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Psychosocial Problems of Refugees: Understanding and Addressing Needs

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## **Abstract**

Because all refugees have, by definition, left their country due to a “well-founded fear of persecution due to race, political opinion, ethnic origin, religion, or belonging to a particular social group,” it must be assumed that they have experienced trauma, making psychosocial problems ubiquitous among refugees (Bulbul, 2011; M. Carballo, personal communication, 29 September 2011). Research has shown that refugees often experience a range of psychosocial problems, yet research about the potential avenues for ameliorating these problems and their consequences is lacking and must be increased. Through a combination of interviews and a review of the field’s existing literature, it was found that the most common problems include depression, anxiety, post-traumatic stress disorder, and a range of social problems, many of which stem from linguistic or cultural barriers and the rigid structure of life in refugee camps. Compounding these problems, it became evident that existing methods for psychological diagnosis and psychotherapy often fail to meet the needs of refugees. Further, programs designed to aid the more social problems, such as consistent language or cultural-immersion courses, are scarce. Ultimately, making the living conditions in refugee camps and self-settlements more conducive to psychosocial wellbeing and making access to adequate resources more prominent, general psychosocial wellbeing should improve for refugees.

**Keywords:** cultural psychology, psychotherapy, psychosocial problems, refugees

## **Introduction**

According to Dr. Manuel Carballo (2011), it must be assumed that all refugees have experienced trauma and that the choice to leave their home country was not their own. As a result of these traumatic events, which can occur before leaving home, during migration, or even after entering the host country, about half of refugees will arrive at their final destination with psychosocial problems (Carballo, 2011). These problems range from the presence of specific psychopathologies, which can be diagnosed and treated by a psychologist, to problems that are more closely related to the social world, such as difficulties with linguistic and cultural barriers, or wondering whether or not they will be granted refugee status and therefore asylum. Of course, dealing with such problems in a foreign country is often difficult due to a plethora of

reasons, particularly for refugees with traumatic pasts. The living conditions for refugees, either in self-chosen settlements or in refugee camps, are also often less than ideal, with each type of settlement posing unique additional barriers to psychosocial wellbeing (Connor, 1989). Along with consequences of these living conditions, many challenges faced by refugees stem from the cultural and linguistic differences that may lead to misunderstandings, especially in situations of psychotherapy. Ultimately, if such conditions of life are improved and misunderstandings are identified and decreased in psychotherapy, psychosocial problems of refugees will be more easily and effectively ameliorated.

In many cases, the conditions in which refugees live in their host countries fail to foster an environment promoting optimal psychosocial health. Those living in refugee camps, which are defined as “human settlements which may vary enormously in size, socio-economic structure and political character,” are often deprived of basic freedoms and provided with inadequate living spaces, due to the poorly planned infrastructure of many camps (Crisp & Jacobsen, 1998, p. 27; Cuny, 1977). Refugees living in self-settlements, where housing structures are still inadequate much of the time, often face xenophobia and discrimination in their new communities (Connor, 1989). Still, there is much more autonomy than for those living in camps. These living conditions each foster a new set of threats to psychosocial wellbeing of refugees, so the differential living situations, which are often ignored in research, must be acknowledged when discussing psychosocial health of refugees.

In spite of these differing challenges, studies suggest that irrespective of their native cultures, host cultures, or living conditions, psychologists report that refugees have a universally high risk of developing depression, anxiety and post-traumatic stress disorder, hereafter referred to as PTSD, although incidences do vary due to a range of factors, with living situation as a significant predictor of the problems (Silove, 2004, Gorst-Unsworth & Goldenberg, 1998). Specific events or circumstances that have occurred throughout the lives of refugees, including poverty, loneliness, and conflicts with immigration officials, have also been found to correlate with the development of these disorders and social problems. Considering that these are experiences that are

commonly known to refugees, especially those living in camps, it is not surprising that reported rates of these psychological disorders are high.

Although incidences are high, accurate diagnoses are difficult, partly due to bias among practitioners and also due to the Western cultural bias of the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision, later referred to as the DSM IV-TR. With these highly trusted, yet not universally accurate guidelines for diagnoses, some psychological problems may be misinterpreted and therefore misdiagnosed (M. Carballo, personal communication, 2 November 2011). Providing evidence of misdiagnoses, Watters (2001) uses data from interviews with psychologists to argue that psychologists and clinicians often specifically look for PTSD in refugees and that they focus their diagnoses on factors related to refugees' home countries (2001, p. 1709). Doctors ignore the host country's wide range of potential stressors, such as conditions in refugee camps or self-settlements, as well as other psychosocial or medical problems that refugees may have, resulting in many false diagnoses of PTSD. From the other side of the spectrum, Weinstein, et al. (2000) argues that psychologists often fail to recognize the refugee status or culture of their patients and that due to this shortcoming, "even when refugees seek medical care in a highly regarded country health system, their unique problems are rarely addressed" (2000, p. 303). Evidently, accurate diagnosis of refugees poses a problem for psychologists.

Compounding these barriers to accurate diagnosis, linguistic and cultural differences often prevent refugees from being able to express their true feelings or experiences. As Sue notes, issues as seemingly inconsequential as forms of nonverbal communication can lead to some of the most severe forms of misunderstanding, demonstrating that a therapist must thoroughly understand many aspects of their client's culture to provide effective treatment (1990, p. 425). As a result, refugees may share only limited information, which often fails to accurately portray their past. These incomplete accounts are then mixed with preconceived ideas of psychologists and the bias in the DSM IV-TR, leading many diagnoses to be based on information that hardly relates to the unique situation of the refugee in question. For these reasons, psychologists must fully acknowledge the cultural background of their patients as well as their personal history when developing therapeutic methods and providing therapy.

Given that so many refugees arrive at their final destination with some psychosocial problem, further research and innovation in valid, culturally sensitive psychotherapeutic methods is urgent, especially because life in the host country can so easily spur new problems (Carballo, 2011). Unfortunately, there also lacks significant research regarding differences among psychosocial problems faced by refugees at different stages in the asylum-seeking process and their different living conditions. Appropriate culturally sensitive procedures for treatment should then be crafted through a collaboration of professional psychologists and anthropologists, all of which must understand the unique cultural and psychological backgrounds of refugees, along with the realities of their everyday lives and living situations. Interventions must be created to help minimize everyday stressors as well, as to promote overall psychosocial health. This paper will explore these differential living situations that are common for refugees and the psychosocial problems that they promote. Developments of appropriate psychotherapeutic methods for refugees in each situation will be discussed, as will programs that may help decrease psychosocial problems brought about by daily life. With the use of such methods and the acknowledgement of the realities of the lives of refugees, psychologists will, ideally, be capable of providing truly accurate diagnoses and effective treatments for psychosocial problems that are common among refugees and psychosocial problems stemming from everyday situations will be decreased.

## **Methodology**

In order to further identify the range of psychosocial problems that are common among refugees living in each situation and to develop propositions for potential methods for improving psychosocial conditions, this paper utilizes information obtained in personal interviews of psychologists, social workers, and experts, supplemented by a review of the existing literature in the field. The three semi-directive face-to-face interviews contributing to this paper were conducted with two psychologists and two health specialists working at Camarada, in Geneva, all of which specialize in researching or working with refugees and other migrants. A fourth freewheeling face-to-face interview was conducted with an expert in the field of migration and public health. From their experiences working with refugees and the extensive research that they

have done in the field, each interviewee was able to supply information regarding their work and describe the psychosocial problems that they have seen experienced by refugees.

