LITERATURE REVIEW

Refugees, resettlement experiences and mental health: a systematic review of case studies

Refugiados, experiências de reassentamento e saúde mental: uma revisão sistemática de estudos de caso

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ABSTRACT

Objective: In 2017 the number of refugees around the world reached 25.4 million. These people make up one of the most vulnerable populations globally. This study aims to understand the strategies refugees used to cope with the impact on their mental health by the difficult pre- and post-resettlement circumstances they encountered. **Methods:** A systematic review of articles reporting case studies concerning adult refugees' experiences in the hosting country. The electronic databases searched were: PubMed, The Cochrane Library, PsycINFO, Embase, Scopus and Web of Science. Eligible manuscripts were examined through a narrative synthesis. **Results:** Twenty-two articles fitted the inclusion criteria and four main themes were highlighted: reasons for fleeing; the impact of negative experiences on mental health; supportive experiences and coping strategies; and experiences of mental health treatment. **Conclusions:** Refugees present a significant impact on mental health due to pre- and post-migration experiences. The approach offered to this group and reported as the most effective to deal with such an impact was the multidimensional approach that, besides caring for the psychic aspects, contemplated the cultural context of each one, assisted in housing, employment, financial aid, support with learning the new language and social activities.

Keywords
Refugees, resettlement experiences, mental health, case studies, trauma.

RESUMO

Objetivo: Refugiados fazem parte de uma das populações mais vulneráveis do mundo, que em 2017 alcançou a cifra de 25,4 milhões de pessoas nessa condição. Este estudo visa compreender as estratégias utilizadas por eles para lidar com o impacto na saúde mental sofrido devido às circunstâncias pré e pós-reassentamento pelas quais perpassam. **Métodos:** Revisão sistemática de artigos apresentando estudos de caso sobre experiências de refugiados adultos no país anfitrião. Foram pesquisados os seguintes bancos de dados: PubMed, The Cochrane Library, PsycINFO, Embase, Scopus e Web of Science. Os manuscritos elegíveis foram examinados por meio de síntese narrativa. **Resultados:** Vinte e dois artigos preencheram os critérios de inclusão e quatro temas principais foram destacados: razões para abandonar o país de origem; o impacto de experiências negativas na saúde mental; experiências de apoio

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Palavras-chave
Refugiados, experiências de reassentamento, saúde mental, estudos de caso, trauma.

e estratégias de enfrentamento; e experiências de tratamento em saúde mental. **Conclusões:** Refugiados sofrem um significativo impacto na saúde mental devido às experiências pré e pós-saída do país de origem. A abordagem ofertada a esse grupo e relatada como mais eficaz para lidar com tal impacto foi a multidimensional, que, além dos cuidados aos aspectos psíquicos, contemplou o contexto cultural de cada um e auxiliou em questões de moradia, emprego, ajuda financeira, apoio ao aprendizado da nova língua e atividades sociais.

You shall leave everything you love most:
this is the arrow that the bow of exile shoots first.
You are to know the bitter taste of others' bread,
how salty it is, and know how hard a path it is
for one who goes ascending and descending others' stairs.

Dante Alighieri, *The Divine Comedy*

INTRODUCTION

In 2017, the number of refugees around the world reached 25.4 million, while the number of asylum seekers attained 3.4 million[1]. The concern about displaced people was legally categorised as a worldwide issue when the United Nations created the UNHCR in December of 1950. The *1951 Convention relating to the status of refugees* is an international treaty which globally states who is a refugee and the kind of legal protection to which they are entitled. It defines a *refugee* as any person who "is outside his or her country of nationality or habitual residence; has a well-founded fear of being persecuted because of his or her race, religion, nationality, membership of a particular group or political opinion; is unable or unwilling to avail him or herself of the protection of that country, or to return there, for fear of persecution"[2].

To receive the legal documents of a refugee, displaced people must go through the asylum-seeking process. An asylum seeker is somebody who has claimed refuge in a hosting country but is still waiting for the legal response of the local government, so there is no certainty regarding the answer he or she will receive. But in fact, the majority of people in the world categorized as 'refugees' never go through this official process. Instead, they are recognized as refugees by the UNHCR after fleeing their country of origin[2].

Policies related to refugees and asylum seekers are complex and include different levels, as these people cross international borders. There are regional policies defined by each country's local governments; supra-national policies defined by structures such as the European Union (EU) in Europe or *Mercado Comum do Sul* (Mercosul) in South America; and global policies defined by the United Nations (UN)[3].

Refugees and asylum-seekers differ from immigrants in that they experience a forced flight from their home country without time to organise their journey. They also have little choice or control over it[4,5]. A 1979 study conducted by Liu, Lamanna and Murata, among Vietnamese refugees, found that 85% of them made the decision to leave their homeland between two days and two hours before departure[6]. António Guterres, the United Nations High Commissioner for Refugees, claims that refugees are considered one of the most susceptible and vulnerable populations globally[2]. Massive disruptions such as violence, war and genocide in any society affect its social order and structures of meaning. Fear and uncertainty become common feelings among its citizens and the turmoil is reflected in their health, which is carried with them wherever they go[4]. Access to basic human needs, such as water, food, shelter, health care, public services and safety is lacking when displaced people are on the move, living in refugee camps or when they do not find support in the hosting country[3].

The Grand Challenges in Global Mental Health initiative has identified the need to study the impact of violence, warfare and migration as one of its twenty-five primary research priorities for the next ten years to ameliorate the condition of people with mental health problems worldwide[7]. Studies have proven that refugees are a population at high risk of presenting mental disorders[3,8-12]. As well pointed out by Nieves-Grafals: "Refugees are survivors by definition"[13]. They are trauma survivors of a world "in which they have knowledge of the vagaries of miserably bad luck and intimate experiences of evil"[14].

The after-effects of psychic trauma present a huge health problem in the world[15] and among forced displaced people it might involve three different levels: the psychiatric problems already present before fleeing their homeland; aggravation of their mental illness by the flight; a new mental health difficulty caused by the whole process encountered by them[3].

