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Journal of Psychosomatic Research 138 (2020) 110260

Contents lists available at ScienceDirect

Journal of Psychosomatic Research

journal homepage: www.elsevier.com/locate/jpsychores

Editorial

Special issue flight and migration

This special issue focuses on the topic of flight and migration. The initial idea for this collection came from our symposion “Mental health of immigrants and refugees” in the 2018 annual meeting of the European Association of Psychosomatic Medicine (EAPM) in Verona - when Europe and the world focused their attention on the great challenge of refuge and migration. In the conversation after the symposion the editor in chief of the Journal of Psychosmatic Research, Jess Fiedorowicz, invited us to publish a special issue on this topic. Now the last articles have been reviewed and published finally and we are glad that we have given this space to the phenomenon of migration, one of the most important social developments in our decade, and thus supported the representation of this topic in academic research in psychosomatic medicine.

The authors of the special issue stem from seven European countries that have been confronted with the flight movements of recent decades namely Germany, Finland, Norway, Sweden, Italy, Turkey, Great Britain, and the United States of America. Many issues that have a crucial impact in the context of migration and flight are represented and discussed: Separation, representation of mental illness, trauma, politically motivated extreme violence and their impact on the course of migration. Let us take a look together at the articles from this special issue, organized thematically.

1. Separation

Two contributions deal with the direct consequences of separation. In their study on a cohort of 13,345 individuals born between 1934 and 1944 and separated temporarily from their parents in childhood during World War II Salonen et al. [1] show the detrimental effects of separation after decades. Longer duration of separation was associated with early exit from the workforce compared with people without separation experience.

Georgiadou et al. [2] analyzed the impact of separation in the context of Syrian refugees in Germany. They compared two groups of married Syrian refugees who arrived in Germany between 2014 and 2017. The first group lived together with their partners in Germany at the time of the investigation while the second were married but separated. The separated group of refugees reported significantly lower quality of life in the domains of psychological and social health, in comparison to the refugees who were resettled together with their partners.

Separation and attachement are crucial issues in the framework of migration. Firstly, migration is always associated with the loss of significant reference persons to whom the migrant was attached. Being separated from significant others, especially parents or partners may lead to a dysregulation of attachement. Research of recent decades shows that unsatisfiying attachment experiences in early childhood have a direct impact on the ability to mentalize, of pain perception, and emotional regulation (Feldmann) [3]. Ultimately, the mental health of the adult depends to a high proportion on sufficient attachement experiences in childhood (Vritica and Vuilleumier) [4]. In connection with the separation of parents and children, as proposed for immigrants on the borders of the United States of America by political decision-makers today, severe psychological consequences are to be expected. The mentioned articles in this special issue emphasize the evidence of this phenomenon in the framework of migration.

2. Special mental illnesses and illness concepts of immigrants and refugees

In a comparison of two samples of adult cancer survivors consisting of firstly labor migrants of Turkish origin living in Germany for 34.9 years and migrants of Polish origin with a length of residence in Germany of 25.2 years and secondly native Germans, Morawa and Erim [5] found no substantial differences regarding the risk of being depressed. This may show the effect of longer duration of stay in Germany that is associated with protective factors like good language proficiency, having acquired German citizenship/unlimited residence permit, which may contribute to eliminate inequalities in social life and also equalize the risk for depression. However, larger sample sizes with sufficient statistical power are required to replicate and secure this finding, as the authors state.

The working group of Renner et al. [6] analyzed illness representations of Syrian refugees in Germany who had received a residence permit after their flight in 2015. They reported hopelessness, fear, and worries, and mentioned numerous emotional symptoms in the context of war, indicating their awareness of mental health sequelae in the aftermath of acts of war, but post-traumatic symptoms were not mentioned. The authors conclude that illness represantations regarding post-traumatic stress are not available in Syrian refugees. Adequate psychoeducation should be offered to afflicted persons to enhance their understanding of their symptoms and to enable them to evaluate their own complaints. The findings of the last two groups on illness representations confirm assumptions that culturally different groups have different concepts of disease at the beginning of the adaptation process after migration, as in the example of the Syrian refugees in Germany. In the course of immigration, a convergence and alignment of concepts of disease can emerge like all other socio-cultural concepts. Putatively, Turkish migrants who have been living in Germany for decades may have adopted Western concepts of disease to some extent and they show similar risk of being depressed like the native Germans. On the other hand, we may assume that the risk of mental health problems are most relevant in the early phase of resettlement and decline over time after migration when adaptational stress decreases.

