Chapter 1

Introduction: setting the scene

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Introduction

People have migrated from one place to another since the start of human existence, for all kinds of reasons and varying durations. These reasons have included exploration and survival. Although researchers and clinicians have observed responses to migration and studied its impact ever since explorers and merchants started to travel around the world, it is only recently that a sobering assessment of the impact of migration on individuals, taking into account social and economic factors related to globalisation, is being studied closely. According to a United Nations estimate, one-third of the world's population can be defined as a migrant, i.e. they live and/or work in a place away from their region of birth. The International Organisation for Migration (2008) estimates there are about 214 million migrants worldwide, making them 3% of the world's population.

Definitions

Migration can be defined as a change in location of the place of residence of an individual for any length of time. This shift can be across national and cultural boundaries or within the boundaries of the same country, from rural to urban areas or from urban to rural areas. Thus migration can be international or intranational. The factors which influence migration can be described as 'pull' or 'push' factors (Rack, 1982). Pull factors attract the individual for economic betterment or for educational uplift, whereas push factors include political factors which may extrude individuals out of one culture into another. Aspirations on the part of the individual and their family will influence the reasons for and settlement after migration. Changing demographics in the population of western societies, which mean that migrants are required to carry out unpopular jobs, and continuing political turmoil in some regions are likely to encourage people to migrate, either internally or externally.

Effect of migration and factors affecting mental health

The process of migration can be divided into three stages: pre-migration, migration and post-migration. Pre-migration involves the decision to migrate and the preparation for such a move. The second stage, migration itself, is the physical relocation of individuals from one site to another. The third stage, post-migration, is defined as the adjustment of the immigrant to the social, political, economic and cultural framework of the new society. Social and cultural rules of the new culture and new roles related to gender, employment, etc. will have

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to be learnt at this stage. In the initial stages of migration, migrants may have comparatively lower rates of mental illness and health problems than in the latter stages. This may be because of the younger age at the initial stage of migration and subsequent problems with acculturation and the potential discrepancy between attainment of goals and actual achievement in the latter stages (Bhugra *et al*., 1999). Although three discrete stages have been described there will inevitably be an overlap between stages. For example, preparation for migration may well continue while the migratory process is taking place and also the post-migration adjustment period may carry on for a considerable period after migration. Migration can influence mental health as a result of a number of social, economic, psychological, physical and cultural causes, especially among vulnerable individuals; and in return all these factors can also affect the process and reasons for migration, although the directional nature of this relationship may not always be entirely clear.

The impact of migration on an individual's mental health is multifaceted and affects different aspects of the individual, whether it is biological, social or psychological. It is possible that the three stages of migration will bring specific challenges and stressors with them (Bhugra, 2004).

Pre-migratory factors will include both personal and sociocultural factors. For example, schizotypal personality, pre-existing propensity to mental disorder associated with vulnerability factors, be they biological or sociopsychological (such as perinatal trauma and early childhood adversities), can predispose individuals to mental disorders at a later stage. Alienation from one's own culture may well bring about isolation and will affect an individual's identity. The process of migration can itself add stress and contribute to this process. The planning of the process of migration and degree of disparity between pre-migration and post-migration ethnic, cultural and socio-economic status are important, and the resultant experience can vary widely.

In the post-migration phase, individuals and groups will settle down in different ways. Most migrants are able to adjust well with binational or bicultural identities. Most migrants will make huge contributions to the new culture and economy as well as to the countries or regions of their origin. Migrants worldwide remit back billions of dollars to families, which has a positive impact in these regions and can be a big contributor to the local economy.

Stress – biological

Studies from the Japanese in the USA and the Sudanese in the UK have illustrated that the rates of physical illness change and start to match those of the new country accordingly over a period of time (Lin *et al*., 1979). (See also Chapter 23 on physical health.)