The interviews with the psychologists, conducted with Adrienn Kroó of the Cordelia Foundation in Budapest, Hungary and Celine Froidevaux of Dr. Jean-Claude Métraux's clinic in Lausanne, Switzerland, discussed the most common psychosocial problems that the psychologists encounter when working with refugees. The interviewees also described the methods that they use to avoid cultural misunderstandings, prevent misdiagnoses, and promote effective care for the population in need. Additionally, these psychologists spoke about the differences between psychosocial ailments that they have found to be common among refugees living in different types of refugee camps and how they differ from the issues common among those living in mainstream societies. The doctors finally described their hopes for future methods of improving psychosocial conditions for refugees, as to provide an understanding of what controllable conditions they thought aggravated the psychosocial health of refugees.

Both of these interviews were conducted in person, based on a list of questions that were prepared in advance and brought to the interview on a sheet of paper. The interviews were conducted in English, although Froidevaux provided some brief explanations and asked for some clarifications in French. Throughout the course of the interviews, questions were spontaneously altered as seen fit based on comments made by interviewees. Both interviews took place in the offices of the interviewees, in which psychotherapy sessions are often conducted. At Kroó's office, none aside from an administrative assistant were present in the building, and at Dr. Métraux's clinic, I waited for Froidevaux among the clinic's other clients and was taken back into her office, as though I was there for an appointment, as were the others. Because of this isolation, responses were not likely to have been altered by either interviewee, as to avoid offending any refugees or other clients at the practices.

The third semi-directive, face-to-face interview was conducted with Anne Divorne, public health nurse, and Caroline Eichenberger, health coordinator, at Camarada, in Geneva, Switzerland. This interview, also conducted with a list of

previously formulated questions, used additional questions when seen fit. The interview took place in Eichenberger's office, which was isolated from where classes took place. Questions were asked in English, although Eichenberger translated them into French for Divorne. Responses from Divorne were all given in French and Eichenberger spoke primarily in English, although some responses were instead given in French. Together, Divorne and Eichenberger discussed interventions that their organization has developed to promote successful integration of migrants. In particular, they described the programs that they offer that aid their psychosocial wellbeing through education, community, and health-related interventions within their classes. Divorne and Eichenberger also described other key issues in improving psychosocial health and explored the more social side of the issues. Their interventions focused only on migrants living in mainstream society, some of which are refugees.

Unlike the previous interviews, which were all conducted with psychologists or social workers, the fourth face-to-face personal communication contributing to this project was with an expert in the field of migration and health, Dr. Manuel Carballo, director of the International Center for Migration, Health and Development in Geneva Switzerland. He provided a broader perspective on the issue, in spite of being unable to meet for a formal, semi-directive interview. Instead, Dr. Carballo responded to spontaneously prepared questions regarding the basics of the paper's theme and elaborated in the directions that he saw fit. Notes were written during this interview only, which was not recorded. Other students from the School for International Training were present, all of which had similar research questions and were also able to listen to Carballo's responses. With insights regarding conditions of life for refugees and potentially psychosocially damaging experiences known to refugees, he was able to provide valuable information known only to those who have spent years interacting with refugees. Observations and personal research were described, allowing for a wealth of unpublished information to be exposed.

With the exception of Dr. Carballo's interview, each interviews was recorded, to which all interviewees consented. Following each interview, notes were taken based on the recordings of the interviews and themes were identified within each interview and between interviews. Based on similarities, differences, and the general themes, the

data were then coded with relation to these themes, and finally categorized in the two tables that can be found in the Appendix.<sup>1</sup>

Supplementing these interviews, the existing peer-reviewed literature as well as work published by prominent international organizations provided a wealth of information that would not have been otherwise accessible. Due to temporal, bureaucratic, and geographical constraints, observations at refugee camps, which could have provided an assessment of living conditions, were impossible. Direct conversations with refugees were also unable to be conducted due to language barriers and difficulty in reaching refugees. For these reasons, it was helpful to be able to use work that has already been conducted by experts and approved by their peers in the academic community to supplement field-based research. Ultimately, through this combination of resources, many dimensions surrounding the issues relating to psychosocial health of refugees are explored and critiqued.

Data from this literature was coded and systematized as well. After the full literature review, themes similar to those found in the interviews were identified. Differences between the themes found in the interviews and the existing literature were identified as well and were analyzed. Finally, the data were added to the tables that were created from data from interviews. The full range of data was then synthesized and suggestions for future alterations were identified. Ultimately, this data helped to put the data obtained in interviews into the context of the greater field, and confirmed that these data were not merely outliers.

## **Results**

Based on the interviews conducted, it is clear that refugee camps and the living situations that they provide for refugees must be explored when discussing common psychosocial problems. Of the approximately 12 million refugees throughout the world, over 7 million report having lived in camps or a segregated settlement for a period of ten or more years (Smith, 2004). For some, a camp may provide a safe haven in which to live and may be the first step in escaping terrible conditions in their home country, therefore escaping a traumatic, psychologically damaging experience (Adams, et al.

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<sup>1</sup> Refer to pages 25-28 for the Appendix.

2004). Yet, others describe living situations in their camps as confining, putting restrictions on their lives and habits (A. Kroó, personal communication, 8 November 2011). Because many camps work specifically to integrate refugees into society by distancing them from their old culture and ways, these camps actively reinforce powerlessness and dependency of refugees through conditions relating to “possessions, status, space, time, mobility, and regulations” (Mortland, 1987, p. 375). As a result of their structure, the conditions of camps, in and of themselves, often promote new obstacles to psychosocial wellbeing of the refugees, as their freedom is greatly compromised in such living situations.

Evidently, the living situations of refugees play a significant role in determining the psychosocial problems that they will encounter in their host country. Kroó (personal communication, 8 November 2011) breaks these living situations down in to three groups, specifically reception camps, integration camps, and self-settlements. As she emphasized, each situation is unique, as are the characteristics of the refugees who most commonly live in them. Each living situation is associated with a certain legal status and a certain length of time already spent in living in the host country. Froidevaux (personal communication, 15 November 2011) stresses the impact of the insecurities relating to whether one has a permanent, temporary, or no resident’s permit at all on psychosocial wellbeing, making it clear that this association between living situation and legal status is important to note. As a result, whether a refugee lives in a reception camp, an integration camp, or a self-settlement and has the associated legal status can serve as a significant predictor of the psychosocial problem that they will face.

The effects of these living situations will be examined through a case study of Hungary. Upon arrival in the host country, refugees often initially reside in a reception camp, such as the Debrecen Camp in Hungary. This type of camp houses recently arrived refugees who do not yet have a permit, but are in the process of obtaining one. These camps can also be home to refugees who have been denied asylum, but who are in the process of attempting to repeal the refusal. As noted in Table 1<sup>2</sup>, the legal

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<sup>2</sup> Refer to Table 1 (page 25-26) for a full description of all obstacles in reaching psychosocial wellbeing for refugees in reception camps, integration camps, and self-settlements.

status of refugees living in reception camps promotes stress concerning obtaining this permit and more recent traumas often have lingering psychological effects. Kroó (personal communication, 8 November 2011) notes that life in these camps drives refugees into a regressive state, as they nearly force refugees to become fully dependent on the structure and authority of the camp, leading them to develop a sense of powerlessness. Kroó also described the stressors in reception camps as having a focus on the past, as it is the most overwhelming aspect in the lives of these refugees. Froidevaux (personal communication, 15 November 2011) adds that the lack of positive distractions in the camp such as a job, the fact that refugees are surrounded by other, often distraught, refugees, and the lack of knowledge about what sort of permit may be received, further detract from the ability of refugees to focus on a positive image of their future. Additionally, the constant noise and lack of personal space can worsen some symptoms of PTSD. Evidently, reception camps fail to foster a good environment for the psychosocial wellbeing of their residents.

