

Prolonged Humanitarian Crises – Mental Health in a Refugee Setting at the Thai-Myanmar Border

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Since 1945 there is systematic research on the psychological impact of traumata in the context of war and forced migration on the affected populations especially concerning post-traumatic stress disorder and related disorders. The so-called Hill tribes of Myanmar, living as long-term refugees at the Thai-Myanmar border are facing destroyed expectations for a better future. Non-governmental organizations as well as responsible stakeholders in the self-organizations of the camps should be alert about psychosocial problems and their manifestations like domestic violence, suicidal ideations/attempts, drug and alcohol abuse as well as social withdrawal. The mental health service should be encouraged to focus not only on sickening and the negative coping with stress and the feeling of uselessness, helplessness, hopelessness, but on salutogenetic aspects of mental health and psychosocial problems and the way people are coping with in a positive way. Resilience is a factor, easily overlooked by health care providers, especially in situations, which make people depending on help.

Keywords: *Resilience, Long-term refugee settings, Mental health, Humanitarian aid*

Introduction

The aim of this article is to describe the specific situation of a displaced ethnic group in a remote rural area in Southeast Asia, with focus on the mental health of those affected, the risk factors that arise due to the living situation and the existing resources and resistance factors acquired during the displacement. The article presents interventions that are supposed to improve the mental and general health of the affected population and would like to point out possible difficulties in working with them.

The structure of this article is as follows; in the first part, a brief overview of global perspective on mental health in humanitarian crises is given. The following is a description of the specific setting at the Thai-Myanmar border - with an overview of the living conditions of the Karen ethnic group, to which this article is dedicated. The first part ends with a description of the procedure.

Then it is introduced the topic of mental health in general and in refugees, followed by a description of the mental health in the refugees in the camps at the Thai-Myanmar border. Furthermore, psychotherapeutic interventions in post-traumatic stress disorders (PTSD) and related disorders and the role of expectations and causal-attribution in mental health are discussed. The second part concludes with an analysis of the sustainability of Mental Health Psycho-

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social Support (MHPSS) services. The mentioned observations are discussed and the article closes with the conclusion.

The Global Perspective on Mental Health in Humanitarian Crises

Since 1945 there is systematic research on the psychological impact of traumata in the context of war and forced migration on the affected populations. Main disorders are anxiety disorders including phobias, and its special form of occurrence: PTSD; depressive disorders (withdrawal, apathy, guilty feelings); suicidal thoughts and attempts; anger, aggression and violent behavior (often towards spouse or children); drug and alcohol abuse; (jealous) delusions; mistrust; hysterical symptoms; somatization disorders and insomnia.

In the course of the Vietnam War, the interest in mental health grew – not only regarding the refugee populations but especially in the US health authorities, being confronted with returning traumatized combatants. Starting from 1975, around 3 million Vietnamese boatpeople found a home away from home in western countries, but the conditions for refugees have continued to worsen since then (Jablensky et al. 1994, Kinzie and Boehnlein 1989, Kinzie et al. 1990, Kinzie and Jaranson 1998, Krupinski et al. 1973).

Nowadays a refugee is waiting an average of 18 years in a refugee camp (Milner 2012) with the young generation does not know a different existence than being a refugee. Dadaab, a vast refugee camp in Kenya is the worst example of long-term detention, as it houses families that have been sequestered in a remote and insecure location for more than three generations (Silove et al. 2017). It is estimated that half of the world's over 65 million people who are forcefully displaced from their homes as internally displaced persons (IDPs) within their countries or refugees who have crossed an international border, remain in "protracted situations," unstable and insecure locations, most commonly in dense urban areas, but also in refugee camps, increasing often for a long time.

The so-called Hill tribes of the northern and eastern regions of Myanmar, the former Burma, are only another not so well-known example of a prolonged humanitarian crisis. Other refugees from tribes such as the Shan, Karenni, and Karen are living as internally displaced persons in Myanmar for about 3 decades or have been forced to migrate across the green border into Thailand.

The Setting at the Thai-Myanmar Border–The Displaced Population of the Karen

Since 1976, the civil war between ethnic minorities and the military regime in Myanmar (Burma) has resulted in a mass influx of refugees and migrants into neighboring Thailand, Bangladesh and India. Flight to these countries continues for those forcibly expelled from the conflict zones. Approximately 100,000 refugees live in nine refugee camps (by the Thai government referred as temporary shelter (<https://www.burmalink.org/background/thailand-burma-border/displaced->

in-thailand/refugee-camps/) along the Thai-Myanmar border (TBC 2018), with the Karen People as the largest ethnic group, comprising 80.1% of the total population).

About 30% of the population is young people between 10–24 years who have grown up isolated in this closed setting and with little access to the outside world, information, education and a notable aid dependency as well as facing boredom, an unclear future and unhappiness. Formal education is limited to ten years of schooling, while job opportunities and access to universities as well as other forms of higher education are very limited. Traditional social norms and religion (Burmese Theravada Buddhists, Christian or Animists) do strongly influence the daily life and behavior of the refugee population (Benner et al. 2010).

The refugees are fully depending on Thai and international support for shelter, food, education, water/sanitation and health services, while income opportunities are limited (Benner et al. 2008). Malteser International (MI) has a long history of working in Asia and has been implementing a health project for Karen and Myanmar refugees along the Thai-Myanmar border already since 1993, funded by the European Union (Europe Aid and European Commission Humanitarian and Civil Protection Office).

