Chapter #1

POST-TRAUMATIC STRESS RESPONSES AMONG REFUGEES FOLLOWING XENOPHOBIC ATTACKS IN DURBAN, SOUTH AFRICA

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ABSTRACT
Following a spate of xenophobic attacks against foreign nationals in Durban, South Africa, displacement camps were set up to shelter predominantly Congolese and Burundian refugees. Embedded within the emergency program a prevalence study of symptoms of posttraumatic stress disorder (PTSD) was conducted among a convenience sample of this population. Twenty-seven participants included men and women who were screened for symptoms using the Harvard Trauma Questionnaire (HTQ). Results indicate a prevalence rate of 85% among this population. Limitations include the small sample size and potential self-reporting. The high prevalence rate of people who meet diagnostic criteria for PTSD has profound implications for psychosocial interventions and access to mental health services for this community – as well as significant broader legal and social justice implications.

Keywords: PTSD, refugees, trauma, cross-cultural.

1. INTRODUCTION

Over the past two decades, there has been an increasing interest in the question of trauma among refugee populations. In general, the literature reports greater mental health difficulties among refugees compared to general populations within host communities, documenting statistically significant higher levels of post-traumatic stress, anxiety and depression (Abbott, 2016; Ainamani, Elbert, Olema, & Hecker, 2017; de Arellano & Danielson, 2008; Lambert & Alhassoon, 2015; Van Ommeren et al., 2001). Significant rates of medically unexplained pain and somatoform disorder have also been highlighted (Drozdek, Noor, Lutt, & Foy, 2003; Van Ommeren et al., 2001). In terms of PTSD prevalence specifically, a meta-review conducted by Steel and colleagues in 2009 (Steel et al., 2009) examined results of 181 surveys comprising 81 866 refugees and other conflict-affected persons from 40 countries, which revealed an average prevalence rate of PTSD across all surveys of 30.6%. However, there was an alarmingly large inter-survey variability of symptoms (0%-99%) noted. Other meta-reviews have similarly noted diverse prevalence rates of PTSD among refugee communities ranging from 4% to 86% across studies (Hollifield et al., 2002; Tekin et al., 2016). This discrepancy remains unexplained (Bogic et al., 2012).

Despite a high prevalence of PTSD noted among refugee communities, the assessment of refugees' mental health remains complicated. There have been significant concerns raised in the literature over the cross-cultural validity of PTSD itself as a diagnostic construct, particularly among humanitarian interventions (Bracken, 2001, 2002; Eagle, 2014; Marsella, 2010; Summerfield, 1996). There is also a lack of standardized measurement tools for posttraumatic stress responses among culturally diverse populations, a reflection of the significant void in our knowledge regarding the relation of culture to trauma and the relevance of a PTSD diagnosis to refugee populations (Drozdek & Wilson, 2007; Mattar, 2011; Summerfield, 2001). Furthermore, the medicalisation of trauma on an individual level, linked to specific 'traumatic' events in the past, risks rendering us blind to other ongoing aspects of interpersonal, political and social violence on a more global scale, including significant post migration factors that may be deemed equally traumatic by refugees (Bäärnhielm, 2016; Maier & Straub, 2011; Derrick Silove, Austin, & Steel, 2007; Steel et al., 2011).

Although systematic research into the mental health of refugees is in its infancy, there is growing evidence that salient migration stress facing refugees adds to the effect of previous trauma in creating risk of ongoing posttraumatic stress disorder and other psychiatric symptoms (Derrick Silove et al., 2007; Derrick Silove, Steel, & Watters, 2000). In a meta-review of the literature focussed on moderating effects of a variety of enduring, contextual stressors, Porter and Haslam (Porter & Haslam, 2005) found that the psychological consequences of forced displacement were varied significantly as a function of chronic stressors (e.g., locus of displacement and type of accommodation in exile) and were also associated with other factors. Post-migration experiences, such as unemployment, insecure residency, fear of repatriation, and social discrimination have similarly been shown in the literature to be significantly correlated with mental problems in refugees (Bogic et al., 2012; Loizos, 2002; Tekin et al., 2016; Volkan, 2004; Watters, 2001).

