AINO JOURNAL, Vol. 2, 2003, pp. 37－41

Review

Stigma, refugees and mental disorders

Solvig EKBLAD

Adjunct Associate Professor in Transcultural Psychology
Section of Psychiatry, Neurotec Department
Karolinska Institutet, Stockholm, Sweden, and
Head, Unit for Immigrant Environment and Health
National Institute for Psychosocial Medicine,
Stockholm, Sweden

Introduction

Recent estimates indicate that the international refugee and displaced person population is still at an alarming level. Today, the estimated number of persons of concern who fall under the mandate of UNCHR is nearly 20 million (of which nearly 9 million are in Asia, 4.9 million in Europe and 4.2 million in Africa) and about the same the number again of displaced people. International and relief organizations rightly concentrate their efforts on refugees' immediate physical needs. The effects of different traumatic life events on the psychiatric status of asylum seekers, displaced persons and refugees, are often ignored by the resettlement countries because of the stigma attached to mental health problems. Once refugees have reached relatively safety in a camp or host country it is impossible to isolate these problems from the context in which they arise.

Within the field, critics claim that the psychiatric impact of trauma on refugees has been overstated, that it is inappropriate to assign diagnoses such as posttraumatic stress disorder (PTSD) to normative manifestations of human suffering, and that mental health services and other interventions are culturally alien to most non-Western populations. According to Silove and Ekblad (2002) "although motivated by human rights concerns, this critique could be distorted for political purposes" (p. 401).

In order to apply ethical guidelines to the research and clinical field of refugees and mental disorders, it is urgent to effect a paradigm shift from a biomedical model to ethical concerns in the social, political and economic factors that play a major role in refugees' experience. In this, the implication of pluralism of meanings given to privacy, confidentiality, morality and understanding has to be seriously taken into consideration. In promoting the application of research and clinical ethics safeguarding the rights and welfare of asylum seekers, refugees and displaced people, public discussions combining practice and theory are of great importance. After defining the concepts of refugee and stigmatization, this article summarizes and discuss the challenges that need to be embraced in order to reduce stigma, and presents recommendations for future interventions.

Refugees

The 1951 UN Convention Relating to the States of Refugees defines a refugee as "a person who, owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country." Refugee women with their children account for as much as 80 per cent of the refugee population. Policies for refugee reception differ from country to country and are reported elsewhere (www.unhcr.ch).

Forced migration by displacement or tem-

porary or permanent refuge abroad compelled by governments, groups or on one's own initiative take many forms and have many causes. For instance, people may decide to leave a country because of human rights violations, persecution, repression, torture, natural and human-made disasters. However, those who receive and secure a legal status in their new homeland may face chronic unemployment, racial discrimination and stigma, poverty, lack of access to medical care, difficulties in finding safe housing, high levels of crime and lack of compensation for lost family and community network in their home country. Gender-based violence may be encountered, including rape, enforced prostitution, and trafficking, torture, and other cruel, inhuman and degrading treatment, such as enslavement. International human rights law is also applicable in armed conflicts. International humanitarian law and human rights law should be applied on a non-discriminatory basis.

What are the roots of stigma?

Stigmatization of people with mental disorders has persisted throughout history. According to a report on Mental Health (1999) by the Surgeon General "it is manifested by bias, distrust, stereotyping, fear, embarrassment, anger and/or avoidance" (p. 6). Further, such stigma results in others avoiding living, socializing or working with, renting to, or employing people with mental disorders. People with mental disorders also have reduced access to housing, jobs and recreation and decreased self-esteem, which in turn leads to isolation and a feeling of having no future and no hope. When stigma is overt it results in discrimination and abuse. However, on a more sophisticated level it reduces the person's dignity and inhibits full participation in society. Why is stigma towards refugees so strong despite a better public understanding of mental illness?

