DOI: 10.1590/1807-57622016.0929

Galina VF, Silva TBB, Haydu M, Martin D. Literature review on qualitative studies regarding the mental health of refugees

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The experience of seeking refugee status may lead to mental disorders for some people. This literature review and analysis is about the mental health of refugees. Peer reviewed papers were researched on the online database, Social Science Citation Index® on Web of Science™. We found 35 qualitative studies published from January 1993 to January 2016. Analysis focused on the mental health of adult refugees, the mental health of child and adolescent refugees and health care of refugees. There has been an increase in publications in this area. The themes include: cultural diversity, the effects of family and network support, the practitioners' work caring for refugees, the presence or not of mental illness, and interventions and commitment regarding human rights.

Keywords: Refugees. Mental health. Literature review. Qualitative research.

Introduction

This bibliographic review aims to present the state of the art on the mental health of the refugees identifying more frequent themes and highlighting some topics relevant to their understanding. It is intended to contribute to the debate on the mental health challenges of people under refugee status.

The exponential growth of forced migrants around the world is justified by the increasing catastrophic humanitarian occurrences such as crises, political and social conflicts, wars and natural disasters. In 2015, forced migration reached 65.3 million people by the end of the year. Brazil has also been impacted by this new international migratory flow[1].

According to CONARE (National Refugee Council, 2016), Brazil currently has 8,863 recognized refugees, from 79 different nationalities (28.2% of them are women) - including resettled refugees. The main groups are nationals of Syria (2,298), Angola (1,420), Colombia (1,100), Democratic Republic of Congo (968) and Palestine (376).

Brazil is a signatory to the main international human rights treaties and is a party to the 1951 United Nations Convention on the Status of Refugees and its 1967 Protocol[2]. In July 1997 the country enacted its refugee law (No. 9,474 / 97), including the main regional and international instruments on the subject. The law adopts the expanded definition of refugee established in the 1984 Cartagena Declaration, which considers the "general violation of human rights" as one of the causes of recognition of refugee status[2].

Experiences that lead people of different nationalities to seek refuge from their home countries usually involve factors with the potential to trigger mental disorders such as Depression and Post-Traumatic Stress Disorder (PTSD), among other disorders[3,4]. Diverse kind of violence, torture, massacres, death of relatives and friends are traumatic circumstances to which many refugees are exposed. Hunger and loss of assets are also frequent in this population, in addition to the sociocultural shock in the country where they seek refuge[5].

According to Martins-Borges (2013), because of the involuntary and sudden character of their displacement, refugees carry with them very little of what had characterized their identity, and these departures are often related to a psychological suffering related to the trauma to which they were subjected in the pre-migratory and migratory period.

In Brazil, there are few studies on health in general and also on the mental health of refugees. Most of the research was published in international journals. In the national context regarding the mental health of refugees, we highlight the work of Martins-Borges and Pocreau[6] presenting the Specialized Psychological Assistance Service for Immigrants and Refugees whose activities take place in the Department of Psychology of Laval University (Québec, Canada). The study by Martins-Borges[5] addresses involuntary migration as a risk factor for mental health. Santana and Lotufo Neto[7] carried out an investigation into the mental health of refugees in São Paulo, resulting in the implementation of a preventive and therapeutic care program.

According to Miller and Rasco[8], psychologists, psychiatrists, and other mental health professionals have begun to recognize and document the high levels of psychological stress experienced by refugees and displaced people around the world. Several authors have been studying the consequences of the refuge situation in the mental health of different populations, evidencing associations between traumas in the migratory process and conditions of vulnerability and mental disorders[3,4,9].

This brief description shows the interest of this subject in the field of Collective Health and Psychology and the commitment of these areas of knowledge to human rights.

Method

The review of the international literature on the subject of mental health of refugees sought to determine the state of the art of scientific production in the period between January 1993 and January 2016. The collection of bibliographic data was carried out between November 2014 and January 2016 through the Portal of CAPES Newspapers (www.periodicos.capes.gov.br/).