In a recent review of the literature, Kartal and Kiripoulos (Kartal & Kiropoulos, 2016) note that the relationships between traumatic events, migration, and mental health outcomes upon arrival in the host country are complex and poorly understood. Acculturative stress within the sample of refugees they examined was associated with greater experiences of cultural loss and nostalgia. This loss itself was found to exacerbate PTSD symptoms. They suggest that the influence of post-migratory demands on mental health differs not only based on the individual's acculturation process alone. It also depends on the characteristics of the local context reflecting the acculturative preferences of the host society. The authors highlight these findings as a confirmation of Berry's (Berry, 1997, 2003; Sam & Berry, 2010) acculturation model. This model delineates the mechanisms through which the host society impacts on the acculturation process of refugees by imposing either encouraging or less desirable acculturative strategies (either encouraging or opposing ethnic diversity and participation in the larger society) which in turn influences mental health. This model has been confirmed elsewhere in the literature: multiple comparative studies examining correlations between the post-migration context and refugees from the same country of origin yet who have resettled in different countries convincingly demonstrate the significant effect of post-migratory factors on symptoms of PTSD. Bogic and colleagues (Bogic et al., 2012) for example, assessed 854 war refugees from the former Yugoslavia having resettled across three countries. They found higher rates of PTSD to be significantly associated with migration-related stress and having a temporary resident permit. Similarly, Kartal and Kiropoulos (Kartal & Kiropoulos, 2016) assessed a sample of 138 Bosnian refugees resettled in both Austria and Australia. After controlling for age, sex, and exposure to traumatic events, acculturative stress associated with post-migratory experiences predicted severity of PTSD.

Acceptance of the host society matters. In a multi-agency guide on the mental health of refugee populations released in 2015, UN agencies and other international humanitarian organizations have highlighted the fact that for most refugees and migrants potentially traumatic events from the past are not the only, or even most important, source of psychological distress but that the majority of emotional suffering is directly related to current stresses and worries and uncertainty about the future (IASC, 2015; MHPSS, 2015). Given the significantly high prevalence rate of PTSD noted among refugees, further exacerbated by reception conditions in the host country, we examine the prevalence of PTSD among refugees who were exposed to xenophobic attacks in their host country of South Africa.

2. BACKGROUND

In April 2015, following an upsurge in violent xenophobic attacks throughout the country, displacement camps were set up to house roughly 7,500 foreign nationals seeking refuge in Durban, KwaZulu-Natal. Médecins Sans Frontières/Doctors without Borders (M.S.F.) were among the actors intervening in the camp by providing the population with basic medical care and psychosocial support. The majority were refugees and asylum seekers from the Democratic Republic of Congo and Burundi who choose to remain in the camps: stating that they cannot return home to their countries of origin safely due to fear of persecution and that they fear returning to the South African communities from which they fled, in many cases after experiencing significantly violent attacks on themselves and their property. The people remaining in the displacement camps represent a population which has been exposed to multiple traumatic events – both in their countries of origin and more recently in South Africa – and were therefore presumed to be at risk of experiencing symptoms of post-traumatic stress. As part of a package of psychosocial care offered by MSF in the displacement camps, a study of post-traumatic stress symptoms was conducted among a convenience sample of refugees in order to explore the extent of the psychological trauma among this particular population, to reflect on the relevance of a PTSD diagnosis within this particular cultural setting and to offer relevant treatment.

3. METHODS

After obtaining authorization from the local municipality and campsite managers, men and women – all of them foreign nationals from the DRC or Burundi - were approached on site at three displacement camps by a researcher/clinical psychologist working for M.S.F. The Harvard Trauma Questionnaire (H.T.Q.) was used as a screening instrument due its recognised cultural sensitivity in assessing highly traumatised populations (Mollica et al., 1992; Mollica, McInnes, Poole, & Tor, 1998; Shoeb, Weinstein, & Mollica, 2007). The HTQ was subsequently administered with the assistance of the researcher and results scored. PTSD was defined according to a scoring algorithm previously described by the Harvard Refugee Trauma Group on the basis of DSM IV diagnostic criteria (American Psychiatric Association, 1994; Mollica et al., 1992). The aim was to identify and highlight the mental health needs of this particular population, to develop a culturally-appropriate intervention programme as well as to enrich advocacy campaigns for their humane treatment by state and non-governmental organizations alike.

