Chapter 56

Specialist services: practice

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Overview of mental health and quality of life for asylum-seekers and refugees

Refugees flee from war, persecution, imprisonment and torture. Many refugees have suffered adverse and complex traumatic experiences in their countries of origin, extending through childhood, adolescence and in adulthood, that may contribute to increasing the severity of mental health symptoms (1). In addition, adverse experiences during flight and challenges in the exile country add to their burden.

A broad range of stressful events across the lifespan impact refugees' mental health directly and indirectly (2) (family violence, near-death experiences, seeing close ones be maltreated or killed, torture, rape and so forth (3)). Several studies on refugee populations document high levels of mental health problems, e.g. post-traumatic stress disorder (PTSD), anxiety disorders, depressions, somatising disorders and psychotic disorders (1, 4-8). There are, however, significant variations in findings. Prevalence in different populations has varied in different researches: depression: 16-81%, anxiety disorders: 17-90%, PTSD: 10-90%, (9). These differences are, among others, related to methodological problems and differences in target groups. High prevalence of mental health problems has been found in asylum centres (10) and also among specific groups, such as unaccompanied minors (11-13).
Research indicates that as much as 12 to 34 percent of refugees have posttraumatic stress disorder (PTSD), often comorbid with depression (3, 6). There is uncertainty regarding frequencies due to variance in methodology and groups researched on. Long term outcome research indicates that at least around 20 percent may suffer chronic conditions (14). The extent of symptoms and problems of living have severe consequences for the refugees' wellbeing and capacity to function (15, 16). Most traumatized refugees go untreated for longer time and even with no treatment at all (17). An increasing number of clinical studies on treatment and intervention are, however, now being reported.

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Traumatisation may disturb personality functions such as cognitive, relational, affect- and somatic regulation, causing problems in everyday functioning (18-22).

Traumatised refugees may suffer from complex conditions with multi-layered aetiology and difficult social situations (poverty, poor housing, lack of support; low quality of life (1)). Families are affected when a member is traumatized, and there are possibilities for transgenerational problems such as insufficient early care taking and traumatisation of children (23-29). Having a traumatised family member may cause severe suffering for spouse and children due to the traumatised person instability in close relationships with withdrawal, outbursts of anger and sometime violence. This may lead to breakdown of the family. We have shown in research on children of traumatised refugees that children often spend more time with the sicker parents as the healthier need to spend much time at work. These children then have a severe task coping with a sick parent, which may interfere with school work and ability to be with peers (30). We have also shown that these families may live for years after traumatisation without adequate treatment (1). The fact that early traumatisation may increase the possibility of developing posttraumatic and other disorders after adult traumatisation (31), and be part of the aetiology in other conditions (i.e. borderline personality disorders (21), eating-disorders (32), dissociative disorders (33), and somatization disorders (34), underlines the need for early interventions also with preventive goals.

The picture is complex; refugees may have several symptoms and personality problems in addition to a difficult family situation and a precarious social situation due to a stressful acculturation process. The overall picture is, however, characterized by high level of coping and resilience (35-37) to a large depending on contextual factors (38).

The overall situation for refugees during flight has worsened significantly in recent years (39). The walls around Europe and other western countries has become higher and more brutal. Many refugees[1] live in camps or detention around/outside western countries in centres with extreme lack of most: food, health services, schooling, protection. Australia is an extreme example of dehumanising treatment of refugees (40, 41). Well-known is the deadly boat traffic across Mediterranean to Italy and to the Greek islands. There are worrying reports of maltreatment, torture, abduction, trafficking along the route (42). The

[1] I use the term refugee here as designating those who have fled and are on their way or have arrived in potential host country but asylum seeker when the context demands it.

mental health status of refugees in non-western countries seems serious. In one cross-sectional study the frequency of PTSD was 33.5%, and the probability rose to 71%, if they had the following features: with female gender; being diagnosed with psychiatric disorder in the past; having a family history of psychiatric disorder; and experiencing 2 or more traumas (43). Other studies show the same tendency (44-47).

It is now reasonable evidence that refugees during flight, in temporary stay in different countries' refugee camps and upon arrival in host countries, may have multitude problems regarding mental and somatic health, social adjustment and acculturation. The increasing xenophobic attitudes and the harsh rejection/return politics existing especially in western countries, makes the situation qualitatively different from what we for example saw when refugees arrived from the Balkan wars. Millions of people now live in more or less adequately equipped refugee facilities throughout the world.

Ours and others research has shown that there is a significant group that have long-standing mental health disabilities (48-50). Many refugees go untreated when arriving in host countries (17). In a study in Norway we found that traumatised refugees came to treatment on an average around 11 years after arrival (51). Similar experience has been reported from other countries (52).

There are strong indications that what happens after traumatization; during flight and upon arrival in a host country, may be decisive for future integration, and for their mental health and quality of life, especially for vulnerable groups like mothers with small children (37, 38, 53-56).

In this context organisation of reception centres, the degree of care for refugees and targeted interventions and treatment for vulnerable individuals and groups are crucial.