The next step for some refugees is living in an integration camp, such as the Bicske Camp in Hungary, which houses only those who have received their permits. Here, refugees often have a more secure sense of their future, which is often accompanied by hope, as opposed to only the fear and worry experienced by those in reception camps. Still, it is important to note that all living in any type of refugee camp face rigid structures and schedules, not only those in the initial reception camps, which causes a lack of independence in their everyday life. As opposed to the reception camps, where the pasts of refugees are the most significant causes of psychosocial stress, Kroó (personal communication, 8 November 2011) explains that the psychosocial problems of refugees living in these integration camps focus instead on the present and future situations of the refugees. Still, the past traumas and experiences play a large role in determining their psychosocial wellbeing, but the focus of their worries is certainly less oriented toward the past than their fellow refugees living in reception camps.

The third possible living situation for refugees is a self-settlement, here focusing on self-settlements in Budapest, Hungary. Unlike those living in either type of camp, refugees living in self-settlements have the autonomy to make choices about their life,

which is psychologically and socially liberating for these refugees. Still, they must learn to become integrated into a new culture and society, which poses its own wide range of threats to psychosocial wellbeing. Many face significant discrimination, stigmatization, and xenophobia, which only compound these challenges. Another difference between the psychosocial states of refugees who are living on their own and those living in camps is that self-settled refugees have often lived in their host country for a longer period of time and therefore are less strongly affected by previous traumas (A. Kroó, personal communication, 8 November 2011). Other times, refugees initially move into a self-settlement, showing their independence along with an ability and psychosocial stability to take the initiative to live on their own in their new country, making them generally less prone to threats to psychosocial wellbeing than those living in camps. Regardless, refugees living in self-settlements have often been granted asylum and are the most likely of the three groups to have a 10-year permit to live in Hungary. With a 10-year permit, refugees are officially allowed to stay in the host country for ten years. After ten years, the permit is supposed to be easily renewable, making this type of permit considered permanent (A. Kroó, personal communication, 8 November 2011). Additionally, refugees who have received 10-year permits are allowed to bring their families to join them in the host country. Five-year permits, on the other hand, are considered temporary permits and cannot be easily renewed and cannot allow for family reunification. Because of these permits and the other reasons described above, it is clear that the living situation of a refugee can both predict and contribute to the psychosocial problems of an individual.

Evidently, psychosocial problems are quite common among refugees and their amelioration must become a focus for psychologists and others. Although the UNHCR guarantees basic medical care in refugee camps and those living in mainstream society are technically eligible for the same health care as locals, problems remain omnipresent and successful treatment is uncommon. This is partly because access to psychotherapy in refugee camps is rare and adequate care for the unique needs of refugees, even in mainstream society, is hard to come by (A. Kroó, personal communication, 8 November 2011). Although psychotherapy is offered in Hungarian refugee camps, it is an unusual situation. The structures of camps in other countries

often make it difficult for refugees to have the chance to speak with psychologists. In Switzerland, for instance, refugees must obtain written permission from a general practitioner in order to visit a psychologist or psychiatrist, which prevents many needing care from receiving necessary help (C. Froidevaux, personal communication, 8 November 2011). Evidently, services available for refugees in camps differ based on location.

Refugees living in mainstream society often have a hard time accessing care as well. According to Kroó (personal communication, 8 November 2011), psychotherapy is not included in Hungarian health insurance. Therefore, all seeking care must find a private psychologist. For refugees, this may pose problems, as they may be unable to afford the care or may not know where to look to find appropriate psychologists. For these reasons, even refugees who are living as the locals do may still be unable to receive the necessary therapy for whatever psychosocial problems they may have.

Nonetheless, even when refugees do receive care, doctors from host countries sent to work with migrants, and especially refugees, often claim that their medical training has not adequately prepared them to deal with the complex and unique needs of their patients (Adams, et al. 2004). Further, psychologists are known to misdiagnose refugee clients on a regular basis, due to cultural differences that alter the expression of certain disorders and symptoms, which leads to further problems (M. Carballo, personal communication, 2 November 2011). In an effort to improve this avenue for miscommunication and inadequate practice, the UNHCR has developed a booklet known as “Concepts of Care: A Workbook for Community Practitioners,” which attempts to give practitioners the information that they need to adequately prepare themselves for working with their target population in camps (2007). The booklet includes a section specific to psychosocial issues and trauma, which works to “broaden community practitioners’ knowledge about trauma and psychosocial issues among communities that experience violence and other atrocities” (2007, p. 29).

In the booklet, there is a strong emphasis on understanding the relation between a refugee’s culture’s community reactions to trauma and the attitudes and values that accompany these reactions. Because each community and culture perceives trauma in a unique way, particularly in the collectivistic cultures from which many of these

refugees come, developing an understanding of the trauma in the eyes of the refugee is especially important. Traditions, culture, religion, and language must all be taken into account, and based on the knowledge and understanding of these values, a practitioner will more easily be able to aid the refugees with which they are working. Refugees commonly come from collectivistic cultures, so the UNHCR provides a section describing the links between an individual and their community as well, as general assumptions often cannot be made regarding the view of oneself within the context of their community and culture. Therefore, techniques such as group therapy are common among these populations. With the use of such booklets and their proposed methods, it is hopeful that community practitioners will feel better equipped to work with refugees living in camps, suffering from the aftermath of traumatic experiences.

Due to these factors described by the UNHCR, although access to care is important, methods of care that will genuinely address the unique needs of refugees are also necessary for successful psychotherapy. Organizations such as the Hungarian Cordelia Foundation and Dr. Métraux's practice in Lausanne have begun to develop methods of culturally sensitive methods of psychotherapy as well, which are outlined in Table 2<sup>3</sup>. Through these methods, their psychologists and psychiatrists are able to sufficiently treat their clients, without running into nearly as many of the problems of misdiagnosis and misunderstanding that are all too common.

The Cordelia Foundation's team of psychologists, who visits Hungarian refugee shelters on a regular basis to provide counseling to refugees, has developed two main models of treatment, as well as a number of therapeutic methods (Hárdi & Kroó, 2011). The first of these models, known as the "go model," provides therapy in the home of the client, empowering them through their position as the host for the psychologist, while remaining within the security of their own home (2011, pp. 90-91). The "stay model," on the other hand, allows clients to find the office on their own and meet with psychologists in a more traditional manner (2011, pp. 91-92). Through this model, clients who are psychologically ready for independence can begin their process of psychological rehabilitation for integration into society, focusing on strength and innovation.

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<sup>3</sup> Refer to Table 2 (pages 27-28) for a full summary of services provided by the Cordelia Foundation, Dr. Métraux's Clinic, and Camarada.

Additionally, a community center is at their disposal, where clients can interact with other refugees and share experiences as well as social networks.