The search selected the Social Science Citation Index® collection in the Web of Science ™ database. The choice is justified as this collection covers essential data from 3000 of the world's leading Social Science journals involving 50 disciplines, including Anthropology, Sociology, and Psychology. We searched in the English

language using the term "refugees" combined with the descriptors "mental health"; "Mental disorder"; "trauma"; "Depression"; "PTSD"; "Posttraumatic stress disorder" and "psychological".

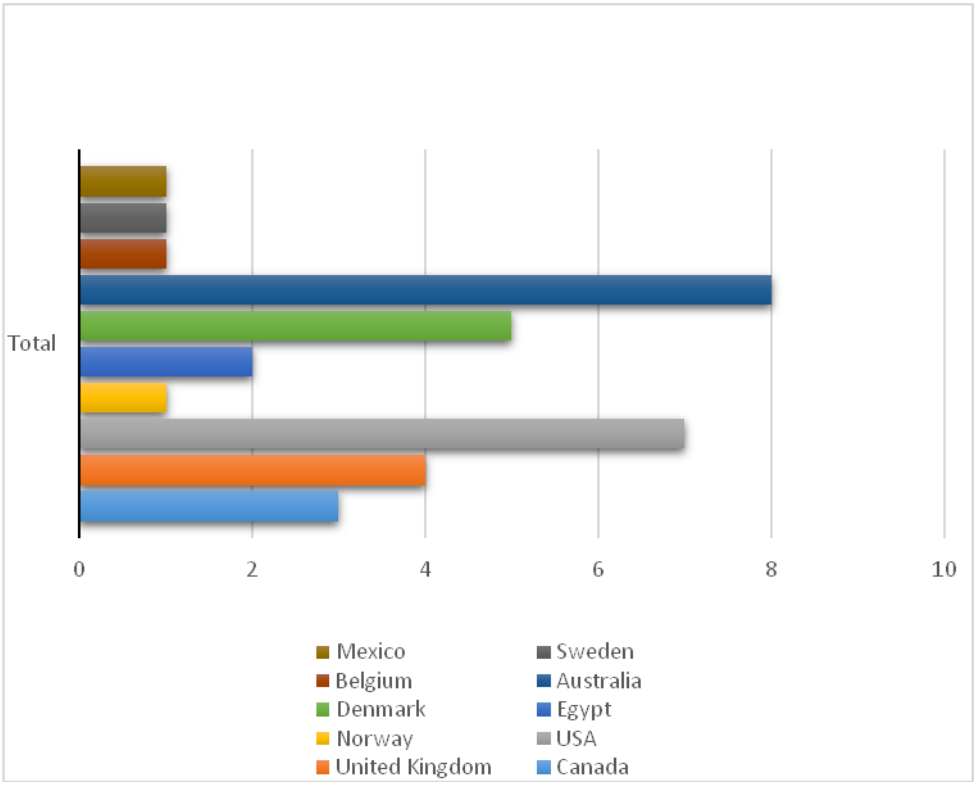
The selection was based on the following criteria: original articles, peer-reviewed, available in the English language, published in periodicals indexed in the Social Science Citation Index®, which report qualitative studies whose central theme was refugee mental health. A filter was used to search just for articles that presented these terms contained in the respective titles, in order to track the most relevant and focused publications. The initial intention of this work was to cover articles dated between January 2000 and January 2016, but due to the low number of publications prior to the year 2000, the authors decided to search for and include all previously published studies according to the aforementioned criteria, expanding the search to older work dating back to 1993. We chose to consider only the qualitative studies and those using multimethods involving a qualitative part. Repetitions, quantitative studies, reviews, review articles, editorials and books were excluded. We found 27 valid publications, excluding replicates. The search for national articles, carried out through the Scielo database, did not result in publications that fulfilled the criteria of this study. Throughout the development of this review, new publications have emerged and have been incorporated because they met all the criteria described. Thus, 35 studies published in English in international journals from 1993 to January 2016 were analyzed.

