet, Lammertyn, Broekaert, & Derluyn, 2014). Unaccompanied refugee minors in Europe have been reported to exhibit similar or higher rates of psychological disorders as accompanied minors (Hebebrand et al., 2016), but lower rates of externalizing behaviors (Jakobsen et al., 2014). Among children held in immigration detention, a ten-fold increase in the incidence of PTSD, depression, anxiety disorders, self-harm, and sleep issues have been documented (Dudley, Steel, Mares, & Newman, 2012; Steel et al., 2004), and developmental regressions are common (Lorek et al., 2009). Growing evidence across multiple settings suggests that the trajectory of distress remains high over time, indicating that some refugee youth face a long-term persistence of psychological difficulties (Sack et al., 1993; Vervliet et al., 2014).

Treatment for trauma-related disorders in forcibly displaced populations

Psychological treatment for trauma-related disorders in adult refugees and asylum-seekers

In recent years, considerable evidence regarding the treatment of traumatized refugees has accumulated, which can be used to guide clinical decisions. The majority of treatment research conducted with refugees and asylum-seekers has evaluated the efficacy of trauma-focused approaches in reducing PTSD symptoms, with a series of randomized controlled trials (RCTs) being conducted to compare the efficacy of these interventions to inactive and active control groups. To date, a more or less consistent pattern has emerged from the findings of these trials. Recent reviews of the literature (Nose et al., 2017; Slobodin & de Jong, 2015; Tribe, Sendt, & Tracy, 2017) are consistent with previous summaries (Crumlish & O'Rourke, 2010; Nickerson, Bryant, Silove, & Steel, 2011) in finding that Narrative Exposure Therapy (NET) and adapted versions of Cognitive Behavioral Therapy (CBT) are

the most promising therapies for the treatment of PTSD in traumatized refugees. NET has been tested with a broad range of refugees from Africa living in low resource countries (such as Uganda) as well as refugees from various countries living in Germany (Hensel-Dittmann et al., 2011; Neuner et al., 2010), Norway (Stenmark, Catani, Neuner, Elbert, & Holen, 2013) and the US (Hijazi et al., 2014). Among the different variants of CBT, an adaptation of CBT for Cambodian refugees that incorporates interventions for culture-specific symptom presentations (Hinton et al., 2005) has been successfully tested in a randomized trial. Among all variants of CBT, complex (Hinton et al., 2005) as well as very pragmatic versions (Bolton et al., 2014) seem to be effective as long as they include trauma-focused interventions, such as imaginal exposure to the trauma memory or the modification of trauma-related beliefs. The evidence for eye movement desensitization and reprocessing (EMDR) is mixed. While Acaturk (2015) found clinically significant effects for EMDR, the effect size in another EMDR study was markedly lower than the effects achieved by other trauma-focused approaches (Ter Heide, Mooren, van de Schoot, de Jongh, & Kleber, 2016).

It is important to note that conceptualizations of refugee mental health and wellbeing have traditionally varied markedly between western-based researchers and aid agencies operating in humanitarian settings, with these conceptualizations substantially influencing the treatment approaches implemented in specific settings (Ventevogel, in press). Researchers based in high-income countries have been criticized for focusing on PTSD to the exclusion of other psychological disorders experienced by refugees and asylum-seekers, as well non-pathological distress. It has been argued that the focus on the psychological sequelae of past trauma has led to the development of interventions that are too narrow in scope to address the psychological needs of displaced persons, and that do not consider the contextual factors (such as daily stressors or environmental conditions) that also influence wellbeing. In contrast, agencies operating in humanitarian emergency settings have traditionally taken a psychosocial approach, which focuses on the strengthening of family, community and social networks to promote wellbeing. Operating from a social ecological perspective, this involves mobilizing community resources and facilitating the healing of "collective wounds" of war. Accordingly, there exist numerous psychosocial and multimodal treatments (both with and without trauma-focused elements), as well as family and social interventions targeting PTSD, depression and overall functioning in refugees and asylum-seekers. While some interventions have yielded promising results (Drozdek, Kamperman, Bolwerk, Tol, & Kleber, 2012; Drozdek, Kamperman, Tol, Knipscheer, & Kleber, 2014; Goodkind et al., 2014; van Wyk, Schweitzer, Brough, Vromans, & Murray, 2012; Weine et al., 2008), others have failed to find significant reductions in psychological symptoms and/or improvements in functioning (Birck, 2001; Buhmann, Nordentoft, Ekstroem, Carlsson, & Mortensen, 2016; Carlsson, Mortensen, & Kastrup, 2005). Although a few multimodal treatments have targeted nonclinical outcomes as well (e.g., improving social support), operational definitions of such outcomes have varied widely (Tol et al., 2011). In addition, often these interventions are implemented in settings where severity of psychopathology is high and there is substantial comorbidity, thus it is unclear whether the mixed results can be attributed to a lack of efficacy in the intervention, or to other uncontrolled factors. In the acute phase of a humanitarian emergency, psychological first aid (PFA) is often implemented to foster conditions of safety, security and support natural recovery (National Child Traumatic Stress Network, 2006; Save the Children, 2013; World Health Organization, War Trauma Foundation & World Vision International, 2011). While this represents a promising approach, however more research evidence is required before it can be recommended as an evidence-

based strategy across humanitarian contexts (Dieltjens et al., 2014). Overall, a lack of rigorous evaluation of the impact of these interventions on consistently-defined outcomes has precluded firm conclusions regarding the efficacy of these approaches to date (Nickerson, Bryant, et al., 2011; Slobodin & de Jong, 2015).

Taken together, the findings of randomized controlled trials with refugees are consistent with the recommendation that trauma-focused psychotherapy is the first choice treatment for PTSD in other trauma survivors (Foa, Keane, Friedman, & Cohen, 2008). Among the different variants of trauma-focused therapies, NET has the broadest evidence base with studies in various populations and settings ranging from low income regions to advanced healthcare systems in industrialized countries. There is a need, however, for rigorous evaluation of multimodal and psychosocial approaches to determine whether these interventions may be effective in reducing psychological symptoms and increasing wellbeing for refugees and asylum-seekers with complex presentations and in a variety of settings.

It is important to note that, across treatment approaches, the characteristics of the specific health care system, predisposing factors among refugees (e.g., demographics, social structure, beliefs about the causes and treatment of mental disorders, lack of knowledge about the health system, language skills) constitute barriers in access to health care for refugees and asylum-seekers. It is likely that only a small and selected minority of refugees seek and find treatment options for mental health impairments even in industrialized countries. An important finding in this context is that trauma-focused therapies such as NET as well as the transdiagnostic CETA (common elements in therapy approach) have been successfully applied by trained lay counsellors (Bolton et al., 2014; Neuner, Onyut, et al., 2008) in resource poor settings. In addition, Problem Management Plus (PM+), a brief, behaviorally-based intervention that is intended to be scalable has been successfully implemented, and been found to reduce psychological distress, in a conflict-affected area in Pakistan (Khan et al., 2017; Rahman et al., 2016) and with women with a history of gender-based violence in Kenya (Bryant et al., 2017). These findings show that task-shifting can be an important measure to increase capacities for treatment in LMICs as well as in developed health care systems that are overburdened by a large number of traumatized refugees in need of treatment. At the same time, *screen-and-treat approaches* that identify traumatized individuals directly in the community can be an efficient tool to overcome barriers to treatment for refugees (Neuner, Catani, et al., 2008). Another potentially promising tool to increase access to treatment is a stepped-care approach, with low-level interventions such as group therapy provided as a first step, and specialized treatment only as a second step in cases of non-response. Modern information technology may also be used to support and provide psychological treatments - ranging from basic app-based education to highly developed internet-based psychotherapeutic treatments. Digitally supported interventions hold the potential of substantially scaling up psychological interventions, to reach patients in areas of ongoing conflict and to reduce some of the perceived barriers (i.e., stigma) (Bockting, Williams, Carswell, & Grech, 2016). A recent study in Arabic-speaking individuals with PTSD comparing internet-delivered CBT to waitlist found significant reductions in symptoms of PTSD (Knaevelsrud, Brand, Lange, Ruwaard, & Wagner, 2015). However, the efficacy of low-intensity and online interventions for the treatment of traumatized refugees as well as the feasibility of stepped care approaches remain to be tested in rigorous treatment studies.

In addition to specific treatment approaches, a set of Mental Health and Psychosocial Support (MHPSS) guidelines was developed by the Inter-Agency Standing Committee (IASC) to inform agency responses in humanitarian emergencies. The term MHPSS was coined to unite

the disparate approaches to mental health and wellbeing taken by aid and health sector agencies operating in humanitarian settings (Inter Agency Standing Committee, van Ommeren & Wessells, 2007). MHPSS refers to "any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder (IASC, 2007)". The Inter-Agency Standing Committee (IASC) comprises UN agencies, the Red Cross and Red Crescent agencies, as well as intergovernmental organizations and nongovernmental organizations who contribute to global humanitarian policy. In 2005, the IASC appointed a Task Force to develop guidelines for MHPSS during emergencies. These guidelines provide a set of minimum responses to support wellbeing during emergencies, with the goal of promoting intersectorial collaboration (IASC, van Ommeren & Wessells, 2007). These guidelines encompass social support, protection, severe mental disorders, acute trauma-related distress and substance use. While not representing an intervention per se, these guidelines provide a broad set of principles to guide the activities and resources of agencies operating to support mental health in the context of humanitarian emergencies.

Pharmacological treatment for trauma-related disorders in adult refugees and asylum-seekers

There are few studies focusing on pharmacological interventions for traumatic stress symptoms in forcibly-displaced populations (Buhmann et al., 2016; Sonne, Carlsson, Elklit, Mortensen, & Ekstrom, 2013). To the best of our knowledge there are only two studies that directly compare the effects of pharmacological agents (Smajkic et al., 2001; Sonne et al., 2013). Preliminary evidence suggests that selective serotonin reuptake inhibitors(SSRIs; sertraline) are associated with a decrease in PTSD symptoms, and, in combination with psychoeducation, have led to improvements in secondary outcomes, such as depression, in severely trauma-affected refugee populations (Buhmann et al., 2016; Smajkic et al., 2001; Sonne et al., 2013). In addition, it is important to note that benzodiazepines are contraindicated for the treatment of PTSD in general (Foa, 2009). There remains a need, however, for studies that further examine the effect of other pharmacological agents as well as when and how these agents should be combined with psychological treatments.

It is also important to note that there may be geographical variations in genetic factors across countries and ethnicities (Lin & Shen, 1991; Noerregaard, 2012), which may affect the efficacy of pharmacological treatments across groups. Research in this area has not been conclusive to date, however, and further study is needed before definitive recommendations can be made a about cross-cultural implementation of pharmacological treatments.

