PSYCHOLOGICAL SUPPORT FOR REFUGEES

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Abstract: *In Romania, the massive flow of refugees entering the European countries is reflected by the media primarily as a problem of other European countries, because only a small number of migrants cross the national territory. At the discourse level of the public authorities, the topic is not a major one, the main concern being to ensure the living conditions for the refugees share allocated to Romania (2000 people so far). The article presents the findings of the research conducted in the European countries (since the 90s) on the mental health problems of the refugees and the main types of psychological support developed to deal with this problem. These experiences are relative to the current context of offering mental health services in Romania, starting from the reality that it is expected that about 30% of the refugees from the armed conflicts have mental health problems (Steel et. al., 2009); hence, at least 600 people will have to be supported psychologically (through psychotherapy, counseling, etc.) in the coming years.*

Keywords*: mental health; psychological support; migration*

1. INTRODUCTION

The Romanian media presents many accounts related to the difficulties of managing a large number of people who are in transit or who want to reside in the European countries. Less present are the accounts about individual cases, about the refugees' fates and traumas.

The main topic discussed in the Romanian media regarding the refugees is the controversy over the mandatory quota of refugees who will be resettled in all the EU countries, so that all its members to contribute jointly in order to improve their situation. In this case, also, the media discourse is impersonal, taking into consideration only the logistical and financial aspects, not the people who went into exile (who are perceived predominantly in a stereotypical manner – Andronic, 2016).

It is foreseeable that the refugees' situation will not be in the near future only a topic for the media in Romania, but it will require intensely the public services, especially and primarily the mental health ones. Based on the results of some reference research (Steel *et. al.*, 2009), based on the meta-analysis of the literature on the traumas suffered by refugees, which shows that about 30% of them suffer from mental health disorders (Steel *et. al.*, 2009) one can make a rough estimation: in the coming years it is possible to be necessary to provide specialized services to a significant number of people, possible 600 (30% of the 2,000 refugees allotted to Romania).

2. TRAUMAS AND DIAGNOSTICS

An important number of studies have focused on the trauma of the refugees from Bosnia-Herzegovina who arrived in other European countries, these revealing an incidence of posttraumatic *stress disorder* (PTSD) which varied between 45% and 82% for a batch investigated in Norway and between 18% and 33% in the research carried out in Sweden (Thulesius & Hakanson, 1999). Comparable results were obtained after studying the incidence of PTSD in Bosnian adolescents who fled to other parts of their own country (Hasanovic, 2012). Similar studies have been conducted on other continents; for example in the USA, a batch of Bosnian refugees was examined three and a half years after their settlement in the United States, and the results show that "44% of women and 8% of men meet the criteria for diagnosis with PTSD" (Vojvoda *et al.*, 2008:421).

At present, the situation of the refugees concerns us primarily due to the scale of the phenomenon. The *Office of the United Nations*

High Commissioner for Refugees estimated that in 2012 there were over 45 million refugees in another country, but also within the same country (Schnyder *et al*., 2015:267) while in Europe about 1 million refugees arrived only in 2015 (Musaro, 2016:13).

In addition, it is also worrying the very high proportion of migrants / refugees suffering from psychological traumas (terms that are used interchangeably in the media – Musaro, 2016):

> However, for the refugees affected by trauma, usually there isn't a unique event that leads to emotional distress, but rather prolonged and repeated trauma in their home countries, often exacerbated by more stressful events during and after their departure (Sonne *et al.*, 2016:2).

Regarding the psychiatric diagnoses used to describe the medical condition of the approximately 30% of the refugees who have mental health disorders (Steel *et al*., 2009), prevailing is the PTSD (defined by the World Health Organization in ICD 10 as a

> non-psychotic anxiety disorder resulting from some exceptional threats or a catastrophic experience that could cause distress for almost all men,

but there are also others, such as the major depression (Levecque & Van Rossem, 2015), somatic disorders etc.