Regardless of whether psychologists or clients are the ones traveling to the location of the psychotherapy session, therapy is always conducted in the client's native language, unless therapy is nonverbal. Specific therapeutic methods used within either the "go" or "stay" models include traditional individual verbal therapies, family verbal therapies, and non-verbal group therapies, which use art, relaxation, and movement techniques to aid refugees in the initial stages of the rehabilitation process (Hárdi & Kroó, 2011, pp. 92-95). Further, the psychologists working for the foundation rarely use formal diagnoses from the DSM IV-TR. This allows them to be able to more accurately work with their clients, instead of focusing on creating a formalized diagnosis, which is likely to not accurately fit the issues known to clients from non-Western cultures (M. Carballo, personal communication, 2 November 2011).

Dr. Métraux's clinic, another group dedicated to providing psychotherapy to refugees, also avoids formal diagnoses and uses a model for psychotherapy that is similar to the Cordelia Foundation's "stay model." Froidevaux (personal communication, 15 November 2011) explains that this model is used because they believe that this structure allows refugees to separate themselves from their status as a refugee and feel as though they are part of mainstream society. As do non-refugees, they are able to leave their home and independently attend their therapy sessions.

In their attempt to tailor their therapeutic methods to the needs of the refugees visiting their office, Dr. Métraux's clinic hires psychologists from the origins of many of their clients. When this is impossible, cultural and linguistic interpreters are used to aid during therapy (C. Froidevaux, personal communication, 15 November 2011). At this clinic, which works with many refugees from Kosovo, Bosnia, and Serbia, psychologists come from a range of cultural backgrounds. Accordingly, the clinic has psychologists from Kosovo, Bosnia, and Turkey, as well as a Swiss psychologist who is fluent in Serbo-Croat and Swiss psychologist who is half Algerian. Still, when psychologists are unfamiliar with their client's culture and must work with an interpreter, the psychologists research their clients cultures before working with them, as to gain an understanding of the cultural context in which they will be working.

It is through these methods that psychologists attempt to understand their clients' backgrounds and adequately work around cultural barriers in their treatment. Both the Cordelia Foundation and Dr. Métraux's clinic are able to provide adequate treatment to their clients because of these methods. Also, through programs that allow refugees living in camps to either visit the clinic or allow psychologists to visit camps, refugees living in camps can access such tailored methods of care. Methods such as the "stay method" and the more traditional way in which clients come directly to Dr. Métraux's office allow self-settled refugees to access these resources, not limiting them to refugees in camps. Unfortunately, many psychologists and psychiatrists fail to do so, making it important for these two groups to continue to spread the use of their methods (M. Carballo, personal communication, 2 November 2011).

Still, neither of these organizations helps to ameliorate problems that are more closely related to the social world. For this purpose, Camarada, a group working with migrant women in Geneva, exists. The group offers programs for language learning and intertwines medical and social interventions with these courses (C. Eichenberger, personal communication, 18 November 2011). Workshops are also provided, in which students can learn skills and have a chance to converse with others, sharing experiences with others who may be able to relate. Further, medical workers provide active listening sessions with students, which let students express their feeling and share their stories. By exposing their clients, whether refugees or voluntary migrants, to social networks and important resources for legal, psychological, or cultural assistance, they are able to provide the students with a local community with which to interact and a range of resources to help their wellbeing. With such a center at their disposal, women are able to improve their lives and psychosocial wellbeing through interaction with others in similar situations, in spite of the fact that migrants and refugees are dispersed throughout Geneva, not living in one concentrated area (A. Divorne, personal communication, 18 November 2011).

Through the use of these services and methods, refugees may be able to experience improvements in their psychosocial wellbeing. In many cases, these services directly intersect with solutions to the psychosocial problems identified as common among refugees. This paper will continue with a discussion of the particular

ways in which these interventions help to ameliorate such problems. Additional suggestions for future developments based on what was described above will be proposed as well.

## **Discussion**

Taking these comments into consideration, it is evident that the living situations and resources available to refugees must be improved in order to promote their optimal psychosocial wellbeing. Additionally, for ideal outcomes, these psychosocially blemished refugees must receive specially crafted psychotherapy that will address their unique needs. Beyond this, refugees living in reception camps, integration camps, and self-settlements must each receive treatment and other services that focus on what they need most, due to their differing stages in the immigration and integration processes as well as their different psychosocial states. The methods used by the Cordelia Foundation and Dr. Métraux's practice bring to light a range of potential avenues for improvement, although a need for more universal change still exists, considering that many psychologists do not even acknowledge the refugee status or unique problems of their clients (Watters, 2001; Weinstein, 2000). Services provided by Camarada also give an example of potential methods for aiding refugees living in self-settlements, but still needing help adjusting to life in their new home. Other such interventions should be planned to help improve the psychosocial situations of refugees, particularly those who currently are in situations that make psychosocial wellbeing difficult.

Regarding life in refugee camps, as specified by Froidevaux (personal communication, 15 November 2011), problems relating directly to the camps themselves, such as the regressive state into which refugees are forced into due to many camps' structures or the problems precipitated by excess noise and lack of privacy, serve as one of the greatest threats to psychosocial wellbeing for refugees. Evidently, these unfavorable situations must be altered to encourage better psychosocial health. After a case study in India, Cuny (1977) identified the importance of proper structure and well-planned organization in the psychosocial wellbeing of a camp's inhabitants. With social spaces allotted for interactions and group activities, along with the allowance of considerable say in the activities of the camp, refugees fare

much better than in camps where they lack all autonomy. If more camps were organized in ways that were more conducive to psychosocial wellbeing, refugees would cease to suffer as badly in refugee camps. This would leave refugees only needing to deal with the psychosocial problems resulting from legal procedures and the related stressors, which cannot be easily remediated, as opposed to also being exposed to a plethora of additional threats to their psychosocial health based on their living situations, which can, in fact, be changed.

Based on this case study, it is evident that camps have differential abilities to promote or discourage the psychosocial health of their residents, often based on their structure. With well-planned improvements in the living conditions and freedoms given to refugees, their psychosocial wellbeing is likely to be helped. A simple recommendation for ameliorating some of these problems relating to structure is a decrease in the constant level of noise in the camps, as well as giving refugees a larger amount of space in which to live. As mentioned above, many refugees currently live very close to others, giving them little privacy and little space to call their own. If the close proximity of living spaces, as well as high noise levels found in camps, were to be decreased, refugees suffering from PTSD would be able to more easily adjust to their new home and have a more rapid recovery from the disorder (C. Froidevaux, personal communication, 16 November 2011).

The current state of refugee camps, particularly those similar with the camps in Cuny's study, which fail to provide autonomy or spaces for social interactions, often precipitate anxiety and discomfort for those with PTSD, and these conditions and their consequences could be relatively easily altered. These particular psychosocial problems that can be precipitated by life in the camp itself make it especially evident that increasing access to psychosocial care for refugees that live in camps is essential. Such care will work not only to help overcome problems related to trauma experienced in the home country or during the journey to the host country, but also to deal with problems that have arisen as a result of the camp's living conditions.

Froidevaux (personal communication, 15 November 2011), who spent time working as a psychologist while living in a Hungarian reception camp, described having psychologists living and working among refugees as a very successful method for

effectively providing psychotherapy to suffering refugees. Unlike in Switzerland, where no such services exist, psychologists are truly able to work with their clients and reach out to those who would otherwise not be able to receive treatment. If all refugee camps were able to have psychologists frequently visit and provide treatment to any who appear to be in need, the problematic aspects of the camp could improve.

