Perspective/Viewpoint

The Current Refugee Problem around the World: Implications for Social Psychiatry

Abstract

In the last 3 years, the numbers of forcibly displaced people around the world have reached a record high. Experiences of war, persecution, violence, torture, participating in killing, disruptions of attachments, and emotional losses increase the risk for psychological distress and may contribute to the risk of developing psychiatric disorders, especially in child and adolescent refugees. We briefly review the existing psychiatric literature on refugees, discuss sociological reasons that explain the recent crisis, psychiatric consequences, and long-term prognosis, and discuss the implications for policy, practice, and research.

Keywords: *Displacement, psychiatry, refugee, social*

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Introduction

Civilian populations are very often the victims of war, violence, and persecution. The number of refugees around the world is constantly changing, and developing countries were host to four-fifths of the world's refugees. By the end of 2016, 65.6 million individuals were forcibly displaced worldwide as a result of persecution, conflict, violence, or human rights violations.[1] That was an increase of 300,000 people over the previous year, and the world's forcibly displaced population remained at a record high. During the year 2016, 10.3 million people were newly displaced by conflict or persecution. This included 6.9 million individuals displaced within the borders of their own countries and 3.4 million new refugees and new asylum seekers. The number of new displacements was equivalent to 20 people being forced to flee their homes every minute. Children below 18 years of age constituted about half of the refugee population in 2016, as in recent years. Children make up an estimated 31% of the total world population, and the office of the United Nations High Commissioner for Refugees (UNHCR) estimated that at least 10 million people were stateless or at risk of statelessness in 2016.[1] However, the data captured by governments and reported to UNHCR were limited to 3.2 million stateless individuals in 75 countries, so the true total numbers are estimated to be higher. Developing regions hosted 84% of the world's refugees. The least developed countries provided asylum to a growing proportion, with 28% of the global total (4.9 million refugees). Refugees who returned to their countries of origin increased from recent years. During 2016, 552,200 refugees returned to their countries of origin, often in less than ideal conditions. The number is more than double than the previous year, and most of these refugees returned to Afghanistan (384,000). The number of new asylum claims around the world remained high at 2.0 million, and Germany was the world's largest recipient of new individual applications with 722,400 such claims, followed by the United States of America (USA) (262,000), Italy (123,000), and Turkey (78,600). Lebanon continued to host the largest number of refugees relative to its national population, where one in six people was a refugee. Jordan (1 in11) and Turkey (1 in 28) ranked second and third, respectively. More than half (55%) of all refugees worldwide came from just three countries: The Syrian Arab Republic (5.5 million), Afghanistan (2.5 million), and South Sudan (1.4 million). In 2016, the UNHCR referred 162,600 refugees to other countries

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for resettlement. According to government statistics, 37 countries admitted 189,300 refugees for resettlement during the year, including those resettled with UNHCR's assistance. The USA admitted the highest number (96,900). Unaccompanied or separated children, mainly Afghans and Syrians, lodged some 75,000 asylum applications in 70 countries during the year, although this figure is assumed to be an under-estimate. Germany received the highest number of these applications (35,900).[1]

Explanations for Forced Migrations

Refugees rarely have a choice in the decision to migrate; the most common cause of sudden flight is the targeting of an individual or a group due to their tribal, racial, religious, political, or ideological identity. This may result in their actual expulsion, or more often, the decision to escape is due to an attempt to avoid being arrested, segregated, tortured, or killed, sometimes in genocidal campaigns known as "ethnic cleansing." Sometimes, people are caught in the crossfire of wars and other conflicts that have little to do with who they are, and these individuals also seek safer havens in other lands.[2] In the 1960s, refugees were primarily produced by decolonization, revolutions, and proxy wars between the US and the Soviet Union, and this progressed into the mid-twentieth century. The global dynamics of forced migration changed in 1991 with the end of the Cold War. Instead of conflict between states, the underlying cause of most forced migration is now ethnic or religious conflict in fragile, failing, or failed states.[3,4] Currently, three-quarters of the world's refugees were to be found in nations neighboring their countries of origin, with more than half (55%) of all refugees worldwide coming from five countries: Afghanistan, Somalia, Iraq, Syria, and Sudan.[1] The case of Afghanistan is very important for debates about the causes of forced migration and its solutions. At its peak in the late 1990s, estimates suggest that about 8 million people, or one to two-thirds, or 64% of all living Afghans have been refugees at one point in their lives.[2]