Psychological treatment for trauma-related disorders in children and adolescents

When working with forcibly displaced children and adolescents, it is necessary to conceptualize interventions from a systemic perspective. Although refugee children may present with a range of both internalizing and externalizing manifestations of mental health problems, when addressing these presentations it is critical to consider not only the individual needs of that child but their broader context. This may include their home and living conditions; the stability and wellbeing of those with whom they live (be that parents or other guardians/carers) and the school in which they are placed and its preparedness and capacity to welcome refugee children (who often arrive at non-traditional points and times of entry). It is also necessary to take into account the broader community and societal context, for example their engagement in the immigration determination process, and the possibility of removal into detention or back to countries of transit and origin.

Individual treatments targeting PTSD have the strongest evidence-base in forcibly displaced children. NET (described above) has been adapted for children (KIDNET) (Robjant & Fazel, 2010). This treatment has led to significant reductions in symptoms of PTSD in refugee

children. Treatment studies have demonstrated that KIDNET can be effectively delivered by teachers and lay-workers, as well as mental health professionals (Robjant & Fazel, 2010). Accordingly, KIDNET is well-suited to being scaled up to meet the needs of the growing number of children affected by persecution and displacement (Robjant & Fazel, 2010). There are also other psychological interventions for PTSD that have demonstrated efficacy in non-refugee children including trauma-focused cognitive-behavior therapy (TF-CBT) and eye movement desensitization and reprocessing (EMDR), which warrant testing with forcibly displaced groups (Brown, Witt, et al., 2017; Hinton & Jalal, 2014; ter Heide, Mooren, van de Schoot, de Jongh, & Kleber, 2016).

As noted previously, there is a high prevalence of depressive symptomatology amongst forcibly displaced children. To date, there is limited specific research evidence regarding the best treatments for depression for refugee children, although there is some data to show that parenting interventions can improve depressive symptomatology in children (Trentacosta, McLear, Ziadni, Lumley, & Arfken, 2016). In the absence of more conclusive evidence, depression in refugee children should be managed according to current best-practice guidelines for all children, but with added focus on family and living circumstances.

While the overall evidence-base on interventions for refugee children is limited to CBT-inspired interventions, school and family-based interventions represent promising avenues for further investigation. For forcibly-displaced children, schools can potentially be a location for interventions that facilitate access to mental health interventions (Fazel, Garcia, & Stein, 2016). Interventions trialed in schools to date have generally targeted at-risk children, such as those who have been exposed to traumatic events, and comprised creative arts interventions such as psychodrama, as well as cognitive-behavioral interventions. Increasingly these interventions are trying to address needs at different levels by adopting a tiered approach (Fazel, Hoagwood, Stephan, & Ford, 2014; Tyrer & Fazel, 2014). Family-based interventions may be especially important for those refugee children who are accompanied by a primary caregiver. The focus of these interventions is often on easing daily stressors; teaching parenting strategies; and reducing overall risk of exposure to ongoing violence - especially if that violence is experienced within their homes (Brown, de Graaff, Annan, & Betancourt, 2017). Several studies indicated that family violence against children may be increased in families that have been affected by war (Catani, Jacob, Schauer, Kohila, & Neuner, 2008; Catani et al., 2009) and that family violence impairs mental health in the context of war (Olema, Catani, Ertl, Saile, & Neuner, 2014). The data indicates that these family-based interventions, focusing on parenting strategies, can reduce intrafamilial discord and aggression (Belhadj Kouider, Koglin, & Petermann, 2015; Puffer, Annan, Sim, Salhi, & Betancourt, 2017).

Cultural considerations in the mental health of forcibly displaced populations

Influence of culture on mental health

Culture organizes systems of meaning, and most major refugee crises of the 21st century - Syria, Sudan, Afghanistan, and Democratic Republic of Congo (UNHCR, 2017) - are situated well outside of the cultural contexts in which DSM-5 and ICD-10 nosologies have been organized Cavallera et al., 2016; Hassan et al., 2016). This leaves most mental health professionals at a cultural disadvantage in their encounters with refugees. This mismatch has been recognized by several international humanitarian bodies as a barrier to reliable psychosocial assessment and valid intervention (e.g., IASC, 2007). Aside from intercultural logistical barriers such as language interpretation resources or the availability of multilingual

mental health professionals, potential culture-related barriers include differential symptom expressions across cultures, the potential for limited construct validity of disorders in different groups, and unclear cultural validity of clinical interventions. Accordingly, the development of cultural competence among clinicians is of key importance when working with refugees and asylum-seekers from a variety of backgrounds (Kirmayer et al., 2010).

Culture and psychological assessment

Culturally proscribed response styles and symptom expression are important to consider in assessment. Extreme and acquiescent responding directly affects the use of scoring thresholds for post-trauma psychopathology among refugees (Rasmussen, Verkuilen, Ho, & Fan, 2015; Vindbjerg, Klimpke, & Carlsson, 2014). In addition, different cultural groups emphasize symptoms differently within specific disorders. Good examples for culturally adapting measures (rather than simply translating them) do exist, and several authors provide clear guidelines and have empirically validated measures that were developed on the basis of these guidelines in the field (e.g., Haroz et al., 2014; Kaiser, Kohrt, Keys, Khoury, & Brewster, 2013). In addition, a Cultural Formulation Interview has been developed for the DSM-5 to assist clinicians in undertaking cultural assessments to inform diagnosis and treatment planning (American Psychiatric Association, 2003).

The ways in which people conceptualize distress also varies considerably across cultures. There are multiple factor analytic studies that suggest that patterns of PTSD and depression symptoms are similar to DSM-5 models across a variety of samples (Palmieri, Marshall, & Schell, 2007; Rasmussen, Smith, & Keller, 2007; Schnyder et al., 2015; Vinson & Chang, 2012). However, this etic (i.e., universalist) statistical evidence does not necessarily imply the constructs' emic (i.e., insider's) cultural validity. There is a wide variety of cultural constructs of distress (CCDs) documented in post-trauma settings (for a review, see Rasmussen, Keatley, & Joscelyne, 2014), and some debate as to whether similarities between these CCDs and PTSD as described by the DSM-5 and ICD-10 suggest that PTSD is valid cross-culturally (Hinton & Lewis-Fernandez, 2011) or not (Rasmussen et al., 2015). Only a few studies have compared CCDs to DSM-5 and ICD-10 disorders empirically, but findings from these studies suggest that CCDs are slightly better associated with third variables like trauma exposure and functional impairment (Jayawickreme, Jayawickreme, Atanasov, Goonasekera, & Foa, 2012; Rasmussen, Ventevogel, Sancilio, Eggerman, & Panter-Brick, 2014). In humanitarian aid practice, small advantages to adapting or developing more culturally relevant measures of CCDs may be outweighed by the expediency of using available measures of DSM-5 and ICD-10 disorders in the short term; however, over the long term these small differences likely add up to substantial numbers of false negatives and false positives (Rasmussen et al., 2014). Unfortunately, to date few researchers have sought to measure CCDs in mental health assessment, and as a result there is scant information about CCD assessments' reliability or validity (Kohrt et al., 2014).

Culture and psychological treatment

Evidence-based treatments for trauma-related disorders in forcibly displaced populations are generally not explicitly designed around cultural content (Tribe et al., 2017). Instead they rely on clinicians' cultural competence in delivery - whether they are foreign therapists or trained refugees. There is limited preliminary evidence to suggest that having trained refugees act as therapists results in effect sizes that are equivalent to or larger than using foreign mental health professionals (e.g., for NET; Gwozdziewycz & Mehl-Madrona, 2013). It should, however, be noted that some forcibly displaced clients prefer to work with clinicians from a different background due to difficulty trusting others from their communities following

experiences of betrayal and persecution. In any event, integrating war-affected populations into psychosocial care delivery is an empirically supported practice, and several good examples of this exist in the literature (e.g., Jordans et al., 2010).

There are few examples of interventions that incorporate specific elements of the target group's culture into treatment. Those that exist do so by either supporting culturally sanctioned healers and healing practices (e.g., Eisenbruch, de Jong, & van de Put, 2004), or altering specific treatments using culturally meaningful elements. Hinton's adaptation of cognitive behavioral therapy for Cambodian refugees with comorbid PTSD and panic disorder (Hinton & Patel, 2017; Otto & Hinton, 2006) incorporates Buddhist rituals into relaxation techniques and allows for both psychiatric and *Khmer* medicine explanatory models of distress. The latter is distinctive in that it is one of the few culturally-adapted treatments of psychopathology in refugees that has been empirically supported in RCTs (Hinton et al., 2005). To a certain degree, such interventions meet patients within their own belief systems, in contrast to imported treatments that involve considerable psychoeducation in western explanatory models.

Barriers to treatment for trauma-related disorders in forcibly displaced populations

There is a gap between the number of refugees, asylum-seekers and forced migrants in need of treatment for psychological disorders and the number who receive appropriate assessment and care in both the context of displacement and settlement (Kinzie, 2006; Laban, Gernaat, Komproe, & De Jong, 2007; Shannon, O'Dougherty, & Mehta, 2012). Even in settlement countries, for those who do receive treatment, many refugees do not access psychological services until several years after arrival in the host country (Buhmann, Nordentoft, Ekstroem, Carlsson, & Mortensen, 2016; Sonne, Carlsson, Bech, Elklit, & Mortensen, 2016; Schick, Zumwald, et al., 2016). There are a number of important barriers to accessing treatment in forcibly displaced populations, both at the individual and systemic levels.

Numerous practical barriers exist that may prevent or delay access to adequate treatment for refugees and asylum-seekers. In LMICs, mental health services, and the resources and systems to support them may not be readily available (Patel et al., 2009; Saxena et al., 2007). Trained staff who can implement the interventions may be scarce, and training and supervision processes may be costly and time-consuming (Bolton, in press). In settlement countries, specialised care may not be easily accessible and treatments are often expensive, and, even in the case of freely-available services, lack of financial resources amongst refugees and asylum-seekers may make travel to access treatment prohibitive (Drummond et al., 2011; Wong et al., 2006). Additionally, in settlement countries treatment options are often dependent on the residency status of the individual. For example, in many countries, asylum-seekers and undocumented migrants may only be offered access to emergency care or allocated a limited number of therapy sessions (Norredam, Mygind, & Krasnik, 2006). When treatment is available, there may be a lack of culturally-appropriate service providers who are able to deliver the treatment in a manner that is tailored to the client's cultural background (Ellis et al., 2011). Logistic barriers such as adequate resources to engage with treatment (i.e., caring responsibilities, lost work hours, financial resources for travel) and geographical distance from the site of treatment may also reduce uptake in LMICs and high-income settlement countries even when treatments are available (Bolton, in press). In addition, practical concerns are often of central importance to refugees and asylum-seekers, particularly in the initial years after settlement. Obtaining residency, securing housing, financial stability, and reunification with displaced family members are likely to be prioritized, while psychological needs may be considered to be secondary (Ellis et al., 2011).