Stigma, risk factors, seeking help and coping among refugees

Refugees are at particular risk not only for developing mental disorders but also for failing to receive treatment for these illnesses (Jaranson, Forbes Martin and Ekblad, 2001). Experiences during premigration, migration and postmigration contribute more or less to this risk. Negative stress factors include acculturation pressures, financial and employment failures, imbalance between their sociocultural values and the new values in the host country, social isolation and intergenerational stresses.

Jablensky et al. (1994) have reported the following risk factors for determinants of poor mental health, and these factors occur throughout all phases of the refugee resettlement process. These factors are marginalization and minority factors, socio-economic disadvantage, poor physical health, starvation and malnutrition, head trauma and injuries, collapse of social supports, mental trauma and adaptation to host cultures. Further, psychological distress and impairment in psychosocial function are influenced by individual, family, cultural and social variables (Ekblad, Ginsburg, Jansson & Levi, 1994).

In order to understand and clarify stigma and refugees' mental illness it is useful to consider the major psychosocial systems on different levels. Ekblad and Silove (1998) suggest the following simplified framework in which five fundamental systems are threatened or disrupted: "(1) The attachment system: Many refugees are affected by traumatic losses and separations from close attachment figures.... (2) The security system: It is common for refugees to have witnessed or encountered successive threats to the physical safety and security of themselves and those close to them.... (3) The identity/role system: The refugee experience poses a major threat to the sense of identity of the individual and the group as a whole. Loss of land, possessions, and profession divest individuals of a sense of purpose and status in society.... (4) The human rights system: Almost all refugees have been confronted with major challenges to their human rights. These include arbitrary and unjust treatment, persecution, brutality, and in some instances, torture.... (5) The existential-meaning system: The refugee experience poses a major threat to the sense of coherence and meaning that stable civilian life usually provides for most communities" (pp. 10–13).

The most common symptoms and signs that appear in refugees across different cultures include "anxiety disorders, depressive disorders, suicidal ideation and attempts, anger, aggression and violent behaviour, drug and alcohol abuse, paranoia, suspicion and distrust, somatization and hysteria, and sleep-

lessness" (for a review, see Jaranson, Forbes Martin, and Ekblad, 2001, p. 123). The most frequent psychiatric diagnoses in the literature have been identified as posttraumatic stress disorder (PTSD) and major depression. Rape has a very high rate of acute PTSD and may lead to high rates of chronic PTSD, especially if not treated.

According to Silove (1999), the highest rates of PTSD have been recorded within psychiatric clinic populations, intermediate rates have been recorded in sampled community groups and the lowest levels have been recorded in epidemiological samples. Further, war-related stress issues, environmental factors, persistent grief, mourning, loneliness, and isolation tend to predispose women living in war situations, and refugee women, to sustained stress that may lead to depression (for a review, see Jaranson, Forbes Martin, and Ekblad, 2001). Children's reactions to stress, and vulnerability to child morbidity usually mirror their family's response, i. e. transgenerational effects.

Much of the debate has centered on the role of PTSD, which was only recognized as a distinct psychiatric category in 1980. Young (1995) has pointed out that this diagnosis arose in a particular social and economic context following the Vietnam war yet has gone on to be applied universally to survivors of war and persecution regardless of cultural group and place of origin. Thus, it is not a homogenous, neutral and value-free category and mental health services developed for this diagnosis are influenced by a wide range of factors. Even though there are similar symptoms after traumatic life events across cultures, cultures differ in the meaning ascribed to the key concepts of traumatic life events and torture. There are also cultural differences in attitudes toward suffering and when it is appropriate to relate the trauma story. Beliefs that suffering is inevitable or that one's life is predetermined may deter, for instance, some practicing Muslims or Buddhists from seeking health care. In group-oriented societies, as opposed to Western and modern societies, intervention-based group activities may be more appropriate than individual approaches. However, it is also of importance to pay attention to coping strategies, which may prevent intervention.