Among the common pre-migration experiences lived or witnessed by forced migrants and presenting an impact on their mental health are included: torture, violence, persecution, imprisonment, war, destruction, abuse, loss of relatives and friends and loss of their belongings[8,9]. In a new country, the challenges of adjustment continue for a long time in their lives: managing a different environment, a new culture, their traditions and memories left behind with their present needs[6,8,10-12,16]. Common difficulties also encompass learning another language, seeking employment and a place to live, homesickness, social isolation and barriers to access social care, healthcare and educational services[9].

The main psychiatric disorders presented by refugees are post-traumatic stress disorder (PTSD), anxiety disorders and major depression[8,9,17]. Crumlish and O'Rourke[18] state that the rate of PTSD is 10 times higher among refugees than in the general population. According to the results of a systematic review conducted by Fazel *et al.*[17] among refugees resettled in Western countries, 9% of them presented PTSD (in a range from 3% to 44%, depending on group characteristics), 5% major depression, 4% anxiety disorder and 2% psychotic disorder. Steel *et al.*[19] discuss this variation of prevalence of PTSD and depression among populations exposed to mass conflict and displacement in a major systematic review of 181 surveys comprising 81,866 subjects. They found a large intersurvey variability, accounting for rates ranging from 0% to 99% of reported PTSD and 3% to 85.5% of depression. Populations that had more individuals reporting torture presented highest rates of PTSD, followed by those reporting cumulative exposure to potentially traumatic events (PTEs), those living ongoing conflicts (or ceased for less than 1 year) and those experiencing high level of political terror. For depression, exposure to PTEs, time since conflict, torture and residency status were associated with higher levels of this disorder. Furthermore, there are other mental disorders related to trauma but in lower prevalence, such as dissociative disorders, somatisation, psychosis, bipolar disorder and borderline personality disorder[8].

Nevertheless, statistical studies have shown that there are post-migratory protective factors for psychological wellbeing. Employment, financial support, secure housing, proficiency in the language of the new country, social network, social support and achieving the legal status of a refugee are reported as being supportive during the resettlement process[8,9,12]. However, individual experiences might show more particular needs of refugees.

In their studies, Harrell-Bond[10] and Moorehead[11] state that the resettlement process encompasses so many aspects that it is impossible to understand it through numbers and statistics only. In spite of that, Harrell-Bond[10] and Newbigging *et al.*[20] highlight how health and social care practices are not decided through input from the refugees themselves, but basically based on the scientific and statistical knowledge about their needs when in the new country. By this practice of generalising their experiences, they become depersonalised and are known by their new identity: "First of all, we are refugees"[12].

METHODS

This study aims to understand the strategies refugees used to cope with the impact on their mental health by the difficult pre- and post-resettlement circumstances he or she encountered. The method chosen to assess individual cases was a systematic review of qualitative and mixed methods studies with at least one case study component.

The guide presented by the Centre for Reviews and Dissemination[21] was followed: the results were analysed and summarised through a narrative synthesis; a report of findings of included papers was developed; relationships between them were explored and the robustness of the synthesis was assessed.

The following electronic databases were searched: PubMed, The Cochrane Library, PsycINFO, Embase, Scopus and Web of Science.

The selected search terms were: *Refugee* (OR *asylum seeker*) AND *Narrative** (OR *"case study"* OR *story* OR *stories* OR *"phenomenological study"* OR *histor** OR *psychoanaly**) AND *Recovery* (OR *remission* OR *"get better"* OR *"mental health"* OR *"well-being"* OR *wellbeing* OR *healthy* OR *welfare* OR *resettl** OR *resilien**).

The quality of articles was assessed using a tool from the Critical Appraisal Skills Programme (CASP)[22] named the Qualitative Research Checklist. This tool consists of 10 questions that systematically consider the validity, particularity and applicability of each study result. For each question, articles were given one score if the question was extensively addressed, a half-score if it was partially addressed or zero score if it was not addressed at all. As there is a lack of agreement of a cutting-off point in quality assessments of qualitative research[23], it was decided that those articles scoring 4 or less on a 10-point scale were considered *low quality*.

The studies found in each database were assessed against the following inclusion and exclusion criteria. Inclusion criteria: (a) Original articles presenting a case study on mental health concerning an adult (18 years old or over) with the legal status of refugee in the country of resettlement in order to obtain the experience of people who were already settled permanently and had restarted their daily life in the new country as there are important differences between asylum seekers and resettled refugees (especially with regard to post migratory living conditions); (b) Papers from the 1st of January 2000 to the 1st of July 2015. The time span was decided in order to include a more recent reality, but not so short that it would exclude a huge amount of experiences that are still found today; (c) The full text of the article must be in English, Portuguese, French or Spanish.

Exclusion criteria: (a) Quantitative studies; (b) Papers not centred on refugees themselves (about mental health professionals or health services, for instance); (c) Not about mental health (but only about physical health, for example); (d) Not about people with the legal status of refugees (but asylum seekers, migrant, immigrants, internal displaced people or mixed groups); (e) Not about adults; (f) Group analyses in which the individual experiences of each case could not be discerned, since the focus of this study is to highlight each individual experience instead of a group

experience; (g) Articles with the quality score of less than 4. Two papers were excluded due to low quality, both scoring 4.

The inclusion of papers describing multiple case studies (when it was possible to identify each participant's narrative) introduced a methodological matter: the case studies in the same paper were exploring the same issues (e.g. orthostatic panic attack among the Vietnamese refugees living in the USA in Hinton *et al.*[24]) and it would bias our sample. To tackle this problem, only one case study was chosen from papers with more than one participant. The case study chosen was always the one with the longest description in the article (regarding the number of words).

When the eligible manuscripts reached the final number, a thematic analysis proceeded. From this process, four themes emerged and are presented in the results section: *reasons for fleeing*; *the impact of negative experiences on mental health*; *supportive experiences and coping strategies* and *experiences of mental health treatment*.