Interpreters may be necessary for conducting therapy with clients who do not speak the dominant language in the host country; there is evidence that psychological therapies for PTSD can be effectively delivered by interpreters, but that this form of delivery is more resource-intensive (Schulz, Resick, Huber, & Griffin, 2006). In addition, interpreters may not be available in the client's preferred language or, when available, the cost of these services may represent a critical barrier to accessing treatment. In addition, there are complexities within the interpreter-client-therapist relationship, such as client concerns relating to trust and confidentiality and the possibility of client experiences impacting on the mental health and wellbeing of the interpreter (Miller, Martell, Pazdirek, Caruth, & Lopez, 2005).

As noted above, many refugees are from cultural backgrounds in which psychological symptoms may be conceptualized differently to the dominant culture in their host country. Divergent conceptualizations of emotional distress and a lack of understanding of western concepts of mental health (as well as treatments) are likely to contribute to both the treatment gap as well as the delay in treatment in settlement countries (Guerin, Guerin, Diiriye, & Yates, 2004; Piwowarczyk, Bishop, Yusuf, Mudymba, & Raj, 2014; Slewa-Younan et al., 2014). In some communities, beliefs in non-medical explanations of psychological symptoms prevail and therefore help may be sought from spiritual and traditional healers, rather than within the mainstream health system of the host country (Adeosun, Adegbohun, Adewumi, & Jeje, 2013; Khalifa, Hardie, Latif, Jamil, & Walker, 2011). Healthcare systems in host countries often differ substantially from those in the country of origin, and lack of knowledge regarding mental health care in the host country may lead to fear of seeking treatment in an unfamiliar context (Burnett & Peel, 2001; Piwowarczyk, Bishop, Yusuf, Mudymba, & Raj, 2014; Wong et al., 2006).

Stigma related to mental illness represents an important barrier to accessing treatment for refugees (Alonso et al., 2008; Bettmann, Penney, Clarkson Freeman, & Lecy, 2015; Drummond, Mizan, Brocx, & Wright, 2011; Shannon, Wieling, Simmerlink-McCleary, & Becher, 2015). Fear of being perceived negatively or even ostracized by one's community may reduce the likelihood that an individual from a refugee background will seek help for psychological symptoms (Drummond et al., 2011; Shannon et al., 2015). This may be further compounded by distrust of those in authority, arising from persecution, marginalization and trauma experienced in the country of origin (Ellis, Miller, Baldwin, & Abdi, 2011; Shannon et al., 2015).

Conclusions & Recommendations

There are a growing number of refugees, asylum-seekers and other forcibly displaced persons worldwide. Exposure to potentially traumatic events in the country of origin and during displacement, coupled with significant daily stressors, gives rise to high levels of psychological symptoms in these groups. Government and non-government agencies, service providers and clinicians are tasked with providing mental health care to this vulnerable population. Following are recommendations arising from the current evidence base surrounding the mental health of forcibly displaced populations to inform policy, research and clinical practice.

Public Health Policy

Evidence-based psychological therapies should be made available to refugees and asylum-seekers in need of treatment. This may include the following measures:

- Provision of no-cost psychological treatment including costs for interpreters.

- Increasing the competence to provide evidence-based treatment by prioritizing training in evidence-based therapies for forcibly displaced populations.
- Provision of cultural competence training at a systemic level for those working with forcibly displaced populations.
- Creating and supporting complementary treatment, training and research facilities for traumatized refugees and asylum-seekers to relieve overburdened health care systems, to increase and maintain competence for the treatment of forcibly displaced groups and to overcome barriers to treatment.
- The involvement of individuals from forcibly displaced groups in mental health programming and implementation, as well as in a task-shifting capacity as cultural mediators and lay therapists.
- The provision of stigma reduction programs and education regarding available treatment options for displaced communities, as well as training in working with mental health stigma for individuals providing services for refugees and asylum-seekers.

Immigration and Settlement and MHPSS Policy

It is critical that policymakers consider the substantial impact of the displacement or settlement context on the mental health of forcibly-displaced groups. It is recommended that the following steps be taken:

- Refugee and asylum-seeking communities are highly resilient. Immigration, settlement and MHPSS policy should facilitate positive adaptation and good mental health outcomes in forcibly-displaced populations through the provision of critical health, economic, housing, social, and other resources.
- Policymakers should consider the negative mental health effects of restrictive immigration policies such as immigration detention, insecure residency/temporary protection, extended processing times, and separation from family on forcibly-displaced groups.
- Decision-makers should consider the impact of psychological symptoms on memory for traumatic events when conducting immigration interviews. The provision of training to decision-makers on mental health and trauma memories is recommended.
- Children and adolescents are especially vulnerable to exploitation during displacement, and reunification with family members should be prioritized.

Clinical Practice

When providing treatment for psychological disorders to forcibly-displaced groups, it is recommended that the following measures be taken:

- Evidence-based interventions should be implemented where possible. To date, research suggests that trauma-focused therapies have the strongest evidence for reducing PTSD in forcibly-displaced groups. Relatively less research evidence exists to specifically guide the treatment of depression, other anxiety disorders and grief amongst forcibly displaced groups, and thus broader treatment guidelines should be consulted for these disorders.

- Psychological interventions should be provided via a trained interpreter if required.
- The role of daily stressors in contributing to psychological distress should be considered. For example, traumatic stress symptoms may be less salient than current stressors related to immigration status, economic resources and social isolation. It may be appropriate for the client to receive support from an aid agency, caseworker or settlement service provider before or at the same time as commencing psychological treatment.
- The cultural background of the individual should be considered in clinical practice. Professionals working with forcibly displaced groups should inform themselves regarding the client's culture, where possible drawing on expertise from within the client's community. In addition, professionals should be prepared to work with a broad range of attitudes, beliefs and educational backgrounds among the refugee clients.
- When working with forcibly displaced children, family and school contexts should be considered. Schools present important channels for implementing psychological intervention. When working with adults, enquiries should be made regarding the wellbeing of any children in the family; and whether they are exposed to ongoing trauma, including violence at home and victimization at school.

<u>Research</u>

Compared to other trauma-affected populations, there is relatively less research to guide the understanding and treatment of psychological distress in forcibly displaced groups, especially those in LMICs and in contexts of sustained displacement. Below are recommendations for future research.

- Community participatory designs should be implemented in research studies where possible to ensure that research is informed by, and conducted in partnership with, forcibly displaced communities.
- Research projects should be conducted in collaboration with service providers, clinicians, and policymakers, where possible. The integration of research into clinical practice and settlement support would allow for the identification of gaps in knowledge, and the generation of outcomes that directly inform policy and practice.
- Research into the mental health of forcibly displaced populations should extend beyond the current focus on PTSD and depression to understand the breadth of psychological symptoms experienced by refugees. As the majority of forcibly-displaced individuals do not meet criteria for a psychological disorder, studies should also investigate factors contributing to positive mental health outcomes amongst refugees and asylum-seekers.
- More research attention should be paid to cultural conceptions of distress, and how these relate to current psychiatric nosologies. In addition, efforts should be made to adapt existing validated instruments for psychological symptoms to incorporate cultural conceptions of distress.
- Longitudinal studies should be carried out to determine the temporal causal relationship between exposure to traumatic events and post migration stressors, and mental health and real-life outcomes (education, employment, etc.).

- Research should investigate the role of psychological, biological and social mechanisms in influencing refugee mental health using a variety of methods including experimental, longitudinal, biological, and neuroscience. The identification of these mechanisms would directly inform the development and tailoring of interventions to address the key factors underlying psychological distress in refugees.
- Research should be conducted in LMICs to increase knowledge regarding the mental health of refugees living in conditions of sustained displacement.

Further research is needed to identify effective interventions for reducing psychological distress and increasing functioning amongst forcibly displaced groups.

- Randomized controlled trials should be conducted to establish the efficacy of psychological and pharmacological interventions for psychological disorders in forcibly displaced populations. The implementation of rigorous research methodologies (i.e., appropriate control conditions, blind assessments, long-term follow-up assessments, clearly delineated treatment components, etc.) will enhance the evidence base for treatments for psychological disorders in refugees and asylum-seekers.
- Treatment studies should investigate the efficacy of interventions in reducing psychological symptoms of prevalent disorders amongst refugees, beyond PTSD (e.g., depression, grief, anxiety disorders), and improving broader outcomes (e.g., functional impairment, quality of life).
- Stepped-care and on-line interventions should be evaluated as possible pathways to providing greater access to mental health care in forcibly displaced populations. In addition, interventions with a broader community and societal focus (e.g., psychosocial interventions) should be tested.
- Early intervention and prevention programs should be developed and evaluated. In particular, more research should be conducted to evaluate the efficacy of Psychological First Aid in facilitating recovery in the immediate post-trauma environment.
- Research should be conducted to identify individuals who fail to benefit from psychological and pharmacological interventions, to understand factors that impact on treatment response (e.g., age, gender, immigration status), and to develop tailored interventions for these individuals.
- Prevention and intervention programs to support sensitive parental care and to increase functional parenting practices in trauma-burdened refugee families should be developed and evaluated.

<u>Professional Organizations</u>

Professional organizations (such as ISTSS) should implement an increased focus on research, practice and policy issues related to refugee and asylum-seeker mental health. This could be achieved by:

- Highlighting research relating to refugees and asylum-seekers at conferences and meetings that bring together the society membership.

- Facilitating collaborations between researchers, clinicians, refugee services, government agencies and non-government organizations in the field.
- Providing opportunities for training and education on evidence-based practice with refugees and asylum-seekers.
- Facilitating the sharing of research findings with policymakers and global stakeholders.
- Increasing engagement with a variety of individuals involved in refugee mental health efforts, i.e., researchers, clinicians, humanitarian workers, and support service workers working with refugees, and also individuals from a refugee background who are engaged in supporting those in their communities.

References

Acarturk, C., Konuk, E., Cetinkaya, M., Senay, I., Sijbrandij, M., Cuijpers, P., & Aker, T. (2015). EMDR for Syrian refugees with posttraumatic stress disorder symptoms: Results of a pilot randomized controlled trial. *European Journal of Psychotraumatology, 6*(1), 27414. doi: 10.3402/ejpt.v6.27414

Adeosun, I. I., Adegbohun, A. A., Adewumi, T. A. & Jeje, O. O. (2013). The pathways to the first contact with mental health services among patients with schizophrenia in Lagos, Nigeria. *Schizophrenia Research and Treatment, 769161*. doi: 10.1155/2013/769161.