4. RESULTS

27 participants completed the Harvard Trauma Questionnaire with the researcher. The results of questions 1-16 of part 4 of the HTQ were subsequently noted and scored. The mean score was 2,87. Participants included 12 women, out of which all 12 (100%) met diagnostic criteria and 15 men, out of which 12 (80%) met diagnostic criteria. When questioned about the traumatic event which participants had either experienced, witnessed or heard about, the majority referred to events which had taken place in their country of origin, as well as the recent xenophobic attacks. 22 participants (81%) reported experiencing or witnessing conflict, murder, torture and/or sexual violence. All participants had been in the camp for at least 7 weeks after the xenophobic violence. For all participants, the traumatic symptoms reported were related to events which had happened in their countries of origin, exacerbated by the xenophobic violence and experiences of being in a refugee camp.

Participants rated the items of the HTQ on a scale of 1 to 4. A score of 1 indicates 'not at all', 2 indicates 'a little,' 3 indicates 'quite a bit' and 4 indicates 'extremely.' The mean results of these scores are indicated below, in table 1.

Table 1.
Mean scores of the HTQ.

	ITEM	Mean Score	Standard Deviation
1.	Recurrent thoughts or memories of the most hurtful or terrifying events	3,11	0,89
2.	Feeling as though the event is happening again	3,41	0,75
3.	Recurrent nightmares	2,37	1,21
4.	Feeling detached or withdrawn from people	3,00	1,11
5.	Unable to feel emotions	2,48	1,25
6.	Feeling jumpy, easily startled	3,00	0,92
7.	Difficulty concentrating	2,78	0,93
8.	Trouble sleeping	3,04	0,94
9.	Feeling on guard	3,19	0,89
10.	Feeling irritable or having outbursts of anger	3,07	0,87
11.	Avoiding activities that remind you of the traumatic or hurtful event	2,85	1,67
12.	Inability to remember parts of the most traumatic or hurtful events	1,93	1,11
13.	Less interest in daily activities	2,96	1,06
14.	Feeling as if you don't have a future	3,15	1,06
15.	Avoiding thoughts or feelings associated with the traumatic or hurtful experience	2,41	1,15
16.	Sudden emotional or physical reaction when reminded of the most hurtful or traumatic events	3,34	0,83
TOTAL MEAN		3,34	

There were no statistically significant outliers in terms of the mean response to individual items ($p<0,05$). However, it must be noted that the mean response of items 3, 5, 12 and 15 fell below 2,5. This suggests that participants reported not being strongly affected by recurrent nightmares, an inability to feel emotions, an inability to remember

part of the most traumatic or hurtful event in their lives or a sense of avoiding thoughts or feelings associated with the traumatic or hurtful experience. In general, participants reported being fully aware and emotionally responsive to the traumatic events which they had experienced or witnessed. The highest mean response to an individual item was to item number 2 (mean score = 3,4). This item refers to a feeling that the event is happening again. When questioned, the majority of participants explained that the recent xenophobic attacks which they had experienced or witnessed in South Africa had triggered traumatic memories or flashbacks of events from which they had had to flee in their country of origin.

The greatest standard deviations were for item 3 ('recurrent nightmares,' std dev = 1,21), 5 ('unable to feel emotions,' std dev = 1,25) and 11 ('avoiding activities that remind you of the hurtful or traumatic event,' std dev = 1,67).

5. DISCUSSION

Examining trauma among migrants, more specifically refugees, is a complex issue. One needs to consider a myriad of interacting factors including pre-migration exposure to trauma, the potentially traumatizing nature of the migration experience itself as well as the post-migration acculturation process and current living difficulties. It is interesting to note that the highest mean scores for the items were obtained for the items: "Feeling as though the event is happening again" (3,41). It is impossible to know, but we suggest that this item regarding triggers of previous trauma may similarly be linked to post-migration factors which risk retraumatizing this population – having to relive experiences of violence and consequent fleeing once more after arrival in the host country. The prevalence of PTSD noted among this population appears to have been influenced not only by pre-migration traumas and the post-migration adjustment experience but also by the current social and political environment in which the refugees found themselves. All of these factors tend to be interrelated, multi-faceted and generally cumulative.

