Help for refugees
Solvig Ekblad, Eva-Lena Klefbeck, Christina Wennström, & Anna-Liisa Pietkäinen

The reception and treatment of refugees traumatized by war and violence are discussed with particular reference to the authors’ experience of such work in a suburb of Stockholm.

Migration, especially when forced, involves hardships and can cause ill-health. A reception programme for refugees should try to uncover their survival and coping capacities, help them to understand the connection between traumatic stress and mental health, and provide them with tools for recovery.

Risk factors

The following factors may heighten pathogenic stress among refugees during resettlement, thus increasing the risk of mental disorders:
- marginalization and minority status;
- socioeconomic disadvantage;
- poor physical health;
- malnutrition;
- injuries;
- collapse of social supports;
- mental trauma;
- adaptation to the host culture (1).

Refugee adjustment can be conceptualized in a multivariate risk/resilience model of trauma experience and adaptation (see table) (2). The psychosocial risk/resilience factors for refugees who have fled from war or other violence are viewed in relation to the periods of preturbulence, turbulence (migration) and resettlement (postmigration). Various individual and environmental factors may influence adjustment and acculturation to the host society. A combination of factors from each period may lead to a range of mental health outcomes.

Refugees and immigrants generally have poorer mental health than the established residents of a host country. There are exceptions, however, among non-traumatized immigrant groups with good social integration and opportunities for upward mobility in the host society. According to a recent review (2), the following risk factors exist for adverse mental health outcome:
- not being married;
- low socioeconomic level;
- traumatic events, these constituting the most potent factor.

Although psychological distress usually declines with time in a host country, traumatized refugees may suffer mental ill-health for prolonged periods after migration, especially if their status remains unresolved. A very long time may elapse before the appearance of post-traumatic
### Multivariate risk/resilience model of trauma exposure and refugee adjustment and adaptation

<table>
<thead>
<tr>
<th>Pre-war</th>
<th>War/violence</th>
<th>Flight and resettlement</th>
<th>Mental health outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sociodemographic factors: age, gender, education, marital status</td>
<td>Witnessed war deaths, injuries, torture</td>
<td>Access to basic services/care</td>
<td>Somatic complaints/psychosomatic disorders</td>
</tr>
<tr>
<td>Medical history (handicaps, disability, chronic organic disease, mental illness, personality disorder, substance abuse)</td>
<td>War exposure (duration, frequency)</td>
<td>Level of distress on arrival</td>
<td>Post-traumatic stress disorder Anxiety</td>
</tr>
<tr>
<td>Psychological history (earlier life events of high/low magnitude, degree of resolution)</td>
<td>Imprisonment (duration, mistreatment, torture)</td>
<td>Second traumatization</td>
<td>Pain</td>
</tr>
<tr>
<td>Personal resources (coping strategies, sense of control, cultural/philosophical foundation)</td>
<td>Active combat experience</td>
<td>Loss of resources, separation</td>
<td>Depression</td>
</tr>
<tr>
<td>Social network (family, neighbours, society at large)</td>
<td>Loss of resources/ separation:</td>
<td>Social ties/ support</td>
<td>Substance dependence (alcohol, drugs, tobacco, eating disorders)</td>
</tr>
<tr>
<td>Work experience</td>
<td>Cognitive appraisal of violence:</td>
<td></td>
<td>Positive outcome (perception of integration)</td>
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<tr>
<td></td>
<td>- degree of control</td>
<td></td>
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<tr>
<td></td>
<td>- degree of predictability</td>
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<td>- degree of threat to life</td>
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stress disorder, and the condition may be triggered by new disturbing events affecting a refugee’s life.

Premigration psychiatric morbidity appears to confer a risk of psychological distress after migration. Not all migrants develop stress disorders after trauma. Exposure to trauma is negatively related to the sense of coherence (3), a personality factor that accounts for individual differences in coping with trauma. The degree of success of integration in exile is influenced by earlier life events.
Traumatic experiences are responsible for much of the special behaviour observed in refugees and displaced people, which should be considered as a response to abnormal situations. The specific reactions to traumatic experience which a person may manifest include:

- flashbacks, nightmares, panic attacks and sleep disturbance;
- avoidance behaviour, social retreat, and emotional and somatic anaesthesia;
- hyperarousal with startled responses and psychosomatic symptoms, aggressiveness, clinging, and self-medication with alcohol and drugs;
- sadness and depression related to loss of home, health, and community, the death of family members and friends, and, especially, violent death and maiming among children (4).

Stress symptoms tend to make people feel as helpless as they were in the traumatic situations from which they have emerged, and may erode resilience, independence and natural resourcefulness. It has been argued that many humanitarian efforts may contribute to the development of passivity, dependency and learnt helplessness, making it more difficult for refugees to rebuild their lives. There may be long-lasting setbacks, including concentration problems, insomnia, difficulty in learning the language of the host country, a low level of functioning and perceived health, marginalization, and consequences for the next generation.