What do asylum seekers/refugees need?

There is a large potential for resilience, coping and positive development in the refugee as a whole. In order to survive, the refugees and migrants have to be pretty resilient both psychologically and physically. The situation for most who arrive is, however, characterized by uncertainty, lack of basic needs like safety and security, positivity and log waiting time for asylum procedures. An overriding need is stable, empathic relationships, especially with family and extended family.

Refugees are a diverse group, but what is common for all is that they have lost their home and need to build a home in exile. This is the same for families and for single refugees. For all, the family is in different ways at the centre for their concern. Thus homebuilding is maybe the primary task in exile (57, 58).

Significant groups need early specified interventions, support and other interventions made by health workers not in specialist services. This concern for example; single mother with small children, pregnant women, tortured, elderly.

There is thus a need for a comprehensive, well-planned approach at the different stages in the refugee journey. Specialist service should be involved directly or indirectly at all stages. The needs for care, support and health services will be different at different stages and different groups will have different needs so careful evaluation is needed as early as possible. There is generally a lack of coordinated and well-planned services both during and after flight. The situation is, however, quite varied in different countries.

The following is an attempt to set up a list of health problems and service-needs for different groups of refugees at different stages in their refugee journey:

During flight:

Health problems: often extreme psychic stress and abuse leading to psychic conditions like posttraumatic conditions, depression, anxiety conditions, somatisation, and so forth. Family problems may appear or be aggravated. People under such stressful conditions will often supress symptoms and sufferings but long stay in for example provisional tent-camps may cause eruption of symptoms and cause extreme sufferings. Examples are refugees who stranded in bad tent- camps at the border to Macedonia and those who now are stranded in the over-crowded Moira camp in Lesvos, Greece.

Action needed: Protection against abuse, torture, abduction. This concerns the general situation of refugees today where human-smuggler organisations has been left the task of “refugee transport” and is primarily a problem and a task for governmental and non-governmental organisations and international collaboration. More humanistic general policies in the refugee field is needed. It is important to underline that the human rights abuses involved and the dangers during flight involves great health risks. Here, people working in specialist services have a moral

responsibility to investigate the health risks involved and inform policy makers and the public. Physical as well as emotional torture, for example, seems to be not uncommon during flight (59). Treatment and preventive efforts during flight are needed but in an ongoing study of newly arrived refugees to Norway, the respondents reported that they seldom received any health care during flight (60). There are, however, important efforts several place. The "Mobile teams" in Serbia organised by IAN (International Net Work) in Belgrade is an outstanding example. Teams with doctor, nurse, psychologist and interpreter seek refugees at cross-border points, in parks and other places where they gather and offer medical and psychological services (61)

In refugee camps and detention centres:

Health problems: posttraumatic responses, depression, suicidal behavior, psychosis, family problems/pathology (43, 62-67). Today an increasing number of refugees are stuck in such camps (Lebanon, Jordan, Turkey, Greece, Italy, Serbia etc.). The conditions are as a rule damaging for health and abuse and traumatization happens. There is lack of provisions for basic needs and children are often not offered school. Despair and lack of hope may dominate.

Action needed: comprehensive preventive programs, identifying vulnerable groups like single mothers and their children, interventions and program for unaccompanied minors, specific treatment programs for depression and posttraumatic conditions. Suicide prevention is an important but under-prioritized task in refugee camps and detention centres. Traumatised persons who stay under difficult conditions in such place seem to be particularly vulnerable in relation to suicide (66, 68) (see chapter 63 by Vijayakumar et al in this volume).

The situation varies a lot and some camps may have reasonable condition where refugees are offered possibility to be active and productive (Uganda) and others where the conditions are extremely inhumane and illness producing. The camps/detentions centres on Nauru outside Australia are example of the last (66, 69).

In asylum centres and detentions upon arrival

Health problems: The health problems are reasonably well documented although there is sparse research on refugees who arrived in connection with the recent refugee crisis. Most studies show high prevalence of most psychiatric conditions (PTSD, depression, somatisation, anxiety disorders and possibly psychosis (see for example (4, 10, 12, 44, 70, 71)). It is common experience that symptoms and psychic suffering may emerge when refugees arrive in a potential host country. Their conditions will be highly dependent on the conditions they are offered which more often than not may promote rather than prevent psychic illness. Family problems that have been held in check may now come to the fore. In unstable and less protected situations vulnerable groups may be exposed to danger and abuse, like unaccompanied women, unaccompanied minors etc. The stay in receptions centres are for most people characterised by unpredictability and insecurity. The process of asylum application and the waiting time for answers are regularly experienced as a kind of mental torture. Many describes this process as worse than anything they have experienced before (72). Suicidality seems to be an increasing problem (66). After having interviewed refugees at different asylum centres it is obvious that there are great differences in standard, accessibility to activity, health care and atmosphere of friendliness or the opposite (60). Most centres lack any systematic thinking on prevention of psychic disturbances, special interventions for vulnerable groups and there are as a rule difficult to get help from the specialist services for those in need.