Ahmad, A., Sofi, M., Sundelin-Wahlsten, V., & Von Knorring, A. L. (2000). Posttraumatic stress disorder in children after the military operation "Anfal" in Iraqi Kurdistan. *European Child & Adolescent Psychiatry, 9*(4),235-243. doi: 10.1007/s007870070026

Almqvist, K., & Broberg, A. G. (1999). Mental health and social adjustment in young refugee children 3½ years after their arrival in Sweden. *Journal of the American Academy of Child & Adolescent Psychiatry, 38*(6),, 723-730. doi: 10.1097/00004583-199906000-00020

Alonso, J., Buron, A., Bruffaerts, R., He, Y., Posada-Villa, J., Lepine, J. P., . . . The World Mental Health Consortium (2008). Association of perceived stigma and mood and anxiety disorders: Results from the World Mental Health Surveys. *Acta Psychiatrica Scandinavica, 118*(4),, 305-314. doi: 10.1111/j.1600-0447.2008.01241.x

American Psychiatric Association (2013). Diagnostic and statistical manual of mental disorders, 5th edition. American Psychiatric Publishing: Arlington, Virginia.

Basoglu, M., Paker, M., Paker, O., Ozmen, E., Marks, I., Incesu, C., . . . Sarimurat, N. (1994). Psychological effects of torture: A comparison of tortured with nontortured political activists in Turkey. *American Journal of Psychiatry, 151*(1), 76-81. doi: 10.1176/ajp.151.1.76

Beiser, M., & Hou, F. (2001). Language acquisition, unemployment and depressive disorder among Southeast Asian refugees: A 10-year study. *Social Science & Medicine, 53*, 1321-1334. doi: 10.1016/s0277-9536(00)00412-3

Belhadj Kouider, E., Koglin, U., & Petermann, F. (2015). Emotional and behavioral problems in migrant children and adolescents in American countries: A systematic review. *Journal of Immigrant and Minority Health, 17*(4), 1240-1258. doi: 10.1007/s10903-014-0039-2

Berry, M., Garcia-Blanco, I., & Moore, K. (2015). Press Coverage of the Refugee and Migrant Crisis in the EU: A Content Analysis of Five European Countries. UNHCR

Betancourt, T. S., & Khan, K. T. (2008). The mental health of children affected by armed conflict: Protective processes and pathways to resilience. *International Review of Psychiatry, 20*(3), 317-328. doi: 10.1080/09540260802090363

Betancourt, T. S., Newnham, E. A., Birman, D., Lee, R., Ellis, H., & Layne, C. M. (2017). Comparing trauma exposure, mental health needs and service utilization across clinical samples of refugee, immigrant and non-immigrant children. *Journal of Traumatic Stress, 30,* 209-218.

Betancourt, T. S., Newnham, E. A., McBain, R., & Brennan, R. T. (2013). Post-traumatic stress symptoms among former child soldiers in Sierra Leone: Follow-up study. *The British Journal of Psychiatry, 203*(3), 196-202. doi: 10.1192/bjp.bp.112.113514

Bettmann, J. E., Penney, D., Clarkson Freeman, P., & Lecy, N. (2015). Somali refugees' perceptions of mental illness. *Social Work in Health Care, 54*(8), 738-757. doi: 10.1080/00981389.2015.1046578

Birck, A. (2001). Torture victims after psychotherapy: A two year follow-up. *Torture, 11*(2), 55-58.

Bockting, C. L. H., Williams, A. D., Carswell, K., & Grech, A. E. (2016). The potential of low-intensity and online interventions for depression in low- and middle-income countries. *Global Mental Health (Camb), 3,* e25. doi: 10.1017/gmh.2016.21

Bogic, M., Njoku, A., & Priebe, S. (2015). Long-term mental health of war-refugees: A systematic literature review. *BMC International Health and Human Rights, 15,* 29. doi: 10.1186/s12914-015-0064-9

Bolton, P. (in press). Development and evaluation of mental health interventions for common mental disorders in post-conflict settings. In (Eds). N. Morina & A. Nickerson. *Mental health in refugee and post-conflict populations.* Springer: Amsterdam

Bolton, P., Bass, J. K., Zangana, G., Kamal, T., Murray, S., Kaysen, D., . . . Rosenblum, M. (2014). A randomized controlled trial of mental health interventions for survivors of systematic violence in Kurdistan, Northern Iraq. *BMC Psychiatry, 14*(1), 1693. doi: 10.1186/s12888-014-0360-2

Boss, P. (2009). Ambiguous loss: Learning to live with unresolved grief. Harvard University Press.

Brown, F. L., de Graaff, A. M., Annan, J., & Betancourt, T. S. (2017). Annual research review: Breaking cycles of violence - a systematic review and common practice elements analysis of psychosocial interventions for children and youth affected by armed conflict. The *Journal of Child Psychology and Psychiatry, 58*(4), 507-524. doi: 10.1111/jcpp.12671

Brown, R., Witt, A., Fegert, J., Keller, F., Rassenhofer, M., & Plener, P. (2017). Psychosocial interventions for children and adolescents after man-made and natural disasters: A meta-analysis and systematic review. *Psychological Medicine.*

Bryant, R. A., Schafer, A., Dawson, K. S., Anjuri, D., Mulili, C., Mdogoni, L., Koyiet, P., Sijbrandij, M., Ulate, J., Shehadeh, M. H., Hadzi-Pavlovic, D., & van Ommeren, M. (2017). Effectiveness of a brief behavioural intervention on psychological distress among women with a history of gender-based violence in urban Kenya: A randomised clinical trial. *PLoS Med, 14,* e1002371.

Buhmann, C. B., Nordentoft, M., Ekstroem, M., Carlsson, J., & Mortensen, E. L. (2016). The effect of flexible cognitive-behavioural therapy and medical treatment, including antidepressants on post-traumatic stress disorder and depression in traumatised refugees: Pragmatic randomised controlled clinical trial. *British Journal of Psychiatry, 208*(3), 252-259. doi: 10.1192/bjp.bp.114.150961

Burnett, A., & Peel, M. (2001). Health needs of asylum seekers and refugees. *BMJ, 322*(7285), 544-547.

Carlsson, J. M., Mortensen, E. L., & Kastrup, M. (2005). A follow-up study of mental health and health-related quality of life in tortured refugees in multidiscipilinary treatment. *The Journal of Nervous and Mental Disease, 193*(10), 651-657. doi: 00005053-200510000-00003

Catani, C., Jacob, N., Schauer, E., Kohila, M., & Neuner, F. (2008). Family violence, war, and natural disasters: A study of the effect of extreme stress on children's mental health in Sri Lanka. *BMC Psychiatry, 8*, 33. doi: 10.1186/1471-244X-8-33

Catani, C., Schauer, E., Elbert, T., Missmahl, I., Bette, J. P., & Neuner, F. (2009). War trauma, child labor, and family violence: Life adversities and PTSD in a sample of school children in Kabul. *Journal of Traumatic Stress, 22*(3), 163-171. doi: 10.1002/jts.20415

Cavallera, V, Reggi, M., Abdi, S., Jinnah, Z., Kivelenge, J., Warsame, A.M., Yusuf, A.M., Ventevogel, P. (2016). Culture, context and mental health of Somali refugees: a primer for staff working in mental health and psychosocial support programmes. Geneva, United Nations High Commissioner for Refugees. https://data2.unhcr.org/en/documents/download/52624

Ceri, V., Özlü-Erkilic, Z., Özer, Ü., Yalcin, M., Popow, C., & Akkaya-Kalayci, T. (2016). Psychiatric symptoms and disorders among Yazidi children and adolescents immediately after forced migration following ISIS attacks. *Neuropsychiatrie, 30*(3), 145-150. doi: 10.1007/s40211-016-0195-9

Chen, W., Hall, B. J., Ling, L., & Renzaho, A. M. (2017). Pre-migration and post-migration factors associated with mental health in humanitarian migrants in Australia and the moderation effect of post-migration stressors: Findings from the first wave data of the BNLA cohort study. *Lancet Psychiatry, 4*(3), 218-229. doi: 10.1016/S2215-0366(17)30032-9

Chu, T. Q., Keller, A. S., & Rasmussen, A. (2013). Effects of post-migration factors on PTSD outcomes among immigrant survivors of political violence. *Journal of Immigrant Minority Health, 15*, 890-897. doi: 10.1007/s10903-012-9696-1

Coffey, G. J., Kaplan, I., Sampson, R. C., Tucci, M. M. (2010). The meaning and mental health consequences of long-term immigration detention for people seeking asylum. *Social Science & Medicine, 70*(12), 2070-2079. doi: 10.1016/j.socscimed.2010.02.042 20378223

Correa-Velez, I., Gifford, S. M., & Barnett, A. G. (2010). Longing to belong: Social inclusion and wellbeing among youth with refugee backgrounds in the first three years in Melbourne, Australia. *Social Science & Medicine, 71*(8), 1399-1408. doi: 10.1016/j.socscimed.2010.07.018

Crumlish, N., & O'Rourke, K. (2010). A systematic review of treatments for post-traumatic stress disorder among refugees and asylum-seekers. *Journal of Nervous and Mental Disease, 198*(4), 237-251. doi: 10.1097/NMD.0b013e3181d61258

Dapunt, J., Kluge, U., & Heinz, A. (2017). Risk of psychosis in refugees: a literature review. Translational psychiatry, 7(6), e1149.

Daud, A., af Klinteberg, B., & Rydelius, P.A. (2008). Resilience and vulnerability among refugee children of traumatized and non-traumatized parents. *Child and Adolescent Psychiatry and Mental Health, 2*(1), 7. doi: 10.1186/1753-2000-2-7

Devi, S. (2016). Unaccompanied migrant children at risk across Europe. *The Lancet, 387*(10038), 2590. doi: 10.1016/s0140-6736(16)30891-1

de Jong, J. T. (2002). Public mental health, traumatic stress and human rights violations in low-income countries. In J. de Jong (Ed.), *Trauma, War, and Violence: Public Mental Health in Socio-cultural Context* (pp. 1-91). New York, NY: Kluwer Academic/Plenum Publishers

Dieltjens, T., Moonens, I., Van Praet, K., De Buck, E., & Vanderkerckhove, P. (2014). A systematic literature search on Psychological First Aid : Lack of evidence to develop guidelines. *PLoS ONE, 9*, e114714.

