

# Health and Social Needs of Traumatized Refugees and Asylum Seekers: An Exploratory Study

Patricia J. M. Strijk, RN, MSc, Berno van Meijel, RN, PhD, and Claudia J. Gamel, RN, PhD

Patricia J. M. Strijk, RN, MSc, is a nurse in clinic Centrum '45 for Refugees and Asylum Seekers, Foundation Centre '45, Oegstgeest, the Netherlands; Berno van Meijel, RN, PhD, is an Associate Professor in Mental Health Nursing, Institute for Advanced Studies and Applied Research, INHolland University for Applied Sciences, Research Group Mental Health Nursing, Amsterdam, the Netherlands; and Claudia J. Gamel, RN, PhD, is Rho Chi Chapter-at-large, and Associate Professor, Master of Science in Nursing, Department of Nursing Science, University Medical Center Utrecht, Utrecht, the Netherlands.

## Search terms:

Needs, needs assessment, nursing, refugees

## Author contact:

p.strijk@centrum45.nl or  
Patriciastrijk@hotmail.com, with a copy to the  
Editor: gpearson@uchc.edu

First Received November 9, 2009; Final Revision  
received March 25, 2010; Accepted for  
publication April 23, 2010.

doi: 10.1111/j.1744-6163.2010.00270.x

**PURPOSE:** The purpose of this study was to describe the care needs of adult traumatized refugees and asylum seekers.

**DESIGN AND METHODS:** A mixed-methods design was used. A survey was conducted using the Camberwell Assessment of Need (CAN) among 30 patients. Semi-structured in-depth interviews were subsequently conducted with eight of these patients.

**FINDINGS:** Key themes among refugees are loneliness and grief. Refugees are in severe psychological distress. They also encounter all kinds of practical problems that influence their quality of life. Furthermore, many of them suffer from serious psychiatric and trauma-related problems.

**PRACTICE IMPLICATIONS:** The results of this explorative study can contribute to the quality of care for traumatized refugees.

Most refugees have experienced multiple traumatic situations that trigger complex psychiatric symptoms (Fazel, Wheeler, & Danesh, 2005; Herman, 1998). The problems confronting refugees are often multifaceted and involve diverse life areas associated with their past, the present, and the future (Holli-field et al., 2002; Jongedijk & Hoekstra, 2006).

Experience in the Netherlands with adult traumatized refugees and asylum seekers treated in a specialized psychiatric hospital for survivors of organized violence shows that refugees generally have trouble expressing what they expect from their hospital admission or psychiatric treatment. They often rely on the expertise of the healthcare professionals because they are convinced that these professionals know what needs to be done. When talking to nurses, these refugees primarily give a list of physical and mental complaints and symptoms, implicitly asking if the nursing staff can alleviate or take away their complaints. It is noteworthy to mention that research findings partly contradict these practice findings (Watters, 2001). Watters (2001) reports that when refugees are asked what would help most in their situations, they are more likely to mention social and economical aspects rather than psychological aspects.

It seems as if there is a barrier preventing refugees from openly and fully expressing what they need. Nurses often

assume that traumatic experiences, among other things, hinder refugees in actually saying what they need (Centrum '45, 2003; Gangsei & Deutsch, 2007). Furthermore, it appears that refugees are not encouraged by staff to tell, in their own words, what they really expect and want from the health and social institutions (Watters, 2001). Moreover, the literature shows that no instrument has been specially developed to help identify the health and social needs of refugees (Strijk, Meijel, & De Vree, 2006).

Consequently, nurses are limited in making a thorough assessment of problems and needs in joint consultation with the refugee, and this restricts nurses' abilities to define the kind of care appropriate to a specific case (Burnett and Peel, 2001; Strijk et al., 2006). Furthermore, the language barrier often plays a role. Therefore, nurses generally use their intuition and experience when determining what kind of care should be provided.

The aim of this exploratory study was to enable traumatized refugees to tell their own stories so that their experiences and needs could be more adequately addressed in the nursing process. The key research question was: "What are the health and social needs of adult traumatized refugees and asylum seekers treated in a specialized psychiatric hospital for survivors of organized violence?"

## Methods

### Design

A mixed-methods design using both quantitative and qualitative research strategies was used. The Camberwell Assessment of Need (CAN) is often used with psychiatric patients; however, it is not sufficiently specific for the target group under examination. Moreover, the CAN does not provide any comprehensive understanding of what the refugees themselves perceive as the precise nature of their problems and needs. These omissions were remedied by the addition of qualitative in-depth interviews.