Actions needed: A comprehensive health examination is needed for all which also include a thorough psychiatric examination. In many countries including Norway, the main emphasis is on identification and management of infections such as tuberculosis which may present a health risk for the local population. There is a need for early detection of existing and emerging psychiatric conditions in order to prevent worsening of existing disorders or development of manifest psychiatric disorders. Vulnerable groups, like torture survivors, elderly with poor heath, young mothers with their children, must be identified and low-cost programs and interventions must be implemented with the support of specialist services. For example: in order to prevent maternal depression and development of early harm to attachment bonds for babies and

young children, a community-nurse may follow-up the mother-child dyad to ensure that attachment bonds develop and that both child and mother feel safe and help mother develop her mothering capacity. Suicide prevention must be a priority. Conditions that promote passivity must be counteracted by general interventions in order to promote resilience in the individuals, the families and groups. There must thus be a coordinated action between health workers (including specialist services), centre leaders, community managers and politicians to make the asylum entre a place to live and as far as possible, a place to thrive. An important example has been developed in Darmstadt, Germany. This first reception camp is named "Michaelisdorf" (the Michaelis Village) and offers refugees security and protection. The feeling of uprooting, loneliness and insecurity are actively counteracted. Therefore, everyday structures, contacts and relationships among the inhabitants are crucial: An initial feeling of community, of an initial arriving and belonging – like in a village – is promoted. As many studies have shown, this has an important effect on the refugees' later willingness to integrate. The refugees arriving there are thus offered a way out of passivity and in connection with the many activities there, heath services directed by specialist services, are provided. Special treatment groups for severely traumatised are organised and interventions for vulnerable groups are offered. Importantly, the interventions are followed up in specialist psychiatric health service when refugees settle in the community. (65)

After resettlement

Health problems: Refugees who have settled in their new country and achieved permission and documentation to stay (for shorter or longer periods) may encounter diverse health problems. The acculturation process implies many challenges and possibilities and there is a wide variety of destinies regarding the long-term process. There are risks for chronic development of already existing mental problems as well as possibilities for growth and healing. Many refugees go untreated even for serious posttraumatic and other conditions for a long time (17) with devastating consequences for the sick person and their

families and close ones. In one study we found that severely traumatised waited around 10 years before proper treatment were implemented (1). There is a high degree of comorbidity. Common mental health disorders for exiled persons are depression, PTSD, anxiety disorders, somatisation disorders and some develop permanent personality changes. There is high risk that second generation experience stress and possibly mental disorders due to the strain of having severely traumatised parents (27, 30, 73, 74). Unaccompanied minors is a vulnerable group with special needs (75) and elderly refugees may have high risk of developing mental disorders, although there is little research on this population (76).

Action needed: Treatment and rehabilitation of refugees with posttraumatic and other condition is as a rule a complex and often long-lasting process. A coordinated teamwork is often necessary, and specialised methods for treatment and skills in using translators are also necessary. This work demands specialist competence in the treatment of posttraumatic conditions, in transcultural psychiatry and in the stresses and challenges of the acculturation process. In practice, however, much of the care and treatment for this group of patients is left to primary health care: GPs, psychiatric nurses, social workers and so forth. I will describe what I think is the best way of organising mental health care for refugees in this situation.

Which place for specialized services for refugees

Even though there is lack of research and information on refugees/asylum seekers mental health and needs, there is convincing evidence that many have substantial mental problems when they arrive.

Ideally, there should not be a sharp distinction between specialized and non-specialized services. Health services for refugees should be organized as a chain where early intervention primarily should have preventive aim: prevention of development of mental disorders and prevention of worsening of already existing disorders. There is a need for research-based knowledge on vulnerable group, but already now, several can be identified: mothers with small children, tortured, elderly, unaccompanied minors. Targeted

interventions including specialized treatment for those who need it, should be organized as soon as possible.

Specialized psychosocial professionals should be involved in this primary care, mainly as consultants.

Further, general psychiatry should be scaled up to be able to treat traumatized and other seriously mentally ill refugees as there in most countries are not enough competent personnel. Special training for mental health professionals working in the refugee field is needed but this field must already be introduced in the basic training as doctors, psychologists, nurses etc.

Specialized clinics seem to be a necessity both in order to treat the most severely traumatised and ill refugees but also to secure training and supervision of mental health workers in general psychiatry and professionals in primary care.

We don't have sufficient evidence for what is best practice at different levels of health services for asylum seekers and refugees and present research has not been able to elucidate factors contributing to the different, and often discouraging, treatment effects in this population.

The knowledge we do have, however, on the importance of the first phase after refugees arrive in a new country, implies strongly that early interventions and development of a "pool" of best practices for caring for, rehabilitation and treating individuals and families in need is called for. There is a need for continuity in in intervention similar to what they attempt to achieve in "Michaelisdorf" in Germany. The dominant fragmentation and lack of coordination of services marks asylum seekers and refugees as an underprivileged group in the healthcare system and basic ideas on public health services needs to be revived also for this group.