Further, if psychologists were able to interact with those planning the structure and degree of autonomy available in the camps, the psychologists could communicate the problems and concerns exposed by refugees and potentially be able to alter the way that camps are run. For instance, noise levels could be reduced, as to make those suffering from PTSD more comfortable and help reduce their symptoms. Psychologists are well aware of this issue, and it is likely that it does not even occur to those planning the setup of the camps (C. Froidevaux, personal communication, 15 November 2011).

Additionally, psychologists recognize that if refugees were given more autonomy and freedom to live as they wished within the camp, the regressive state of dependence into which many are forced to fall could be avoided as well. Providing jobs or constant, but optional, activities for refugees in camps could decrease boredom and help to distract refugees from the traumatic experiences of their past, as well as help to create social ties among those living in the camp. The lack of boredom and loneliness could also decrease their predisposition to developing depression, anxiety, and PTSD, all of which can be precipitated by loneliness and boredom (Silove, 2004, p. 36). Having the opportunity to find a paying job in the camp would also help refugees feel more secure about their new life, as they will have an income, giving them financial power in their new home.

Each of these propositions could help to ameliorate problems that psychologists who counsel refugees would be able to easily point out to those developing camps. If such cooperation were to exist, camps could be designed and run in a way that is more conducive to the psychosocial wellbeing of the camp's residents. Although planning of camps often must happen quickly, due to the nature of their purpose, it would still be more productive to take the extra time to consult psychologists before immediately beginning construction, as to avoid further problems along the road. As it stands today, it is rare for those who have knowledge about the ideal setup to promote psychosocial

wellbeing in camps to interact with those who quickly build camps when emergencies strike.

Another issue that needs to be altered in order to increase psychosocial wellbeing of refugees is the way in which they access psychotherapy when it is not brought to the camp, as is done in Hungary. In Switzerland, refugees must first interact with a general practitioner and then receive written permission to visit a psychologist or a psychiatrist. This poses a number of barriers. Initially, these general practitioners are unlikely to have extensive knowledge of psychology and therefore may not be qualified to determine whether someone may benefit from psychotherapy. Also, it has been noted that many refugees somaticize their psychological symptoms, making it even more likely for doctors to simply prescribe pain relievers for something, such as a headache, which may be linked to an underlying psychological cause, such as depression (A. Kroó, personal communication, 8 November 2011). As a result, the refugee will often not receive the needed permission to visit the psychologist, and will instead fail to receive adequate treatment. For this reason in particular, it is important for this practice to be ended and the method for receiving psychotherapy to be altered.

The Hungarian system, clearly, is more effective than the Swiss system, as those living in Hungarian camps are able to speak with psychologists in the safety of their camps, without needing to leave or receive permission. Because of the perpetual presence of psychologists, the stigmatization of psychotherapy, which is a problem in many cultures, is likely to begin to disappear. If refugees must leave the camp and go through a special process to receive permission to begin therapy, it is more likely that others in the camp will see psychotherapy as a distant, possibly stigmatized entity, rather than just a welcoming, helpful part of their daily lives. Also, a presence of psychologists within the camp encourages participation from all who wish to take part. This presence, in and of itself, improves the psychosocial state of many living in the camp, as they know that there is somewhere for them to go if they need help. In cases where help is distanced, it is less likely that refugees will feel that they are able to access it, especially when a long process is necessary to gain permission.

Refugees living outside of camps do not, by any means, have an easy time either, much of the time. Because psychotherapy is not covered by insurance in

Hungary, it is often difficult for a refugee to find counseling that is affordable or accessible. Additionally, linguistic and cultural barriers may complicate finding a psychologist with whom they share a language and culture, so the treatment that they receive may be inadequate. If psychologists who have developed appropriate methods began to increase their outreach programs, outcomes for these refugees could be more successful.

Regarding this psychotherapy provided by psychologists, whether living in the camp, visiting the camp, or requiring refugees to visit their office outside of the camp, it is important that psychotherapists working with refugees are fully informed of what they must do in order to succeed with their clients. As many acknowledge, the DSM-TR-IV is quite biased and is inadequate to properly diagnose many refugees, due to cultural differences, including the differing degrees of somaticization of PTSD symptoms between cultures (M. Carballo, personal communication, 2 November 2011).

To help ameliorate this problem, more psychologists should follow the lead of the Cordelia Foundation and the clinic of Jean-Claude Métraux, neither of which uses formal DSM-based diagnoses on a regular basis, as they find these diagnoses inadequate (A. Kroó, personal communication, 8 November 2011; C. Froidevaux, personal communication, 15 November 2011). As psychologists working with both groups remark, the need to provide a diagnosis based on DSM-criteria only hinders the potential success of the psychotherapy, which is limited by the bias in the DSM. For this reason, formal diagnoses are used only in the cases where they are necessary, such as for a legal report or for a prescription of medications.

Ultimately, if greater understandings of clients' cultures are realized by those providing psychotherapy, the outcomes of psychotherapy will be much more successful for refugees. As are used in Dr. Métraux's practice, interpreters who are able to translate both the language and the culture of clients are ideal for gaining a full understanding of the particular psychosocial experience of a client. Further, cultural research done by psychologists before working with refugees, as Froidevaux (personal communication, 15 November 2011) described, is very important in allowing the psychologist to be able to adequately understand and treat their clients. When the culture, religion, and language of clients are universally factored into psychotherapy,

outcomes for refugees will be considerably more effective. It is through these measures that Sue's (1990) criticism of the misunderstanding of small cultural variations in expression can be avoided. Further, if more psychologists are able to treat the symptoms that they see, which their clients are accurately able to portray to them in a way that they are accurately able to understand, psychotherapy will be much more successful than if methods are applied to treat a specific disorder, as defined for western cultures.

In the future, such approaches should be taken, in which a client's culture is taken into account and the DSM IV-TR's criteria are used only as guidelines, not solid rules. Such culturally sensitive methods will, hopefully, be able to ameliorate the situations for many refugees, who are currently suffering further as a result of their psychologist or psychiatrist's inadequate ability to provide proper psychotherapy. More than anything, this helps to remind psychotherapists that their client is, after all, human, just as is the psychologist (C. Froidevaux, personal communication, 15 November 2011). As a result, the psychologist will often treat their clients more reasonably and a personal relationship will be able to be established, not only one between a doctor and a patient.

In addition to these suggestions regarding the more psychological side of the psychosocial spectrum, organizations such as Camarada can help ameliorate more social problems that are experienced by refugees, specifically those living among mainstream society. Were more services available to help refugees form communities in their new homes, they would be able to feel less isolated from others and would be less likely to become depressed as a result of loneliness or boredom (Silove, 2004). With an outlet to speak with others, many of which may have experienced similar pasts, refugees can finally open up and meet friends, in spite of living in the middle of what is often a large city full of strangers. If refugees living in self-settlements are able to connect with others living in self-settlements, they will be able to feel more accepted and normal in society.