For people whose lives are characterized by ongoing hardship, often shaped by discrimination, poverty and other current and future dangers, traumatic events may fall within a continuum of suffering and may not be singled out or experienced with the same precision as the definition of PTSD appears to demand (Eagle, 2014). Furthermore, individuals with a trauma history rarely experience only a single traumatic event but rather are likely to have experienced several episodes of traumatic exposure (Cloitre et al., 2009). In many countries around the world, conflict is not an abnormal situation of short duration but rather a '*fait connu'* (Summerfield, 1996) p. 33., influencing all aspects of political, socio-economic and cultural relations in a society. As such, extreme trauma owing to torture and war is both an individual and collective process that refers to and is dependent on a given social context, marked by its intensity, extremely long duration and interdependency between the social and the psychological dimensions (Becker, Lira, Castillo, Gomez, & Kovalskys, 1990). This is a particularly relevant consideration for the mental health of refugees in light of the multiple and arguably ongoing environmental stressors and potentially traumatic experiences with which they are faced.

6. FUTURE RESEARCH DIRECTIONS

Many participants reported experiencing symptoms arising from multiple types of traumatic events or incidents. The notion of prolonged exposure to trauma as potentially resulting in a 'complex PTSD' pathology was first developed by Herman (Herman, 1992) – and has since become an integral concept in the literature examining the complex and

prolonged traumatic experiences of refugee communities (Drožđek, 2015; Drozdek et al., 2003; Mollica et al., 1998; Momartin, Silove, Manicavasagar, & Steel, 2003; D Silove, Ventevogel, & Rees, 2017). The notions of 'cumulative trauma' first developed by Khan (Khan, 1977), 'complex PTSD' developed by Herman (Herman, 1992, 1997), 'extreme trauma' developed by Becker (Becker et al., 1990) and 'Continuous Traumatic Stress' introduced by those offering psychological services to political activists during the repressive apartheid years in South Africa (Eagle, 2014; Eagle & Kaminer, 2013), were all constructs developed to conceptualize trauma as having been accumulated over time through exposure to repeated stressors within the environment. We believe that such concepts could allow for a more thorough understanding of the traumatic experiences of the participants in this study.

Limitations of the study include the convenience sampling and the small sample size taken by convenience. Meta-analyses of prevalence studies have indicated that small studies have much higher prevalence than the apparent true prevalence (Terhakopian, Sinaii, Engel, Schnurr, & Hoge, 2008). A recommendation for future research would therefore be to increase the sample size, as well as to compare this group of individuals with a control group of people from the same national group who are not living in the displacement camp. Another limitation is potential self-reporting bias. Perceived secondary gain for being considered psychologically impacted by the events may have included, for example, the perceived hope of improved access to social, medical, psychological and legal services. To minimise the impact of this bias, all participants were clearly informed of the fact that responses to the questionnaire would in no way impact treatment by state mechanisms or NGOs. Future research could include an added qualitative component whereby the results of the questionnaire are interpreted in the light of the participant's qualitative explanations of symptoms elicited through qualitative interview techniques.

7. CONCLUSION/DISCUSSION

This study found a significantly high prevalence rate (85%) of post-traumatic stress symptoms which were self-reported among a convenience sample of refugees and asylum seekers residing in displaced camps after fleeing from xenophobic violence in Durban, South Africa. This population experienced numerous traumatic events and suffered from repressive measures inside and outside of their countries of origin, and continued to face uncertainty about their security and future within South Africa. PTSD symptoms scores among the participants were significantly more than those reported in other long-term refugee populations screened using the HTQ, such as 45,5% among earthquake survivors in Wenchuan China (Kun et al., 2009), 37.2% among Cambodian refugees living on the Thai–Cambodian border camps (Cardozo, Talley, Burton, & Crawford, 2004), 29,3% among populations living in conflict-ridden southern Lebanon (Farhood, Dimassi, & Lehtinen, 2006) or 11.8% among Guatemalan refugees living in Chiapas, Mexico (Sabin, Cardozo, Nackerud, Kaiser, & Varese, 2003). It is possible that the high prevalence rate of traumatic stress response symptoms reported could be partly attributed to the current significant levels of environmental stress and insecurity. The individual item symptom analysis suggests a culturally specific presentation of trauma response which could be explored in future research.