RESULTS

The search terms in each database presented the following outcome: Pubmed displayed 228 results and, after scanning titles, abstracts and full articles, had 9 papers fitting the criteria. The Cochrane Library showed 57 results, but no new article after scanning titles and abstracts. PsycINFO presented 243 results and 8 new articles were selected. Embase displayed 65 results, but no new paper fitted the criteria. Scopus found 132 articles, but only 1 new paper to be included. Web of Science showed 404 results, but only 4 new ones fitting the criteria. In total, from 1129 results, 22 articles fitted the criteria for this review, as displayed in figure 1.

The 22 included articles are exhibited in table 1.

Reasons for fleeing

All refugees in the 22 papers indicated that they fled their home countries due to war or political turmoil. They were located in the Horn of Africa, Liberia, Southern Sudan, Somalia, Libya and Democratic Republic of Congo in Africa; Cambodia, Vietnam, Sri-Lanka, Burma or Myanmar, Iraq and another Middle Eastern country, in Asia; Bosnia, in Europe; and in a Latin American country.

Eight participants were in danger due to war or turmoil in their country, but with no particular reason related to them[4-6,24,26,31,33,37]. Another eight refugees needed to escape because they were from an oppositional party, clan or tribe in their country[15,25,28,30,32,36,39,40]. Six individuals fled as a consequence of belonging to a specific ethnic origin that was being pursued or suffering ethnic cleansing in their country[14,27,29,34,35,38].

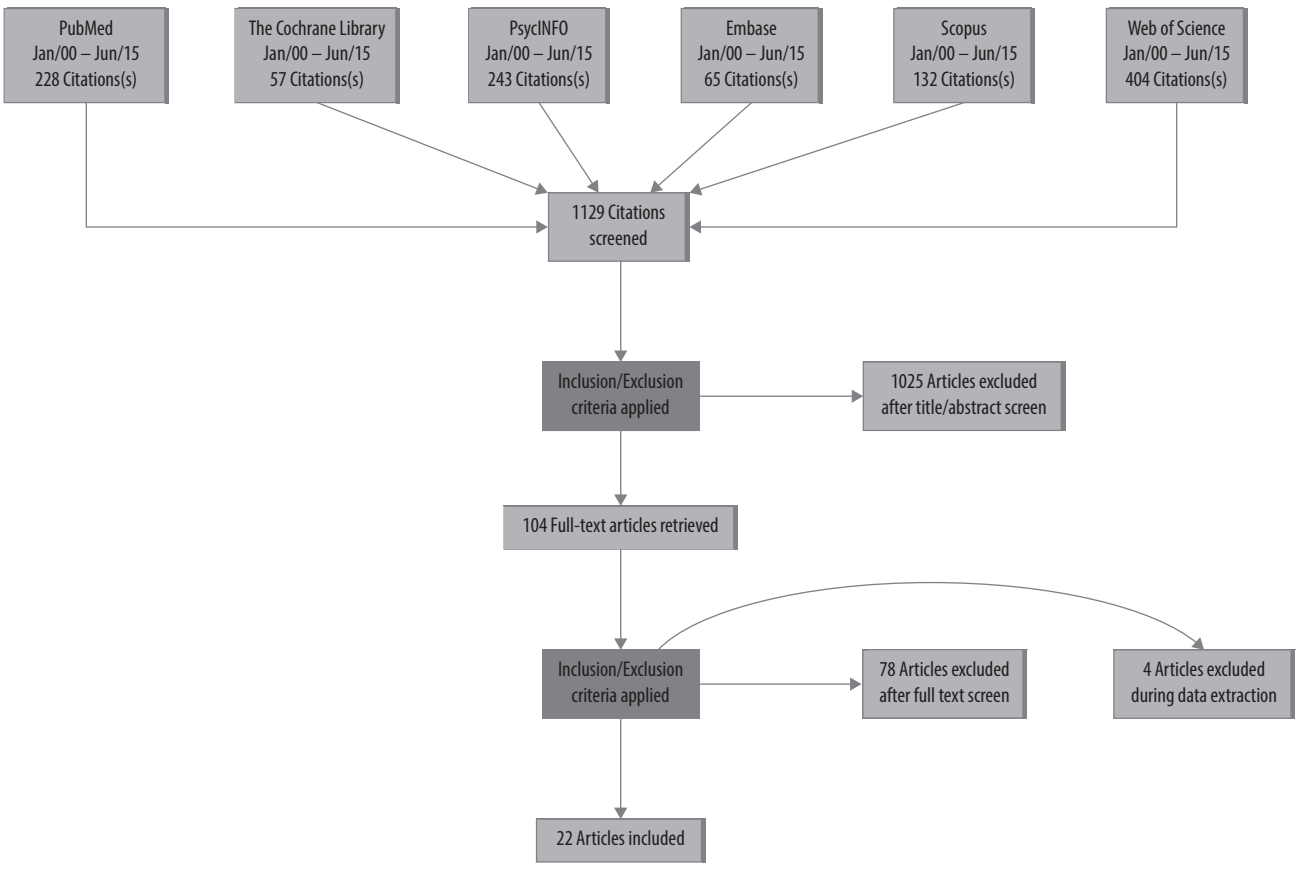

Figure 1. Flow Diagram.