Reception of refugees

In Sweden the Immigrant Board has agreements with most of the country’s municipalities on the reception of refugees and certain other persons from abroad. In recent years many refugees have arrived as a result of the war in former Yugoslavia. As from 1991 the municipalities have been required to devise plans for the introduction of refugee adults and children into Swedish society. Each plan has to be drawn up in consultation with the refugee to whom it applies and in collaboration with the local employment office. A holistic approach is adopted, involving cooperation between different sectors. Trade unions, employers and non-governmental organizations are required to assume a more active role than hitherto. Special emphasis is placed on the need for immigrants to learn Swedish, and there are other key elements in the areas of both education and labour market policy. At the beginning of their resettlement in a municipality, refugees generally live on an introduction allowance. The municipalities receive reimbursement for every person covered by the refugee reception scheme for approximately three years. Immigrant policy is based on the principles of equality, freedom of choice, and partnership.

The reception process demands an integrated psychosocial approach focusing on trauma education and aiming to empower the refugees and improve their quality of life. Refugees should not be regarded as helpless but as having a strong capacity for survival. Bridges have to be built to the community, the primary health care system, and psychiatric outpatient clinics. The following challenges are particularly noteworthy in a reception programme:

- Refugees may have different ideas about health, illness and the quality of life from those prevailing in the host country.
- The health care system may be unfamiliar and incomprehensible to refugees,
who may have unforeseen expectations of doctors and other personnel.

- The availability of counselling and treatment may be limited by funding constraints and shortages of professionals knowledgeable about refugee culture, language and experience.

**Psychosocial prevention**

Psychosocial prevention requires early identification of mental health problems in vulnerable groups and then intervention with, for example, trauma education, counselling and psychosocial support. In the Stockholm suburb of Botkyrka, where there are many immigrants, a psychosocial preventive strategy initiated in 1994 as part of an immigrant rehabilitation project at the Fittja psychiatric outpatient clinic (5) has been developed in conjunction with primary care.

Careful assessments were made of the health needs of each refugee during the language course and before practical work began, so as to minimize the likelihood of failure. Groups of 15–26 newly arrived adult refugees attended a total of 11 health promotion meetings between November 1994 and December 1996, at each of which

- understand their situation, increase their sense of coherence, and reduce their anxiety by learning about the connection between trauma and mental health;
- discover their potential and to act, minimizing their use of the emergency health services when assailed by feelings of panic;
- recognize their own sufferings in others, thus reducing their sense of isolation;
- obtain information about care in the community.

Each meeting began with an explanation of the aim of the meeting, and the participants introducing themselves and mentioning their countries of birth and how long they had been in Sweden. It was made clear that everything discussed in the group would be treated as strictly confidential. The meetings lasted an hour and a half and included a short break. Information was given on primary health care, psychiatric outpatient facilities, reactive symptoms (see box) after traumatic life events, risk and buffer factors for mental health outcome, and the steps individuals could take to help themselves to recover.

Also discussed were traumatic life events in children, reactions among refugee children, imbalance of emotions between children and parents, and ways of creating hope, reducing chaos and developing structured daily activities. After each meeting the organizers met to consider improvements for later meetings.

The participants were eager to know when it would be possible to visit dentists or other health specialists but seldom asked about diseases and symptoms. They often expressed anxiety about financial matters, housing, and relatives who had not yet arrived in Sweden, and were advised to

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Some common reactions after traumatic life events

- **Cognitive**
  - Difficulty in remembering things
  - Difficulty in making decisions
  - Confusion
  - Distortion of time
  - Difficulty in concentrating
  - Too many thoughts at once
  - Thinking about suicide
  - Flashbacks
  - Replaying events

- **Spiritual**
  - Loss of faith
  - Spiritual doubts
  - Withdrawal from church community
  - Lapses in spiritual practice
  - Questioning old beliefs
  - Sense of the world being changed, out of kilter
  - Despair

- **Behavioural**
  - Abuse of alcohol, drugs and medication
  - Withdrawing from people
  - Irritability, impatience
  - Reacting strongly to small changes in environment (sounds, visitors, etc.)
  - Clinging to people
  - Disruption of daily activities
  - Loss of skills

- **Emotional**
  - Feeling helpless, hopeless or powerless
  - Grief
  - Numbness
  - Dread/fear/safety concerns
  - Guilt
  - Feeling vulnerable and dependent
  - Anger, rage
  - Emotional rollercoaster
  - Nightmares
  - Feeling of worthlessness
  - Feeling of isolation
  - Feeling lack of control over own life
  - Feeling of uncleanness
  - Fear of what other people think
  - Fear of continuing victimization


Take such matters up with staff in the reception programme. Many responded well to the trauma education and recognized the importance of receiving it on their arrival rather than after a long inter-

val. They felt relieved that their reactive symptoms were not taken to be signs of derangement. The numbers of patients attending a psychiatric outpatient clinic did not increase after the meetings.
It is possible to build up a sense of coherence regarding trauma, crisis and recovery in a single trauma education session, which should be held at the earliest opportunity. Empathy is a very important quality in people advising and counselling refugees. Refugees differ from one another and should not be treated in a generalized way with regard to risk and buffer factors.

It is intended to direct further efforts towards finding persons at risk for mental

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illness among migrants and exiles, determining whether their basic needs should be satisfied before their emotional needs, and creating an atmosphere in which they feel able to control their own lives as soon as possible after arrival and are not subjected to undue pressure.

References