It is not surprising that, as a result of environmental changes, such as climate and food, biological changes may occur. Furthermore, continuing stress and cumulative life events will affect biological responses. If the theory of entrapment and low self-esteem in the aetiology of depression is explored further, it is inevitable that migrants may feel caught, not only across cultural divides, but they may also feel trapped in their jobs, houses and other settings. Such a feeling will contribute to feeling low and alienated and will lower their self-esteem further.

Physical illnesses can contribute to mental illness and associated stress; therefore it is crucial that psychiatrists are aware of the links and are willing to explore them. Migration and associated stress will influence a whole spectrum of mental health disorders, as illustrated later in this book. There are also important issues around identification of these disorders, especially how cultures affect them and their presentations and care pathways into the healthcare system. There is also the impact or 'burden' on the healthcare system as well as on individuals and those who care for them in the personal or social sector.

Cultural bereavement

Migration involves a series of losses, such as the family and the familiar society; both emotional and structural losses are experienced. There may be a loss of language (especially colloquial and dialect), and changes in attitudes, values, social structures and support networks. Grieving for this loss can be viewed as a healthy reaction and a natural consequence of migration; however, if the symptoms cause significant distress or impairment and last for a specified period of time, psychiatric intervention may be warranted (Wojcik and Bhugra 2010; see also Chapter 11).

The expressions of bereavement are modified by cultural norms – how culture dictates rituals and taboos related to loss and grief. The role of culture in dealing with bereavement and grief is very important. The importance of culturally contextualising these expressions of grief is crucial in differentiating between abnormal and normal reactions to loss.

Normal adaptation occurs mostly in the form of acculturation. However, adaptation is not a simple process: a whole new process of redefining one's identity and place in the new society has to be negotiated and many find themselves maladapted to their surroundings. Factors can both increase risk and protect against this and are often interwoven and vary at both individual and community levels. Cultural identity includes factors such as gender, generation, culture of origin, language proficiency, socio-economic factors, religion, preferred cuisine, lifestyles, intergender relationships, level of sociocentricity, cultural attitudes and values, etc.

Migration and mental disorders

There is little doubt that many factors determine the outcome of migration. Premorbid personality traits will undoubtedly influence the way in which an individual perceives and copes with the process of migration and settlement afterwards. As an individual's own concept of self and their cultural identity changes, a sense of 'self' and the migratory experiences all contribute to coping with the settling down in the new culture and the outcome thereafter. Social support and networks and the attitude of the new society to the migrants and migration will also affect how one fits in. A person's ability to communicate with others from different backgrounds and wider culture, both verbally and non-verbally, will also have an impact on the experience of settling down and a sense of belonging. The migrant's intent, purpose of migration, knowledge about the new culture, openness to new experiences and previous proximity (cultural and geographical) to the new culture will influence the individual's response, as will the new culture's attitudes to the migrant, which can vary from being friendly to ambivalent or antagonistic. There is no doubt that migration itself brings about changes in the socio-economic, vocational, cultural and legal status for the migrant, and discrepancies in aspiration and achievement will further contribute to the stress of settling down.

Associated factors: the role of social and economic inequalities

The relationship between social inequalities and mental health is well known and it is inevitable that if migrants suffer from social and economic inequalities they are also likely to suffer from mental ill-health, though the mediating factors may well vary. Ever since Ödegaard's findings (1932), the link between migration and psychosis has been studied and, in spite of various challenges, cannot be discounted. One of the major findings in Ödegaard's study, that the peak of mental illness occurred 10–12 years after migration, is often ignored. The question

that needs to be addressed is – why this gap? Is it social factors which cause the discrepancy between social expectations, personal expectations and achievement? Ethnic disadvantage, racialisation and social inequalities could play a fundamental role in mental ill-health as a component of wider disadvantage. Other than aetiological investigations, epidemiological studies can help to monitor trends and risk factors of diseases. They also assist investigation of inequalities in health and ensure access to appropriate treatment (see also Chapter 8).