A comprehensive Primary Health Care project was implemented with curative, preventive and promotional components. The aim was and is to limit the risk of epidemics, reduce mortality and morbidity and if needed and feasible strengthen further the capacity and capability of the camp community for self-reliance and sustainability, once the people return back to Myanmar. Since 2004 resettlement to different countries like US, Canada, Norway, Australia, is taking place, not only providing a chance for registered refugees to leave the camps, but also aiming at a reduction of the camps' population. Since several years, refugees are encouraged to repatriate, i.e., the (voluntary) returning to (former villages in) Myanmar. One of the greatest obstacles the refugees are facing when returning to their home country or being resettled is the fact that they have to be self-reliable and stand on their own feet. This special condition of "imposed helplessness" is the result of the increased humanitarian assistance started in the mid-nineties to support the increasing number of refugees to ensure sufficient services and to avoid disease outbreaks (Benner et al. 2008). However, there are different ways to cope with these uncertainties by considering the sociocultural and religious background of the Karen People as traditional social norms and religion strongly influence the daily life and behavior of the refugee population (Keenan 2010, Benner et al. 2010). The majority of Karen in Myanmar is Theravada Buddhists, who also practice animism, while approximately 35% are Christian (Karen Buddhist Dhamma Dutta Foundation 2010).

MI is providing health services as well as the covering the water and sanitation needs (including waste management) for two camps: Ban Mae La-Oon (MLO) and Mae Ra Ma Luang (MRML). MLO camp is located in Sop Moei district about 80 km south of Mae Sariang (the base for Malteser International), about 5 km from MRML camp and about 4 km from the border to Myanmar. The camp is located in a degraded, hilly environment, with one access road. The population was up to 17,000 and is now at 11,700 (2018), mainly from Papun township. MRML camp is located in Sop Moei district as well, about 75 km south

of Mae Sariang, located in a similar setting like MLO camp with equally difficult access during the rainy season. The camp is accessible via two roads. The camp is spread over an area of approximately 4 km along the Yuam River. The population was up to 17,000 in 2009 and is currently 13,000 people (2018).

The United Nations Refugee Convention (1951) and later Protocol (1967) proclaimed that host countries have a responsibility to provide "favourable" conditions for refugees, including, *inter alia*, the right to work, to freedom of association and movement, and to appropriate services.

The large exodus of Southeast Asian refugees in the 1970s and 1980s created a new challenge for the Convention (Ghosh 2016). The willingness of recipient countries to accept refugees was and is not only in Europe inversely related to the rate of influx and ethnic and religious difference of the incoming group (Joly 2016). This, and additionally due to experience with the preceding influx of the refugees of Vietnam, Cambodia and Laos, the difficulties of the Thai government to handle the situation along their Burmese border properly, is at least somewhat comprehensible. In consequence of the Thai as well as Burmese politics, refugees were made to the problem and not to a part of the solution.

The policies applied to refugees by host countries are crucial to the mental health of that population. It had never happened that the Karen refugees were integrated into the Thai national health system, although the refugees have been living on Thai soil since the 90s of the last century, a precondition for making the humanitarian system relevant for future public health responses (Spiegel 2017).

Mental Health in Refugees

Since 2000 approaches to a better integration of mental health services into the general health sectors had been named, like using the schools for promoting mental health, integration of mental health services within the Primary Health Care System, inventing urban based programmes like the Healthy City projects, the introduction of psychiatric wards in general hospitals or the replacement of large hospital for mental disorders with community mental health centres (Mohit 2001). Against the background of the importance of mental health for refugees, a wide adoption of influential policies and guidelines that assist the planning and implementation of programs, for example, the Inter-Agency Standing Committee (IASC) Guidelines for Mental Health and Psychosocial Support in Emergency Settings and the SPHERE handbook had taken place (Batniji et al. 2006, IASC 2007). A further major achievement has been the clinical guidelines produced by the WHO's mh-GAP, especially the module focusing on emergencies (WHO 2015, WHO 2013). Disregarding its efficiency in acute humanitarian crises, the mh-GAP always has to be contextually and culturally adapted to local needs.

This also applies to prolonged humanitarian crises. Here, under confined conditions, with a prospectively unclear ending, the coping mechanisms of the affected population become exhausted over the years, as it is known from to some extent comparable settings like the in Palestinian refugees (Afana et al. 2004).

Traumatic events such as war, displacement, loss of loved ones (negative life events) or stress in daily life can trigger this predisposition (or "weak points") for mental disorders like psychosis (schizophrenia or major depression or mania) or can cause milder forms of mental disorder (without psychotic symptoms) like minor depression, anxiety, and others. But: "the depressive syndrome represents a small fraction of the entire field of depressive phenomena. It is a cultural category constructed by psychiatrists in the West to yield a homogeneous group of patients." (Kleinman 1977). Mental health has to be considered as being deeply interwoven with economic and political concerns, such as poverty, hunger and malnutrition, violence, social change and dislocation (Desjarlais et al. 1995). It is needless to mention that mental health mirrors to a large extent "healthy" social (and environmental) conditions.

Subject of mental health is behaviour of people. Ultimately the doctors/medics task is to answer the question: "Is this behaviour normal?" This question lies at the heart of cross-cultural psychiatry, which must determine normality in its cultural context.