Digidiki, V., & Bhabha, J. (2017). Emergency within an Emergency: The Growing Epidemic of Sexual Exploitation and Abuse of Migrant Children in Greece. Boston: FXB Center for Health and Human Rights, Harvard University

Drozdek, B., Kamperman, A. M., Bolwerk, N., Tol, W. A., & Kleber, R. J. (2012). Group therapy with male asylum seekers and refugees with posttraumatic stress disorder: A controlled comparison cohort study of three day-treatment programs. *Journal of Nervous and Mental Disease, 200*(9), 758-765. doi: 10.1097/NMD.0b013e318266f860

Drozdek, B., Kamperman, A. M., Tol, W. A., Knipscheer, J. W., & Kleber, R. J. (2014). Seven-year follow-up study of symptoms in asylum seekers and refugees with PTSD treated with trauma-focused groups. *Journal of Clinical Psychology, 70*(4), 376-387. doi: 10.1002/jclp.22035

Drummond, P. D., Mizan, A., Brocx, K., & Wright, B. (2011). Barriers to accessing health care services for West African refugee women living in Western Australia. *Health Care for Women International, 32*(3), 206-224. doi: 10.1080/07399332.2010.529216

Dudley, M., Steel, Z., Mares, S., & Newman, L. (2012). Children and young people in immigration detention. *Current Opinion in Psychiatry, 25*(4), 285-292. doi: 10.1097/yco.0b013e3283548676

Eisenbruch, M., de Jong, J. T., & van de Put, W. (2004). Bringing order out of chaos: A culturally competent approach to managing the problems of refugees and victims of organized violence. *Journal of Traumatic Stress, 17*(2), 123-131. doi: 10.1023/b:jots.0000022618.65406.e8

Ellis, B. H., MacDonald, H. Z., Klunk [illegible] Gill, H. J., Lincoln, A., Strun (2010). Discrimination and mental health among Somali refugee adolescents: The role of acculturation and gender. *American Journal of Orthopsychiatry, 80*(4), 564-575. doi: 10.1111/j.1939-0025.2010.01061.x

Ellis, B. H., MacDonald, H. Z., Lincoln, A. K., & Cabral, H. J. (2008). Mental health of Somali adolescent refugees: The role of trauma, stress, and perceived discrimination. *Journal of Consulting and Clinical Psychology, 76*(2), 184-193. doi: 10.1037/0022-006X.76.2.184

Ellis, B. H., Miller, A. B., Baldwin, H., & Abdi, S. (2011). New directions in refugee youth mental health services: Overcoming barriers to engagement. *Journal of Child and Adolescent Trauma, 4*, 69-85. doi: 10.1080/19361521.2011.545047

Ezard, N. (2012). Substance use among populations displaced by conflict: A literature review. *Disasters, 36*, 533-557. doi: 10.1111/j.1467-7717.2011.01261.x

Fazel, M., Garcia, J., & Stein, A. (2016). The right location? Experiences of refugee adolescents seen by school-based mental health services. *Clinical Child Psychology and Psychiatry, 21*(3), 368-380. doi: 10.1177/1359104516631606

Fazel, M., Hoagwood, K., Stephan, S., & Ford, T. (2014). Mental health interventions in schools in high-income countries. *Lancet Psychiatry, 1*(5), 377-387. doi: 10.1016/S2215-0366(14)70312-8

Fazel, M., Karunakara, U., & Newnham, E. A. (2014). Detention, denial, and death: Migration hazards for refugee children. *Lancet Global Health, 2*(6), e313-314. doi: 10.1016/S2214-109X(14)70225-6

Fazel, M., Reed, R. V., Panter-Brick, C., & Stein, A. (2012). Mental health of displaced and refugee children resettled in high-income countries: Risk and protective factors. *The Lancet, 379*(9812), 266-282.

Fazel, M., Rees, S., & Silove, D. M. (2017). Refugees and populations exposed to mass conflict. *Oxford Textbook.*

Fazel, M., & Stein, A. (2003). Mental health of refugee children: Comparative study. *British Medical Journal, 327*(7407), 134. doi: 10.1136/bmj.327.7407.134

Foa, E. B., Keane, T. M., Friedman, M. J., & Cohen, J. A. (2009). *Effective treatments for PTSD*, 2nd Edition. New York: Guilford Press.

Goodkind, J. R., Hess, J. M., Isakson, B., LaNoue, M., Githinji, A., Roche, N., . . . Parker, D. P. (2014). Reducing refugee mental health disparities: A community-based intervention to address postmigration stressors with African adults. *Psycholoigcal Services, 11*(3), 333-346. doi: 10.1037/a0035081

Gorst-Unsworth, C., & Goldenberg, E. (1998). Psychological sequelae of torture and organised violence suffered by refugees from Iraq. Trauma-related factors compared with social factors in exile. *British Journal of Psychiatry, 172*(1), 90-94. doi: 10.1192/bjp.172.1.90

Gwozdziewycz, N., & Mehl-Madrona, L. (2013). Meta-analysis of the use of narrative exposure therapy for the effects of trauma among refugee populations. *The Permanente Journal, 17*(1), 70-76. doi: 10.7812/TPP/12-058

Haroz, E. E., Bass, J. K., Lee, C., Murray, L. K., Robinson, C., & Bolton, P. (2014). Adaptation and testing of psychosocial assessment instruments for cross-cultural use: An example from the Thailand Burma border. *BMC Psychology, 2*(1), 31. doi: 10.1186/s40359-014-0031-6

Hassan, G, Kirmayer, LJ, Mekki Berrada, A., Quosh, C., el Chammay, R., Deville-Stoetzel, J.B., Youssef, A., Jefee-Bahloul, H., Barkeel-Oteo, A., Coutts, A., Song, S. & Ventevogel, P. (2015). Culture, context and the mental health and psychosocial wellbeing of Syrians: a review for mental health and psychosocial support staff working with Syrians affected by armed conflict. Geneva: UNHCR. http://www.unhcr.org/55f6b90f9.pdf

Hebebrand, J., Anagnostopoulos, D., Eliez, S., Linse, H., Pejovic-Milovancevic, M., & Klasen, H. (2016). A first assessment of the needs of young refugees arriving in Europe: What mental health professionals need to know. *European Child and Adolescent Psychiatry, 25*(1), 1-6. doi: 10.1007/s00787-015-0807-0

Hensel-Dittmann, D., Schauer, M., Ruf, M., Catani, C., Odenwald, M., Elbert, T., & Neuner, F. (2011). Treatment of traumatized victims of war and torture: A randomized controlled comparison of narrative exposure therapy and stress inoculation training. *Psychotherapy and Psychosomatics, 80*(6), 345-352. doi: 10.1159/000327253

Herlihy, J., Jobson, L., & Turner, S. (2012). Just tell us what happened to you: Autobiographical memory and seeking asylum. *Applied Cognitive Psychology, 26*(5), 661-676. doi: 10.1002/acp.2852

Herlihy, J., Scragg, P., & Turner, S. (2002). Discrepancies in autobiographical memories--implications for the assessment of asylum seekers: Repeated interviews study. *BMJ, 324*(7333), 324-327. doi: 10.1136/bmj.324.7333.324

Herlihy, J., & Turner, S. W. (2007). Asylum claims and memory of trauma: Sharing our knowledge. *British Journal of Psychiatry, 191*(1), 3-4. doi: 10.1192/bjp.bp.106.034439

Hijazi, A. M., Lumley, M. A., Ziadni, M. S., Haddad, L., Rapport, L. J., & Arnetz, B. B. (2014). Brief narrative exposure therapy for posttraumatic stress in Iraqi refugees: A preliminary randomized clinical trial. *Journal of Traumatic Stress, 27*(3), 314-322. doi: 10.1002/jts.21922

Hinton, D. E., Chean, D., Pich, V., Safren, S., Hofmann, S., & Pollack, M. (2005). A randomized controlled trial of cognitive-behavior therapy for Cambodian refugees with treatment-resistant PTSD and panic attacks: A cross-over design. *Journal of Traumatic Stress, 18*(6), 617-629. doi: 10.1002/jts.20070

Hinton, D. E., & Jalal, B. (2014). Guidelines for the implementation of culturally sensitive cognitive behavioural therapy among refugees and in global contexts. *Intervention, 12*, 78-93. doi: 10.1097/wtf.0000000000000069

Hinton, D. E., & Lewis-Fernandez, R. (2011). The cross-cultural validity of posttraumatic stress disorder: Implications for DSM-5. *Depression and Anxiety, 28*(9), 783-801. doi: 10.1002/da.20753

Hinton, D. E. & Patel, A. (2017). Cultural adaptations of cognitive behavioral therapy. *Psychiatric Clinics of North America,* doi10.1016/p.psc.2017.08.006

Hobfoll., S. (2014). Resource caravans and resource caravan passageways: A new paradigm for trauma responding. *Intervention, 12*(S1), 21-32.

Hollander, A. C., Dal, H., Lewis, G., Magnusson, C., Kirkbride, J. B., & Dalman, C. (2016). Refugee migration and risk of schizophrenia and other non-affective psychoses: cohort study of 1.3 million people in Sweden. bmj, 352, i1030.

Hocking, D. C., Kennedy, G. A., & Sundram, S. (2015). Mental disorders in asylum seekers: The role of the refugee determination process and employment. *Journal of Nervous and Mental Disease, 203*(1), 28-32. doi: 10.1097/NMD.0000000000000230 25503784

Hondius, A. J., van Willigen, L. H., Kleijn, W. C., & van der Ploeg, H. M. (2000). Health problems among Latin-American and middle-eastern refugees in The Netherlands: Relations with violence exposure and ongoing sociopsychological strain. *Journal of Traumatic Stress, 13*(4), 619-634. doi: 10.1023/A:1007858116390

Hou, W. K., Hall, B. J. & Hobfoll, S. E. (2017). Drive to thrive: A theory of resilience following loss. In (Eds). N. Morina & A. Nickerson, *Mental health of refugee and post-conflict populations.* Springer: Amsterdam.

Ichikawa, M., Nakahara, S., & Wakai, S. (2006). Effect of post-migration detention on mental health among Afghan asylum seekers in Japan. *Australian and New Zealand Journal of Psychiatry, 40*(4), 341-346. doi: 10.1111/j.1440-1614.2006.01800.x 16620316

Inter-Agency Standing Committee (IASC) (2007). *IASC guidelines on mental health and psychosocial support in mergency settings*. Geneva: IASC.

Inter-Agency Standing Committee Task Force on Mental Health and Psychosocial Support in Emergency Settings, van Ommeren, M. & Wessells, M. (2017). Inter-agency agreement on mental health and psychosocial support in emergency settings. *Bulletin of the World Health Organization, 85,* 822-823.