https://doi.org/10.1016/j.jpsychores.2020.110260
Received 22 September 2020; Accepted 22 September 2020

Rometsch et al. [7] investigated the somatic complaints and concepts of illness of female refugees who were captured as victims and experienced extreme violence by the "Islamic State". Pain was the main somatic complaint with a moderate rated severity, followed by feelings of suffocation and movement disorders in this cohort. Pain had a central position among the listed complaints, in a linear regression model, pain explained the variance ($R^2 = 0.325$) of the refugees' self-reported health-related wellbeing.

It is not surprising that this working group secondly reviewed the specific interventions for refugees with posttraumatic stress disorder and chronic pain. The results of the systematic review by Rometsch et al. [7,8] promise some initial hope for optimization in this academically neglected scientific field. Rometsch et al. show that cognitive behavioral therapy (CBT), Narrative Exposure Therapy (NET) with biofeedback, manualized trauma psychotherapy, Traditional Chinese Medicine (TCM) and Emotional Freedom Techniques were specific interventions resulting in positive outcomes for both in pain severity and PTSD symptoms.

2.1. Somatic distress

Mc Grath et al. [9] recall that cultural assumptions shape the manner in which distress is experienced and communicated. In a representative group of resettled Syrian refugees in Istanbul, they found that 42% of people were experiencing high somatic distress. Pain and fatigue as manifestations of somatic distress showed strong, positive correlations with all common mental disorders, cardiopulmonary symptom scores had strong positive correlations with depression and anxiety. The authors presume that the high levels of stigma concerning the use of mental health services observed in Syrian refugees may increase the tendency for people to show physical, rather than psychological symptoms. These results are in line with former findings of Escobar and Gureje [10] that somatization and somatic distress are universal phenomena, there are many similarities regarding the form and content of these somatic presentations across cultures, but there is also evidence for cultural patterning of symptoms. In any case, cardiologic symptoms in Syrian refugees often seem to be associated with somatization, and physicians in the host countries should be informed about this in order to support the patients and avoid unnecessary cardiologic diagnostic and therapeutic efforts.

3. Violence, trauma history and posttraumatic stress disorder

History of violence, trauma exposure and posttraumatic stress disorder were dealt with in several papers. In a group of 167 help seeking traumatized refugees, Heeke et al. [11] investigated the differences in prevalence rates of post traumatic stress disease when diagnosed according to DSM-5 versus ICD-11 model. They reported that the DSM-5 algorithm for PTSD identified significantly more cases (88%) than the ICD-11 criteria (80%). There was a high agreement between the diagnostic systems and comorbid depression was diagnosed with a high prevelance. Since the PTSD diagnosis is usually the ticket for the approval of psychotherapeutic treatment, this could constitute a disadvantage for refugees. As access to psychotherapy is generally more difficult for refugees, initiatives in research and health services are necessary to prevent a possible discrimination of traumatized refugees by the new diagnostic classification.

Sengoelge et al. [12] investigated the heterogeneity of traumatic events within refugee populations. Three profiles of trauma experience were recognized due to violence exposure. ´Multiple violent and non-violent trauma' 'witnessing violence and multiple non-violent trauma' and `low multiple non-violent trauma´. Across all three classes of trauma experience, living with a partner was associated with lower severity of mental disturbances regardless of trauma exposure classes, emphasizing the importance of social support. On the other hand, violence was a primary marker for higher likelihood of multiple trauma exposures and severity of mental health. The classification of Sengoelge et al. is commendable because it draws our attention to sociopolitical millieus in which trauma is not only personal fate but can become the experience of entire ethnic groups. When investigating the consequences of violence and traumatization, we should consider not only personal resources of the affected person but also the socio-cultural structure in which those live.