Racial disadvantage

Modood *et al.* (1997) reported that in the UK one in eight people of ethnic minority experiences some form of racial harassment in a year. Repeated racial harassment is a common experience, including physical attacks on self or property. In their study, one-fifth reported being refused a job for racial reasons and only a few believed that there was no racial prejudice with employers. One in four whites reported prejudice against Asian people and a fifth against Caribbean people. There is no doubt that these affect an individual's self-esteem and allow the continuing hassle to act as a chronic stressor, which will contribute to poor social functioning. Using the immigration experiences to Britain as an example, Layton-Henry (1992) noted that the public picture of tolerance and friendliness was partly correct but needs to be qualified in a number of ways as there is public discrimination in employment (from employers and unions alike) and housing. Incidents of violence against migrants were reported as far back as 1948. Racist views expressed by politicians further contributed to discrimination, both public and private. Migrant women have made a significant contribution to the economies of countries in western Europe and contribute to offsetting the impact of ageing populations. With the increase in heterogeneity has come an increase in racism and discrimination (Layton-Henry, 1992, page 220).

According to UK studies, those of African-Caribbean descent are three to five times more likely to be admitted to a psychiatric hospital with a first diagnosis of psychosis than white people (see Chapter 2). They have more complex and coercive pathways into care, are more likely to present to hospital services in crisis and to be assessed as dangerous by healthcare workers, and to have compulsory treatment. They are also more likely to remain in long-term contact with services after discharge. However, there are low rates of treatment for depression for African-Caribbeans, indicating that there may be different causative factors and approach strategies. If they were related to cultural bereavement, then rates of depression would be higher, but the rates across different migrant groups are variable, in the UK at least (see Nazroo 1997).

The role of racialised social relationships needs further scrutiny. Racism reflects an ideology of superiority and justification of institutional and individual practices that create and reinforce oppressive systems of race relations and inequality between racial or ethnic groups, thus creating a racialised social order. This is reflected in racist interpersonal behaviour, and institutional policies and formal and informal practices, including everyday 'minor' incidents. This attitude leads to economic and social deprivation, socially inflicted trauma (experienced or witnessed) and negative interactions and mistrust with public agencies and resulting inadequate healthcare. However, sociocultural problems around identity, intergenerational differences, ambivalence towards both the host and originating cultures, and dysfunctional acculturation, complicated by cumulative discrimination and racism (both overt and covert) factors are likely to contribute to stresses experienced by these groups.

Perceived discrimination has been studied as a possible precipitant and stressor for the development of psychosis. Veling *et al.* (2006) found perceived discrimination among

ethnic minority groups classified in terms of discrimination to be high in Moroccans, medium in migrants from Netherlands Antilles, Surinam and other non-western countries, low in the Turkish and very low in those from other western/westernised countries. This rate corresponds roughly with the rate of prevalence of psychosis in these communities.

The social defeat hypothesis (Cantor-Graae and Selten, 2005) takes into account various forms of inequalities (social, financial, educational, employment, etc.) in relation to high expectation and low achievement and the possible effect on the dopaminergic system in the mesolimbic pathway, which is seen to play a significant role in the development of schizophrenia. They propose that repetition of such experiences leads to behavioural sensitisation and mental health problems.

A large study looked at the possible effect of migration on psychopathology of psychoses in migrant groups in Austria and in their home countries (see Chapter 9). Independent of their migration status, patients from post-modern/modern countries more frequently report on delusions of grandeur or guilt, while delusions of persecution are more frequent in migrants. Delusions of being loved, of poisoning and visual hallucinations are more frequently reported by patients living in their countries of birth than by migrants. The latter report more auditory hallucinations. Thought insertion and withdrawal are more prevalent in migrants from traditional countries; first rank symptoms and auditory hallucinations in migrants from post-modern/modern countries. Made volition and somatic passivity are most frequent with patients living in post-modern/modern countries.