International Detention Coalition. (2012). Captured childhood: Introducing a new model to ensure the rights and liberty of refugee, asylum seeker and irregular migrant children affected by immigration detention. Melbourne, Australia: IDC Secretariat

Jakobsen, M., Dermott, M., & Heir, T. (2014). Prevalence of psychiatric disorders among unaccompanied asylum seeking adolescents in Norway. *Clinical Practice and Epidemiology in Mental Health, 10*(1), 53-58. doi: 10.2174/1745017901410010053

Jayawickreme, N., Jayawickreme, E., Atanasov, P., Goonasekera, M. A., & Foa, E. B. (2012). Are culturally specific measures of trauma-related anxiety and depression needed? The case of Sri Lanka *Psychological Assessment, 24*(4), 791-800. doi: 10.1037/a0027564

Jordans, M. J., Tol, W. A., Komproe, I. H., Susanty, D., Vallipuram, A., Ntamatumba, P., . . . de Jong, J. T. (2010). Development of a multi-layered psychosocial care system for children in areas of political violence. *International Journal of Mental Health Systems, 4*(1), 15. doi: 10.1186/1752-4458-4-15

Kaiser, B. N., Kohrt, B. A., Keys, H. M., Khoury, N. M., & Brewster, A. R. (2013). Strategies for assessing mental health in Haiti: Local instrument development and transcultural translation. *Transcultual Psychiatry, 50*(4), 532-558. doi: 10.1177/1363461513502697

Karunakara, U. K., Neuner, F., Schauer, M., Singh, K., Hill, K., Elbert, T., & Burnha, G. (2004). Traumatic events and symptoms of post-traumatic stress disorder amongst Sudanese nationals, refugees and Ugandans in the West Nile. *African Health Sciences, 4*(2), 83-93.

Kazour, F., Zahreddine, N. R., Maragel, M. G., Almustafa, M. A., Soufia, M., Haddad, R., & Richa, S. (2017). Post-traumatic stress disorder in a sample of Syrian refugees in Lebanon. *Comprehensive Psychiatry, 72*, 41-47. doi: 10.1016/j.comppsych.2016.09.007

Keatley, E., Ashman, T., Im, B., & Rasmussen, A. (2013). Self-reported head injury among refugee survivors of torture. The *Journal of Head Trauma Rehabilitation, 28*(6), E8-E13. doi: 10.1097/HTR.0b013e3182776a70

Keller, A. S., Rosenfeld, B., Trinh-Shevrin, C., Meserve, C., Sachs, E., Leviss, J. A., . . . Ford, D. (2003). Mental health of detained asylum seekers. *The Lancet, 362*(9397), 1721-1723. doi: 10.1016/S0140-6736%2803%2914846-5 14643122

Khalifa, N., Hardie, T., Latif, S., Jamil, I. & Walker, D.-M. (2011). Beliefs about Jinn, black magic and the evil eye among Muslims: Age gender and first language influences. *International Journal of Culture and Mental Health, 4,* doi: 10.1080/17542863.2010.503051

Khamis, V. (2016). Does parent's psychological distress mediate the relationship between war trauma and psychosocial adjustment in children? *Journal of Health Psychology, 21*(7), 1361-1370. doi: 10.1177/1359105314553962

Khan, M. N., Hamdani, S. U., Chiumento, A., Dawson, K., Bryant, R. A., Sijbrandij, M., Nazir, H., Akhtar, P., Masood, A., Wang, D., Wang, E., Uddin, I., Van Ommeren, M. & Rahman, A. (2017). Evaluating feasibility and acceptability of a group WHO trans-diagnostic intervention for women with common mental disorders in rural Pakistan: A cluster randomised controlled feasibility study. *Epidemiology and Psychiatric Sciences, epub ahead of print, 1-11.* doi:10.1017/S2045796017000336

Killedar, A., & Harris, P. (2017). Australia's refugee policies and their health impact: A review of the evidence and recommendations for the Australian Government. *Australian and New Zealand Journal of Public Health, 41*(4), 335-337. doi: 10.1111/1753-6405.12663

Kinzie, J. D. (2006). Immigrants and refugees: The psychiatric perspective. *Transcultural Psychiatry, 43*(4), 577-591. doi: 10.1177/1363461506070782

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., ... & Pottie, K. (2011). Common mental health problems in immigrants and refugees: general

approach in primary care. Canadian Medical Association Journal, 183(12), E959-E967.
Knaevelsrud, C., Brand, J., Lange, A., Ruwaard, J., & Wagner, B. (2015). Web-based psychotherapy for posttraumatic stress disorder in war-traumatized Arab patients: Randomized controlled trial. *Jounral of Medical Internet Research, 17*(3), e71. doi: 10.2196/jmir.3582
Kohrt, B. A., Rasmussen, A., Kaiser, B. N., Haroz, E. E., Maharjan, S. M., Mutamba, B. B., . . . Hinton, D. E. (2014). Cultural concepts of distress and psychiatric disorders: Literature review and research recommendations for global mental health epidemiology. *International Journal of Epidemiology, 43*(2), 365-406. doi: 10.1093/ije/dyt227
Krahn, H., Derwing, T., Mulder, M., & Wilkinson, L. (2000). Educated and underemployed: Refugee integration into the Canadian labour market. *Journal of International Migration and Integration, 1*(1), 59-84. doi: 10.1007/s12134-000-1008-2
Laban, C. J., Gernaat, H. B., Komproe, I. H., & De Jong, J. T. (2007). Prevalence and predictors of health service use among Iraqi asylum seekers in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology, 42*(10), 837-844. doi: 10.1007/s00127-007-0240-x
Laban, C. J., Gernaat, H. B., Komproe, I. H., Schreuders, B. A., & De Jong, J. T. (2004). Impact of a long asylum procedure on the prevalence of psychiatric disorders in Iraqi asylum seekers in The Netherlands. *Journal of Nervous and Mental Disease, 192*(12), 843-851. doi: 10.1097/01.nmd.0000146739.26187.15
Li, S. S., Liddell, B. J., & Nickerson, A. (2016). The relationship between post-migration stress and psychological disorders in refugees and asylum seekers. *Current Psychiatry Report, 18*(9), 82. doi: 10.1007/s11920-016-0723-0
Lorek, A., Ehntholt, K., Nesbitt, A., Wey, E., Githinji, C., Rossor, E., & Wickramasinghe, R. (2009). The mental and physical health difficulties of children held within a British immigration detention center: A pilot study. *Child Abuse & Neglect, 33*(9), 573-585. doi: 10.1016/j.chiabu.2008.10.005
Migrant death toll passes 5,000 after two boats capsize off Italy. (2016, 24 December 2016). *Guardian*. Retrieved from https://www.theguardian.com/world/2016/dec/23/record-migrant-death-toll-two-boats-capsize-italy-un-refugee
Miller, K. E., Martell, Z. L., Pazdirek, L., Caruth, M., & Lopez, D. (2005). The role of interpreters in psychotherapy with refugees: An exploratory study. *American Journal of Orthopsychiatry, 75*(1), 27-39. doi: 10.1037/0002-9432.75.1.27
Miller, K. E., & Rasmussen, A. (2017). The mental health of civilians displaced by armed conflict: An ecological model of refugee distress. *Epidemioly and Psychiatric Sciences, 26*(2), 129-138. doi: 10.1017/S2045796016000172
Moisander, P. A., & Edston, E. (2003). Torture and its sequel--a comparison between victims from six countries. *Forensic Science International, 137*(2-3), 133-140. doi: 10.1016/j.forsciint.2003.07.008
Mollica, R. F., McInnes, K., Pham, T., Smith Fawzi, M. C., Murphy, E., & Lin, L. (1998). The dose-effect relationships between torture and psychiatric symptoms in Vietnamese ex-political detainees and a comparison group. *Journal of Nervous and Mental Disease, 186*(9), 543-553. doi: 10.1097/00005053-199809000-00005
Mollica, R. F., McInnes, K., Poole, C., & Tor, S. (1998). Dose-effect relationships of trauma to symptoms of depression and post-traumatic stress disorder among Cambodian survivors of mass violence. *British Journal of Psychiatry, 173*(6), 482-488. doi: 10.1192/bjp.173.6.482

Mollica, R. F., McInnes, K., Sarajlic, N., Lavelle, J., Sarajlic, I., & Massagli, M. P. (1999). Disability associated with psychiatric comorbidity and health status in Bosnian refugees living in Croatia. *Journal of the American Medical Association, 282*(5), 433-439. doi: 10.1001/jama.282.5.433

Momartin, S., Silove, D., Manicavasagar, V., & Steel, Z. (2004). Comorbidity of PTSD and depression: Associations with trauma exposure, symptom severity and functional impairment in Bosnian refugees resettled in Australia. *Journal of Affective Disorders, 80*(2-3), 231-238. doi: 10.1016/S0165-0327(03)00131-9

Montgomery, E. (2008). Long-term effects of organized violence on young Middle Eastern refugees' mental health. *Social Science & Medicine, 67*(10), 1596-1603. doi: 10.1016/j.socscimed.2008.07.020

National Child Traumatic Stress Network (2006). Psychological First Aid: Field Operations Guide. National Child Traumatic Stress Network: http://www.nctsn.org/content/psychological-first-aid

Neuner, F., Catani, C., Ruf, M., Schauer, E., Schauer, M., & Elbert, T. (2008). Narrative exposure therapy for the treatment of traumatized children and adolescents (KidNET): From neurocognitive theory to field intervention. *Child and Adolescent Psychiatric Clinics of North America, 17*(3), 641-664. doi: 10.1016/j.chc.2008.03.001

Neuner, F., Kurreck, S., Ruf, M., Odenwald, M., Elbert, T., & Schauer, M. (2010). Can asylum-seekers with posttraumatic stress disorder be successfully treated? A randomized controlled pilot study. *Cognitive Behaviour Therapy, 39*(2), 81-91. doi: 10.1080/16506070903121042

Neuner, F., Onyut, P. L., Ertl, V., Odenwald, M., Schauer, E., & Elbert, T. (2008). Treatment of posttraumatic stress disorder by trained lay counselors in an African refugee settlement: A randomized controlled trial. *Journal of Consulting and Clinical Psychology, 76*(4), 686-694. doi: 10.1037/0022-006X.76.4.686

Neuner, F., Schauer, M., Karunakara, U., Klaschik, C., Robert, C., & Elbert, T. (2004). Psychological trauma and evidence for enhanced vulnerability for posttraumatic stress disorder through previous trauma among West Nile refugees. *BMC Psychiatry, 4*, 34. doi: 10.1186/1471-244X-4-34

Nickerson, A., Bryant, R. A., Silove, D., & Steel, Z. (2011). A critical review of psychological treatments of posttraumatic stress disorder in refugees. *Clinical Psychology Review, 31*(3), 399-417. doi: 10.1016/j.cpr.2010.10.004

Nickerson, A., Bryant, R. A., Steel, Z., Silove, D., & Brooks, R. (2010). The impact of fear for family on mental health in a resettled Iraqi refugee community. *Journal of Psychiatric Research, 44*(4), 229-235. doi: 10.1016/j.jpsychires.2009.08.006

Nickerson, A., Liddell, B. J., Maccallum, F., Steel, Z., Silove, D., & Bryant, R. A. (2014). Posttraumatic stress disorder and prolonged grief in refugees exposed to trauma and loss. *BMC Psychiatry, 14*, 106. doi: 10.1186/1471-244X-14-106

Nickerson, A., Schick, M., Schnyder, U., Bryant, R. A., & Morina, N. (In press). Comorbidity of posttraumatic stress disorder and depression in tortured, treatment-seeking refugees *Journal of Traumatic Stress*.