The major responsibility will probably continue to be in the primary health and social care system where much needed treatment and prevention can be done. The support from specialist health system is often lacking as was shown in our research (77)

There are further barriers to health care access among refugees (78). People from various cultures are not well acquainted with western health care and also have difficulties in expressing their problems and needs in a way that can be heard and understood. Psychoeducational programs for this population may there be beneficial and help them to use available services adequately (79). On the other hand, there is often resistance in the

health care system, maybe especially in psychiatry against receiving patients from other cultures, who are traumatised and need interpreter (20).
And ideal organisation of services may look like this:

FIGURE 53.1 here

In this model, the specialised mental health services for refugees and asylum seekers are based at the specialised centres or clinics. They provide specialised treatment and rehabilitation for asylum seekers and refugees, especially for the severely traumatised and their families, they supervise in the primary health sector and also, when possible, at asylum/reception centres. They will have training programs for this type of special mental health care. These centres/clinics will also be in close contact with the ordinary psychiatric service system and provide supervision and guidance.
In many countries such specialised centres exist but they are mainly organised by private, ideal organisation and there is also often much voluntary work. These specialised centres need, however, to be integrated in the ordinary health care system and be publicly funded.

What kind of treatment and rehabilitation is needed?

Here I will concentrate on specialised psychiatric/psychological treatment for the more severely ill asylum seekers and refugees. Severely traumatized patients in general and even more so with refugees, have as a rule complex condition with multi-layered etiology. Families are affected and there is high frequency of transgenerational problems (27). The picture is complex; refugees seeking treatment may have several symptoms and personality problems in addition to a difficult family situation and a precarious social situation due to a stressful acculturation process. It is necessary to see their problems in its totally where psychotherapeutic treatment must be coordinated with any somatic treatment (for example for torture sequel), family interventions and different social care interventions, preferably performed in a team.
An integrated, sequential response to refugees' mental health problems should be resilience oriented, as continuous as possible and geared towards longstanding principles of social medicine: early detection, primary, secondary and tertiary prevention (80).

Psychotherapy (individual, family, group) is one important treatment modality for traumatised refugees. There are no medications that can target specifically posttraumatic symptoms, even though several are used for symptomatic relief, e.g. alfa-blocker for intrusions and antidepressants for depression are a rational choice provided the treatment is carefully followed up (which often is not the case).

Several types of psychotherapy forms are offered with claim to be trauma-specific and effective for posttraumatic conditions, even though there are few studies demonstrating convincing effect for the traumatised refugee population. They are often used in treatment of traumatised refugees alone or in combinations with other treatment modalities, e.g. EMDR (81), cognitive therapy (82, 83), narrative exposure therapy.

Taking into consideration the complex problems of many traumatised refugees there are good arguments for psychotherapies with a more holistic approach which takes development and personality functions into consideration and may well be more acceptable in other cultures. Narrative therapies have for example shown good results (84, 85). Psychodynamic therapies represent a holistic approach as they do not necessarily focus only on traumatic events, but take personality and development into consideration in a systematic way. There is also evidence for more lasting effects (see for example (86)).

The trauma concept as formulated in kognitive inspired theories may be problematic. It is used with differen meanings; for an overwhelming event, for the reactions to an hurtful experience, as a diffuse reference to something disturbing in the mind, as a target for therapeutic interventions and so forth. The word trauma is a noun indicating something static inside the person's mind and coheres with more mechanistic models of the mind as in the theory of structural dissociation (87). (For a critique of structural dissociation, see (88)). This approach represents a non-dynamic view and may obscure the understanding of the complicated reactions in the mind, body and in the capacity for social relations after traumatisation (89). These reactions after traumatisation includes both the frozen responses characteristic of posttraumatic states but also resilient reorganisations. What is seen in the aftermath of severe human rights abuses is a balance bewteen reorganisations and attempts at reparations, and tendencies toward more chronic development (for a personal description of this see (90)).

There is thus arguments for more holistic approaches to traumatised refugees and in clincial practice eclectic approaches is often used. There is sparse research on what

determines outcome of these treatemtn (traumatic background, earlier, childhood traumatisation, social situation etc). This is now explored in an ongoing study in Norway (91).

Summary

Norway is now receiving a low number of asylum seekers, lower than in many years (around 2700 in 2018). The same tendency is seen in most western countries. This is result of the closing of borders around and in the outskirts of Europe and an explicit governmental policy of rejection. The arguments advocated is difficulties in integrations, high costs and, resistance from organised anti-immigration groups, perceived dangers to the culture and cohesion of society. I will not discuss this debate her, only underline that anti-immigrant/refugee sentiments and more or less open racism, may have profound effect on asylum seekers and refugees' wellbeing, quality of life and even psychic health, as demonstrated in ours and others' researches refugees (60, 92).

The situation is volatile, however, and can change suddenly. More refugees are now coming across the Mediterranean and the so-called deal with Turkey has not worked. It is reason to be prepared for new influx of refugees to western countries. In spite of this situation, many reception centres are now closed down and valuable expertise on receiving asylum seekers may be lost.