Even though cannabis and substance misuse has been linked to psychosis, there is little evidence that increased use of illicit substances explains the raised rates of psychoses among immigrant groups. Evidence from both the UK and the Netherlands suggests that the frequency of cannabis consumption in the general population is not raised in the black Caribbean group. Veen and colleagues (2002) have shown that the raised rates of schizophrenia in Moroccan and Surinamese immigrants in the Netherlands are unlikely to be due to substance abuse (not restricted to cannabis).

Depression, anxiety and other common mental disorders

The findings are mixed for differences in prevalence of common mental disorders and rates are not as elevated as for psychosis. Two major UK studies found differences in the prevalence of depression: the ONS National Study of Psychiatric Morbidity did not find any evidence of raised rates in black groups (Jenkins *et al.*, 1997a; b), while the Ethnic Minority Illness Rates in the Community (EMPIRIC) observed a 60% higher prevalence in black compared to the white group (Weich *et al.*, 2004). However, black groups may be less likely to receive a diagnosis of depression from their GP (Gillam *et al.*, 1989). Smaller studies have found a raised rate in Asians with possibly higher somatisation disorders (Commander *et al.*, 1997, 2004).

Suicidal and self-harm behaviour appears to vary by ethnicity and sex. South Asian men have lower rates of suicide in the UK than the white group (Thompson and Bhugra, 2000), while Asian women, particularly younger women, have higher rates although this might be changing (Soni-Raleigh *et al.*, 1990; Thompson and Bhugra, 2000). Many Asian immigrant communities have maintained their cultural identity and traditions even after generations of overseas residence. There is a premium on academic and economic success and a stigma attached to failure. There is also the overriding authority of elders (especially parents and in-laws) and expected unquestioning compliance from younger family members. Pressures are intensified for young Indian women, given their rigidly defined roles in

Indian society: submission and deference to males and elders, arranged marriages, the financial pressures imposed by dowries, and ensuing marital and family conflicts (Soni-Raleigh *et al*., 1990; Soni-Raleigh and Balarajan, 1992). There is a lower rate of suicide in black Caribbean groups (Soni-Raleigh *et al*., 1990). Studies have found higher rates of suicide in migrants to Sweden, particularly second-generation groups (Hjern and Allbeck, 2002). Suicide and suicidal behaviour may be related to social stress and acculturation.

Eating disorders: research evidence indicates that rates of eating disorders are elevated in teenagers who have migrated, although these findings are not consistent (Bhugra and Bhui, 2003).

PTSD: most research on post-traumatic stress disorder (PTSD) in migrants in refugee and asylum groups and a review of over 7000 refugees found PTSD to be ten times more likely in these groups than in the general population (Fazel *et al*., 2005). There may be some overlap with psychosis (15–40%) and a greater risk of other common mental disorders.

Some substance misuse disorders are related to cultural backgrounds. Khat use in the Somalian and Ethiopian migrant communities in some European countries has brought about new challenges. The use of cannabis in some African-Caribbean migrant communities has come under scruting but it is debatable whether this differs significantly from the local populations, although recent evidence indicates that more potent cannabis may be more likely to produce high levels of schizophrenia.

Migration and environment

The impact of migration on the environment is not discussed widely. It is inevitable that mass movement of peoples is likely to influence changes in the environment, which in turn may cause biological changes in the individuals themselves. There are isolated populations that have high rates of consanguinity in two types: primary (ancient tribes with biological equilibrium) and secondary (where a group detaches itself from a larger group) (Neel, 1992). Groups may start as small sized, but may expand slowly. Yanase (1992) divides isolates into four categories, and argues that isolation affects breeding structures, migration patterns and genetic distance. These changes can be seen as an evolutionary process.

Migration of isolates raises some interesting questions about the impact of the process itself on social and biological variations. The study of migrants has included looking at biological markers and seeing whether these are genetically fixed or not (Lasker and Mascie-Taylor, 1988; Baker, 1992). Baker (1992) rightly cautions that in studies related to migration, not all environmental variables can be controlled. Apart from methodological problems alluded to in the conduct of epidemiological studies control of multiple environmental factors adds another dimension.