Compared to the common infectious diseases in the study area, which can mostly be cured by modern medicine, mental health disorders are often persistent and sometimes require lifelong treatment, particularly for high levels of symptoms of PTSD, major depression, schizophrenia etc. These disorders regularly require a combination of medical, psychological, social, and legal intervention. In order for mental health care to be effective, it is essential that primary health care serve as the main health service infrastructure. The challenge is to orientate and train primary health care workers in mental health skills and services, including diagnosis and therapy. Mental health services should be closely coordinated with general health services, psychosocial services, and other relevant rehabilitation, social, educational, occupational, cultural, and recreational activities. Mental health services should be community based, and, wherever possible, focus on early intervention at the primary and later at the secondary and tertiary levels of prevention (Patel 2002).

Too often, medical anthropologists and sociologists accuse psychiatrists of transforming social problems into medical conditions. Yet social scientists who place illness entirely in the social realm deny the personal dimension, the personal experience of suffering (Kleinman and Kleinman 1991). Confessing that there are improvements in these areas, still the problem of acceptance of all of these approaches by the refugee population is unsolved. Only a holistic approach in mental health, which encloses apart from the bio-psycho-social sides and other additional dimensions, like cultural and spiritual can increase the understanding on both sides of the table.

Refugees are particularly at risk of developing mental disorders due to traumatic pre-migration experiences and events while migrating, like the loss and separation from related people and the hardships while migrating and when finally arriving at a host country. The threat or loss of the security system, in terms of its own physical integrity or that of loved ones, makes it even more difficult to stay mentally healthy (Lipson 1993, Ekblad and Silove 1998). Further factors associated with poor mental health amongst refugees include beside socio-

demographic characteristics and stressors in the post-displacement environment, the circumstances of prolonged detention, insecure residency status, challenging refugee determination procedures, restricted access to services, and lack of opportunities to work or study. All these straits are capable to compound the effects of past traumas in exacerbating symptoms of PTSD and depression (Silove et al. 2017). In refugee settings, the loss of human rights by threatening fundamental rights as there are arbitrary or unjust treatment, prohibition of expression or belief, persecution, use of force, torture is accompanied by the elimination of stable social framework. The meaningfulness of life is questioned, leading to existential crisis of meaning, as well as to endangerment of individual and social identity.

According to the International Classification of Diseases (ICD-10), the PTSD (F43.1) has to be diagnosed when the onset of symptoms occurs within 6 months after the traumatizing event. A "probable" diagnosis can be made even if the interval is more than 6 months, provided the clinical features are typical and no other diagnosis can be made (anxiety, obsessive-compulsive disorder or depressive episode). In addition to the event of a trauma typical additional symptoms are repeated inescapable memory or re-enactment of the event in memory, daydreaming or dreams (flashback); significant emotional withdrawal, emotional numbing, avoidance of similar stimuli are common, but not essential for the diagnosis. In the case of persistence of complaints, the diagnosis of a persistent personality change after extreme stress ICD-10 F62.0 should be applied, which is defined by new arising symptoms and persisting for at least 2 years in the person concerned. The severity of symptoms of PTSD patients correlates with the number of traumas suffered (Smith-Fawzi et al. 1997, Mollica et al. 1997).

The body of research conducted after disasters in the past three decades suggests that the burden of PTSD among persons exposed to disasters is substantial. Post-disaster PTSD is associated with a range of correlates including sociodemographic and background factors, event exposure characteristics, respective scenarios in crises, war and flight/forced migration, social support factors and personality traits. Relatively few studies have employed longitudinal assessments enabling documentation of the course of PTSD. There are no universal valid data on the prevalence of PTSD and other trauma-related mental health disorders. The frequencies of PTSD after following scenarios are 50–65% after direct war experiences with personal danger; 50–55% after rape and sexual abuse; 3–11% after traffic accidents; approx. 5% after natural disasters, fire, and fire disasters; and 2–7% in witnesses of accidents and violence (Neria et al. 2008). The prevalence of PTSD in refugee camps had been located between 4% and 20% (Silove 1999), in earlier studies up to 50% (Kinzie and Boehnlein 1989, Mollica et al. 1993), while recent studies yielded a prevalence rate for PTSD to 15%, correcting the tendency to regard all refugees as "traumatized" and in need of counselling (Priebe et al. 2016) Actually, it seems not possible to specify an empirical criterion by means of which traumatic and non-traumatic life events can be differentiated (Dobricki and Maercker 2010). Sack (2004) suggested the complex PTSD, which includes disturbances of affect-regulation, sexuality, self-perception, relationship formation, dissociative symptoms, somatization, changing

personal beliefs and values, should be taken into consideration. The proposal of a complex PTSD category that comprises three clusters of intra- and interpersonal symptoms in addition to core PTSD symptoms by Karatzias et al. (2017) will be included into the ICD-11.

Failure to include indigenously derived measures that capture local expressions or idioms of distress also can lead to the under-enumeration of mental health problems (Kaiser and Benner 2003). To estimate the need for mental health services needs also to bear in mind that due to stigmata, there is an underreporting of mental and psychosocial problems, and help-seeking behavior. Mistrust in western mental health specialists and lack of knowledge of services may limit the extent to which refugees access mental health services, even if available. The sources of cultural and individual identity have to be taken into consideration (Groen et al. 2017), as these are typically endangered in prolonged crises. Particular men define themselves over income or the ability to feed and care for their families. In a refugee setting the role/position within the family, the social status in the community and the entire social context with changing of internal and external values of an ethnic group due to the close contact with members of foreign cultures and the dependence on them can be severely threatened.