Results

The articles were analyzed in large groups of subjects according to their frequency and relevance related to the objectives of the study, resulting in three categories: [1] articles on mental health of adult refugees (34.3%), [2] articles on mental health of refugees in childhood and adolescence (22.85%) and [3] articles on refugee health care (45, 7%). It is worth mentioning that some articles meet the criteria of more than one of the aforementioned focus for categorization purposes and, therefore, have been included in more than one category. Some themes, although important, were scarcely present and for this reason were not specifically addressed. Only one study dealt with research methods with refugees in the field of mental health[10], and it discussed ethical issues about the use of narratives with people who have suffered trauma.

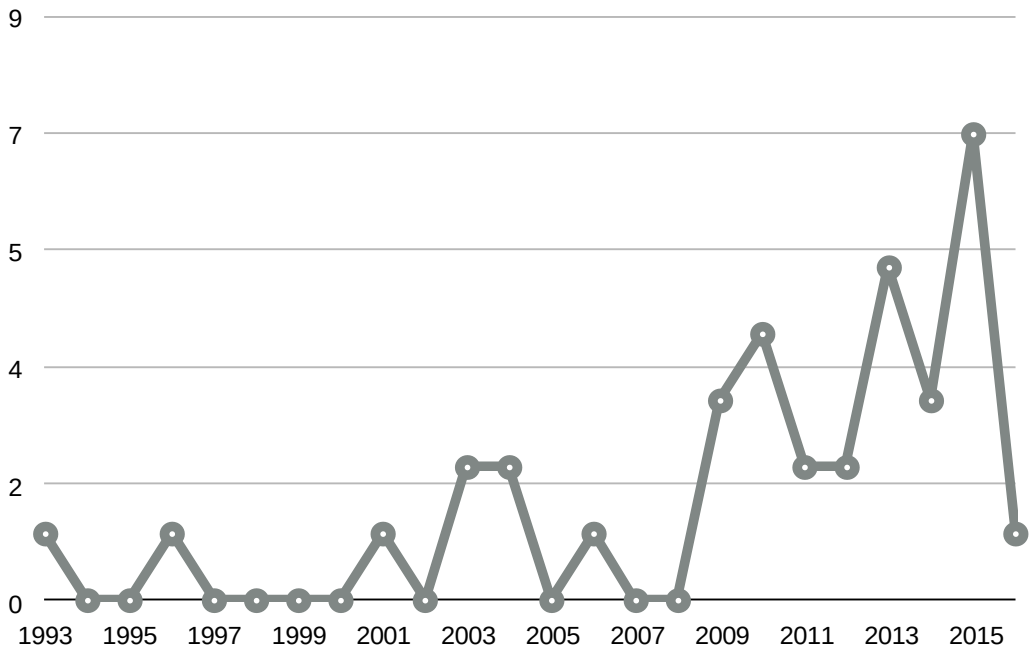
With regard to the places where the surveys were carried out, shown in figure 1, there are a variety of countries, most notably Australia, with 22.85% of the articles found as well as the USA, with 20% of the articles found. Denmark, the United Kingdom and Canada have lower but no less significant magnitude. Other studies have been carried out by universities in these and other countries but have been developed in the countries of origin of the refugee populations to be investigated, such as Egypt, Lebanon and South Korea.

Graph 1. Places where the searches were carried out.



When analyzing the distribution of selected articles per year of publication - shown in Graph 2 -, from the period from 1993 to 2016, it was verified that until 2008 the publications were not very expressive. As of 2009, however, there has been an increasing increase in publications, especially in the year 2013 to the peak observed in 2015, with 20% of the studies found in this review. A significant part of the articles published in 2015 was undertaken in Australia. Only one 2016 study was identified because of the review period - early 2016.

Graph 2. Distribution of publications per year.



Regarding the methodologies used, most of the studies use the qualitative method only (68.6%), using mixed methods (multi methods) in the remainder of the studies - which also involve qualitative methods.

As for the populations studied, a wide range of refugee origins was found. Some studies have addressed refugees from a single country or region, such as those from Bosnia and Somalia. Most of the research has worked with refugees from diverse or unspecified countries and regions.