Table 1. Data Extraction Table

Study (Authors, year)	Score CASP (/10)	Date of collecting data	Objective of study	Subject info	Flew from – to (year)
1. Deljo[25]	9	Late 1990s	Case study of a refugee who had to deal with the legal justice system in Australia, to present how police conduct can adversely affect the mental health of a traumatised refugee.	Ali, around 30y, male, from the Horn of Africa, a devout Muslim, with his wife and 3 children, tortured in his country and in the first asylum country, was now unable to work due to mental health problems.	Horn of Africa – a neighbouring country (when he was 18y and where he spent 9 years) – Australia (in the early 1990s)
2. Becker *et al.*[4]	9	Before 2000	Ethnographic study to explore how Cambodian refugees with chronic illnesses respond to the welfare reform, cutting government support, usually the only income they have to live in the USA.	Mr. K, 58y, Khmer, male, married, with children (only one living with them), was a teacher in Cambodia and now his only income is from Supplemental Social Assistance (SSI).	Cambodia – Refugee camp – USA (in the early 1980s)
3. Rechtman[26]	9	Before September, 2000	Clinical case study to highlight the importance of focusing on the singular experience of the individual presenting mental health symptoms, rather than taking only the cultural explanation for interpreting it.	Miss V, Khmer female, 22y, living with her father, stepmother and three half-siblings. She was helping at home and working for free with her father.	Cambodia – Paris, France (when 22 years old/before year 2000)
4. Fitzpatrick[6]	9	1998	Case study with Bosnian refugees to assess the use of art therapy as a mental health intervention with refugees.	Nina, 38y, Bosnian female, married with two children. She was a bank manager in Bosnia.	Bosnia – Perth, Western Australia (15 months before 1998)
5. Summerfield[27]	7.5	May, 1997 to September, 2000	Clinical case study that illustrates the lack of validity of psychiatric diagnoses to understand the effects of surviving war and ethnic expulsion.	Samir, male, 45y, married, with an 8y daughter, a truck driver for family business in home country, assaulted but not seriously injured.	Zvornik, Bosnia – Refugee camp – London, UK (1996)
6. Phan *et al.*[5]	7	2004	Review historical influences on the identity development of Vietnamese refugee women and how it affects their resilience and coping mechanisms. A clinical case is presented to illustrate it.	Thuy, 32y, Vietnamese female, single, with parents and 7 siblings. Social worker.	Saigon, Vietnam – USA (26th of April, 1975)
7. Hrycak and Jakubec[28]	7	Before June, 2006 and after the 1990s	Case analysis of a refugee woman to highlight the importance of listening to every personal history to improve access to and experience with health care.	Elena, female, middle-aged, married, with two young adult children, suffered torture and rape.	Latin America country – neighbouring country – Canada (1990s)
8. Grønseth[29]	9	Between 1996 and 2000	Investigate how health and sickness are related to cultural values and social life of Tamil refugees in a fishing village in Norway.	Raji, Tamil female, married with two children, working as a cutter in the fishing industry.	Sri-Lanka – Arctic Harbour, Northern Norway (before 1996)
9. Schulz *et al.*[14]	9	2000 (for 9 months)	Case study demonstrating the course of cognitive-behavioural therapy for PTSD with a Bosnian refugee woman who had suffered rape.	Marina, 64y, Bosnian Muslim refugee woman, living alone, raped and physically assaulted in her country, never attended school but acquired some literacy in Serbo-Croatian.	Former Yugoslavia (current Bosnia) – Germany (1999, following a refugee rescue mission) – St. Louis, USA (1999)
10. Rosenbaum and Varvin[15]	9	Before 2007, started when the patient was in his mid-thirties and lasted for 6 years	Case study and psychoanalytic research to present how traumatic experiences affect different dimensions of mind and its ability to regulate emotions.	Hassan, male, from Middle-East, in his mid-thirties at the beginning of treatment, alone, living in a hostel. In his country, he was from a minority group and was the designated leader of his clan, tortured and imprisoned.	A Middle-East country – a desert refugee camp in a neighbouring country (when he was in his twenties and where he spent 4 years) – a Nordic country (in his thirties)
11. Hinton *et al.*[30]	8	From 1999 to 2001	Compare the rate and severity of orthostatic panic attacks among Vietnamese refugees a month before and a month after September 11, 2001. A case study is reported to illustrate the role of this type of response to trauma.	Trung, 61y (in 1999), male Vietnamese married, 4 children (but only two sons with him in the USA), a lieutenant chief of police before being arrested, probably not working in the USA, severely tortured.	Vietnam – the USA (1993)

Study (Authors, year)	Score CASP (/10)	Date of collecting data	Objective of study	Subject info	Flew from – to (year)
12. Hinton *et al.*[24]	8	From 1999 to 2001	Present orthostatic panic attack as a cultural expression of traumatic experiences among Vietnamese refugees attending a psychiatric clinic. Authors present case examples to demonstrate its phenomenology.	Thach, 57y (in 1999), female, widowed, four children, living with her daughter, suffered from war, famine and a violent husband.	Saigon, Vietnam – Malaysia (1983) Malaysia – New York, USA (1984)
13. Charlés[31]	8.5	Before 2009, after 1 year patient was living in the USA.	Case study of home-based therapy with a female refugee to illustrate how a therapist can work in the context of the client's home.	Veronique, 28y, Liberian woman, with 2 children and her sister (her husband was still in the camp), in disability benefits because she was shot in both legs, but willing to work.	Liberia – "Peace (refugee) Camp", Ivory Coast (when she was 12y) – eastern city in the USA (when she was 27y)
14. Franco-Paredes[32]	8	Before May, 2009 – 16 months after patient had arrived in the USA	Clinical case to present an unusual expression of PTSD in a Sudanese refugee.	Mr. A, Sudanese male, alone, last 20 years before arriving in the USA spent in refugee camps, unable to work due to stabbing pain.	Southern Sudan – Refugee camps of Southern Sudan, Kenya, Egypt and Ethiopia (where he lived for 20 years) – USA (16 months prior medical treatment)
15. Langellier[33]	9.5	Summer of 2006	Narrative analysis of a young refugee living in Lewiston, Maine, to examine how a Somali woman deals with her identity.	Caaliya, 22y, Somali Muslim woman, working in the service sector and attending college in Lewiston.	Somalia – Kenya (1996, when she was 12y) – West Coast of the USA – Lewiston, Maine, USA (2004, when she was 20y)
16. Vongkhamphra *et al.*[34]	8	March, 2008	Report a case study of the resettlement process of a Somali Bantu refugee in the USA to highlight some of the refugees' needs and how to meet them.	Ms. X, born in the late 70s, Somali Bantu woman, divorced twice, with 5 children (4, 6, 10, 12 and 14y), not working due to kidney failure.	Southern Somalia – Dadaab, a refugee camp in Kenya (when she was a young teenager, where she spent 1 year and moved to another camp in Kenya) – Kakuma refugee camp – Nashville, Tennessee, USA (2006, after living 14 years in refugee camps)
17. Pedersen[35]	7	During 15 months between 2004-2005	Fieldwork among Iraqi observant Muslim refugee women to explore how social class relations, ethnicity and gender affect the integration of well-educated women in Danish society. A case study is presented as an example of what these women experience.	Umm Zainap, 49y, Iraqi observant Shiite Muslim woman, married, with 3 children, with a technical university degree, teaches Arabic to children at the mosque and has a temporary job in an Arab school.	Baghdad, Iraq – Copenhagen, Denmark (1992, when she was 37y)
18. Quackenbush and Krasner[36]	10	Before 2012	Present a case report to examine elements of psychotherapy carried in the 'Second Life' virtual environment.	Randy, male, 34y, alone, engineering degree.	Libya – 'a large city in a more developed Arab country in the Middle East' (before 2012)
19. Green[37]	9	2010	Present a clinical case study of a Congolese refugee woman who suffered violent xenophobia in South Africa and to explore the relationship with the therapist.	Gabrielle, 35y, Congolese woman, married, working at home, making cushions, suffered many violent attacks including rape.	Democratic Republic of Congo (DRC) – Kenya (1998) – Cape Town, South Africa (2001)
20. Smith *et al.*[38]	9	Before October, 2011 and after 2008	Case study demonstrating the value of engagement in meaningful occupation (weaving) as an important component of resettlement.	Paw Law Eh, female, in her 40s (born in 1965), married, with four children, a school-teacher in her home country and in refugee camps and weaving teacher in the USA.	Karen State of Burma – Thailand (1977) Burma - Umpiem Mai refugee Camp in Thai-Burma border (where she lived for 24 years) – United States (2008)
21. Jensen[39]	9	Before December, 2012 and after 1993	Case report to evidence the application of exposure therapy treatment in a tortured refugee in need of an interpreter.	Zaid*, 60y, male, married, with children, tortured.	Iraq – Denmark (1993)
22. Medeiros *et al.*[40]	7.5	From December, 2010 to September, 2013	Case report to present successful multidisciplinary treatment with a traumatised refugee from the Democratic Republic of Congo.	Djo*, 23y, male, alone, tortured.	Democratic Republic of Congo – Brazil (2010)