Mental health services are lower in developing than in developed countries, as the proportion receiving services tended to correspond to countries' percentages of gross domestic product spent on health care (Wang et al. 2007). The main reason for this is the scarcity and inequitable distribution of services, but other factors contribute to the situation, including difficulties in coordinating national and international efforts, barriers to accessing care even when services are available, and persisting stigma associated with being both a refugee and mentally ill (Silove 2005). However, the evidence base for MHPSS interventions in stable settings is generally weaker than for the other topics like infectious diseases and so it is less possible to generalize findings to crisis-affected settings (Blanchet et al. 2017). Therefore, a substantially greater number of MHPSS intervention studies are required from these settings (Tol et al. 2011). Most studies focused predominantly on psychological interventions (for PTSD, in particular). Particular disorders that seem to be neglected include alcohol and other substance use disorders and there is also very little evidence on how interventions influence overall functioning (as opposed to specific mental disorders) (Porter and Haslam 2005). The same can be said about other stress-related behaviors like aggression (especially in the form of domestic violence) and social withdrawal. Only a small number of studies have followed up refugees for 10 years or longer, in all instances being limited to the measurement of general symptoms of anxiety and depression using screening instruments (Hauff and Vaglum 1995, Lie 2002, Beiser and Hou 2001).

Mental Health in the Refugees in the Camps at the Thai-Myanmar Border

The basic idea, the aim of the article is to point out the meaningfulness and necessity of MHPSS in settings like the one described. Especially in long-term refugee settings, after extensive control of communicable diseases, consideration

of mental health is of great importance. Up to 2015, the psychological state of the presented population was paid less attention, apart from data on suicidality. For this reason, the data situation is scarce, so that the primary concern here is to point out the shortage and to induce a corresponding awareness among the organizations active in the health sector.

This section describes the way data on the mental health in the refugees in the camps were gained, and what procedures were implemented to improve the health conditions.

Health indicators should give reliable information about the conditions of the health sub-sector it covers. The indicators may be the result of quantitative and/or qualitative methods of evaluation and monitoring. The more quantitative data are available, the better the indicators can be compared to other data collections in other settings or of other cohorts.

Until recently (2015) no data were collected on mental health beside suicide rates in the both temporary shelters supported by MI. This neglect can be explained to some extent by lack of interest in donors, no trained health workers and doctors, preoccupation with others, more obvious health problems like infections, hygiene, mother and child health, and underreporting of mental health disorders due to stigmatization.

In this setting at the Thai-Myanmar border, from relevant mental health indicators like suicide rates, prevalence of psychosis and other mental disorders, drug and alcohol consumption (and related morbidity and lethality), domestic violence, prescription of psychotropic drugs etc., only data on suicide rates, recently implemented mental health services and the results of a KAP-B-Survey are available. There is probably an underreporting of domestic violence to the health services, and there was an underreporting of mental disorders, caused to the classification of these diseases under the category of "chronic disorders" before training took place in 2015.

The Health Information System (HIS, version revised January 2010) is designed to monitor primary health care services in a protracted refugee context in order to be able to detect epidemics and outbreaks early. Beside general reports on morbidity and mortality, several other, more specific HIS-data-reports like Injury Report, Nutrition Report, HIV/AIDS-Report etc., including a report on Mental Illness are generated with a special HIS toolkit. The data collection should get an overview on the psychosocial condition of the screened population. As mentioned, until 2015, mental health was not in the focus. Further reasons, why prevalence of moderate mental disorders (moderate depression and anxiety) can only be estimated, is underdiagnosing, as somatisation is quite regularly a way to cope with mental problems. In contrast, patients with acute episodes of psychosis like schizophrenia, are predominantly brought to Outpatient Department (OPD) and therefore detected. Contradictory to the former prevalent idea, that the prevalence of schizophrenia is worldwide more or less the same, schizophrenia and other psychotic disorders can be triggered by stressful life-events. It is known that these are more prevalent amongst refugees, resettled in high-income countries compared to other immigrants and host populations (Hollander et al. 2016).

According to the data for quarterly reports to the Thai Ministry of Interior (Health Care Project for Uprooted People in Sob Moie District, Northern Thailand) and annual reports to ECHO (European Commission Directorate General for Humanitarian Aid: Health Project for Karen and Burmese Refugees along the Thai-Myanmar Border), between 2006 and 2009, the suicide rates varied in both camps between 0 and 4 per camp per year. Regarding the population of MLO with 11,700 refugees and MRML with 13,000 refugees respectively, the annual suicide rates between 2010 and 2016 fluctuated between 1 case per year (equivalent to 10 per 100,000) and up to 9 casualties per year, corresponding to 77 in 100,000), with an increase in the last 2 years. In comparison: the suicide rate worldwide in 2015 was 10.7 per 100,000. Thailand had a suicide rate of 6.8 in 2014 (7.8 in 2002), while Germany had a suicide rate of 12.5 (in 2013) (WHO 2018).