Governments are often not good in creating a welcoming atmosphere for refugees. Huge efforts are now done to export people who have had their asylum application rejected out of the country. In addition, lot of resources are used to track down so-called false refugees, that is, people where there seem to have been given wrong information when they arrived. A recent case was a family who had lived in three generations in Norway, where all were supposed to lose their citizenship.

Unaccompanied minors in many countries live with the threat of having to return to their country when they become 18 years old.

There is thus a harsh climate for refugees in western countries. Governmental resources are to a large degree used for keeping foreigners out of the country.

Specialised services suffer in this process. There is therefore a need that specialists advocate upgrading of these services both in professional area and in the public spheres.

References

1. Opaas M, Varvin S. Relationships of childhood adverse experiences with mental health and quality of life at treatment start for adult refugees traumatized by pre-flight experiences of war and human rights violations. J of Nerv and Ment Dis. 2015;203(9):684-95.
2. Hollifield M, Warner TD, Krakow B, Westermeyer J. Mental Health Effects of Stress over the Life Span of Refugees. Journal of clinical medicine. 2018;7(2):25.
3. Steel Z, Chey T, Silove D, Marnane C, Bryant RA, van Ommeren M. 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 (JAMA). 2009;302:537-49.
4. Alemi Q, James S, Cruz R, Zepeda V, Racadio M. Psychological Distress in Afghan Refugees: A Mixed-Method Systematic Review. Journal of immigrant and minority health / Center for Minority Public Health. 2013;16:1247-61.
5. Drozdek B, Kamperman AM, Tol WA, Knipscheer JW, Kleber RJ. Seven-Year Follow-Up Study of Symptoms in Asylum Seekers and Refugees With PTSD Treated With Trauma-Focused Groups. J Clin Psychol. 2013.
6. Fazel M, Wheeler J, Danesh J. Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. The Lancet. 2005;365:1309-14.
7. Kroll J, Yusuf A, Fujiwara K. Psychoses, PTSD, and depression in Somali refugees in Minnesota. Soc Psychiatry Psychiatr Epidemiol 2011;46:481-93.
8. Carlsson J, Sonne C, Silove D. From pioneers to scientists: challenges in establishing evidence-gathering models in torture and trauma mental health services for refugees. The Journal of nervous and mental disease. 2014;202(9):630-7.
9. Stompe T, Holzer D, Friedmann A. Pre-migration and mental health of refugees. In: Bhugra D, Craig T, Bhui K, editors. Mental Health of Refugees and Asylum Seekers. Oxford: Oxford University Press; 2010. p. 23-38.
10. Jakobsen M, Thoresen S, Johansen LEE. The validity of screening for post-traumatic stress disorder and other mental health problems among asylum seekers from different countries. J of Ref Stud. 2011;24:171-86.
11. Seglem K, Oppedal B, Raeder S. Predictors of depressive symptoms among resettled unaccompanied refugee minors. Scandinavian Journal of Psychology. 2011;52(5):457-64.
12. Vervliet M, Meyer Demott M, Jakobsen M, Broekaert E, Heir T, Derluyn I. The mental health of unaccompanied refugee minors on arrival in the host country. Scandinavian Journal of Psychology. 2014;56(1):33-7.
13. Oppedal B, Idsoe T. The role of social support in the acculturation and mental health of unaccompanied minor asylum seekers. Scandinavian Journal of Psychology. 2015;56(2):203-11.
14. Vaage AB. Long-term mental health of Vietnamese refugees in the aftermath of trauma. The British Journal of Psychiatry (2010) 196: 122-125. 2010;196:122-5.
15. Momartin S, Silove D, Manicavasagar V, Steel Z. Comorbidity of PTSD and depression: associations with trauma exposure, symptom severity and functional impairment in Bosnian refugees resettled in Australia. Journal of affective disorders. 2004;80(2-3):231-8.
16. van Wyk S, Schweitzer R, Brough M, Vromans L, Murray K. A longitudinal study of mental health in refugees from Burma: The impact of therapeutic interventions. Australian & New Zealand Journal of Psychiatry. 2012;46(10):995-1003.