Nickerson, A., Steel, Z., Bryant, R., Brooks, R., & Silove, D. (2011). Change in visa status amongst Mandaean refugees: Relationship to psychological symptoms and living difficulties. *Psychiatry Research, 187*(1-2), 267-274. doi: 10.1016/j.psychres.2010.12.015

Noh, S., Beiser, M., Kaspar, V., Hou, F., & Rummens, J. (1999). Perceived racial discrimination, depression, and coping: A study of Southeast Asian refugees in Canada. *Journal of Health and Social Behavior, 40*(3), 193-207. doi: 10.2307/2676348

Nose, M., Ballette, F., Bighelli, I., Turrini, G., Purgato, M., Tol, W., . . . Barbui, C. (2017). Psychosocial interventions for post-traumatic stress disorder in refugees and asylum seekers resettled in high-income countries: Systematic review and meta-analysis. *PLoS One, 12*(2), e0171030. doi: 10.1371/journal.pone.0171030

Olema, D. K., Catani, C., Ertl, V., Saile, R., & Neuner, F. (2014). The hidden effects of child maltreatment in a war region: Correlates of psychopathology in two generations living in Northern Uganda. *Journal of Traumatic Stress, 27*(1), 35-41. doi: 10.1002/jts.21892

Olsen, D. R., Montgomery, E., Bojholm, S., & Foldspang, A. (2007). Prevalence of pain in the head, back and feet in refugees previously exposed to torture: A ten-year follow-up study. *Disability and Rehabilitation, 29*(2), 163-171. doi: 10.1080/09638280600747645

Otto, M., & Hinton, D. E. (2006). Modifying exposure-based CBT for Cambodian refugees with posttraumatic stress disorder. *Cognitive and Behavioral Practice, 13*(4), 261-270. doi: 10.1016/j.cbpra.2006.04.007

Palmieri, P. A., Marshall, G. N., & Schell, T. L. (2007). Confirmatory factor analysis of posttraumatic stress symptoms in Cambodian refugees. *Journal of Traumatic Stress, 20*(2), 207-216. doi: 10.1002/jts.20196

Papageorgiou, V., Frangou-Garunovic, A., Iordanidou, R., Yule, W., Smith, P., & Vostanis, P. (2000). War trauma and psychopathology in Bosnian refugee children. *European Child & Adolescent Psychiatry, 9*(2), 84-90. doi: 10.1007/s007870050002

Patel, V., Weiss, H. A., Chowdhary, N., Naik, S., Pednekar, S., Chatterjee, S. . . . Kirkwood, B. R. (2010). Effectiveness of an intervention led by lay health counselors for depressive and anxiety disorders in primary care in Goa, India (MANAS): A cluster randomized controlled trial. Lancet, 376(9758), 2086-2095.

Piwowarczyk, L., Bishop, H., Yusuf, A., Mudymba, F., & Raj, A. (2014). Congolese and Somali beliefs about mental health services. The *Journal of Nervous and Mental Disease, 202*(3), 209-216. doi: 10.1097/NMD.0000000000000087

Porter, M., & Haslam, N. (2005). Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: A meta-analysis *JAMA, 294*(5), 602-612. doi: 10.1001/jama.294.5.602

Procter, N., Kenny, M., Eaton, H., & Grech, C. (2017). Lethal hopelessness: Understanding and responding to asylum seeker distress and mental deterioration. *International Journal of Mental Health Nursing*. doi: 10.1111/inm.12325

Puffer, E. S., Annan, J., Sim, A. L., Salhi, C., & Betancourt, T. S. (2017). The impact of a family skills training intervention among Burmese migrant families in Thailand: A randomized controlled trial. *PLoS One, 12*(3), e0172611. doi: 10.1371/journal.pone.0172611

Raghavan, S., Rasmussen, A., Rosenfeld, B., & Keller, A. S. (2013). Correlates of symptom reduction in treatment-seeking survivors of torture. *Psychological Trauma: Theory, Research, Practice, and Policy, 5*(4), 377-383. doi: 10.1037/a0028118

Rahman, A., Hamdani, S. U., Awan, N. R., Bryant, R. A., Dawson, K. S., Khan, M. F., . . . van Ommeren, M. (2016). Effect of a multicomponent behavioral intervention in adults impaired by psychological distress in a conflict-affected area of Pakistan: A randomized clinical trial. *JAMA, 316*(24), 2609-2617. doi: 10.1001/jama.2016.17165

Rasmussen, A., Keatley, E., & Joscelyne, A. (2014). Posttraumatic stress in emergency settings outside North America and Europe: A review of the emic literature. *Social Science and Medicine, 109*, 44-54. doi: 10.1016/j.socscimed.2014.03.015

Rasmussen, A., Nguyen, L., Wilkinson, J., Vundla, S., Raghaven, S., Miller, K. E., & Keller, A. S. (2010). Rates and impact of trauma and current stressors among Darfuri

refugees in Eastern Chad. *American Journal of Orthopsychiatry, 80*(2), 227-236. doi: 10.1111/j.1939-0025.2010.01026.x

Rasmussen, A., Smith, H., & Keller, A. S. (2007). Factor structure of PTSD symptoms among west and central African refugees. *Journal of Traumatic Stress, 20*(3), 271-280. doi: 10.1002/jts.20208

Rasmussen, A., Ventevogel, P., Sancilio, A., Eggerman, M., & Panter-Brick, C. (2014). Comparing the validity of the self reporting questionnaire and the Afghan symptom checklist: Dysphoria, aggression, and gender in transcultural assessment of mental health. *BMC Psychiatry, 14*, 206. doi: 10.1186/1471-244X-14-206

Rasmussen, A., Verkuilen, J., Ho, E., & Fan, Y. (2015). Posttraumatic stress disorder among refugees: Measurement invariance of Harvard Trauma Questionnaire scores across global regions and response patterns. *Psychological Assessment, 27*(4), 1160-1170. doi: 10.1037/pas0000115

Robjant, K., & Fazel, M. (2010). The emerging evidence for Narrative Exposure Therapy: A review. *Clinical Psychology Review, 30*(8), 1030-1039. doi:10.1016/j.cpr.2010.07.004

Robjant, K., Hassan, R., & Katona, C. (2009). Mental health implications of detaining aslyum seekers: Systematic review. *British Journal of Psychiatry, 194*, 306-312. doi: 10.1192/bjp.bp.108.053223

Rousseau, C., Drapeau, A., & Rahimi, S. (2003). The complexity of trauma response: A 4-year follow-up of adolescent Cambodian refugees. *Child Abuse & Neglect, 27*(11), 1277-1290. doi: 10.1016/j.chiabu.2003.07.001

Sack, W. H., Clarke, G., Him, C., Dickason, D., Goff, B., Lanham, K., & Kinzie, J. D. (1993). A 6-year follow-up study of Cambodian refugee adolescents traumatized as children. *Journal of the American Academy of Child & Adolescent Psychiatry, 32*(2), 431-437. doi: 10.1097/00004583-199303000-00027

Save the Children. (2013). Psychological First Aid Training: Manual for Child Practitioners. Save the Children. https://resourcecentre.savethechildren.net/library/save-children-psychological-first-aid-training-manual-child-practitioners

Savic, M., Chur-Hansen, A., Mahmood, M. A., & Moore, V. (2013). Separation from family and its impact on the mental health of Sudanese refugees in Australia: A qualitative study. *Australian and New Zealand Journal of Public Health, 37*, 383-388. doi: 10.1111/1753-6405.12088

Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007). Resources for mental health: Scarcity, inequity, and inefficiency. Lancet, 370(9590), 878-889.

Schick, M., Zumwald, A., Knopfli, B., Nickerson, A., Bryant, R. A., Schnyder, U., . . . Morina, N. (2016). Challenging future, challenging past: The relationship of social integration and psychological impairment in traumatized refugees. *European Journal of Psychotraumatology, 7*(1), 28057. doi: 10.3402/ejpt.v7.28057

Schnyder, U., Muller, J., Morina, N., Schick, M., Bryant, R. A., & Nickerson, A. (2015). A comparison of DSM-5 and DSM-IV diagnostic criteria for posttraumatic stress disorder in traumatized refugees. *Journal of Traumatic Stress, 28*(4), 267-274. doi: 10.1002/jts.22023

Schulz, P. M., Resick, P. A., Huber, L. C., & Griffin, M. G. (2006). The effectiveness of cognitive processing therapy for PTSD with refugees in a community setting. *Cognitive and Behavioral Practice, 13*(4), 322-331. doi: 10.1016/j.cbpra.2006.04.011

Schweitzer, R. D., Brough, M., Vromans, L., & Asic-Kobe, M. (2011). Mental health of newly arrived Burmese refugees in Australia: Contributions of pre-migration and post-migration experience. *Australian and New Zealand Journal of Psychiatry, 45*(4), 299-307. doi: 10.3109/00048674.2010.543412

Shannon, P., O'Dougherty, M., & Mehta, E. (2012). Refugees' perspectives on barriers to communication about trauma histories in primary care. *Mental Health in Family Medicine, 9*(1), 47-55.

Shannon, P. L., Wieling, E., Simmerlink-McCleary, & Becher, H. (2015). Beyond stigma: Barriers to discussing mental health in refugee populations. *Journal of Loss and Trauma, 20*(3), 281-296. doi: 10.1080/15325024.2014.934629

Silove, D. (2013). The ADAPT model: a conceptual framework for mental health and psychosocial programming in post conflict settings. *Intervention, 11*(3), 37-48.