Despite limitations, the high prevalence rate of people who meet diagnostic criteria for PTSD has profound implications for psychosocial interventions and access to mental health services for this community – as well as significant broader legal and social justice implications. Given such high prevalence of mental health problems in this population,

interventions need to be largely community-based rather than health facility-based. The long-term and ongoing nature of the ongoing violence and a history of composite trauma reported by participants necessitate a long-term intervention, including dialogue with local communities concerning the re-integration of this population and sustained engagement with local community-based services.

REFERENCES

Abbott, A. (2016). The troubled minds of migrants. *Nature, 538*, 158-161.

Ainamani, H. E., Elbert, T., Olema, D. K., & Hecker, T. (2017). PTSD symptom severity relates to cognitive and psycho-social dysfunctioning–a study with Congolese refugees in Uganda. *European journal of psychotraumatology, 8(*1), 1283086. doi:10.1080/20008198.2017.1283086

American Psychiatric Association, A. (1994). Diagnostic and statistical manual of mental disorders American Psychiatric Association. *Washington, DC*, 471-475.

Bäärnhielm, S. (2016). Refugees' mental health-a call for a public health approach with focus on resilience and cultural sensitivity. *European Journal of Public Health, 3*(1), 375-376. doi:10.1093/eurpub/ckw055

Becker, D., Lira, E., Castillo, M. I., Gómez, E., & Kovalskys, J. (1990). Therapy with victims of political repression in Chile: The challenge of social reparation. *Journal of Social Issues, 46*(3), 133-149. doi:10.1111/j.1540-4560.1990.tb01939.x

Berry, J. W. (1997). Immigration, acculturation, and adaptation. *Applied psychology, 46*(1), 5-34.

Berry, J.W. (2003). Conceptual approaches to acculturation. In K. Chun, P. Balls Organista, & G. Marin (Eds.), *Acculturation: Advances in theory, measurement and applied research* (pp. 17–37). Washington, DC: APA Press.

Bogic, M., Ajdukovic, D., Bremner, S., Franciskovic, T., Galeazzi, G. M., Kucukalic, A., Schützwohl, M. (2012). Factors associated with mental disorders in long-settled war refugees: refugees from the former Yugoslavia in Germany, Italy and the UK. *The British Journal of Psychiatry, 200*(3), 216-223. doi:10.1192/bjp.bp.110.084764

Bracken, P. (2001). Post-modernity and post-traumatic stress disorder. *Social Science & Medicine, 53*(6), 733-743.

Bracken, P. (2002). *Trauma: Culture, meaning and philosophy*: Whurr Publishers.

Cardozo, B. L., Talley, L., Burton, A., & Crawford, C. (2004). Karenni refugees living in Thai–Burmese border camps: traumatic experiences, mental health outcomes, and social functioning. *Social Science & Medicine, 58*(12), 2637-2644.

Cloitre, M., Stolbach, B. C., Herman, J. L., Kolk, B. v. d., Pynoos, R., Wang, J., & Petkova, E. (2009). A developmental approach to complex PTSD: Childhood and adult cumulative trauma as predictors of symptom complexity. *Journal of traumatic stress, 22*(5), 399-408. doi:10.1002/jts.20444

de Arellano, M. A., & Danielson, C. K. (2008). Assessment of Trauma History and Trauma-Related Problems in Ethnic Minority Child Populations: An INFORMED Approach. *Cognitive and Behavioral Practice, 15*(1), 53-66. doi:10.1016/j.cbpra.2006.09.008

Drožđek, B. (2015). Challenges in treatment of posttraumatic stress disorder in refugees: towards integration of evidence-based treatments with contextual and culture-sensitive perspectives. *European journal of psychotraumatology, 6*: 24750. http://dx.doi.org/10.3402/ejpt.v6.24750

Drozdek, B., Noor, A. K., Lutt, M., & Foy, D. W. (2003). Chronic PTSD and medical services utilization by asylum seekers. *Journal of refugee studies, 16*(2), 202-211. doi:10.1093/jrs/16.2.202

Drozdek, B., & Wilson, J. P. (2007). *Voices of trauma: treating psychological trauma across Cultures*: Springer Science & Business Media.

Eagle, G. (2014). From evolution to discourse: Key conceptual debates in the history and study of traumatic stress. *Psychology in Society*(47), 01-20.