Due to the fact that the refugees suffer from a series of severe traumas (being very frequently victims of torture, witnessing massacres and / or murder of family members, etc.), their diagnosis proved to be difficult. For example, there are notable differences in the results obtained by diagnosing them based on the criteria included in the DSM IV, compared with DSM V (Schnyder, Muller, Morina, Schick, Bryant, and Nickerson, 2015) and even while operating with the "brother" diagnosis of the PTSD, the complex PTSD (abbreviated CTPSD), which was introduced in ICD 11 just in order to capture "repeated, prolonged exposure to the traumas caused by the interpersonal relationships", being particularly relevant for the groups of refugees "given their typical exposure to repeated and prolonged interpersonal trauma" (Nickerson *et al*., 2014).

The diagnostic difficulties (by default, the standard intervention) are explained by a variety of factors, starting with the fact that, due to resettlement, the refugees cannot access the different categories of resources (labor relations, ways of spending their leisure time, etc.) used to reduce distress, continuing with the type of traumas suffered as a result of the events they were exposed to, on the edge of the human condition (such as, for example, the case described by Rami Bou Khalil, 2013) or by claiming that refugees come quite often from countries with a low or medium level of development, where "over 90% of people with mental health disorders are not treated" and "only 13% of the traumatic stress studies are made in these countries" (Schnyder *et al.,* 2016:8). In other words, it is likely that PTSD was not diagnosed in their home countries and was not treated, and the refugees suffer other traumatic events on their way to Europe.

Also, a major difficulty in diagnosing refugees is the fact that PTSD / CPTSD is diagnosed based on some symptoms that are commonly reported verbally, while the refugees predominantly come from cultures where the ability to talk about their traumas is not the rule, but rather the exception. Therefore, there are frequent the cases with "patients who are reluctant to talk with the therapist about their traumatic experiences, which is a sine qua non in virtually all evidence-based trauma treatments" (Schnyder *et al.,* 2016:8). Hence, in making the diagnosis there are common situations where refugees prefer to draw, paint, dance or play an instrument to invoke the traumatic event, but not to talk about it, even if direct communication with the therapist is possible (i.e. without a translator).

To diagnose refugees specific tools tailored to their culture have been developed or standardized instruments were used (such as *Harvard Trauma Questionnaire,* HTQ), designed to investigate the refugees affected by trauma, being validated in multiple languages and cultural contexts (Sonne *et al.*, 2016).

3. FORMS OF SUPPORT FOR REFUGEES

While the studies on the incidence of PTSD have been numerous in recent years, those on the assistance given and their effects are rather rare, especially regarding the predictors of success of the intervention. During the last years, it was investigated the influence of several personal factors on the success of the intervention, among which some significant negative predictors of the intervention proved to be the sex: masculine and the villain status in the country of origin. Regarding the psychosocial factors, employment in their adopted country is a positive predictor, while dependence on the amounts received (without generating income) and even a high level of education (in the home country, usually without an impact in the country of adoption) can be

considered negative predictors of successful intervention (Sonne *et al.*, 2016).

4. CONCLUSIONS

Regarding the assistance efforts, they start from the axiom that the treatment of refugees (especially of those diagnosed with PTSD) generates a very complex situation, both for the patient and the therapist. The vast majority of refugees cannot be subjected to therapies focused on traumatic events, mainly due to cultural differences that make difficult to establish and maintain a therapeutic relationship. Therefore, their assistance refers specifically to stabilization, psychosocial and community support, which are not always sufficient in helping patients effectively. Typically, the assistance given to the refugees from the European countries begins with a "psycho-educational stage", after which they can make the connection between the suffered trauma and the current symptoms. Afterwards, one can proceed to the therapy oriented towards the traumatic event, in which a genuine sensitivity to the cultural issues should be incorporated:

> We treat people, not disorders. As such, culture-sensitive psychotraumatology means having a non-critical and empathetic attitude, trying to understand the cultural basis of each person (Schnyder *et al*., 2016:9).

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