Due to the small total population in the camps and confounding influences (frequent drowning cannot be differentiated, whether it was an accident or suicide), the data on suicides should only be carefully interpreted as indicator of a deteriorating mental health situation – despite the MHPSS trainings which had taken place the last 3 years in the camp. Part of the staff estimates that there is even an underreporting of suicidal attempts due to shame. The problem of rising numbers of reported suicides in the 9 refugee camps along the Thai Myanmar border was even worth an article in the Bangkok Post 2017 quoting, that "family problems were a factor in nearly half of suicides. Alcohol and substance abuse played a role in more than a third." (Bangkok Post 2017).

As the data on suicide have to be interpreted very carefully, it cannot be stated, that these suicides are a sign of loss of hope, as the motivations are not always well known, and are frequently related to family-problems. Religions in general are promoting life (at least the life of their followers), therefore condemning suicide. It can only be speculated, that religious belief in the camps has a preventing impact on the decision of the individuals to end one's life. May be without the reported strong belief, even more people would commit suicide.

Beside the data on prevalence and incidence of mental disorders, further indicators are the quality and quantity of MHPSS provided by trained helpers including campaigns to raise awareness and tolerance as well as the knowledge on this subject in the population.

In 2015 and 2016 the first one week-trainings in mental health services and psychosocial support for the medical staff by the author, a psychiatrist and psychotherapist, took place, aiming to improve psychosocial wellbeing of refugees. MHPSS-counselors in the camps did receive a 3-months training in practical work and 15 days in theory. It was intended that the camp-based psychosocial counselors conduct counseling to clients with anxiety, minor depression and other minor psychosocial problems, when they got aware of the existence of the problems, i.e., the patients did show up at the service facilities. Before the training, health workers (medics with at least 6 months of training, and primary health workers with a 3 months medical education), had difficulties to apply a differential treatment scheme in epilepsy and psychosis patients and in general, the medical staff had no skills on diagnosis and management of non-

psychotic mental illnesses such as anxiety, moderate depression, emotional disorder, mental retardation, developmental and behaviour disorder, problem with alcohol and drug use, posttraumatic stress disorder, self-harm/suicide and medically unexplained somatic complaints. For people with psychotic disorders and epilepsy, OPDs started to open once a week at MI hospitals, and since 2015 regular psychosocial counselling services for people with non-psychotic and psychosocial disorders are implemented (main reasons for counselling are epilepsy, depression, alcohol abuse). Thai residents from neighboring villages have free access to health care services inside the camps whenever needed, in 2009 e.g., 4.2%, of all patients in the OPD have been non-refugees, in Inpatient Department (IPD) admissions of non-refugees amounted to 9.6% of all patients, consultations due to mental health problems are mainly patients with psychotic episodes.

Admittedly, the brain-drain of trained staff jeopardizes sustainable MHPSS, and the planned supervision of the counsellors was not performed on a regular base as scheduled until 2017.

Considering information of section leaders, camp committees, medical staff, it can be assumed that there are a lot of yet undiscovered cases with severe psychosocial problems in the camp, and that some of them are detected but due social reasons are not reported to the medical service. There exists an information-gap between the MHPSS-services offered by MI, and the knowledge, the refugee population has on these services. As there are still stigmata on mental disorders (psychosis) and other deviations in the community, no well-established official referral system for psychological patients between community and clinical services does exist. The different health seeking behaviour (people prefer to consult traditional healers in these kinds of disorders), has its impact too. Independent of this, caregivers seem to be in need of information how to deal with their sick ones.

To identify existing resources, a KAP-B-survey (knowledge, attitude, practice and behavior), was carried out in 2017 (Zwang 2017). It revealed, that current challenges reported regarding a potential return to Myanmar are livelihood/income opportunities, land ownership, security, and health access, making these concerns to major stressors for the refugees. Recently reduced food rations and the increase of expenditure for education by the Thai government and its applied pressure on the refugees seeking repatriation have an additional impact. Post-migration stressors which are typical in long time refugees such as lack of freedom, scarce job opportunity/no income, housing problems, lack of safe environment, and family separation have to be added to the problems (Porter and Haslam 2005, Carswell et al. 2011, Kaiser 2010). The conflicts in family are prominently stressful for all. All these influential factors have an impact on psychosocial wellbeing and demand for reaction. Consequently, leading to a combination of worries, anxiety, depression, suicidal ideas and possible but detrimental ways of coping like alcohol drinking and domestic violence, social withdrawal (Kaiser 2005).

As it is known that religion –or more precise– religious or spiritual belief can increase resilience and as religion plays a major role in coping with all kinds of

stress in refugees (Kaiser and Benner 2003). The KAP-B-survey was also carried out to get a clearer idea about the influence of religious belief in the refugees living in the camps. The survey revealed, for the majority (53%) of the respondents (statistical representative for the whole camp population), "my spirituality" was the strength to help them to cope with their situation, followed by "my family" (23%). Migration (in contrast to the "forced" migration which had led the refugees to the camps years before) has become a major strategy to access sources of income that can no longer be generated at home. This strategy is especially prevalent among young people who traverse the borderlands in search of illegal jobs in factories and as maids in Bangkok and other towns of Thailand. Even for young migrants, religion is an important resource, spiritually as much as materially, and plays a key role in their itinerary. Migrants and refugees often depend on religious networks to support them in their new places of residence to procure jobs, lodgings and a community (Horstmann and Cole 2015).