Eagle, G., & Kaminer, D. (2013). Continuous traumatic stress: Expanding the lexicon of traumatic stress. *Peace and Conflict: Journal of Peace Psychology, 19*(2), 85-99. doi:10.1037/a0032485

Farhood, L., Dimassi, H., & Lehtinen, T. (2006). Exposure to war-related traumatic events, prevalence of PTSD, and general psychiatric morbidity in a civilian population from Southern Lebanon. *Journal of transcultural nursing, 17*(4), 333-340.

Herman, J. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of traumatic stress, 5*(3), 377-391. doi:10.1007/bf00977235

Herman, J. (1997). Trauma and Recovery. 1992. *New York: Basic*.

Hollifield, M., Warner, T. D., Lian, N., Krakow, B., Jenkins, J. H., Kesler, J., Westermeyer, J. (2002). Measuring trauma and health status in refugees: a critical review. *Jama, 288*(5), 611-621. doi:10.1001/jama.288.5.611

IASC, I.-A. S. C. (2015). *IASC guidelines on mental health and psychosocial support in emergency settings*: Inter-Agency Standing Committee.

Kartal, D., & Kiropoulos, L. (2016). Effects of acculturative stress on PTSD, depressive, and anxiety symptoms among refugees resettled in Australia and Austria. *European journal of psychotraumatology, 7*(1), 28711. doi:10.3402/ejpt.v7.2871

Khan, M. M. R. (1977). Das kumulative trauma [Cumulative Trauma]. *Selbsterfahrung in der Therapie: Theorie und praxis [Self-experience in therapy: theory and practice]*, 50-70.

Kun, P., Chen, X., Han, S., Gong, X., Chen, M., Zhang, W., & Yao, L. (2009). Prevalence of post-traumatic stress disorder in Sichuan Province, China after the 2008 Wenchuan earthquake. *Public health, 123*(11), 703-707. doi:10.1016/j.puhe.2009.09.017

Lambert, J. E., & Alhassoon, O. M. (2015). Trauma-focused therapy for refugees: Meta-analytic findings. *Journal of counseling psychology, 62*(1), 28-37. doi:10.1037/cou0000048

Loizos, P. (2002). Misconceiving refugees.In R. Papadopoulos (Ed.) *Therapeutic care for refugees*. *No place like home* (pp. 41-56). London. Karnac Books

Maier, T., & Straub, M. (2011). My head is like a bag full of rubbish": Concepts of illness and treatment expectations in traumatized migrants. *Qualitative health research, 21*(2), 233-248. doi: 10.1177/1049732310383867

Marsella, A. J. (2010). Ethnocultural aspects of PTSD: An overview of concepts, issues, and treatments. *Traumatology, 16*(4), 17-26. doi:10.1177/1534765610388062

Mattar, S. (2011). Educating and training the next generations of traumatologists: Development of cultural competencies. *Psychological Trauma: Theory, Research, Practice, and Policy, 3*(3), 258-265. doi:10.1037/a0024477

MHPSS, U. I.-A. (2015). *Mental Health and Psychosocial Support for Refugees, Asylum Seekers and Migrants on the Move in Europe: A MULTI-AGENCY GUIDANCE NOTE*.

Mollica, R., Caspi-Yavin, Y., Bollini, P., Truong, T., Tor, S., & Lavelle, J. (1992). The Harvard Trauma Questionnaire: validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic stress disorder in Indochinese refugees. *The Journal of nervous and mental disease, 180*(2), 111-116.

Mollica, R., McInnes, K., Poole, C., & Tor, S. (1998). Dose-effect relationships of trauma to symptoms of depression and post-traumatic stress disorder among Cambodian survivors of mass violence. *The British Journal of Psychiatry, 173*(6), 482-488. doi:10.1192/bjp.173.6.482

Momartin, S., Silove, D., Manicavasagar, V., & Steel, Z. (2003). Dimensions of trauma associated with posttraumatic stress disorder (PTSD) caseness, severity and functional impairment: a study of Bosnian refugees resettled in Australia. *Social Science & Medicine, 57*(5), 775. doi:10.1016/S0277-9536(02)00452-5

Porter, M., & Haslam, N. (2005). Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: a meta-analysis. *Jama, 294*(5), 602-612. doi:10.1001/jama.294.5.602

Sabin, M., Cardozo, B. L., Nackerud, L., Kaiser, R., & Varese, L. (2003). Factors associated with poor mental health among Guatemalan refugees living in Mexico 20 years after civil conflict. *Jama, 290*(5), 635-642.