Migration and special groups

Migration and its effect on child mental health

Various factors may impact on the outcome of migration in children. Their experiences will depend on factors such as whether migration occurs with parents and family, separation from one or both parents (owing either to migration of the parents or of the child), who looks after them and where they migrate to. Migration can include seasonal migration of parents or youngsters for work away from home, serial migration of family members, parental migration without the children, family migration etc. Children can be lone migrants for better education or due to factors related to safety (see Chapter 15).

Not all children can cope equally well with adversities and disruption to their lives. Children may be unable to understand the reason for the separations and may feel abandoned. They may have difficulty forming attachments, coping with losses or reunion with families after a period of time. At times older children may end up looking after younger siblings. Parents themselves may suffer the consequences of separation, e.g. guilt and loss. Children, especially girls who are separated from families, are particularly vulnerable to physical, emotional and sexual abuse as well as exploitation.

Much of the research in this area has originated from the USA and may be hard to generalise to other parts of the world. Vollebergh *et al.*, (2005) and Alati *et al.* (2003) did not find higher rates of mental illness in migrant children in the Netherlands and Australia, respectively. However, in the Dutch study immigrant parents reported more problems in their daughters than non-immigrant parents. Teachers reported lower levels of internalising, social and thought problems but higher externalising problems with girls. Internalising problems could lead to depression, anxiety and mental health problems in later life while externalising problems can lead to behavioural problems. Both could result in secondary problems such as poor academic achievement and substance misuse, but research in this area is limited. Kupersmidt and Martin (1997) assessed the prevalence of psychiatric disorders in children (aged 8–11 years) of Mexican and African-American migrant farm workers in North Carolina. They found elevated levels of pathology, with 59% of the children revealing one or more psychiatric disorders. The most common disorders were anxiety related (50%). These included phobias, separation anxiety and avoidance. Parenting styles could differ among cultures and could be interpreted as maltreatment. Underachievement is not universal. Children of some migrant communities have higher levels of school performance owing to values placed on education. Living in a neighbourhood with a higher concentration of immigrants is associated with less problem behaviour but the reverse is true for non-immigrant children and could be related to lesser discrimination, greater social support in the former and disadvantaged socio-economic status of the latter.

Adapting to a new environment by children can be challenging and needs support from authorities and schools. Various factors mentioned above could affect the adaptation process, including overcoming language barriers, attitudes faced in the community and school, integration attained by the family in general, residency status and intergenerational differences. Access to mental health services may be limited because of lack of awareness and lack of perceived need as well as poor provision. It is important to recognise that migrant children will also have the same range of mental health problems as non-migrants and detection of these problems can be a challenge with communication barriers, expectations and attitudes of all involved. 'Migrant children' form a heterogeneous group and their needs vary widely. There needs to be better consensus regarding terminology to identify mental health and social problems, offer culturally sensitive and appropriate interventions, plan services and for improvement in research designs and measuring outcomes to take place.

Elderly

Migration can affect the elderly in various ways. The reasons and motives for migration can be the same as those of younger migrants or could be because of their dependent status on younger family members who are the primary migrants. There is also an ever-increasing group who had migrated in their working years and have grown older in the host culture. Both these groups face a number of challenges with changes in their social, cultural and economic set-ups. They face multiple jeopardy due to problems faced because of ageism,

racism, gender disparities, restricted access to health and welfare services and class struggle (Boneham, 1989; see also Chapter 14).

Communicating distress, especially with language barriers, can be a significant reason in not seeking help and not engaging in therapeutic alliance, no matter what age group is being studied. Many cultures have different idioms for communicating distress and some may even lack comparable terms for clinical concepts of depression and dementia and presentation with more somatic symptoms. Finally, the plight of many elderly people left behind by migrating families needs to be highlighted. At times they may be left with responsibilities of looking after young children and other elderly relatives. Breakdown of the family, of social and financial support, may make them vulnerable. However, many migrant families send money to their elders, who can offset some of the loss of social support but provide much needed financial support. Level of contact and the distance from families may also affect outcomes. The lower prevalence of depression in elderly Thai people left behind by rural–urban migrants compared with elderly rural Thai parents of non-migrants is a possible example (Abas *et al.*, 2009).