* Fictional names given by the authors of this paper.

Eight articles clearly reported that the refugee participant was tortured or physically assaulted before fleeing[14,15,25,27,28,37,39,40] and nine stated that they had witnessed family and friends dying[14,15,24,28,30,31,34,38,40]. The loss of properties and personal belongings was also a common experience.

The impact of negative experiences on mental health

Most of the refugees (18 from the 22 case studies) had mental disorder symptoms described by the authors. Table 2 shows the symptoms displayed during the resettlement process in the new country, as well as cited triggers or causes of these symptoms. All the symptoms were related to negative experiences lived before migration (in their home country or in the refugee camp) or after migration (in the hosting country). No author related psychiatric symptoms to biological or genetic causes.

Supportive experiences and coping strategies

Taking part in cultural activities and connecting with people from the same ethnic origins were related to welfare in some articles. Mr. K[4], a refugee from Cambodia settled in the USA, was less withdrawn after moving to a Cambodian area while Hassan[15], a Middle Eastern refugee in a Nordic country, stopped feeling so isolated after finding support and friendship in a family from the same region as his own. Being able to help other refugees to navigate the system bureaucracy, to use the available services and offer language support was meaningful to Ali in Australia[25] and to Veronique in the USA[31], both refugees from African countries.

On the other hand, Caaliya[33], a Somali woman in the USA, and Umm Zainap[35], an Iraqi woman in Denmark, increased traditional and religious practices as a way of maintaining their identities in the different country. Continuing and increasing traditional practices in occupational activities was also reported as a supportive experience by Paw Law[38] and Gabrielle[37]. In the USA, Paw Law profited from the possibility of maintaining her weaving practice, weaving in groups and teaching this traditional Karen practice she had learned from her grandmother. In the groups, she could meet other Karen women, teach them how to weave and whilst weaving, talk about their lives and memories. She declared finding satisfaction, self-sufficiency and a sense of security when weaving. Gabrielle, a Congolese woman in Australia, benefited from a handicraft activity as well, even though it was alone at home. It also had a metaphoric meaning of overcoming her mother's death. She was making cushions to sell and gave her mother's name to her business as a way of honouring her.

A peculiar way of finding connection was reported by Ranndy[36], a Libyan refugee in a Middle Eastern country who, besides reconstructing Libya in the virtual space of *Second Life* (a three-dimensional virtual world with a platform where users create their own characters and environment)[41], used to chat with people from his country about politics via a political message board online.

There were many reports about how having the correct diagnosis and treatment for a health problem was another helpful experience for the refugees to go on with their lives. Although the Cambodian Mr. K[4] had been in pain since 1992, with swollen ankles and knees, only in 1996 in the USA he was diagnosed with gout. Trung[30] and Thach[24], both from Vietnam, presented a similar story. They had the diagnosis of *a weak heart* and were having cardiac stimulant medication prescribed by a Vietnamese physician when they moved out. In an American psychiatric clinic, they received the correct diagnosis of orthostatic panic attack, an expression of PTSD. A better treatment was also received in the hosting country by Veronique[31]. She was shot in both legs when caught in crossfire in a refugee camp in the Ivory Coast. At the hospital there, her legs were badly repaired. In the USA, she had three surgeries to fix the damage which improved her ability to walk. Ms. X[34], from Somalia, also benefited from the correct diagnosis in the USA. She stated that, for years, she was misdiagnosed in hospitals at the refugee camp and in less than one month, in the new country, she had a precise diagnosis and started treatment.

Another important support highlighted as presenting a positive impact on the subjects' well-being was the social and financial one. In the USA, Mr. K[4] from Cambodia and Ms. X[34], a Somali Bantu refugee, depended on the Supplemental Social Assistance (a financial aid) to have an income. They had a chronic illness that prevented them from working and were able to find a system that provided for all their basic needs and those of their family, like housing, education and healthcare. In the same country, Paw Law[38], from Burma, received social support to continue weaving, sell her products and receive English classes. That had an important impact on the feeling of safety on their lives.