Sam, D. L., & Berry, J. W. (2010). Acculturation when individuals and groups of different cultural backgrounds meet. *Perspectives on Psychological Science, 5*(4), 472-481. doi:10.1177/1745691610373075

Shoeb, M., Weinstein, H., & Mollica, R. (2007). The Harvard trauma questionnaire: adapting a cross-cultural instrument for measuring torture, trauma and posttraumatic stress disorder in Iraqi refugees. *International Journal of Social Psychiatry, 53*(5), 447-463. doi:10.1177/0020764007078362

Silove, D., Austin, P., & Steel, Z. (2007). No refuge from terror: the impact of detention on the mental health of trauma-affected refugees seeking asylum in Australia. *Transcultural psychiatry, 44*(3), 359-393. doi:10.1177/1363461507081637

Silove, D., Steel, Z., & Watters, C. (2000). Policies of deterrence and the mental health of asylum seekers. *Jama, 284*(5), 604-611.

Silove, D., Ventevogel, P., & Rees, S. (2017). The contemporary refugee crisis: an overview of mental health challenges. *World Psychiatry, 16*(2), 130-139. doi:10.1002/wps.20438

Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., & Ommeren, M. V. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. *Jama, 302*(5), 537-549. doi:10.1001/jama.2009.1132

Steel, Z., Momartin, S., Silove, D., Coello, M., Aroche, J., & Tay, K. W. (2011). Two year psychosocial and mental health outcomes for refugees subjected to restrictive or supportive immigration policies. *Social Science & Medicine, 72*(7), 1149-1156. doi:10.1016/j.socscimed.2011.02.007

Summerfield, D. (1996). *L'impact de la guerre et des atrocités sur les populations civiles: principes fondamentaux pour les interventions des ONG et une analyse critique des projets sur le traumatisme psychosocial*: Overseas Development Institute.

Summerfield, D. (2001). The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. *BMJ: British Medical Journal, 322*(7278), 95-98. doi:10.1136/bmj.322.7278.95

Tekin, A., Karadağ, H., Süleymanoğlu, M., Tekin, M., Kayran, Y., Alpak, G., & Şar, V. (2016). Prevalence and gender differences in symptomatology of posttraumatic stress disorder and depression among Iraqi Yazidis displaced into Turkey. *European journal of psychotraumatology, 7*(1), 28556. doi:10.3402/ejpt.v7.28556

Terhakopian, A., Sinaii, N., Engel, C. C., Schnurr, P. P., & Hoge, C. W. (2008). Estimating population prevalence of posttraumatic stress disorder: an example using the PTSD checklist. *Journal of traumatic stress, 21*(3), 290-300. doi:10.1002/jts.20341

Van Ommeren, M., de Jong, J. M., Sharma, B., Komproe, I., Thapa, S. B., & Cardeña, E. (2001). Psychiatric disorders among tortured bhutanese refugees in nepal. *Archives of General Psychiatry, 58*(5), 475-482. doi:10.1001/archpsyc.58.5.475

Volkan, V. D. (2004). From hope for a better life to broken spirits: An introduction. In J. P. Wilson. and B. Drozðek (Eds), *Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture victims* (pp. 7-12). New York. Routledge.

Watters, C. (2001). Emerging paradigms in the mental health care of refugees. *Social Science & Medicine, 52*(11), 1709-1718. doi:10.1016/s0277-9536(00)00284-7

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Short biographical sketch: Nathalie Severy is a clinical psychologist (Master in 1999 with a specialization in intercultural psychology, post master in 2017 in victimology and psycho traumatism). Before joining MSF, she worked in France in association dealing with HIV patients (Association APRAE, Cognac Jay hospital) with victims of torture (Association Primo Levi), refugees (Foyer d'accueil Chartrain) and emergency crisis interventions (IAPR). She has been working in MSF in the field between 2003 and 2010 in different positions (Field psychologist, field coordinator, medical coordinator and consultant) in different contexts (DRC, Occupied Palestinian Territories, Nigeria, Sri Lanka, China, Armenia, Abkhazia, South Sudan, South Korea…). Since 2011, she is the Mental Health Referent at the medical department in MSF.

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