Refugee-perceived mental illness may also be understood from another perspective, namely the context of refugee resilience and coping capacity. The following four protective factors have been identified by Jablensky et al. (1994): (1) availability of extended family; (2) access to employment; (3) participation in self-help groups; and (4) situational transcendence, or the ability of individuals and groups to frame their status and problems in terms that transcend the immediate situation and give it meaning (e. g. ethnic identity, cultural history). Therefore, mental health programs should stimulate these mechanisms of adaptation and foster self-help to minimize helplessness. Nevertheless, some asylum seekers and refugees need access to professional and appropriate care, which is referred to in many declarations of human rights.

Stigma, refugee and interventions

The human rights perspective originates in the United Nations Universal Declaration of Human Rights proclaimed on December 10th, 1948 (United Nations, 1948). This declaration refers to "the inherent dignity" and "the equal and inalienable rights of all members of the human family".

In 1990, the World Health Organization identified three goals in relation to equity in case of equal needs: 1) equity in access, 2) equity in utilization, and 3) equity in quality of treatment (Whitehead, 1990). The Office of the United Nations High Commissioner for Refugees (UNCHR) recognizes violations of human rights as among the principal causes of refugee movement and the protection of human rights as central in regard to treatment in countries of asylum, and ultimately to repatriation in the migrant's home country. However, in Sweden, adult asylum seekers have only the right to emergency medical and dental care, medical emergency being defined by the physician. Asylum seeking children are entitled to the same medical and dental care as other children in Sweden (www.migrationsverket.se).

The best psychiatric care considers the multiple health and social service needs of refugees, as well as their other special needs (Kinzie & Jaranson, 2001). Thus, interventions may not only include standard Western approaches (e. g. pharmacotherapy and psychotherapy) but also community approaches and traditional healing. The refugee may be reluctant to relate the trauma story because of lack of trust, shame, or fear of symptoms. This

is why refugees should be supported in revealing information at a pace that feels comfortable for everyone involved. Such an approach may pose a challenge in orienting and training primary health care workers to recognize signs of trauma and torture. Such training should include diagnostics and therapy approaches. Staff should also learn to inform survivors of torture and trauma that they are not alone and that their symptoms and reactions are common. However, most refugees do not receive formal help. A first step is to see to it that the feelings of stigma towards refugees are overcome.

Reducing stigma : challenges and opportunities

When the public at large understands that refugee mental disorders are not the results of moral failings or limited will power, but are legitimate illnesses that are responsive to specific treatments, much of the negative stereotyping may be reduced. Nevertheless, fresh approaches to disseminating research information and, thus, countering stigma and barriers need to be continuously developed and evaluated. The barriers reflect to some extent failures of communication between policymakers, service providers and scientists. Another barrier reflects basic realities in the delivery of emergency services to asylum seekers, refugees and displaced persons. The demand of informed consent may be complicated even more in a transcultural encounter between clinician and patient.

According to Brody (1994) "many purported assistance programs for refugees in countries of asylum are operated in an authoritarian fashion in which refugees are confined and kept in a state of economic dependency, increasing rather than alleviating the effects of previously experienced trauma. Human rights issues also emerge regarding repatriation, particularly enforced repatriation or incentives for reluctant repatriation. Many observers believe that a humanitarian response to relocating people should go beyond the provision of security to actual training in leadership and supervised participation in the democratic process of the new environment" (p. 63).

In sum, if authorities are given license to ignore the importance of stress reactions in asylum seekers, refugees, and displaced people, there is a risk of applying harsh immigration policies, to avoid asylum seekers and other refugee groups. Therefore, there is a great and urgent need of mental health training programs in refugee service skills regarding basic transcultural communication, clinical skills in stress reactions, cross-cultural sensitivity and human rights. Otherwise there is a great risk of further stigmatization and under/overdiagnosis, and critical errors in treatment will be the result when clinicians encounter asylum seekers, refugees and displaced people. We are all in the same boat, and everyone has a responsibility for realizing human rights, so let's start now!

Acknowledgements

I would like to extend my warmest thanks to Steve Wicks for his great help in transforming the text into readable English.

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