Experiences of mental health treatment

Most of the studies emphasise the need of psychological or psychiatric treatment to deal with the mental problems faced by the subjects. Some authors stated the importance of combining treatment with social support to deal with multiple barriers such as language, employment, housing, financial aid, acquiring legal documents and family reunification.

Among those in need of psychological treatment is Miss V[26], a Khmer woman living in France. Through therapy, she found a way to handle and express conflicting feelings related to her cultural background. In her culture, it was unacceptable to show objection towards her father and her stepmother, even though she was angry about the fact

Table 2. The impact of negative experiences on mental health

Subject	Symptoms of mental health problems (MHP)	Triggers of MHP before immigration	Triggers of MHP in hosting country
MEN			
Ali[25]	PTSD and Major Depressive Disorder symptoms: anxiety, sweating, heart palpitations, insomnia, nightmares, socially-withdrawn, paranoid thoughts.	Persecution, detention and torture.	His home was raided by the police with all his family witnessing it; he was aggressively taken to interrogation; policemen were disrespectful to him and did not give him the right to have a lawyer.
Mr. K[4]	Withdrawn, isolation.	Health problem developed from forced labour in harsh conditions.	Living in an area without people from his country, unable to work (due to health problems) and language barriers.
Samir[27]	PTSD and Major Depressive Disorder symptoms: sleeping disturbance, chain smoking, tension, sadness, withdrawn, dysfunctional and speechless.	Ethnic cleansing, assault, loss of belongings, especially his house, and freedom of the perpetrators, who were unpunished.	The news of the death of his aunt in Bosnia and the crisis in Kosovo.
Hassan[15]	PTSD symptoms: anxiety, fear, difficulties in trusting people, withdrawn, nightmares and paranoid thoughts.	Loss of family and friends. Witnessing death. Persecution, detention and torture. Bodily injury (due to a shot in his arm).	Isolation from family and ashamed for not being able to become the leader of his clan, as expected.
Trung[30]	PTSD symptoms: orthostatic panic attack, dizziness, fear, flashbacks, tachycardia, tinnitus, tension, tightness in the chest and difficulty breathing.	Loss of family and friends. Witnessing death. Persecution, detention and torture for a long period. Starvation and maltreatment.	Being mugged and beaten on the street once. The news of the attack on the World Trade Centre (both worsened already present symptoms).
Mr. A[32]	Unusual PTSD symptoms: abdominal and lower back stabbing pain, nightmares.	Witnessing death and war.	-
Ranndy[36]	Major Depressive Disorder symptoms: socially withdrawn, loneliness, ashamed due to unemployment, a phobia about driving, sexually risky behaviour.	Insecurity due to turmoil in his country. Educated to hide emotion.	The loss of his job. Isolation. General prejudice against his ethnic origin.
Zaid[39]	PTSD and Major Depressive Disorder symptoms: nightmares, anxiety, distress with torture reminders, sleeping disturbance, anger outbursts, startle responses, difficulty in concentrating.	Persecution, detention and torture.	Seeing people from his ethnic origin and other torture reminders.
Djo[40]	PTSD and Major Depressive Disorder symptoms.	Loss of friends and family. Witnessing death. Raped and physically assaulted.	Language and social barriers, lack of friends, family, employment and housing.
WOMEN			
Miss V[26]	Headaches, anxiety, nightmares, withdrawn behaviour, sleeping disturbance and sadness.	Her father's abandonment of her and her mother. Fear of being separated from her mother by the Khmer Rouge regime.	Conflicting emotions when she moved to Paris to live with her father, step-mother and siblings and left her mother in Cambodia.
Nina[6]	Anxiety, unable to deal with emotions and talk about the past.	Loss of friends, family and personal belongings.	Language barriers and difficulties in making new friends.
Thuy[5]	Anxiety, sleeping disturbance and guilt feelings.	-	Conflicting emotions when she decided to marry and have an American wedding instead of a Vietnamese one, which upset her parents.
Elena[28]	Major Depressive Disorder and somatic symptoms: unexplained pain and anxiety.	Loss of family, had to leave her children with her mother. Persecution, detention, torture and rape.	Difficulties with health professionals and health system. Traumatic experience at the hospital after a surgery. Language and cultural barriers.
Raji[29]	Dizziness, pain in her jaws and shoulders, vomiting and without appetite.	-	The loss of her father and having a violent husband. General prejudice against her ethnic origins.
Marina[14]	PTSD and Major Depressive Disorder symptoms: nightmares, blaming herself for being raped, anxiety, angry, not trusting people and fear of men in general.	Loss of family and friends. Witnessing death and war. Impossibility of providing a funeral for her husband. Raped and assaulted by a family friend who was unpunished.	The news that her assailant was living in her house in her homeland. Being alone with men or having to walk alone on the streets.
Thach[24]	PTSD symptoms: orthostatic panic attack, dizziness, tinnitus, nightmares, sleeping disturbance and paralysis, difficulty breathing, hand cramp, flashbacks, tachycardia, tension.	Loss of family and friends. Witnessing death and war. Starvation. Violent family members (stepmother, mother-in-law and husband, who was also unfaithful).	Arguments with her husband and his affair with her half-sister. Being robbed in her flat. Imprisonment of her son. The news of the attack to the World Trade Centre. All events worsened already present symptoms.
Veronique[31]	Nightmares, sadness, missing dead mother and sister and frustration at her mobility problems.	Loss of family and friends. Witnessing death and war. Bodily injury (due to being shot in both her legs).	Staying at home all the time and being inactive. A recent loss of a cousin.
Gabrielle[37]	Emotional unbalance, fearful, withdrawn, isolation, guilt feelings, rage for men.	History of violent attacks.	Gang-raped twice and physically attacked five times due to xenophobia. General prejudice against her ethnic origin. The death of her mother after telling her about the rape episodes. Retraumatized by an invasive gynaecological examination.

that her father had left her and her mother in Cambodia and started a new life and a new family in France. Now that she had left her mother to join her father, it became unbearable to her to deal with the conflicting feelings. As she could not consciously acknowledge her anger and disapproval, it was manifested by her symptoms.