By providing them with skills through workshops, Camarada is also able to help prepare women for jobs, allowing them to see new perspectives for the future, which is likely to increase their psychosocial wellbeing as well. Also, the cultural and linguistic lessons provided by Camarada help enormously with the integration process. Because

of this, these women will not only be able to connect with their fellow students at Camarada, but they will also be able to develop relationships with others in Switzerland, as they develop an understanding of the culture and the language. Finally, the health-related anxieties of many refugees, as described by Kroó (personal communication, 8 November 2011), can be alleviated, at least to a degree, by the health interventions conducted in the language classes at Camarada, which connect the refugees with necessary resources, to which they would otherwise be oblivious. Most importantly, Camarada provides a first step toward independence and a new, strong identity for many women, and programs promoting such developments should be available to more refugees (C. Eichenberger, personal communication, 18 November 2011).

Still, the programs offered only last for a limited period of time, as women are there primarily for classes, not socialization, although socialization can certainly occur at the center. In order to take the final step in securing a community with which refugees can associate permanently, Camarada would need to develop a community center with the sole purpose being to create a social space for refugees and other migrants. This could be similar to the purpose of the center that exists at the Cordelia Foundation, but it could include the wider range of resources that are already available at Camarada. With such a resource at their disposal, refugees would be able to continue their liberating discussions and continue to secure their social networks in their new home.

Additionally, men would need to be included for the full success of this social space. Although Camarada specifically excludes men as to allow women to feel more independent, after spending a good deal of time in Geneva, they may feel ready to interact with men who have had similar experiences by the time they have finished their initial series of classes and workshops. Men often need help integrating as well, and with their inclusion, the center could serve a broader population. With such a sort of community center, refugees and other migrants living in Geneva would be able to continue their integration among their peers, rather than alone. With such a support system, it is probable that psychosocial problems known to many self-settled refugees could be helped.

Beyond the cultural and linguistic issues that can be ameliorated by the initial classes, the cultural center would allow refugees to share more experiences to help one

another find good doctors, psychologists, or living spaces. Further, they could alleviate homesickness, through discussions about familiar topics and discuss their frustrations relating to discrimination felt in their new home. Through this type of space available to refugees, both men and women, a community could be formed for self-settled refugees, who may otherwise feel very isolated, which detracts from their psychosocial wellbeing. Most importantly, those enjoying the space would know that they would not need to leave after they finished their series of classes, but they could stay involved with the community and could join the community even if they never had the need to attend the classes.

Through the services offered by these three organizations, along with the subsequent recommendations for their improvement, the psychosocial situations of refugees could improve. Nonetheless, as the organizations stand now, they are not able to fully help all of the problems that Kroó and Froidevaux describe as being common among refugees, which can be seen in detail in Table 1.<sup>4</sup> Within the coming years, it is hopeful that such suggestions are implemented and that the psychosocial states of refugees improve as a result.

## **Conclusion**

Unfortunately, because of the very reasons that people must flee their countries and become refugees, it is unlikely that traumatic experiences will cease to occur for refugees. For this reason, psychosocial problems will remain closely tied to those who identify as refugees. Further hindering the process of diminishing threats to ensuring psychosocial wellbeing for refugees, it is unlikely that immigration laws and the administrative process of receiving permits will change in refugees' favor within the near future. Nonetheless, the majority of other barriers to psychosocial wellbeing can much more easily be broken down.

Ultimately, if the services provided by the Cordelia Foundation, Dr. Métraux's clinic, and Camarada were ubiquitous as well as extended as proposed above, refugees in all living situations would be able to live a much more psychosocially healthy life in their host country. In order to reach a point at which optimal wellbeing can be achieved,

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<sup>4</sup> Refer to pages 25-26 for Table 1.

the possible steps that can be taken toward achieving solutions to the problems that can be solved should be followed. It is only through these steps that the psychosocial problems that are so common among refugees can be treated, or situations can be altered such that the conditions precipitating the problem will cease to materialize. Fortunately, with the identification and acknowledgement of these problems, a solid foundation for change has been laid.

As Froidevaux stressed (personal communication, 15 November, 2011), it must be remembered that refugees are human beings. Because this mere fact is all too often ignored or forgotten, their conditions of life are much less favorable than they could be, were some effort to be put into improving their wellbeing. Still, there is a growing body of research in this area, as its importance and gravity have become increasingly evident in recent years. Because of innovative ideas, methods of therapy, and interventions that have subsequently been developed and planned, it is possible that in the future, refugees will be able to lead more psychosocially stable lives in their host countries, regardless of living situation, in spite of their frequently traumatic pasts, which are, unfortunately, likely to remain unchanged.

## Appendix

**Table 1**

Case Study: Psychosocial Health of Refugees living in Organized and Self-Settlements in and near Budapest, Hungary. Based on information provided by psychologists A. Kroó (personal communication, 8 November 2011) and C. Froidevaux (personal communication, 15 November 2011).

Living Situation	Threats to psychosocial health include:
<p><b>Reception Camp (Debrecen Camp, Hungary)</b></p>	<ul style="list-style-type: none"> <li>-high incidences of depression, anxiety, and PTSD.</li> <li>-the absolute uncertainty of the future.</li> <li>-the forced dependence on the system and lack of autonomy.</li> <li>-being forced into a regressive state by rigid structure of the camp.</li> <li>-the constant worry and uncertainty about legal and immigration procedures, especially for those trying to repeal rejected attempts to receive asylum.</li> <li>-the high levels of noise in the camp, which can trigger reactions related to PTSD.</li> <li>-the wish for one's own residence.</li> <li>-any problems that arise from linguistic and cultural barriers.</li> <li>-the lack of a way to learn language, as classes are rarely offered regularly and when they are, they are usually quickly cancelled.</li> <li>-traumas that are still very recent, as refugees have just arrived in their host country when in the reception camp, so associated problems are often very prominent.</li> <li>-ever-present fears regarding whether or not will the refugee receive asylum and will be able to stay in Hungary.</li> <li>-fears concerning family reunification, which are often strong, especially for men who come alone and plan to bring families and who do not yet know if they will obtain the necessary 10-year permit, that will allow them to bring their families.</li> <li>-conflicts that can arise between ethnic or national groups who now must live in close proximity, in spite of these tensions.</li> <li>-the fact that psychologists only visit once every two weeks, so although counseling is available, it is not as frequent as may be ideal for some.</li> <li>-the fear of health-related problems, because there is no insurance available to refugees living in camps and doctors are available only during limited hours, providing limited care.</li> </ul>
<p><b>Integration Camp (Bicske Camp, Hungary)</b></p>	<ul style="list-style-type: none"> <li>-high incidences of depression, anxiety, and PTSD.</li> <li>-the potential for the initial optimism following obtaining a permit to be crushed by the rigid structure of the camp.</li> <li>-the realization that Hungary does not provide as much freedom as hoped when left home country.</li> <li>-remaining uncertainties about the future, although they are often not as strong as they were before receiving asylum.</li> </ul>