Silove, D., Sinnerbrink, I., Field, A., Manicavasagar, V., & Steel, Z. (1997). Anxiety, depression and PTSD in asylum-seekers: Associations with pre-migration trauma and post-migration stressors. *British Journal of Psychiatry, 170*, 351-357. doi: 10.1192/bjp.170.4.351

Silove, D., Steel, Z., McGorry, P., Miles, V., & Drobny, J. (2002). The impact of torture on post-traumatic stress symptoms in war-affected Tamil refugees and immigrants. *Comprehensive Psychiatry, 43*(1), 49-55. doi: doi:10.1053/comp.2002.29843

Silove, D., Steel, Z., McGorry, P., & Mohan, P. (1998). Trauma exposure, postmigration stressors, and symptoms of anxiety, depression and post-traumatic stress in Tamil asylum-seekers: comparison with refugees and immigrants. *Acta Psychiatrica Scandinavica, 97*(3), 175-181. Doi: 10.1111/j.1600-0447.1998.tb09984.x

Silove, D., Ventevogel, P. & Rees, S. (2017). The contemporary refugee crisis: An overview of mental health challenges. *World Psychiatry (16),* 130-139. doi: 10.1002/wps.20438

Sirin, S. R., & Rogers-Sirin, L. (2015). The Educational and Mental Health Needs of Syrian Refugee Children. Washington, D.C.: Migration Policy Institute

Sleijpen, M., Haagen, J., Mooren, T., & Kleber, R. J. (2016). Growing from experience: An exploratory study of posttraumatic growth in adolescent refugees. *European Journal of Psychotraumatology, 7*(1), 28698. doi: 10.3402/ejpt.v7.28698

Slewa-Younan, S., Mond, J., Bussion, E., Mohammad, Y., Uribe Guajardo, M. G., Smith, M., . . . Jorm, A. F. (2014). Mental health literacy of resettled Iraqi refugees in Australia: Knowledge about posttraumatic stress disorder and beliefs about helpfulness of interventions. *BMC Psychiatry, 14*, 320. doi: 10.1186/s12888-014-0320-x

Slobodin, O., & de Jong, J. T. (2015). Family interventions in traumatized immigrants and refugees: A systematic review. *Transcultural Psychiatry, 52*(6), 723-742. doi: 10.1177/1363461515588855

Slobodin, O., & de Jong, J. T. (2015). Mental health interventions for traumatized asylum seekers and refugees: What do we know about their efficacy? *Internation Joural of Social Psychiatry, 61*(1), 17-26. doi: 10.1177/0020764014535752

Smajkic, A., Weine, S., Duric-Bijedic, Z., Boskailo, E., Lewis, J., & Pavkovic, I. (2001). Sertralilne, paroxetine and venlafaxine in refugee post traumatic stress disorder with depression symptoms. *Journal of Traumatic Stress*, 14(3), 445-452. doi: 10.1023/a:1011177420069

Sonne, C., Carlsson, J., Elklit, A., Mortensen, E. L., & Ekstrom, M. (2013). Treatment of traumatized refugees with sertraline versus venlafaxine in combination with psychotherapy - study protocol for a randomized clinical trial. *Trials, 14*(1), 137. doi: 10.1186/1745-6215-14-137

Shrestha, N. M., Sharma, B., Van Ommeren, M., Regmi. S., Makaju, R., Komproe, I … de Jong, J. T. (1998). Impact of torture on refugees displaced within the developing world. *Journal of the American Medical Association, 280*(5), 443-448. doi: 10.1001/jama.280.5.443

Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., & van Ommeren, M. (2009). Association of torture and other potentially traumatic events with mental health

outcomes among populations exposed to mass conflict and displacement: A systematic review and meta-analysis. *Journal of the American Medical Association, 302*(5), 537-549. doi: 10.1001/jama.2009.1132

Steel, Z., Liddell, B. J., Bateman Steel, C., & Zwi, A. (2011). Global protection and the health impact of migration interception. *PLoS Medicine, 8*(6), e1001038. doi: 10.1371/journal.pmed.1001038

Steel, Z., Momartin, S., Bateman, C., Hafshejani, A., Silove, D. M., Everson, N., . . . Mares, S. (2004). Psychiatric status of asylum seeker families held for a protracted period in a remote detention centre in Australia. *Australian and New Zealand Journal of Public Health, 28*(6), 527-536. doi: 10.1111/j.1467-842x.2004.tb00042.x

Steel, Z., Momartin, S., Silove, D., Coello, M., Aroche, J., & Tay, K. W. (2011). Two year psychosocial and mental helath outcomes for refugees subjected to restrictive or supportive immigration policies. *Social Science & Medicine, 72*, 1149-1156. doi: 10.1016/j.socscimed.2011.02.007

Steel, Z., Silove, D., Brooks, R., Momartin, S., Alzuhairi, B., & Susljik, I. (2006). Impact of immigration detention and temporary protection on the mental health of refugees. *British Journal of Psychiatry, 188*(1), 58-64. doi: 10.1192/bjp.bp.104.007864

Stenmark, H., Catani, C., Neuner, F., Elbert, T., & Holen, A. (2013). Treating PTSD in refugees and asylum seekers within the general health care system. A randomized controlled multicenter study. *Behaviour Research and Therapy, 51*(10), 641-647. doi: 10.1016/j.brat.2013.07.002

Tay, A. K., Rees, S., Chen, J., Kareth, M., & Silove, D. (2016). Factorial structure of complicated grief: Associations with loss-related traumatic events and psychosocial impacts of mass conflict amongst West Papuan refugees. *Social Psychiatry and Psychiatric Epidemiology, 51*(3), 395-406. doi: 10.1007/s00127-015-1099-x

Ter Heide, F. J., Mooren, T. M., van de Schoot, R., de Jongh, A., & Kleber, R. J. (2016). Eye movement desensitisation and reprocessing therapy v. stabilisation as usual for refugees: Randomised controlled trial. *British Journal of Psychiatry*, *209*(4), 311-318. doi: 10.1192/bjp.bp.115.167775

The Australian Human Rights Commission. (2014). The forgotten children: national inquiry into children in immigration detention 2014. Sydney, Australia: AHRC

Thommessen, S., Laghi, F., Cerrone, C., Baiocco, R., & Todd, B. (2013). Internalizing and externalizing symptoms among unaccompanied refugee and Italian adolescents. *Children and Youth Services Review, 35*(1), 7-10. doi: 10.1016/j.childyouth.2012.10.007

Tol, W. A., Barbui, C., Galappatti, A., Silove, D., Betancourt, T. S., Souza, R., . . . van Ommeren, M. (2011). Mental health and psychosocial support in humanitarian settings: Linking practice and research. *Lancet, 378*(9802), 1581-1591. doi: 10.1016/S0140-6736(11)61094-5

Tozer, M., Khawaja, N. G., & Schweitzer, R. (2017). Protective factors contributing to wellbeing among refugee youth in Australia. *Journal of Psychologists and Counsellors in Schools*, 1-18. doi: 10.1017/jgc.2016.31

Trentacosta, C. J., McLear, C. M., Ziadni, M. S., Lumley, M. A., & Arfken, C. L. (2016). Potentially traumatic events and mental health problems among children of Iraqi refugees: The roles of relationships with parents and feelings about school. *American Journal of Orthopsychiatry, 86*(4), 384-392. doi: 10.1037/ort0000186

Tribe, R. H., Sendt, K. V., & Tracy, D. K. (2017). A systematic review of psychosocial interventions for adult refugees and asylum seekers. *Journal of Mental Health*, 1-15. doi: 10.1080/09638237.2017.1322182

Tyrer, R., & Fazel, M. (2014). School and community-based interventions for refugee and asylum seeking children: A Systematic Review. *PLoS ONE, 9*(2), e89359. doi: doi:10.1371/journal.pone.0089359
UNHCR. (2016). Global trends in forced displacement in 2016. Geneva, Switzerland: UNHCR
UNHCR. (2017). UNHCR projected global resettlement needs 2017. Geneva, Switzerland: UNHCR
UNICEF. (2014). No lost generation: Protecting the futures of children affected by the crisis in Syria, strategic overview. UNICEF
UNICEF. (2016). Danger every step of the way: A harrowing journey to Europe for refugee and migrant children. *UNICEF Child Alert*: UNICEF
Van Ommeren, M., De Jong, J. T., Sharma, B., Komproe, I., Thapa, S. B., & Cardena, E. (2001). Psychiatric disorders among tortured Bhutanese refugees in Nepal. *Archives of General Psychiatry, 58*(5), 475-482. doi: 10.1001/archpsyc.58.5.475
van Wyk, S., Schweitzer, R., Brough, M., Vromans, L., & Murray, K. (2012). A longitudinal study of mental health in refugees from Burma: The impact of therapeutic interventions. *Australian and New Zealand Journal of Psychiatry, 46*(10), 995-1003. doi: 10.1177/0004867412443059
Ventevogel, P. (2017). Interventions for mental health and psychosocial support in complex humanitarian emergencies: Moving towards consensus in policy and action? In (Eds.) N. Morina & A. Nickerson, *Mental health in refugee and post-conflict populations.* Springer: Amsterdam.
Vervliet, M., Lammertyn, J., Broekaert, E., & Derluyn, I. (2014). Longitudinal follow-up of the mental health of unaccompanied refugee minors. *European Child & Adolescent Psychiatry, 23*(5), 337-346. doi: 10.1007/s00787-013-0463-1
Vindevogel, S. (2017). Resilience in the context of war: A critical analysis of contemporary conceptions and interventions to promote resilience among war-affected children and their surroundings. *Peace and Conflict: Journal of Peace Psychology*, *23*(1), 76.
Vindbjerg, E., Klimpke, C., & Carlsson, J. (2014). Psychotherapy with traumatised refugees--the design of a randomised clinical trial. *Torture, 24*(1), 40-48.
Vinson, G. A., & Chang, Z. (2012). PTSD symptom structure among West African war trauma survivors living in African refugee camps: A factor-analytic investigation. *Journal of Traumatic Stress, 25*(2), 226-231. doi: 10.1002/jts.21681
Weine, S., Kulauzovic, Y., Klebic, A., Besic, S., Mujagic, A., Muzurovic, J., Spahovic, D., Sclove, S., Pavkovic, I., Feethan, S. & Rolland, J. (2008). Evaluating a multiple-family group access intervention for refugees with PTSD. *Journal of Marital and Family Therapy, 34*, 149-164. Doi: 10.1111/j.1752-0606.2008.00061.x
Wells, R., Steel, Z., Abo-Hilal, M., Hassan, A. H., & Lawsin, C. (2016). Psychosocial concerns reported by Syrian refugees living in Jordan: Systematic review of unpublished needs assessments. *British Journal of Psychiatry, 209*(2), 99-106. doi: 10.1192/bjp.bp.115.165084
Wong, E. C., Marshall, G. N., Schell, T. L., Elliott, M. N., Hambarsoomians, K., Chun, C. A., & Berthold, S. M. (2006). Barriers to mental health care utilization for U.S. Cambodian refugees. *Journal of Consulting and Clinical Psychology, 74*(6), 1116-1120. doi: 10.1037/0022-006X.74.6.1116
World Health Organization (2013). Guidelines for the management of conditions specifically related to stress. Geneva: World Health Organization.
World Health Organization and United Nations High Commissioner for Refugees. (2015). *mhGAP Humanitarian Intervention Guie (mhGAP-HIG): Clinical management of*

mental, neurological and substance use conditions in humanitarian emergencies. WHO: Geneva.

World Health Organization, War Trauma Foundation & World Vision International (2011). Psychological First Aid: Guide for Field Workers. WHO: Geneva http://www.who.int/mental_health/publications/guide_field_workers/en/