The complexity of the refugee status for the mental health of the people who go through this experience was evident in the analysis of the articles. We will present the main issues pointed out according to the analytical categories.

Adult refugee mental health

An important issue is the context of immigration. In this category, it was observed that while some studies seek to ascertain the relationship between pre-migration challenges and post-migration challenges[11-16], others focus exclusively on post-migration challenges[17-20], that is, the difficulties encountered by refugees in exile.

Articles that address both types of challenges tend to demonstrate the relationships between traumas in the countries of origin and the obstacles encountered in countries of refuge. The analysis made clear the influence posed by post-migration challenges on the mental health of refugees. Weakened by the fear of persecution or actual persecution - their own or their families - in the countries of origin, they often find a hostile and inadequate environment in the countries of refuge.

Articles dealing with post-refugee challenges, in turn, show a landscape of the problems of the countries that host refugees: failing or inaccessible health systems, discrimination, lack of food and water, paucity of

information regarding their rights and duties, Unknown or unfamiliar language, cultural differences, geographic mobility, separation of family, pressure to send money home. These and other factors make up a number of obstacles to be transposed by refugees around the world after migration to another country. In most cases, they are added to the traumatic experiences pre-refuge, which places these individuals in a position of extreme social vulnerability and susceptibility to mental health problems.

All articles addressed interpersonal relationships as a determining factor for the mental health of refugees. In this context, some publications have cited family issues and others have specifically addressed them[19,15,16], with their implicit challenges and their implications.

Other articles discussed the influence of social interactions on cultural adaptation[17,18]. They emphasize that social support and the building of reciprocal relations contribute to the cultural adaptation and integration of refugees in the case of the North American society. In addition, they measure the increase in the quality of life over time and the decrease of the psychic suffering. On the other hand, racial discrimination, seen as a negative factor for mental health, is overcome by the relief of physical security in the post-refuge context[17, 18].

Social support can be a strong mediator of the relationship between traumatic experiences and psychological consequences. Collective traumas were shown to have no significant impact on the mental health of refugees, while personal traumas were closely related to symptoms of depression and PTSD, sustained by unsupported social interactions[14]. Understanding trauma from a shared perspective can be a protective factor against psychological stress.

Regarding the influence of social interactions on the development of mental disorders, isolation is a factor that can promote hallucinogenic experiences, which complicate cases of Post Traumatic Stress Disorder (PTSD)[21]. In addition, it is stated that interpersonal violence is closely related to symptoms of depression and PTSD[12].

From the perspective of family relationships, family separation and role change, as well as concern for relatives in the home country, are the most frequent post-migration stressors. In many cases, the pressure to send money home is also a stressful factor[19, 11, 15, 16].

The focus on refugee mental health may arise from the perspective of well-being or mental illness.

Selected articles address the issue of mental health under a vision of well-being, seeking to present challenges and possible solutions to the problem of the psychological well-being of refugees[17-20]. These do not address mental disorders generated by refugee trauma or correlate experiences with pathological conditions. They only point to factors that hinder or facilitate the well-being of this population by providing material on stressful experiences and coping strategies.

The other publications treat the mental health of refugees from a clinical perspective[11-16]. They present data on trauma and its consequences, such as the development of mental disorders, the most common being PTSD and depression. They present an overview of the relationship between traumatic experiences and resulting mental imbalances that include the following consequences: moderate to severe psychological and emotional suffering, psychological and emotional stress, PTSD development and / or Depressive Disorder with symptoms of anxiety and / or associated psychotic symptoms.

Most of the articles present proposals for social intervention in favor of refugees, such as projects or actions aimed at guaranteeing rights and better living conditions. In this regard, many studies also address

possible coping strategies by refugees[17,18].

Improving the mental health of refugees as well as promoting opportunities for social support seem to be the main ways of intervening in favor of this population. In addition, it was noted the importance of addressing issues of geographic mobility of refugees within the country of exile, as frequent movements can be detrimental to their adaptation and mental health[20].

Mental health of refugees in childhood and adolescence

Some studies, whose population is made up of children and adolescents, treat the issue of mental health by verifying the presence of traumas and disorders[22-25], while others[26-28] point to aspects related to psychological well-being, with no focus on pathologies.