17. Pumariega AJ, Rothe E, Pumariega JB. Mental Health of Immigrants and Refugees. Community mental health journal. 2005;41:581-97.
18. Rosenbaum B, Varvin S. The influence of extreme traumatisation on body, mind and social relations. Int J of Psychoanal. 2007;88:1527-42.
19. Varvin S, Rosenbaum B. Severely traumatized patients' attempt at reorganizing their relations to others in psychotherapy. Another kind of evidence: Karnac Books; 2011. p. 380.
20. Allen J, Vaage AB, Hauff E. Refugees and asylum seekers in societies. In: Sam DL, Berry JW, editors. The Cambridge Handbook of Acculturation Psychology. Cambridge, UK: . Cambridge University Press; 2006.
21. Allen J, Fonagy P. Trauma. In: Luyten P, Mayes L, Fonagy P, Target M, Blatt S, editors. Handbook of Psychodynamic Approaches to Psychopathology. New York, London: The Guilford Press; 2015. p. 165-98.
22. Schore A. Affect Dysregulation & Disorders of the Self. New York & London: W.W. Norton & Company; 2003.
23. Daud A, Skoglund E, Rydelius PA. Children in families of torture victims: Transgenerational transmission of parents´ traumatic experiences to their children. International Journal of Social Welfare. 2005;14(1):23-32.
24. de Mendelssohn F. Transgenerational Transmission of Trauma: Guilt, Shame, and the "Heroic Dilemma". International Journal of Group Psychotherapy. 2008;58(3):389-401.
25. Blanck-Cereijido F, Grynberg Robinson M. Prejudice, transgenerational transmission, and neutrality1. The International Journal of Psychoanalysis. 2010;91(5):1216-9.
26. Krell R, Suedfeld P, Soriano E. Child Holocaust survivors as parents: A transgenerational perspective. American journal of orthopsychiatry. 2011;74(4):502-8.
27. Wiegand-Grefe S, Möller B. Die transgenerationale Weitergabe von Kriegserfahrungen aus dem Zweiten Weltkrieg über drei Generationen – eine Betrachtung aus psychoanalytischer Perspektive. Prax Kinderpsychol Kinderpsychiat. 2012;61:610-22.
28. Silke W-G, Möller B. The transgenerational transmission of traumatic experiences of the Second World War over three generations--a psychoanalytical perspective. Praxis der Kinderpsychologie und Kinderpsychiatrie. 2012;61(8):610-22.
29. Romer G. Transgenerational psychotraumatology. Praxis der Kinderpsychologie und Kinderpsychiatrie. 2012;61(8):559-63.
30. Johansen J, Varvin S. Barn av flyktninger - hvordan klarer de seg i Norge? In: Debeasy J, editor. Migrasjon, helse og profesjon. Oslo: Gyldendal; in press.
31. Opaas M, Varvin S. Relationships of childhood adverse experiences with mental health and quality of life at treatment start for adult refugees traumatized by pre-flight experiences of war and human rights violations. The Journal of Nervous and Mental Disease [Internet]. 2015.
32. Herzog DB, Staley JE, Carmody S, Robbins WM, van der Kolk BA. Childhood sexual abuse in anorexia nervosa and bulimia nervosa: a pilot study. 1993;32(5):962-6.
33. Brenner I. Deconstructing DID. AmJ Psychother. 1999;53(3):344-60.
34. Rodin G, de Groot, J., Spivak, H. Trauma, Dissociation and Somatization. In: Bremner JD, Marmar CR, editors. Trauma, Memory and Dissociation. Washington DC and London: American Psychiatric Press; 1998. p. 161-78.
35. Ellis B, Abdi SM, Miller AB, White MT, Lincoln AK. Protective factors for violence perpetration in Somali young adults: The role of community belonging and neighborhood cohesion. Psychology of Violence. 2015;5(4):384-92.

36. Gakuba T-O, Sall M, Fokou G, Kouakou C, Amalaman M, Kone S. Mental health and resilience of young African women refugees in urban context (Abidjan-Ivory coast and Dakar-Senegal). Women's mental health: Resistance and resilience in community and society. Cham, Switzerland: Springer International Publishing; Switzerland; 2015. p. 185-200.
37. Simich L, Andermann L. Refugee and Resilience. Dordrecht, Heidelberg, New York, London: Springer; 2014.
38. Ungar Me. The Social Ecology of resilience. A Handbook of Theory and Practice. New York, Dordrecht, Heidelberg, London: Springer Verlag; 2012.
39. Turner S. Refugee blues: a UK and European perspective European journal of psychotraumatology. 2015;6.
40. Nrugham L, Procter N, Maniam T. Suicidal behaviour among ethnic minorities. Symposia to the 5th Asia Pacific Conference of the International Association for Suicide Prevention; Chennai, India2012.
41. Newman L, Proctor N, Dudley M. Seeking asylum in Australia: immigration detention, human rights and mental health care. Australasian Psychiatry. 2015;"1(4):315-20.
42. Jovanović A, Trivunčić B, Đurašinović V. "The demographic picture, the assessment of the legal status and needs as well as examination the traumatic experiences of refugees who are in transit through Serbia". Belgrade Center for Human Rights and UNHCR: Belgrade Center for Human Rights and UNHCR; 2015.
43. Alpak G, Unal A, Bulbul F, Sagaltici E, Bez Y, Altindag A, et al. Post-traumatic stress disorder among Syrian refugees in Turkey: A cross-sectional study. International Journal of Psychiatry in Clinical Practice. 2015;19(1):45-50.
44. Hassan G, Ventevogel P, Jefee-Bahloul H, Barkil-Oteo A, Kirmayer LJ. Mental health and psychosocial wellbeing of Syrians affected by armed conflict. Epidemiology and Psychiatric Sciences. 2016;25(2):129-41.
45. Jefee-Bahloul H, Moustafa MK, Shebl FM, Barkil-Oteo A. Pilot assessment and survey of Syrian refugees' psychological stress and openness to referral for telepsychiatry (PASSPORT Study). Telemedicine and e-Health. 2014;20(10):977-9.
46. Jefee-Bahloul H, Barkil-Oteo A, Pless-Mulloli T, Fouad F. Mental health in the Syrian crisis: beyond immediate relief. The Lancet. 2015;386:1531.
47. Silove D, Ventevogel P, Rees S. The contemporary refugee crisis: an overview of mental health challenges. World Psychiatry. 2017;16:130-9.
48. Willard CL, Rabin M, Lawless M. The prevalence of torture and associated symptoms in United States Iraqi refugees. Journal of Immigrant and Minority Health. 2014;16(6):1069-76.
49. Nickerson A, Liddell BJ, Maccallum F, Steel Z, Silove D, Bryant RA. Posttraumatic stress disorder and prolonged grief in refugees exposed to trauma and loss. BMC Psychiatry Vol 14 Apr 2014, ArtID 106. 2014;14.
50. Bogic M, Njoku A, Priebe S. Long-term mental health of war-refugees: a systematic literature review. BMC Int Health and Human Rights. 2015:15-29.
51. Opaas M, Hartmann E, Wentzel-Larsen T, Varvin S. Relationship of Pretreatment Rorschach Factors to Symptoms, Quality of Life, and Real-Life Functioning in a Three-Year Follow-Up of Traumatized Refugee Patients. J of Pers Ass. 2015.
52. Koenen K, Goodwin R, Struening E, Hellman F, Guardino M. Posttraumatic Stress Disorder and Treatment Seeking in a National Screening Sample. Journal of Traumatic Stress. 2003;16(1):5-16.