Rizkallaa et al. [13] conducted in depth interviews in 2014 with 24 Syrian female refugees living in sheltered homes in Jordan. The female refugees experienced extreme violence in the form of diverse war atrocities including shelling, loss of property, separation from family members, and threats to their lives and their beloved ones. The authors call the violence inflicted on those women, which is hardly comprehensible, "politically motivated". They use the method of qualitative investigation to give a voice to the heavy affects of loss, grief and anger among refugee women. The narratives of women also included sequelae to their physical and mental health due to such stressors. The authors work out gender specific factors of posttraumatic stress. The refugee women lived in close family and spousal relationships. In supporting each other they were at risk of secondary traumatization due to close emotional exchange. Finally, although it gives them protection in the first instance, the connectedness of women may also be a risk factor in the development of transgenerational transmission of trauma, as the authors discuss. As access barriers to health services also emerged in the narratives, the authors demand that humanitarian organisations and host counties optimize access for mental and physical treatment especially for female refugees.

Binder et al. [14] examined not the stress experienced by the refugees, but by their social workers. Social workers caring for women and children who had experienced extreme violence through the "Islamic state" reported as the most distressing factors working with interpreters and the exposure to trauma content. The most helpful factor named was communication skills.

The contributionsa of Rizkallaa and Binder show that we need new therapeutic methods not only in the treatment of the victims of violence but also in the emotional coping of the narratives of violence by the therapists so that secondary trauma and vicarious victimization are avoided as far as possible.

4. Postmigration adaptation process, resilience and stressors

Not only premigration traumatic experiences but also the risks and protective factors in the postmigration living situation were focused by the authors of the special issue. Kindermann et al. [15] investigated the trajectory of asylum seekers mental health as manifested in common mental disorders. Language proficiency, origin, religion and gender were stronger predictors of their mental health in the early stages of resettlement than emotion regulation and sense of coherence. Fino et al. [16] were interested in the impact of premigration versus trait resilience factors on the emergence of PTBS. They examined the impact of pre-migration war related trauma, duration of living in a camp and trait resilience on the manifestation and severity of PTSD. The sample under investigation consisted of 83 asylum seekers and refugees from the Middle East, living in a camp for an average of 23.6 years. Both premigration war related trauma and duration of living in refugee camp were significantly associated with PTSD. Trait resilience moderated effects of high-profile trauma exposure on PTSD severity, with higher resilience levels attenuating the effect of traumatic exposure on PTSD development. These results shed light on the ways that resilience can influence the relationship between war trauma exposure and PTSD symptoms.

When results of Fino and Kindermann are considered together, it can be assumed that the role of resilience or sense of coherence only comes into play after a longer stay in the host country, but in the first stages of adaptation specific social skills such as language competence have a greater impact on coping.

Another postmigration stress factor, namely secure residence status was investigated by Solberg et al. [17]. The prevalences of mental health disorders reported in the present study were higher and the associations between post-migratory stressors and mental health disorders appeared to be substantially stronger for asylum-seekers (in comparison to populations who have received resident permits). This result shows the detrimental effects of suboptimal postmigration living situation on mental well-being of refugees.

Jore et al. [18] investigated socio-cultural conditions after resettlement in regard of the emergence of social anxiety among 557 unaccompanied refugee minorsfrom 31 different countries.The effect of pre-migration traumatic events on social anxiety was non-significant while postmigratory perceived discrimination and majority culture competence had significant effects on social anxiety. The positive correlation between discrimination and social anxiety symptoms may as well be a a result of real discriminating actions from the environment, that enhances the fear of negative evaluations, which in turn leads to avoidant behavior.

These contributions deal with post-traumatic living conditions and represent a particular asset, since they remind us that the psychological traumatization of migrants and refugees did not only happen in a distant past and in distant regions of the world, but also in the present, in our Western countries. In the middle of our societies and in the present, we clearly have more opportunities to point out these psychosocial conditions and to change them, in this improve the quality of life and socio-cultural adaptation of migrants and refugees.

We are pleased to see that the health of migrants and refugees, a crucial and contemporary topic, has found its way into a special issue in the *Journal of Psychosomatic Research*. We embarked on this special issue at a time of global rises of violence at one hand and of xenophobic discourses at the other; when the Syrian civil war was driving thousands of people to Europe and the United States of America were adopting brutal policies of forced border separation of parents and children. Europe and the world were confronted with the no longer ignorable phenomenon of migration. The response of countries and their people has been variable and the crises triggered some anti-immigrant sentiments and policies while inspired others to attempt to meet the needs of these displaced communities. By shedding lights on the broad and unique health needs of these communities, may our collection of articles help to ensure that the extremely important issue of the (mental) health of migrants and refugees is not forgotten in the COVID-19 pandemic, where their needs, if anything, may be heightened.

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