LGBT individuals

Lesbian, gay, bisexual and transgendered (LGBT) individuals may migrate either because of their sexual minority status or for other reasons, and discover their sexual identity after migration. The push factors for them will be different, in that homophobia or bi-negativity attitudes in their country of origin will influence the decision to migrate. For transgender individuals, a potential factor may be the availability of medical and surgical interventions which pull them towards the new society (see Chapter 17). Negative attitudes to the sexual minority status in the new country may place them in triple jeopardy – as a result of migrant status, minority or sexual identity which may be further complicated by factors such as age, gender or religion. Thus, further alienation may make it difficult to settle down. Data on the prevalence of psychiatric disorders among these groups are sparse. Clinicians' views on sexual minorities, on religious attitudes to sex and other factors will influence healthcare delivery for this group.

Women and families

Women may be primary migrants or may follow their families, spouses or partners. Their experiences of the act of migration and its consequences will depend upon gender roles and gender role expectations in their culture of origin and in the new society. It is possible that their own culture expects them to have traditional roles and carry traditional values to pass on to the next generation, but that the new culture expects them to have more modern views. With more women migrating and working, it is likely that they will experience more stress and pressure to conform, thereby putting them in a position of conflict between the two cultures (see Chapter 16). When families migrate or come together in the new culture, levels of acculturation in different members will vary, which will affect individual expectations of the new society. Changing structures of the family following migration from more traditional joint or extended families to nuclear families (with altered patterns of social support) will add to the stress being experienced by the individual. These changes will lead to altered social and individual expectations of women and family members.

Needs of refugees

The 1951 Geneva Convention defines a refugee as someone who has 'a 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 . . . ' A further distinction of 'asylum seeker' is made for people who have left their country of origin, have applied to be recognized as a refugee and are awaiting a decision from the new government. Currently, there are over 20.8 million 'people of concern' to the United Nations, and about 40% of these are refugees. Pakistan and Iran host a fifth of the world's refugee population. According to the United Nations High Commissioner for Refugees, in 2005 there were some 668 000 applications for asylum or refugee status in the industrialised world, the majority to Europe (374 000). The USA is followed by the UK and France with the largest number of asylum applications overall, but numbers are starting to fall (United Nations High Commissioner for Refugees. Basic facts, 2006, available at: http://www.unhcr.org/cgibin/texis/vtx/basics).

Refugees are probably the most vulnerable of all groups of migrants. The individual experiences of refugees and asylum seekers can contribute to elevated rates of psychiatric disorders. Forced migration is usually not planned and is associated with various forms of trauma, uncertain legal and immigration status, loss of social support and resources. These problems can be compounded by the attitudes of the host countries, where they might be at the receiving end of discrimination because of race, politics and religion, unwelcoming response, poor living conditions in deprived and even segregated camps, limited employment and educational opportunities, and rights which limit normal day to day existence. After the initial relief of post-migration arrival in a safe haven it is not uncommon for frustration and disillusionment to develop as new problems emerge. These include language and cultural barriers, concerns about legal status and entitlements, unemployment, homelessness, isolation, lack of access to education and healthcare services, and family separation. There is surprisingly little public acceptance of the importance of tackling these problems.