53. Alayarian A. Trauma, resilience, and creativity. In: Alayarian A, editor. Resilience, suffering and creativity. London: Karnac; 2007. p. 1-14.
54. Tummala-Narra P. Conceptualising Trauma and Resilience Across Diverse Contexts: A Multicultural perspective. Journal of Aggression, Maltreatment and Trauma. 2007;14(1):33-53.
55. Westermeyer J, Neider J, Callies A. Psychosocial adjustment of Hmong refugees during their first decade in the United States. J Nerv Ment Dis. 1989;177(3):132-9.
56. Montgomery E. Trauma and resilience in young refugees: a 9-year follow-up study. Dev Psychopathol. 2010;22(2):477-89.
57. Papadopoulos RK. Refugees, home and trauma. In: Papadopoulos RK, editor. Therapeutic Care for Refugees No Place like Home. London New York: Karnac; 2002.
58. Varvin S. Asylsuchende und Geflüchtete: ihre Situation und ihre Behandlungs bedürfnisse. (Asylum seekers and refugees: their situation and treatment needs). Psyche. 2016;70:825-54.
59. Jovanović A, Trivunčić B, Đurašinović V. "The demographic picture, the assessment of the legal status and needs as well as examination the traumatic experiences of refugees who are in transit through Serbia" Final report for the Project "Improved access to legal assistance". Belgrade Center for Human Rights and UNHCR: Belgrade Center for Human Rights and UNHCR, UNHCR BCfHRa; 2015.
60. Varvin S, Sagbakken M. Mental health and quality of life of asylumseekers and refugees. . Research projects2018.
61. Jovic V. Guidelines for short psychosocial interventions for refugees. [unpublished]. In press 2017.
62. Meyer S, Murray LK, Puffer ES, Larsen J, Bolton P. The nature and impact of chronic stressors on refugee children in Ban Mai Nai Soi camp, Thailand. Global public health. 2013;8(9):1027-47.
63. Al-Modallal H, Hamaideh S, Mudallal R. Mental health status of women in Jordan: A comparative study between attendees of governmental and UN relief and works agency's health care centers. Issues MentHealth Nurs. 2014;35(5):386-94.
64. Feyera F, Mihretie G, Bedaso A, Gedle D, Kumera G. Prevalence of depression and associated factors among Somali refugee at Melkadida camp, Southeast Ethiopia: A cross-sectional study. BMC Psychiatry Vol 15 Jul 2015, ArtID 171. 2015;15.
65. Leuzinger-Bohleber M, Rickmeyer C, Tahiri M, Hettich N. What can psychoanalysis contribute to the current 1 refugee crisis? Preliminary reports from STEP-BY-STEP: A psychoanalytic pilot project for supporting refugees in a “first reception camp” and crisis interventions with traumatized refugees. Int J of Psychoanal. 2016;97(4):1077-93.
66. Procter NG, De Leo D, Newman L. Suicide and self-harm prevention for people in immigration detention. Medical Journal of Australia. 2013;199(11):731-2.
67. The Forgotten Children: National Inquiry into Children in Immigration Detention [Internet]. Australian Human Rights Commission, Sydney. . 2014.
68. Preventing suicide: a global imperative [Internet]. World Health Organisation. 2014 [cited 5 september 2018]. Available from: http://apps.who.int/iris/bitstream/handle/10665/131056/9789241564878_eng.pdf;jsessionid=25AEC96EAD50EDD820E2769E86561756?sequence=8.
69. Herald SM. Think Australia's treatment of refugees and asylum seekers is OK? Read this. An open letter from a refugee on Nauru to the leaders of the UN's Summit for Refugees and Migrants. Sydney Morning Herald. 2016.