### Setting

The research study took place within a psychiatric hospital specialized in the treatment of traumatized asylum seekers and refugees who are survivors of organized violence in their countries of origin. This kind of violence, inflicted by fellow human beings, generally constitutes a serious threat to the physical and/or mental health of the traumatized survivors (Dirkzwager, van der Velden, Grievink, & Yzermans, 2007).

### Sampling

A convenience sample was used for the survey. All patients under treatment at the psychiatric hospital ( $n = 65$ ) were approached during the research period of 18 months (March 2005–June 2006). They received written and verbal information about the study. Those who signed an informed consent statement responded to a quantitative survey, and all respondents were invited to return for a qualitative interview.

### Instruments

No instrument specifically measures the needs of traumatized refugees. One instrument that measures health and social needs of adults with mental health problems is the CAN (McCrone et al., 2000). It identifies needs in 22 domains/life areas. Each CAN domain starts with the question, “Does the person have any difficulties in the relevant domain and, if so, what level of help is provided or needed?” A distinction is made between “unmet need,” “met need,” and “no need.” The next question is whether any support is offered by friends, family, and/or care institutions. Finally, the person is asked whether he or she receives the right kind of care and whether he or she is satisfied with the level of care provided. Besides the perspective of the patient, the CAN also offers the opportunity to measure health and social needs from the perspectives of family members and care providers. This study is limited to the patients’ perspectives. The reliability of the CAN was tested in the EPSILON Study 6 (McCrone et al.,

2000). The Cronbach’s alpha, the pre- and posttest reliability, and the interrater reliability were 0.64, 0.85, and 0.93, respectively. The reliability of the instrument is reasonable to good.

Qualitative data were collected by using the CAN results as a basis for asking the interviewees additional questions about unresolved care needs most commonly experienced by them in the past or the present. This choice was triggered by the researchers’ belief that these areas of unresolved care needs indicated by the patient should be given priority in nursing practice. The respondents were interviewed about: (a) the nature of their specific care needs and (b) the degree to which these needs were met in their opinions. The respondents were also given the opportunity to raise issues not covered by the CAN in order to establish whether there were other health and social needs specific to refugees. Additionally, the following background information was collected: age, sex, country of origin, living accommodation, length of treatment, day treatment or full admission, and psychiatric diagnosis.

### Data Collection

Data were collected in the period from March 2005 to June 2006. Quantitative data were collected by filling in the CAN in face-to-face meetings with 14 hospitalized and 16 day care patients. An interpreter was used during face-to-face data collection with 16 of these respondents (53%). The in-depth interviews ( $n = 8$ ) were conducted by the same researcher (PS) who collected the survey data. One interview was conducted in English and two were conducted in the presence of an interpreter. Demographic information was collected from the patients’ records.

### Data Analysis

The CAN data were analyzed using the descriptive analysis methods of SPSS Version 11.5. The qualitative data were analyzed at a textual level with the MaxQDA qualitative text analysis program (MAXQDA, VERBI GmbH, Berlin, Germany). The interviews were taped and transcribed verbatim for data analysis purposes. A code tree was created on the basis of existing CAN domains. Additional code words were used if data did not fit within the existing CAN domains. Where possible, interrelated care needs were reflected as a whole in the description of the results.

## Results

### CAN (Quantitative Research)

In total, 30 of the 65 patients who were approached participated in the CAN survey. These participants were then asked whether they would also be prepared to participate in the additional in-depth interviews. Only 8 of the 30 respondents

**Table 1.** Home Countries of CAN Participants

Home countries of CAN participants		
Afghanistan	Guinea-Bissau	Serbia and Montenegro
Angola	Iraq	Sierra Leone
Armenia	Iran	Somalia
Azerbaijan	Jordan	Sudan
Bosnia and Herzegovina	Kosovo	Tajikistan
Burundi	Moldova	Chechnya
Congo	Niger	

CAN, Camberwell Assessment of Need.

agreed to be interviewed. Reasons for nonparticipation in the in-depth interviews included: (a) a number of refugees were difficult to approach or were unreliable in keeping appointments; (b) the psychiatric and/or social condition of some of the patients prevented their participation; (c) some patients were no longer under treatment at the time of the qualitative interviews; (d) in some instances, no interpreter was available; and, finally, (e) there were patients who had to travel too far to participate.