	<ul style="list-style-type: none"> <li>-the hardships that accompany the attempt to find a job as a refugee, particularly one living in a camp, and the insecurities accompanying the lack of a job.</li> <li>-the wish for one's own residence.</li> <li>-the disappointment that may accompany having only obtained a five-year permit, especially if the hope was to bring a family, which is only possible with a ten-year (permanent) permit.</li> <li>-the remaining lack of autonomy and the strictness of the structure within the camp.</li> <li>-problems that arise from linguistic and cultural barriers, although regular language courses and culture classes are offered to help ease the integration of the refugees.</li> <li>-the after-effects of traumatic experiences, which are often less recent than for those living in reception camps, but these traumas remain present in the minds of many.</li> <li>-the high levels of noise in the camp, which can trigger reactions related to PTSD still exist, although reactions are often not as strong as in reception camps, due to longer span of time since the trauma.</li> <li>-the same conflicts between ethnic or national groups that can arise in reception camps.</li> <li>-the fact that psychologists only visit once every two weeks, which may not provide frequent enough therapy for some.</li> <li>-the remaining fear of health-related problems, because there is no insurance available to refugees living in camps and doctors are available only during limited hours, during which they can only provide limited services.</li> </ul>
<p><b>Self-Settlement (Budapest, Hungary)</b></p>	<ul style="list-style-type: none"> <li>-high incidences of depression, anxiety, and PTSD.</li> <li>-the challenge of learning to live in an entirely new culture, often without much assistance.</li> <li>-the feeling of isolation in a new country, especially if arrived alone.</li> <li>-the cultural and linguistic barriers that may remain problematic.</li> <li>-discrimination, prejudice and indications from Hungarians that they are unwanted in their new home or workplace.</li> <li>-the traumas that may remain fresh in the minds of refugees, although they usually are neither as strong nor as recent as for those living in camps, so effects will still exist, but often to a lesser degree.</li> <li>-the fact that refugees often do not live in a community with others of their own ethnicity, so they may feel lonely or homesick.</li> <li>-the fact that psychological counseling services are not included in health insurance packages, so refugees who suffer from psychosocial problems, as do many, will need to independently seek out a private psychologist.</li> <li>-the fact that their homes may be too small or crowded.</li> <li>-the traditional dress that some refugees may continue to wear, although it is rare or even stigmatized in their host country.</li> </ul>

**Table 2**

Services for refugees offered by the Cordelia Foundation, Dr. Métraux's clinic, and Camarada, based on information provided by A. Kroó (personal communication, 8 November 2011), C. Froidevaux (personal communication, 15 November 2011), and A. Divorne and C. Eichenberger (personal communication, 18 November 2011), respectively.

<b>Organization</b>	<b>Services Provided for Refugees include:</b>
<b>Cordelia Foundation</b>	<ul style="list-style-type: none"> <li>-visiting refugee camps every two weeks to provide psychotherapy to any refugee who may need it, not only those with referrals ("go method").</li> <li>-allowing for refugees to continue to visit the office after leaving the refugee camp ("stay method").</li> <li>-providing culturally sensitive therapies to refugees (Hárdi &amp; Kroó, 2011):               <ul style="list-style-type: none"> <li>----group therapies: used with refugees from collectivistic cultures</li> <li>----family verbal therapy: used to work with both the victim of trauma and their family, who are secondary victims, even if they did not experience the trauma</li> <li>----individual verbal therapy: used less frequently than other methods, but comes into use when conflicts arise or a refugee requests individual sessions to help ease post-trauma symptoms, develop coping methods, and regain trust</li> <li>----non-verbal therapies, using art, relaxation, and movement techniques: used when clients suffer from shame or humiliation and feel unwilling to speak, helps to promote group cohesion and trust</li> </ul> </li> <li>-acting as a resource from which refugees can seek help in camps.</li> <li>-providing a community center for refugees, after they leave the camp, maintaining the connections that they have made with refugees in camps.</li> <li>-providing cultural orientation workshops for outpatients.</li> <li>-referring refugees to other groups who are able to help in ways that Cordelia cannot alone, including lawyers or social workers.</li> <li>-aiding refugees with legal processes, especially those relating to their mental health, such as providing mental health reports.</li> <li>-remaining in contact with former clients even after psychotherapy is over, showing that their services are still available.</li> </ul>
<b>Dr. Métraux's Clinic</b>	<ul style="list-style-type: none"> <li>-providing psychotherapy to refugees, using interpreters to bridge cultural and linguistic gaps.</li> <li>-giving refugees a clinic to go to with a number of therapists from their own culture, specifically for refugees from Turkey, Kosovo, Bosnia.</li> <li>-providing therapy to refugees living either in or out of camps.</li> <li>-allowing refugees to come to the office in Lausanne, as do all living in mainstream society, even if the refugees live in a camp.</li> <li>-aiding refugees by providing mental health reports that may be necessary for legal processes.</li> </ul>
<b>Camarada</b>	<ul style="list-style-type: none"> <li>-making language courses available to migrant women at a minimal</li> </ul>

	<p>cost, which can be paid through helping out around the center if the monetary fee is too high.</p> <ul style="list-style-type: none"><li>-conducting workshops that allow women to develop skills, such as sewing, cooking, and print-making, as well as create social networks.</li><li>-providing health-related interventions in language courses, as to give their students a greater knowledge of the resources that are available to them.</li><li>-allowing students to go to health counselors for active listening sessions.</li><li>-conducting workshops in which women can discuss issues relating to integration or any problems that they have experienced and share similar experiences with other migrants.</li><li>-providing students with resources wherever they are needed, including legal and medical areas.</li><li>-accompanying students to medical appointments when not secure enough to go alone.</li><li>-helping students complete paperwork, such as legal, financial, or residential forms, that may be difficult for them to understand on their own.</li></ul>
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## **Annex: Work Journal**

### **29 September 2011**

#### **Meeting with Dr. Carballo:**

##### **Question Asked:**

- I am planning to research the mental health problems of refugees. Do you have any suggestions?

##### **Notes about informal interview:**

I met with Dr. Carballo along with four other SIT students, not expecting to have him ready to answer questions. I told him about my topic, and he suggested that I focus on “psychosocial” problems, as opposed to “psychological” or “mental health” problems. He noted that all psychological issues were intertwined with social issues, and that they are truly inseparable. After this meeting, I decided to change my focus to “psychosocial” problems, as opposed to “psychological” or “mental health” problems, as to include a wider range of data and issues.

### **2 November 2011**

#### **Meeting with Dr. Viladent and Dr. Fehlmann:**

- Discussed questions prepared for upcoming interview with Adrienn Kroó
- Allowed me to finalize my questions and modify questions that may have potentially been leading

#### **Meeting with Dr. Carballo:**

- Asked for recommendations as to what to be sure to include in my ISP
- Discussed necessary questions for psychologists in interviews
- Suggested that I ask about misdiagnosis, inappropriate treatment, and the lack of cultural sensitivity of the DSM IV-TR (Diagnostic and Statistical Manual of Mental Disorders) in interviews with psychologists

### **8 November 2011**

#### **Interview of Ms. Adrienn Kroó of the Cordelia Foundation:**

##### **Questions Asked:**

- What are the most common psychosocial problems that you see among refugees?
- What stressors do refugees describe in their everyday lives? How do these stressors differ among those living in camps and in mainstream society?
- How do these problems vary by origin of the refugee, experiences of the refugees, and the current living, socioeconomic, and psychological situations of refugees?
- Describe the demographics of the population with which you work.
- Your paper says that you visit local refugee shelters. Is it common for refugee shelters to have psychologists visit, or is this service available only due to the existence of your organization?
- How often do refugees have pre-existing psychosocial problems that are unrelated to their refugee status? How do you separate these problems in treatment, if at all?
- Describe some culturally sensitive methods of psychotherapy that you have found particularly successful.
- I have read many complaints concerning the lack of cultural sensitivity in the Diagnostic and Statistical Manual of Mental Disorders. What are your experiences relating to this limitation and how do you deal with it?
- Does the foundation have services available to connect clients with other organizations or networks, such as cultural centers, educational facilities, or potential avenues for job placement?
- Is there anything else that you would like to add that we have not yet discussed?