Psychotherapeutic Interventions in PTSD and Related Disorders

Evidence-based traumatherapy procedures from the area of trauma-focused cognitive behavioral therapy (TF-CBT) (in contrast to non-trauma-focused) and Eye Movement Desensitization and Reprocessing (EMDR) are successfully used in numerous different settings (refugee camps, prisons, crisis intervention centers and inpatient and outpatient treatment facilities) and are the gold standard in the treatment of PTSD (Foa et al. 2009, Schauer et al. 2005, Bisson et al. 2007). Trauma-focused cognitive behavioral therapy is based on the principles of cognitive behavioral therapy and usually includes central trauma-focused techniques like imaginative exposure related to trauma memory, narrative exposure, in vivo exposure and/or cognitive restructuring related to trauma-related beliefs. The best investigated specific approaches within TF-CBT include prolonged exposure, cognitive processing therapy, cognitive therapy according to Ehlers & Clark, narrative exposure therapy. Non-trauma-focused interventions: These are defined as therapeutic approaches, the main focus of which is not on processing the memory of the traumatic event and / or its meaning. Instead, the focus of these approaches is on teaching emotion regulation skills, dealing with post-traumatic stress symptoms or solving current problems (Schäfer et al. 2019). (EMDR) is a trauma-focused intervention that, after a structured focusing process, leads to an associative process. Both are accompanied by rhythmic hand movements performed by the therapist (Shapiro 2018).

Brief, structured, manualized psychotherapeutic procedures (mainly trauma-focused cognitive behavioral therapies, often in combination with body and mind-awareness exercises) – have been designed for use amongst refugee and post-conflict populations (Hinton et al. 2013).

Nevertheless, one should be very careful when transferring Western diagnostic categories such as PTSD as well as associated trauma-focused therapies to the culturally distinct environments in which most refugees live (Summerfield 1999).

Refugee research to date has predominantly focused on factors that make refugees more vulnerable for developing PTSD and/or psychological distress. Few papers have studied potential protective factors such as resilience. Especially against the background of insufficient psychosocial care, the importance of residence factors and sources of strength on the part of those affected must be emphasized. Not taking these into account and not promoting them would have an even more negative impact on the mental state of those affected. Therefore, more attention needs to be paid to this aspect of mental health.

Within the framework of war and trauma, resilience can be defined as personality traits that help protect against the psychological disorders resulting from exposure to terrifying incidents, such as mass violence or deportation under life-threatening circumstances; it encompasses bouncing back and positive adaptation in the face of safety-challenging experiences (Arnetz et al. 2013, Edward and Warelow 2005, Hoge et al. 2007, Charney 2004) and it explains how a victim of violence can deal positively with past traumatic experiences (Lee et al. 2008, Sossou et al. 2008).

Resilience is associated with less trauma-related psychological distress and should be considered in assessing risk and protective factors among victims of war-related violence. Studies could demonstrate that regardless of migrant status, pre-migration exposure to violence is a significant predictor of both psychological distress and PTSD symptoms. However, resilience is a significant inverse predictor of psychological distress, but not of PTSD symptoms (Arnetz et al. 2013). In this study, the effect of pre-migration trauma was not mitigated by the time elapsed since the event, confirming the findings by Marshall et al. (2005), who reported high levels of psychopathology among Cambodian refugees 2 decades after migration. However, they contradict other previous research (Ehlers and Clark 2003), suggesting that symptoms of PTSD would diminish with time. Items of the used resilience scale reflect the positive and non-passive responses to traumatic events and that participants' high resilience was associated with lower psychological distress. A different study (Holtz 1998) compared Tibetan refugees exposed to torture with a control group of Tibetans without a history of torture and found significantly higher anxiety scores among the torture-exposed. The author concluded that a number of factors such as commitment, spirituality and preparedness foster resilience against psychological distress.

A resilience-oriented rather than a symptom-oriented approach, putting more emphasis on studying the protective and recovery-fostering individual assets rather than focusing on illness-expectancy is what is needed with the large numbers of re-settlers and asylum-seekers arriving from conflict and unstable zones. Therefore, one could recommend studying resilience in prospective research of refugees and immigrant populations who are also likely to face large number of post-migration traumas.

According to the ADAPT (Adaption and Development After Persecution and Trauma model (Quosh 2013), 5 essential psychosocial pillars are disrupted by conflict and displacement, that is, systems of safety and security, interpersonal bonds and networks, justice, roles and identities, and existential meaning and coherence. Psychosocial interventions should therefore help to increase the

capacity of refugees to restore their lost resources, especially their perception of self-efficacy, the therefore necessary supportive social environments are partly provided in the camps, but uncertain in the future settings back home in Myanmar.

Therefore, appropriate therapeutic interventions have to consider the comprehensive perceptions of the refugee experience and follow a multisystem approach, taking the ecosocial framework into account (Bronfenbrenner 1992, Hobfoll 1989, Miller and Rasmussen 2017). Sociotherapy seems to be one of the few well researched group-psychosocial interventions (Richters et al. 2008), the primary focus being the fostering of connections between people. Groups share and discuss daily problems ranging from interpersonal disputes, feelings of marginalization, and strategies to deal with gender-based violence and poverty at the community level.

In the Karen refugees as well, problems are discussed within their community, nevertheless respecting the multitude of taboos, subjects in eastern shame cultures, which emphasizes the blame of the social group rather than of the individual. Implemented group counselling sessions have been very well accepted by the community, the people did appreciate that they could talk about their problems even it was recommended to do the group counselling separated into female and male group.