The participants included 20 men and 10 women. Table 1 shows the diverse countries of origin of the respondents. The most prevalent psychiatric disorders were: anxiety disorder (86.7%), depressive disorder (90%), and post-traumatic stress disorder (86.7%). Additional disorders were diagnosed

in 90% of the respondents. These percentages indicate that many of the patients suffer from multiple psychiatric problems.

The CAN results are summarized in Table 2. The domains have been arranged hierarchically based on percentages of unmet needs. In the following section, the qualitative results are presented. Where pertinent, the quantitative results are integrated and further described. Ten key themes emerged from the interviews with respondents.

### Interviews (Qualitative Research)

*Psychological Distress.* All respondents had problems in the CAN domain labeled as Psychological Distress. Most respondents (86.7%) classified their needs in this domain as unmet at the time of this study. They were generally torn by grief and gloominess when thinking of lost friends and family members in their home countries. They often felt very sad about everything that happened and wondered why it had happened to them. The feelings of grief, gloom, and loneliness were, in most cases, directly related to their displacement and the associated sense of loss. One of the respondents remarked:

When I look around me, I see so many people who feel happy and safe, and I think "Why not me? Why can't I be that person, why can't I have what they have?" It makes me want to cry all the time.

**Table 2.** Scores from the Camberwell Assessment of Need (CAN)

Need domains CAN		Need unmet		Need met		No need		Unknown
		#	%	#	%	#	%	
1	Psychological distress	26	86.7	4	13.3	0		0
2	Company	22	73.3	6	20	2	6.7	0
3	Daytime activities	17	56.7	10	33.3	3	10	0
4	Travel	14	46.7	12	40	4	13.3	0
5	Sexual expression	9	30	9	30	10	33.3	2
6	Psychotic symptoms	8	26.7	15	50	7	23.3	0
7	Safety to self	6	20	20	66.7	3	10	1
8	Childcare	5	16.7	6	20	18	60	1
9	Money	5	16.7	16	53.3	9	30	0
10	Physical health	4	13.3	22	73.3	4	13.3	0
11	Intimate relationships	4	13.3	4	13.3	20	66.7	2
12	Information about condition and treatment	3	10	5	16.7	21	70	1
13	Basic education	3	10	14	46.7	13	43.3	0
14	Accommodation	3	10	19	63.3		26.7	0
15	Safety to others	2	6.7	6	20	22	73.3	0
16	Self-care	2	6.7	14	46.7	13	43.3	1
17	Drugs	1	3.3	1	3.3	28	93.3	0
18	Welfare benefits	1	3.3	29	96.7			0
19	Alcohol	0		3	10	26	86.7	1
20	Using a telephone	0		1	3.3	29	96.7	0
21	Food	0		14	46.7	16	53.3	0
22	Looking after the home	0		10	33.3	18	60	2

*Being a Refugee.* Refugees suffer from the loss of family members and from having to leave behind their homes, their motherland, and the language, culture, and customs of their home countries. It was difficult for respondents to be left with virtually no rights and, from one day to the next, to be regarded as a nobody. One of the respondents spoke of her husband, who had been a university teacher in his home country, while there was no one in the Netherlands who even knew who he was or what he had achieved. She told how difficult it was for her husband to have to accept secondhand clothes from strangers in order to dress his children.

From the very first day of taking up residence in the Netherlands, refugees must make an effort to overcome the social disadvantage they have in comparison to their Dutch peers. The refugees knew that they could never completely catch up with their Dutch peers. Fleeing involved a great deal of uncertainty and many traumatic memories. Refugees did not always feel at home in their new country of residence. They felt out of place most of the time, as illustrated in the following statement:

Where, for God's sake, should I live now? I feel torn between two worlds, Africa and Europe. I have no place of my own anywhere. When I tell my girlfriend how I feel, she sees how I suffer. Sometimes she tells others, who then say that I'm crazy. I don't feel safe here at all.

Many of the respondents wondered continuously whether they had made the right choice by fleeing, but they all had an overwhelming fear about returning to their home countries. The insecurity and the loss of their roots caused high stress levels. Respondents communicated that all they wanted was peace and security, but they were unable to find it. They stated that they were continuously weighed down by the burden of their problems. Some of the respondents confided that they were angry about the injustice done to them in their home countries. Asylum seekers were also treated unjustly in the country to which they had fled. The government-imposed general obligation of having to report to Immigration every week was perceived by many as an unpleasant and fearful event. It made the respondents feel like criminals. The atmosphere at the police station, with the officials all dressed in uniform, was experienced as intimidating and it aroused fear.