**Notes about interview:**

The Cordelia Foundation was founded at the time of Yugoslavia's breakup in 1996 with the purpose of providing psychotherapy to torture victims. In this interview, one of the foundation's psychologists, Adrienn Kroó, described her role as a psychologist who works with refugees living in the Debrecen reception camp and the Bicske integration camp. She stressed the differences between the problems common among refugees living in the two locations. Additionally, she discussed methods that had been developed for working with refugees in therapeutic situations. After years of

working with refugees, the Cordelia Foundation has been able to gain an understanding of the cultures of its clients well enough to be able to truly tailor their therapeutic methods to the unique needs of their patients.

### **8 November-10 November 2011**

#### **Exchange of Emails with Dr. Viladent and Dr. Fehlmann**

- Discussed questions prepared for interviews of Dr. Métraux and Camarada to ensure that no questions were leading, inappropriate, or would evoke unwanted responses from the interviewees

### **15 November 2011**

#### **Interview of Céline Froidevaux:**

##### **Questions Asked:**

- What are the most common psychosocial problems that you see among refugees?
- Do you work primarily with refugees who have lived in refugee camps or have most of them lived in self-settlements since their migration?
  - Would you say their psychosocial problems differ according to their living situations? How so?
- What stressors do refugees describe in their everyday lives?
  - How do these stressors differ for those living in camps and those living in mainstream society?
- How do these problems vary by origin of the refugee, experiences of the refugees, and the current living, socioeconomic, and psychological situations of refugees?
- Describe the demographics of the population with which you work.
- How often do refugees have pre-existing psychosocial problems that are unrelated to their refugee status? How do you separate these problems in treatment, if at all?
- How do you tend to approach psychotherapy with refugees? Do you work with interpreters?

- Describe some culturally sensitive methods of psychotherapy that you have found particularly successful with refugees.
- I have read many criticisms concerning the lack of cultural sensitivity in the Diagnostic and Statistical Manual of Mental Disorders.
  - What are your experiences relating to this limitation and how do you deal with it?
- Is there anything that you would like to add that we have not yet discussed?

**Notes about Interview:**

Dr. Métraux was unable to meet with me due to a sudden emergency, so I spoke with a colleague of his, Celine Froidevaux, who is a psychologist who works with refugees. She answered my questions and told me about her experiences working with this population. Froidevaux described many situations in which she worked with refugees who have not spoken her language, but noted that they have still been able to successfully communicate due to the fact that they were both human and therefore could understand each other. As it turns out, she spent some time working in Hungary with the Cordelia Foundation and during that time, lived in a refugee camp, interacting with refugees on a daily basis. Based on this experience, Froidevaux was able to give me a comparison of the Swiss and Hungarian situations for refugees needing psychotherapy and the differing consequences for the methods available.

**18 November 2011**

**Interview of Ms. Caroline Eichenberger and Ms. Anne Divorne of Camarada**

**Questions Asked:**

- In a meeting at Camarada in September, I was told that you work primarily with providing educational services to non-francophone migrant women living in Geneva, but you also use these courses as an entry point to discuss other important issues.
  - Can you describe the way that you integrate these other services into your curriculum and why you use this method to spread information?
  - What services do you tend to make available through these interventions?

- Does Camarada provide any services to improve the psychosocial wellbeing of its clients, such as visits of psychologists or counselors to the center?
- Describe some of the stressors that your clients report experiencing in their everyday lives.
- Describe the benefits of your services for migrant women.
- In September, you mentioned the importance of cultural sensitivity in your work. How do you promote such sensitivity when working with your clients without hindering their progress in integration and without preventing interactions beyond only the superficial level?
- If you believe that a client may be dealing with a psychosocial problem precipitated events that occurred before, during, or after migration, do you do anything to help them?
- Do you often know whether a migrant has voluntarily or involuntarily come to Switzerland?
  - If so, do you see voluntary migrants and refugees experiencing the same challenges in Geneva? If they face different challenges, how do they differ?
- Is there anything else that either of you would like to add that we have not yet discussed?

**Notes about Interview:**

I interviewed Ms. Caroline Eichenberger, health coordinator, and Ms. Anne Divorne, public health nurse, both of Camarada, as to discuss the health-related interventions that they organize for their students. They told me about the services that they offer and their experiences with migrant women. Although Camarada serves all migrant women, not only refugees, their services are available to refugees and many of their comments apply to the refugee population. From this interview, I gained knowledge about organizations that aid migrants and refugees who live in mainstream society in forming social networks in their new home. I also learned about successful methods for teaching the language of the area and promoting psychosocial wellbeing among migrants who do not live in a community with others from their culture. We

spoke primarily in English, although Divorne responded to questions in French and Eichenberger provided all necessary translations.

## **21 November 2011**

### **Meeting with Dr. Fehlmann**

- Discussed the creation of Table 2, which graphically displays the services provided by each of the three groups interviewed
- Talked about splitting paper into two sections, one for the psychosocial problems and the other for treatment methods, but decided against the division
- Discussed the format of the work journal, the paper, and the powerpoint presentation, specifically noting what was necessary to include and what was not

### **Research Locations**

- A. Kroó was interviewed at the Cordelia Foundation's office in Budapest, Hungary
- C. Froidevaux was interviewed at Dr. Métraux's clinic in Lausanne, Switzerland
- A. Divorne and C. Eichenberger were interviewed at Camarada's center in Geneva, Switzerland
- M. Carballo was interviewed at the International Center for Migration, Health, and Development Headquarters in Geneva, Switzerland
- Meetings with C. Viladent and M. Fehlmann were conducted at the School for International Training office in Nyon, Switzerland

### **Contacts and Potential Informants**

#### **Semih Bulbul**

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Area of Expertise: Senior Desk officer for Iraq Support Unit, Iraqi refugees

#### **Manuel Carballo (advisor)**

International Center for Migration Health and Development (ICMHD), Director

mcarballo@icmh.ch

Area of Expertise: Issues in migration and health, particularly those relating to development

Meetings: 29 September 2011 (informal interview), 2 November 2011 (Geneva, Switzerland)

**Anne Divorne**

Camarada, Public Health Nurse

Area of Expertise: Provides counseling and medical advice to migrant women at Camarada

Interview: 18 November 2011 (Geneva, Switzerland)

**Caroline Eichenberger**

Camarada, Health Coordinator

caroline.eichenberger@camarada.ch

Area of Expertise: Works with migrant women at Camarada, focusing on health-related issues

Interview: 18 November 2011 (Geneva, Switzerland)

**Céline Froidevaux**

Dr. Métraux's Clinic, Psychologist

cfroidevaux@gmail.com

Area of Expertise: Works with refugees, those living in and out of camps, and provides culturally sensitive psychotherapy

Interview: 15 November 2011 (Lausanne, Switzerland)

**Adrienn Kroó**

Cordelia Foundation, Psychologist

adriennkroo@gmail.com

Area of Expertise: Provides psychotherapy to refugees and torture victims, works to develop culturally sensitive therapeutic methods

Interview: 8 November 2011 (Budapest, Hungary)

**Jean-Claude Métraux**

Psychiatrist

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Area of Expertise: Culturally sensitive methods for psychotherapy of refugees

Interview: 15 November 2011 (cancelled)