A further approach of therapy has been applied to Karen refugees as a way of trauma healing and conflict transformation: Storytelling-workshops. The idea was that through mentalizing what is meant by peace, i.e. storytelling as a means to elicit the Karen refugee's ideas of peace. The participants should become aware not only of their confined situation, but of ways out. Another important point was the communication between the members of the storyteller-groups. It has to be questioned whether this approach did have a direct impact on coping but as means of collective conceptualizing what should be in the future the participants could profit (Fuentes 2016). It could be revealed that the overarching notion of peace for Karen refugees is that peace is encompassing. The massive effects of war and displacement on the Karen community made them describe peace as an all-embracing reality that is both personal and social, with economic, political, and psycho-cultural components.

Like all other productions and consequences of culture, storytelling can be a means through which community is constructed. It also enables them to use these stories as bases as they articulate their vision of peace based on their current situation. Rough storytelling, groups and societies create, recreate, and alter social identities, knowledge, memory, and emotion. At least two theories informed the facilitation of storytelling work-shops. One is Freire's (2000) theory of literacy by which every human being (no matter what context he or she is from) is capable of being engaged in the world in an interactive encounter with others. Freire calls this a dialogical teaching/learning process, that is, a process of learning and knowing that invariably involves theorizing about people's experiences shared in the dialogue or in the interactive process. The other theory, person-centered theory, suggests that human development is an ongoing process. Individuals belonging to a community change and adapt to meet the demands of their environment. It means that people have the capacity to learn from experience, changing and

growing through creativity and openness to experience (Fuertes 2004).

The KAP-B-Survey (Zwang 2017) could show a high degree of perceived dependency on help: 38% of the respondents did not have income and totally rely on temporary shelter services. However, 14% had a small shop, sell vegetables or other income through livelihood activities, 12% had a family member working, 15% of the respondents had another activity consisting in weaving, teaching or in a lesser extent raising pigs. Women were more engaged in positions with non-governmental organizations (NGOs) generating an income (13%) than male respondents (4%), this frequently generating problems in the adult family members, realizing or assuming a damage to their role as the head of the household. Alcohol misuse, domestic violence and depression may be the consequences.

The Role of Expectations and Causal-Attribution in Mental Health

The individual worldview determines the way processes of illness and healing are explained – mental health practitioners should keep this in mind and should as well reflect their own view on pathogenesis.

Expectations are defined as cognitions which are future-directed and focused on the incidence or non-incidence of a specific event or experience (Rief and Glombiewski 2017, Rief et al. 2015). Expectations about treatment success are the most prominent predictor of outcome, both in psychopharmacological and psychological interventions, and they are considered to be a major determinant of placebo effects (Schedlowski et al. 2015). In the treatment of mental disorders, examining and modifying patients' expectations, is discussed as a central mechanism of change (Craske et al. 2014, Craske 2015). This focus on expectations does not disregard any past experiences, but considers them only of relevance if they determine predictions about future events. Neurobiology and psychological sub-disciplines such as developmental psychology and social psychology have focused on expectations for decades. Expectations lead to brain activities that sensitize for the expected experience (Koyama et al. 2005), and they are closely linked to affective reactions (Schwarz et al. 2016). Associative learning, influences via group norms and media, and the phenomenon of sticking to expectations despite expectation violations (cognitive "immunization") are psychologically relevant concepts to better understand why specific expectations are present. Some mental disorders are "expectation disorders" by definition. This is particularly so in the case of anxiety disorders, such as phobias. In these cases, patients expect adverse consequences when being exposed to specific stimuli, situations, or experiences (e.g., the phobic stimulus, the experience of palpitations).

The role of expectations in PTSD seems to be more complex. While most people feel secure and do not expect horrible events, this basic confidence in everyday life situations is violated if people suffer from trauma (Janoff-Bulman 1989). Some patients with PTSD do not want to talk about the trauma because they do not expect to be able to bear the emotions that will arise. In other mental disorders, expectations are not part of the diagnostic criteria, but are also of relevance. For example, individuals suffering from depression show more depression-specific negative expectations (Rief and Glombiewski 2016). If

expectations are one of the most powerful predictors of outcome, interventions must maximally modify illness-specific expectations, and positive outcome expectations should be sufficiently established before treatment starts. One of the traditional psychological interventions that may be considered a powerful tool to change expectations is exposure therapy. However, traditional exposure therapy needs to be reformulated to better focus on the change of expectations (e.g., explicit comparison between pre-exposure expectations and post-exposure experiences) (Craske 2015) and is excluded in some sense in war traumata and PTSD.

Expectation-focused psychological interventions (EFPI) (Rief and Glombiewski 2016) places a strong focus on analyzing and summarizing disorder-specific expectations of the patient, and re-evaluates expectations by comparing pre-existing expectations with the experience during exposure.

Discussion

MHPSS in its well-defined sense as mental health service as well as psychosocial support for and with the concerned population are the only way to improve the mental health condition. What does that mean: In regions in which adequate psychiatric and psychotherapeutic care is not guaranteed by specialists, it is necessary to improve psychosocial support through psychoeducational measures and training of peer groups. This in the sense of a reference system, so that simple psychological problems can also be treated on site by laypersons and only the difficult cases are brought up to the few specialists available.