Conflicting feelings due to cultural background were also a problem to Thuy[5]. She was able to work on them in therapy, as well. She was raised in the Vietnamese tradition, although her family had moved to the USA when she was three years old. She identifies mostly with American culture so when she was to marry an American man, she wanted to have an American wedding party, but her parents insisted that she should have a traditional Vietnamese celebration. Her disagreement with her mother and her difficulties in defining her identity developed into anxiety symptoms. In therapy, she was able to understand her bicultural identity and develop her own way to deal with traditional rituals. As a result, her symptoms disappeared.

Six years of psychoanalysis provided the main support received by Hassan[15] after moving from the Middle East and starting a new life in a Nordic country. It helped him to trust and connect with people again and to overcome guilt and conflicting feelings from his past. Gabrielle[37], the woman from DRC, also found her main support in psychotherapy during the tough moments in Australia. She suffered many violent attacks and rape, related to xenophobia. She was unable to conceive and was re-traumatized during a procedure in a gynaecological clinic. When she told her mother the experiences she had endured, her mother had a heart attack and died some weeks later. Gabrielle was overwhelmed and life was very difficult for her at that moment. In therapy, she felt that she was not suffering in silence and was supported to find a way to move on. Nina[6], a Bosnian refugee, also benefited from a psychological intervention of art therapy to deal with her losses, suffering and difficulties in expressing emotions, and presented a positive outcome from the treatment.

Virtual psychotherapy was reported as a supportive care for Ranndy[36], who found a very particular way of dealing with all the difficulties of being a refugee. He started to live a new life in the virtual world of *Second Life*. Although it might have been seen as an avoidance mechanism at the beginning, it was very interesting how he managed a self-reconstruction through the activities he engaged on in *Second Life*. He sought virtual psychotherapy and it helped him to get back to the real world. For the interim, he also started to build his virtual native land of Libya as a tribute to his people. In addition, he engaged in a virtual relationship, which was short-lived as he suggested meeting his girlfriend in the real life. Although unsuccessful, it was a positive step related to his former behaviour.

Psychiatric and psychological treatment together were reported as an important support to overcome PTSD symptoms by Mr. A[32], from Sudan, and Zaid[39], from Iraq. However, three refugees did not present total recovery, although benefiting from treatment: Trung[30] and Thach[24], two Vietnamese refugees, were cared for orthostatic panic attack with psychiatric treatment. The episodes decreased in severity and frequency after therapy, but were still present. Ali[25], from the Horn of Africa, after being re-traumatized by the encounter with the Australian police, had to start psychiatric treatment, take psychotropic medication and counselling. He presented a good, but not complete recovery, as well.

Moreover, some subjects were presented as in need of a combined approach of psychosocial support. Marina[14], a Bosnian woman living in the USA, was assisted by cognitive-behavioural therapy and psychiatric treatment with antidepressants to overcome PTSD but she also received social support, starting an English language course, a gardening programme and obtained information about the healthcare system in the hosting country. At the end of therapy and in the follow-ups, she reported being well and presenting a good quality of life. In the same hosting country, Veronique[31], the refugee from Liberia, had her quality of life improved by psychosocial care, as well. She relied on someone to talk to about her experiences as a refugee, to help her to apply for a vocational training programme to find a job and to deal with the paperwork to take her husband to join her, in the USA. Djo[40], from DRC, after 3 months of only pharmacological treatment, reported worsening of symptoms. He had to receive multiple support to completely overcome a PTSD and depression. He started supportive psychotherapy for 6 months in Brazil, received legal aid to gain legal refugee status, financial aid for 6 months, specialised accommodation for 12 months and was helped with housing transition. Furthermore, he began an intensive language course, received educational support for college and continued medical treatment with antidepressants.

However, one manuscript reported a treatment of a refugee that did not achieve any mental rehabilitation. Summerfield[27] described how Samir, from Bosnia, diagnosed with PTSD and depressive disorder, presented no improvement after 3 years and 5 months of psychiatric treatment and rehabilitation. He had lived for 3 years under threat of torture and murder before he and his family were banished from their country for being Muslims. He lost his house and his country. His brother and his mother resettled in Denmark while he and his family were resettled in the United Kingdom. The symptoms started after arrival in London. He was prescribed different classes of anti-depressants and medication for sleep, but no changes were presented. During all his time in therapy, there were two episodes of slight improvement. Both were after two trips related to his past; one to the Isle of Wight, where he saw an

old mill that reminded him of Bosnia and the other one to the city of Zvornik, where he was able to see his old house, although it was occupied by a Serb dweller. Yet Samir's improvement did not last, the symptoms worsened again and until September 2000 he was still presenting almost the same clinical state as at the beginning of treatment.

DISCUSSION

After examining all the 22 refugees' stories, a conclusion is certain: refugees are survivors. Reading their individual narratives gave evidence to this statement made by Nieves-Grafals[13] and Schulz *et al.*[14] This study also pointed out that generally, refugees do present resilience, individual resources and abilities to deal with inconceivable difficulties, as claimed by Charlés, Hooberman, Rosenfeld, Rasmussen and Keller[42] and Schweitzer, Greenslade, and Kagee[31,42,43]. Most of them were subjected to inhumane conditions. They were taken away from their most private and intimate belongings, people, environment and experiences – their history. The effect of having the place called 'home' destroyed has an important impact on their identity and must be considered when working with this population. Samir could not overcome this scar on his soul and did not have his mental state improved after years of treatment. The impossibility of defending his family and household from perpetrators was unbearable to him. To move on would imply that he had accepted what had happened to him. "Samir had not lost his mind, but his world"[27]. With traumatised people, restoring their belief in humanity might be the greatest, but challenging, contribution that a therapist can make[13].