70. Bronstein I, Montgomery P, Dobrowolski S. PTSD in asylum-seeking male adolescents from Afghanistan.
Author: . Journal of Traumatic Stress. 2012;25(5):551-7.
71. Thommessen S, Corcoran P, Todd B. Experiences of arriving to Sweden as an unaccompanied asylum-seeking minor from Afghanistan: An interpretative phenomenological analysis. Psychology of Violence. 2015;5(4):374-83.
72. Varvin S. Our Relations to Refugees: Between Compassion and Dehumanization. The American journal of psychoanalysis. 2017:1-19.
73. Ruf-Leuschner M, Roth M, Schauer M. Traumatized mothers-Traumatized children? Transgenerational trauma exposure and trauma sequelae in refugee families. Zeitsch fur Klin Psych und Psychother: Forschung und Praxis. 2014;43(1):1-16.
74. van Ee E, Kleber RJ, Mooren TT. War trauma lingers on: Associations between maternal posttraumatic stress disorder, parent-child interaction, and child development. Infant Mental Health Journal. 2012;33(5):459-68.
75. Vervliet M, Lammertyn J, Broekaert E, Derluyn I. Longitudinal follow-up of the mental health of unaccompanied refugee minors. Eur Child Adolesc Psychiatry. 2013.
76. Ashwini V, Shannon D, Chesmal S. The impact of forced migration on the mental health of the elderly: a scoping review. International psychogeriatrics. 2016;28(6):889-96.
77. Varvin S, Aasland OG. Legers forhold til flyktningpasienten. Tidsskrift for Den norske legeforening. 2009;129(15):1488-90.
78. Asgary R, Segar N. Barriers to Health Care Access among Refugee Asylum Seekers. Journal of Health Care for the Poor and Underserved. 2011;22:506-22.
79. Ahmethodzic A. Sunn Start: "Informasjon og veiledning i psykisk helse; et undervisningsmateriell tilpasset personer med innvandrer- og flyktningbakgrunn i Norge". [Unpublished]. In press 2017.
80. Baarnhielm S, Javo C, Mosko MO. Opening up mental health service delivery to cultural diversity: current situation, development and examples from three northern European countries. Advances in psychosomatic medicine. 2013;33:40-55.
81. Acarturk C, Konuk E, Cetinkaya M, Senay I, Sijbrandij M, Cuijpers P, et al. EMDR for Syrian refugees with posttraumatic stress disorder symptoms: Results of a pilot randomized controlled trial. European journal of psychotraumatology. 2015;6.
82. Hinton DE, Pham T, Tran M, Safren SA, Otto MW, Pollack MH. CBT for Vietnamese refugees with treatment-resistant PTSD and panic attacks: a pilot study. J Trauma Stress 2004;17(5):429-33.
83. Kira I, Asgby J, Omidy A, Lewandowski L. Current, Continous, and Cumulative Trauma-Focused Cognitive behavior Therapy: A new Model for Trauma Counceling. Journal of Mental Health Counceling. 2015;37(4):323-40.
84. Stenmark H, Catani C, Neuner F, Elbert T, Holen A. Treating PTSD in refugees and asylum seekers within the general health care system. A randomized controlled multicenter study. Behaviour Research and Therapy,. 2013;51:641-7.
85. Stenmark H, Guzey IC, Elbert T, Holen A. Gender and offender status predicting treatment success in refugees and asylum seekers with PTSD. European Journal of Psychotraumatology Vol 5 Jan 2014, ArtID 20803. 2014;5.
86. Schottenbauer MA, Glass CR, Arnkoff DB, Gray SH. Contributions of Psychodynamic Approaches to Treatment of PTSD and Trauma: A Review of the Empirical Treatment and Psychopathology Literature. Psychiatry: Interpersonal and Biological Processes. 2008;71(1):13-34.

87. van der Hart O, Nijenhuis E, Steele K. The Haunted self. Stuctural dissociation and the treatment of chronic traumatization. London: W. W. Norton and Company; 2006.
88. Lesley J, Varvin S. "Jane vs. Freud" on Traumatization: A Critique of the Theory of Structural Dissociation from an Object Relations Perspective. British Journal of Psychotherapy. 2016;32(4):436-55.
89. Oliner M. Psychic reality in context. London: Karnac; 2014.
90. Morris D. Evil hours. A biography of Post-Traumatic Stress Disorder. Boston, New York: An Eamon Dolan Book. Houghton Mifflin Harcourt; 2015.
91. Opaas M, Varvin S. Predictors of The 10-Year Course of Mental Health Symptoms in Adult Refugee Clients, Assessed and Interviewed at Several Points Before, During, and After Psychological Treatment. 2018.
92. Fekete L. A suitable enemy. Racism, Migration and Islamophobia in Europe. London: Pluto Press; 2009.