Most of the time, refugees realized that their legal status as an asylum seeker placed them in a special position and that they had to adapt to their new environment. However they did not always manage to do that.

*Loneliness.* Loneliness was a problem for many of the respondents. Young, single refugees appeared to consider loneliness a major issue that affected their identities. They felt like a nobody and they felt "left out." A young respondent said that he had trouble with the fact that he knew no one, and that no one knew him or knew who his parents were. Many of the respondents told of their fear of connecting to other people or

meeting new people outside of the place where they received treatment. Various reasons were given to explain this fear. In particular, they were afraid of being discriminated against or of being misunderstood because of differences in language and culture. Their faith in other people had already been damaged by negative experiences in the past in both their home country and the host country. In turn, this exacerbated their fear of meeting new people.

*Discrimination.* Discrimination was a recurring theme in many of the interviews. Respondents were concerned about being regarded as "different." They expected that their neighbors would be afraid of them because their appearance was different. The respondents were also worried about being stigmatized as a terrorist or criminal. All this increased their feelings of dread, loneliness, and impotence. These feelings evoked emotions of sadness or anger.

And, you know, I walk into a shop and they may see that I'm an asylum seeker and they may think I came in to steal. They think I'm a stranger; I'm from the Balkan, from a war perhaps. I may be a drug addict.

*Accommodation.* Accommodation is one of the CAN domains that illustrates that the CAN is insufficiently specific to fully grasp the situation of asylum seekers. The questions fail to take into account the fact that most asylum seekers in the Netherlands live in a center for asylum seekers. The respondents who lived in a center for asylum seekers reported that their housing arrangements were a major problem. They had fled to find peace and security. Yet the center did not offer a peaceful and safe haven. Instead the stay in the center was experienced as an imprisonment. There were too many people living there (too) close to each other, and there was too little to do throughout the day and evening. There was a great deal of irritation and discrimination. The respondents described how difficult it was for the entire family to eat, sleep, and watch TV in just one room for several years in a row.

*Benefits and Money.* Benefits and Money are also CAN domains that are not specific enough to cover the situation of the target group. Asylum seekers are granted benefits well below the benefits level of Dutch citizens. Most respondents had too little money. At first, they were embarrassed to talk about their financial difficulties. They regarded the benefits from the Dutch government as a gift, for which they should be thankful. The interviewees nonetheless confessed that they had a problem in this domain: the money they received was inadequate. Furthermore, benefits of hospitalized patients were cut back to compensate for the days that they were hospitalized or went to the outpatient department. What remained was hardly enough for daily expenses. There was no money for any extras or luxury goods or for buying products from their own countries. Such home products were

important for many of the respondents because they gained a sense of still being connected to their own culture and customs.

A number of respondents indicated that they would like to learn how to manage their finances. They were not familiar with the price differences among the shops and they did not know where they could buy what they wanted. Parents reported how difficult it was for them to explain to their (adolescent) children that they could not provide the same things that the parents of their (Dutch) classmates bought for their children.

*Daytime Activities.* Ninety percent of the respondents qualified their needs in the domain Daytime Activities as being or having been unmet. The lack of purposeful activities during the day was a problem for many. Their inactivity was due in part to the fact that most respondents still had the status of asylum seeker, which meant that their scope of activity was limited by legal restrictions. The most frequently stated activities of choice were training and a job. In the field of training, most respondents expressed a preference for learning the language of their host country or following education. Young respondents had difficulties determining what to do during the day. They were often bored and had problems with planning the day. They expressed a clear wish for receiving support in this area. The lack of activity and the long waits for decisions in their asylum procedure often resulted in brooding, which undermined the physical and mental stamina of the respondents.

The respondents wanted “a normal life.” This wish recurred in almost every interview and was described as “being like others,” “doing the same things that others do,” and “getting a chance.” No respondent wanted to be an exceptional case and they did not want to be treated as such. Traumas from the past and the status as a refugee generally made a normal life something that was out of their reach.

*Symptoms.* A number of the respondents suffered or were suffering from psychotic symptoms (26.7% unresolved, 50% resolved). It should be kept in mind, however, that psychotic symptoms among traumatized refugees must be seen in a broader perspective: both the cultural context and the trauma context must be considered. For example, symptoms or signs regarded as a delusional disorder in a Western context may well be normal, or even be considered of great value, from a transcultural perspective. In that case, the person concerned may have no need or desire for treatment. Furthermore, a distinction should be made between psychotic complaints and symptoms on the one hand, and trauma-related psychosis-like symptoms on the other. Traumatic moments may be captured in a distorted mental picture and re-emerge unexpectedly from time to time in a way that completely overwhelms the victim. He or she may have flashbacks of rape or torture, and

the recollection may produce a psychotic picture resembling derangement, delirium, or psychotic agitation. Some respondents described seeing nonexistent images or experiencing nonexistent smells, whether or not related to their trauma, or they heard voices during the day or at night. Sometimes, these occurrences arose directly from a nightmare. One of the respondents put it as follows:

Yes, it pops up just like that . . . the voice . . . or the smell.