Grief or bereavement is a common emotion due to all the loss they had suffered. This expression might be present immediately, or much later, after arriving in the safe haven, so it does not imply that those who express these feelings immediately will struggle more with the cultural integration while the others will not[16,44,45]. The case studies show that even when refugees are able to move on, there is no certainty about their future mental health because there is no prediction about what will trigger the trauma again, especially because trauma is not only related to the real aspects of the events one has lived but to the meaning that the subject gives to it[46-48]. "Even if refugees have lived the same events, this does not mean that they have experienced the same trauma"[26]. Most important is how the experience is signified (or unable to be) at the moment when it happens and re-signified in the future, in relation to any new experience a refugee might have after arriving in the new country[46].

Ali[25], for instance, was doing extremely well in his resettlement process in Australia. He was reunited with his family, found a job and was helping other refugees to deal with the system there, until he started to have a problem with his manager and had his flat raided by the police. These episodes violated his assumption of safety in the new country and were perceived as connected to the same violence he had suffered in his home country. The old ghosts of his soul were awakened. Consequently, he started to present PTSD symptoms and had to seek psychiatric treatment.

Concerning the impact of the resettlement journey on mental health, it is also important to consider the acculturation process that each refugee endures. The acculturation process relates to the degree of involvement presented by migrants with the culture of the host society and the culture of origin, which gives an understanding of their level of functioning and their needs of support in the new location. Four models of migrants' behaviour in the host society have been categorised: they integrate within its culture, maintaining their traditions and acquiring new ones; they assimilate the dominant cultural aspects, actively participating in it and leaving their original custom behind; they reject the new culture holding onto their traditions, increasing traditional habits; or they marginalise themselves from both cultures, presenting low interest in relationships with people sharing their original culture or the majority culture[49,50].

There is no better model to be followed and outcomes will depend on how individuals manage their new circumstances, but it is a sign of difficulties when the refugee is denying one of the cultures that are part of his or her history (the original or the hosting one). The therapist may become a bridge to the refugees' hosting country, helping in the adaptation process, but also a bridge of acceptance of their traditions, their culture, their background stating that it is part of who they are. It is important for health works to present a sound knowledge of the patient's culture and also of historical issues related to his or her home country[13,49].

Some refugees increase traditional practices as a way of maintaining their identities. It might be a way of overcoming their expressed sense of loss of meaning in everyday life, as claimed by Charlés[31]. Pedersen[35] reported how Umm Zainap, the only person in her Iraqi family who was a refugee in Europe, became more preoccupied with living according to the Qur'an, taking part in Muslim rituals learned in Denmark from a Muslim community. The author makes a comparison with her brother who was living in Syria and whose daughters did not wear veils. To Umm Zainap, joining the activities at the mosque and preserving the Muslim traditions were also a way of maintaining her middle-class identity, especially because in Europe she had experienced downward social mobility.

The construction of an identity has many intricacies and in exile it includes more aspects that must be considered, as presented in the case of Thuy[5]. The difficulties of being a bicultural woman only came to the surface when she was

going to marry an American man. Her identification with the American culture did not protect her from suffering when having to decide between a Vietnamese traditional celebration or an American one.

On the other hand, Caaliya, a Somali young woman, was able to declare: "Wherever I go, I know who I am"[33], explaining the importance of her ethnic identity, especially while living in a place where Somalis were not the majority. She had decided to maintain the Muslim tradition of wearing a veil even though she showed disagreement to other behaviours from her culture. Living in America, she felt free to be a Muslim, but also benefited from literacy and a higher education, showing her manner of integrating both cultures in her identity.

Rosenbaum and Varvin[15] explain that connecting with people with the same origins helps to symbolise the past, the present and the future after suffering traumatic experiences in homeland and in the new country. The experience of suffering alone is even more devastating. Therefore, social support becomes important to overcome trauma.

Additionally, it is necessary to be aware of how the human psyche operates and that cultural differences are not the only possible understanding to every symptom expressed by refugees, as a symptom might use a cultural explanation to hide a deeper conflict. Rechtman[26] presented the case of Miss V, that could have her symptoms understood by the fact that in Cambodia it was not acceptable to show disagreement towards her father, but in a deeper level they also meant that she was identifying with her father in the abandonment of her mother. For a good understanding of refugees' mental health, it is essential that health workers focus on the search of the singular experience lived by each patient and how they give meaning to it.

CONCLUSIONS

Focusing on the refugees' stories showed the importance of recognising the uniqueness of each individual, the different types of support that were effective for each person and gave an understanding of how they 'recreated' their lives and of how they dealt with all the difficulties they had experienced. They revealed stories of horror, but also resilience and the ability to survive. The impact of their experiences on their mental health is usually present and important.

The approach offered to this group and reported as the most effective to deal with such an impact was the holistic multidimensional method that, besides health treatment, also considers the cultural background and social interactions as helpful when reconstructing a new life. In addition, practical assistance was reported as also having a strong influence on their mental health, when helping them to deal with housing, employment, financial subsidy, support with learning the new language and taking part in social activities. Therefore, the most helpful practice health works must comply to is to consider the particular needs of each refugee demanding treatment and address them as important priorities.

Finally, the top 5 hosting countries of refugees in 2017 according to UNHCR[1], were Turkey (with 3.5 million refugees), Pakistan (1.4 million), Uganda (1.4 million), Lebanon (998,900) and Islamic Republic of Iran (979,400). However, in this review only one study described the experience of a refugee in a neighbouring country[36], and only two more related the experience of a refugee in a non-developed country[37,40]. Most research comes from the USA, Canada, Australia and European countries. This does not reflect the state of refugees around the world. There is an urgent demand for international publications concerning the experiences of this people who travel mostly to neighbouring and non-developed countries.

INDIVIDUAL CONTRIBUTIONS

Karin Juliane Duvoisin Bulik – Contributed significantly to the conceiving and design of the study, methodological approach, analysis and interpretation of the data, elaboration and revision of the article and approved the final version to be published.

Erminia Colucci – Supervised the study, contributed significantly to the methodological approach, analysis and interpretation of the data, revision of the content and approved the final version to be published

CONFLICTS OF INTEREST

The authors report no conflicts of interest.

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