The theme of coping strategies emphasizes the resources available to young people to cope with the multiple challenges of refugee status. Signs and stress symptoms of young refugees correspond to Western diagnoses of Depression, Anxiety, and Behavioral Disorders[24].

It is important to take care when bridging the problems of refugee youth into biomedical categories. Trauma relates to other elements of life history, personality and personal projects. The lives of these young people is a continuum that includes trauma and can not be summarized by it, as well as by a diagnosis made in a given moment in a transverse form[28].

Common psychological themes have also been addressed, such as: avoidance, mistrust, loneliness, feelings of loss and fear[27].

On the other hand, psychological stress is not necessarily associated with traumas as there are collective coping strategies involving the whole community - and also the young age with which this population migrated to the refugee camp indicates that many had no strong pre-migration experiences[23].

Some studies have related the mental health of refugee children and adolescents with family factors as well as community support[26,23]. More organized families contribute to the prevention of depression in young refugees[25].

The lack of financial and cultural resources of the families of refugee children and adolescents leaves them relatively economically and academically and socially destitute, resulting in psychosocially stressful situations[24,28]. As far as culture[(e)] is concerned, there are also barriers for refugee children and young people[29]. Discrimination in the country of exile is related to poor mental health[22]. Culture can be a factor that often prevents adolescents from seeking help with their psychosocial problems, difficulties in exposing themselves, cultural differences, and service-related barriers[30].

There are also differences in mental health in children who are permanently resettled in a country of exile versus children living in refugee camps. The existing resources are quite different. Another important difference concerns children with a past built in the country of origin versus children born and raised in the

(e) The term "culture" was analyzed in the studies in a generic fashion, as knowledge and lores, linked to behaviors different from those in the exile country, or identified with the previous nationality. It may be needed a specific study, beyond the limits of the present work, to put focus in the flexibility used for the meaning of this term.

country of exile or refugee camps (second generation). This distinction draws attention to issues related to loss and cultural adaptation[23].

Refugee mental health care

Studies have shown that care is influenced by the prior preparation of health professionals to deal with refugee specific issues, such as cultural diversity, beliefs, customs and understanding of the meanings of the health / illness / care process.

The articles demonstrate the indispensability of specialized training for these teams as a strategic means to facilitate the perception of refugees' needs and rights, as well as the development and implementation of an education aimed at professionals working on this issue and the formulation of a clear and consistent policy towards the integration of refugees. The assessment of health needs should be comprehensive, including pre- and post-refuge experiences and cultural and family dimensions of the current situation[31-37].

It is important to emphasize the importance given to the comprehensive approach to refugee assistance, by guaranteeing access to health services through a support network that operates in an intersectoral way, combining efforts among public agents of health, education and social services with a view to strengthening the patient / health care team and establishing trustful relationships in care relationships[30,38].

Some studies also show that the particularities of refugee social conditions in general hinder the experience of care[24,38,39]. The socioeconomic problems experienced by these people have a negative influence on mental health.

With regard to gender, structural barriers and the status of unsafe immigration combined with economic and financial dependence may leave women vulnerable and in disadvantage to protect themselves. Cultural, social, political, historical and economic factors interact with ethnicity, gender and class to influence the way immigrant and refugee women seek health care[40].

It was possible to observe that the barriers imposed by language in the evolution of care reveal the lack of preparation that health services suffer. The initial contact between health professionals and patients is hampered by the lack of interpreters and translators who can articulate the sharing of the singularities of different refugee groups and the understanding of their specific sufferings and difficulties[13,21,31,33].

On the other hand, the results of some studies suggest that the refugees' distrust of the health services of countries of refuge and the estrangement from some culturally differentiated therapies constitutes a blocking factor for the progress of care[41,42]. The present review points to the need for a discussion and open dialogue between services and community members to ensure that responses to health are sensitive to the cultural diversity, refugee needs and beliefs about health.