Refugee children: children of refugees may have been separated from their parents, witnessed members of their family being tortured, or experienced violence or torture themselves. They may be living with just one parent, in fragmented families or with unfamiliar carers. Some will have arrived alone and most, if not all, will have experienced multiple losses. These experiences will eventually emerge in the form of emotional distress and aberrant behaviours. They may appear mature beyond their age in some settings yet immature in others. The most common conditions include anxiety, depression and conduct disorder. It is not known whether there are any unique manifestations of these disorders in refugees over and above what is commonly seen in the general population. Despite their experiences, most refugee children have many strengths and few need specific psychiatric treatment. Where they do, the principles of management are broadly the same – space and time to think about their experiences, help to become part of the local community, to learn and to make friends. Experiences at school are particularly important – an atmosphere of warmth and stability can go a long way towards restoring a sense of security.

The spectrum of mental ill-health among refugees differs in degree and presentation rather than in any absolute way from that of the host population. The most common disorders are those characterised by anxiety and depression, such as PTSD and major depression, reflecting the experience of trauma and loss that these populations experience. There may be anxieties around families left behind or guilt at having migrated. Post-traumatic disorders are often high in those fleeing troubled regions, physical and sexual violence, torture, loss of family members and persecution. A recent meta-analysis concluded

that rates of common mental disorders were twice as high in refugee populations as in economic migrants (40% versus 21%) (Lindert *et al.*, 2009).

A heavy-handed response by authorities in new countries can further add to the post-migration trauma. PTSD and common mental disorders in asylum groups increase with length of stay in detention (Laban *et al.*, 2004; Hallas *et al.*, 2007) and with unemployment, absence of family support and complicated asylum processes (Laban *et al.*, 2004). Asylum seekers may be less likely to engage with mental health services as shown in the UK (McCrone *et al.*, 2005) and in the Netherlands (Laban *et al.*, 2007).

Once trauma has been disclosed, the acknowledgement of symptoms of anxiety and PTSD are important but need careful interpretation. There is a risk of pathologising and medicalising an otherwise normal human response to extreme adversity. On the other hand, there is a serious danger in dismissing too easily clinically significant disorders as simply caused by trauma. Services have to be sensitive to the needs and required specialised skills, including training of interpreters.

Refugees in some countries are entitled to clinical services and medical treatment, but access is not always straightforward, requiring at the very least some familiarity with how healthcare is organised. In some western countries there has been the development of specialist refugee health teams connected to primary care. These teams provide information and advice to refugees, facilitate access to healthcare and provide support to frontline services. They often work in loose partnership with a variety of refugee community organisations that deliver immigration advice and assistance with housing and welfare benefits. In low- and middle-income (LAMI) countries such as Pakistan and Iran, which have the highest burden of refugees, there are few provisions for specialist healthcare (especially mental health) and the needs of the refugee population add to the burden of the poorly funded local services and usually lead to further marginalisation of this group.

There is substantial evidence for the efficacy of psychological, psychosocial or 'talking therapies', which are primarily western in origin. Their appropriateness among non-western cultures has been questioned by some, who point out that most asylum seekers come from cultures where talking therapy is quite an alien concept. It can be argued that a more acceptable model for counselling might be one that starts with a background knowledge of the circumstances from which the patient has fled and acknowledges the relevance of practical advice and a more problem-focused (rather than emotion-focused) approach. In the absence of empirical studies testing the efficacy of specific psychotherapeutic approaches in refugee populations, experts concur on the following broad principles. An emphasis on helping to problem-solve and to achieve practical outcomes such as access to employment and education may be of as much benefit, if not more. Victims of torture may have co-morbid medical conditions which may mask psychological problems, and both will require treatment.

Sexual violence is a taboo subject in many cultures and, together with the distress the memories produce, victims of torture may be reluctant to talk about their experiences. The notion of disclosing personal experiences to a relative stranger (therapist, counsellor) is an alien experience for many refugees. Time is needed to build up trust, allowing the trauma story to emerge gently so that it becomes a familiar and comfortable theme rather than something shamefully hidden away. Disclosure is best managed when the social situation is stable and when both patient and healthworker are confident about managing the disclosures and the distress that will emerge.

The main aim of mental health and social services should be to provide psychological support, treatment and other support to the refugee patient to achieve basic goals and some