It should be pursued even when well educated and trained mental health workers and doctors are frequently leaving the refugee setting to other places (brain-drain) like third countries and new health workers have to be trained on a regular base. Beside this, the already started -but politically jeopardized-installation of (mobile and at present non-permanent) mental health services in Myanmar, in the region the refugees originated, is a way, which should be kept moving on.

Although brief, structured psychotherapies administered by lay counsellors, including the mentioned ones above, have been shown to be effective in the short term for a range of traumatic stress responses (Silove et al. 2017). One can therefore share the opinion of the British psychiatrist Vikram Patel, author of "Where There is no Psychiatrist," that non-specialist healthcare workers should become the front-line of mental health services, mainly in OPD-services, not only in poor countries and be incorporated into the core of mental health provision (Patel 2008).

It is mandatory for NGOs as well as the responsible stakeholders in the self-organizations of the camps to be alert about psychosocial problems and their manifestations like domestic violence, suicidal ideations/attempts, drug and alcohol abuse as well as social withdrawal in confinements of long-term refugees. NGOs should not only provide and promote mental health services, but educate and train health workers and laypeople to raise knowledge, reduce stigmatization and make mental health a public issue.

The psychosocial program that was started in the camps at the Thai border during 2015 aiming to improve psychosocial wellbeing of refugees is functioning well in both camps. Shelter-based psychosocial counselors conduct counseling to clients with anxiety, minor depression and other minor psychosocial problems. Services for both refugees and hosting community are maintained at surrounding Thai villages. Under consideration of social justice and medical good practice, the needs of the local population must also be taken into account.

Regarding the social and cultural background of the Karen refugees one can ask why the suicides and psychosocial problems could not have been observed more often over the years in the camps. Before their forced migration from Myanmar to Thailand, the Karen were living in small villages with up to 30 or 40 families, performing small scale animal husbandry, practicing cultivation of several sorts of rice and different types of vegetables, beside hunting and fishing and slash and burn agriculture. After their flight to the refugee camps, life did change dramatically for the Karen refugees as the new location are comparable crowded places as each campsite sizes more than 10,000 inhabitants. The higher degree of anonymity forced people to more cooperation in their peer-groups, be it extended families or new neighborhoods. Organizational structures which in the past in this extend were not necessary had to be developed. The establishment of camp committees for various tasks evolved plus engagement with international NGOs.

Family problems in the camps were now not so easy to be hidden; domestic violence became probably more a subject of public discussion as in the past.

Negative coping with stress and the feeling of uselessness (because of not having any work to do), helplessness (because of being dependent on the support of third parties and not being able to support oneself and one's family on one's own), hopelessness (concerning the individual future and that of one's relatives, the situation in the camps and the development in Myanmar in general) (Benner et al. 2010) probably increased the danger of domestic violence and the abuse of alcohol. Even when NGOs tried to establish some educational and health standards in the camps, although the camps are located in remote areas with no access to internet, television, telephone and other kinds of media and systems of communication, it has been very difficult to provide some meaningful support.

Being dependent on the support of the international community and the support by the Thai and Myanmar governments for more than three decades, the refugees are likely facing increased difficulties to cope with the now changing situation and the urge to be repatriated back to Myanmar.

Data on the suicide rate between 2010 and 2016, as well as estimation of the numbers of suicides during 2006 to 2009, suggest that the suicide rate ranks to the highest in the world and could be a serious public health. Even there was no special defined mental health and psychosocial support service in the beginning of the NGO engagement in the camps around twenty years ago, there was additional a cultural barrier to show up with health workers or with close relatives and friends. Like in many other Asian ethnic groups, psychosocial problems, stress and suicidal ideation are taboos, an underreporting of mental health and psychosocial condition-associated problems, casualties and fatalities cannot be excluded.

Nevertheless, one could show that humans are very adaptable to a changing environment of living, this is especially true for the youth. Closed to all of them have been born in the camps and therefore do not know how the life will be in the land of their ancestors, being responsible for one's own.

As in other comparable refugee settings, the focus of the engagement of medical NGOs in the last two to three decades lay in providing first medical aid, improving the general health and hygienic conditions including performing vaccinations and Mother and Child Health-Programs, giving health education et cetera. Unfortunately, only after infectious diseases were under control and the general health condition was more or less stable (not until 2015), mental health as an important topic became a subject in the camps, what reduces the power of meaning of this article.

Conclusion

The mental health service should be encouraged to focus not only on sickening but on salutogenetic aspects of mental health and psychosocial problems and the way people are coping with: In areas of scarce resources, it is important not only to provide a minimum level of mental health services, but to encourage those affected to consider and use their own resources as a form of help for self-help, such as peer support and discussion groups for women, men or on specific topics such as grief, pregnancy etc., or use of indigenous natural products, for example for sleep disorders. Resilience is a factor, easily overseen by health care providers, especially in situations, which make people depending on help. Mental health care should consider the role of expectations and causal-attribution and being able to have a positive impact on it, i.e., in training health workers. It may be necessary to take up and, if possible, modify ideas that are harmful to health and social interaction with regard to the development and maintenance of mental disorders' often ideas regarding the development of infertility, schizophrenia or also regarding the use of violence against women, the elderly or children.

In people like the Karen, the consideration of their heritage and the ways deriving from it, should be respected and valued. In their struggle for daily life, they apply more than one single specific religious belief; the people are reality oriented and rather pragmatic than dogmatic.

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