Mental Health Difficulties in Refugees

A review of 29 studies involving 16,010 refugees of war found that (1) the high prevalence rate of depression, posttraumatic stress disorder (PTSD), and other anxiety disorders among refugees 5 years or longer after displacement, with prevalence, estimates typically in the range of 20% and above; (2) there were a number of unique risk factors for mental disorders which included higher exposure to traumatic experiences and postmigration stress, such as poor postmigration socioeconomic situation (unemployment, low income, poor host language proficiency, and lack of social support), was associated with depression and being a female refugee was associated with higher levels of anxiety, but not PTSD.[5] Other findings included that the risk of having a serious mental disorder is substantially higher in war refugees than in the general population, even several years after refugee resettlement, that among refugees of war was 14 times higher, and the risk of developing PTSD was 15 times higher than in the general population. In the case of child and adolescent refugees, many have been exposed to experiences of persecution, violence, war, killing, or torture as well as the subsequent losses, which increase the risk of psychological distress and psychiatric disorders. PTSD symptoms have been found in children exposed to persecution, war, and organized violence in many parts of the world, including Cambodia,[6] Rwanda,[7] Kuwait,[8] Palestine,[9] Afghanistan,[10] Bosnia,[11] and Cuba.[12]

Long-Term Prognosis

Psychiatric symptoms and mental health difficulties in refugees have been found to persist over many years. A small study of Cambodian children exposed to massive trauma found that 4 years after leaving Cambodia, 50% met diagnostic criteria for PTSD and 53% for depression.[13] Depressive symptoms tended to decrease over time but later increased again after 12 years.[13-15] However, certain investigators have cautioned that these studies describe children that suffered extreme trauma and privations and that the rates of recovery could be slower than in other less traumatized samples.[16] A different study with Iranian preschool refugee children found that symptoms decreased over 2½ years, but that after that period, 82% still had symptoms and 21% met diagnostic criteria for PTSD.[17] A study of Cuban adolescent refugees attending schools in the US after their release from refugee camps revealed that self-report measures of posttraumatic symptoms were elevated, yet the teachers in charge of the students were unable to detect any symptoms when rating these students with a standardized questionnaire.[18] These and other studies reveal that sometimes, child and adolescent refugees experience their symptoms silently, while other responsible adults, such as teachers or parents, are unable to detect their distress. The available research suggests that a long time after the events took place, many young refugees continue to suffer from distressing symptoms, especially those of PTSD. Despite these symptoms, considerable amount of research indicates that most people exposed to trauma recover naturally over time and do not report significant psychopathology.[19] Refugees, especially young refugees, also tend to function relatively well overall, both socially and academically.[6,18,20]

Implications for Policy, Practice, and Research

It is very likely that the numbers of refugees worldwide will continue to increase as a result of regional warfare and conflict, so it is reasonable to expect continued large numbers of refugees will continue to emigrate to the US and other developed nations seeking safety, security, and

freedom.[1] Mental health and support services are most effective in the context of a refugee and immigration policy based on rational national interests rather than on reactions to crises or to xenophobia. Part of such a policy should be to actively prepare all Americans for the demographic changes, resulting in increased cultural diversity, culminating in the lack of any numerical majorities by 2050. Refugees have historically been a significant proportion of the immigrant population in the US. Our nation should develop and implement resettlement policies and practices (in human services and education) that facilitate refugees in learning their new host culture while retaining the strength-based, adaptive aspects of their cultures of origin. The media and all institutions in civil society, including schools, churches, and volunteer organizations, should be recruited toward this important endeavor. Such public education efforts can support enhanced efforts toward proactive refugee services (including mental health services), preventive cultural adaptation programs, and community supports for all immigrant children and their families. International exchange of treatment models and techniques that are effective in diverse cultures and with special populations is also particularly important to disseminate and build upon the experience developed in the field with such models.

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Conflicts of interest

There are no conflicts of interest.

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