Discussion

The suffering associated with the refuge condition, whether due to the pre and post migratory conditions, is evident, and may have more or less serious consequences for the mental health of these people. The studies showed the different needs of people in the refuge situation, emphasizing some aspects of this

complex situation. Some points should be highlighted:

1. Cultural diversity as a challenge to be overcome in the country of exile: language, religion, kinship structures, even racial discrimination;
2. The importance of family and support networks in mental health;
3. The challenges imposed on professionals involved in the care of people in situations of refuge, including interculturality;
4. The presence or not of mental illness classifications in these populations;
5. Possible interventions and their results;
6. The commitment of researchers to ethics and human rights in the context of the refuge.

The studies, the variety of sites where they were produced, showed important characteristics that contribute to understand specific situations addressed by the research questions.

Immigration necessarily poses the problem of difference and refers to the complexity of intercultural relations, as pointed out in several studies.

With regard to interculturality, Menéndez[43] makes an important critique of interculturalism in Mexico that can contribute to think about the problem of refuge in the context of care. According to this author, in the processes of health, disease and care, socioeconomic and power inequalities were not included. There are differences between different groups in terms of religion, gender, political adherence, schooling, power or age groups and ethnic groups function simultaneously through links of solidarity and cooperation as well as conflict and violence. Thus, it is necessary to recognize the limitations of treating social actors as homogeneous and monolithic.

It was pointed out to us that some studies prioritize an association with mental illness and others seek to relativize suffering without treating it exclusively in the context of Western diagnostic categories. Two studies critically address the use of these categories in very different sociocultural contexts[13,33].

It is important to deepen the questions about the pathologization of sufferings in the context of the refugees and the process of legitimating this condition.

The suffering of the refuge situation and its specific needs in the context of the places of exile can lead to an interpretation of these people in a stereotyped way, reducing them to the condition of victim[44]. The refugee happens to be seen as a vulnerable, victimized and passive subject[45], at the mercy of the psychological and psychiatric support offered by the host society.

There are countries, such as France, where, in addition to identification documents, medical certificates (psychiatric and clinical) can be inserted as a way to attest to the physical and emotional sequelae expected of people who migrate in a forced manner, such as the refugees. Thus, as Fassin[46] points out, the body of the individual requesting refuge becomes instituted as the final place of the "truth" about him. This observation is fundamental when it comes to health and, more specifically, the mental health of people in situations of refuge.

In the movement of legitimation of the suffering of the person in situation of refuge by the pathological path, the diseased body joins the diseased mind[47]. The presence of trauma as a relevant factor in the process of refuge recognition is thus fundamental to understanding the victimization of this group of immigrants, which is now linked to the idea of the pathological subject. This view cannot ignore that painful events through which

refugees have passed may be violently reflected in their bodies and minds. It seeks to reflect on the naturalization and generalization of this process, as well as on the social meaning that this tendency can have, since it is instrumentalized[48]. Thus, the reading of the texts is an invitation to go beyond the association with mental health, revealing the social relations present.

Conclusion

The scientific production of this review showed part of the complexity of the mental health of people in situations of refuge. To talk about refugee mental health, besides the obvious suffering, is to talk about their specific needs, cultural differences, socioeconomic and power inequalities, the public policies of the countries of exile and, above all, the possibility of these social actors as agents of their own history. We consider an important gap in this area to deepen studies on gender and on specific populations, such as lesbians, gays (homosexual men), bisexuals, trans-gender, transvestites and intersex (LGBTI). The lack of studies in Latin America and the lack of publications in this region were evident. Given the reality of the refuge in Brazil - with the growing number of recognized refugees - and the scarcity of national publications related to the subject, the state of art itself is an invitation to Brazilian researchers.

Limitations of the study

The categories chosen reveal a possibility of analysis that certainly does not address all the diversity present in the studies described, as well as the focus on qualitative studies, giving less emphasis to multi-method studies.

Acknowledgement

We thank Dr. Patricia Gorisch for having warned about the lack of discussion of the issues related to LGBTI among refugee population.

Collaborators

All the authors participated actively in all the steps of the manuscript production.

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Translated by Félix Héctor Rígoli