And before I know it, I'm back in the past, being tortured.

It makes me feel very, very afraid.

The CAN does not have a specific domain covering aspects of sleep or problems with sleeping. This topic area was raised by the respondents in many of the qualitative interviews when asked whether they had any other problems. All respondents reported that sleeping was or had been a problem. Most of them slept at most a few hours a night. Their brooding about the past prevented them from falling asleep. They confided that they preferred to sleep a few hours extra during the day because this time was less frightening than at night:

I sleep especially poorly when I think a lot about my parents. I lie in bed and start to think, you know. How are my parents doing? Where are they? Or all the fun things I did with my parents in the past come to mind.

Nightmares were a big problem. The nightmares and the anxiety that they produced formed a downward spiral. The respondents stated that they were afraid of new nightmares and dreaded falling asleep or were simply unable to fall asleep. The resulting lack of sleep made them feel tired and listless most of the time. This exacerbated their feelings of gloominess and resulted in inactivity. And some spoke of sleeping and waking up from a nightmare and then they were additionally frightened because of disorientation in terms of both time and place.

Almost all respondents were afraid of being or “going crazy,” or of being regarded as such by others. They sometimes conceded that they “had a problem,” but “being crazy” was something entirely different. Respondents were afraid that the community talked about them behind their backs. They were also worried about being laughed at or misunderstood by the people around them. They felt ashamed and were afraid of being stigmatized:

I don't talk to other people at all; people at the center say that I'm crazy, that I'm insane. If they only knew what I've been through. Everything that happened comes back to me at night, and that makes me brood again during the day.

The respondents indicated that they found it very difficult to tell others about their treatment in a mental healthcare facility. Some could confide in only one specific person with whom they had a very special relationship that was built upon trust. Psychiatry and psychiatric treatment had a special meaning to many respondents because of the taboos on psychiatric care that existed in their cultures.



Family members and other people near to the respondents often found themselves at a loss for how to interpret or react to the respondent's complaints and symptoms. One of the respondents stated as follows:

It's hard for the kids, too. I suddenly get angry, you know, yelling and the like. And I know I shouldn't, and my anger isn't even aimed at the kids, but they clearly ask themselves: "Why is mama so angry, what have we done now?"

*Shared Experience.* Another recurring theme in the interviews was the presence and availability of others who had a similar misfortune. It was a revelation for many refugees during their psychiatric treatment that they met others who had also survived organized violence. It was not until then that they realized they were not the only persons traumatized by the events. Nearly all respondents stated that, after this revelation, they felt acknowledged and that they no longer felt so completely alone or lonely. The shared experience empowered them to go on and encouraged them to connect to other people.

*Transport.* Both the CAN results and the qualitative interviews showed that using public transport posed problems to many respondents. They were afraid of being stared at and became aware that they were different. They were convinced that other people found them strange or frightening. Many respondents also reported that they were afraid of train conductors, especially their uniforms. Public transport was a setting with numerous "triggers" that reminded them of their trauma. As a result, the use of public transport often evoked mental pictures of the past, which added to the fear of traveling. The respondents were afraid of becoming entangled in their own thoughts and of switching from the "here and now" to the "then and there." Those who lived with this fear indicated a need to learn how to cope better.

## Discussion

This study demonstrates that the health and social needs of traumatized refugees and asylum seekers are spread over a range of social domains and other areas of life. One frequently recurring theme is the need for refugees to be heard and to have their plight acknowledged by others.

Psychological distress was a condition that all respondents shared. They all went through periods of grief and gloom, and often felt lonely. A great deal of psychological distress arose from their refugee status and the associated sense of loss and displacement. For many respondents, the loss of their roots and their insecure situations caused great stress. Moreover, the respondents experienced social difficulties, caused mainly by the stressful situation in which asylum seekers often find themselves. Refugees are constantly aware

of their exceptional situation and of the necessity to adapt to their new environment. Poor housing conditions, limited financial means, an unfulfilled desire to go to school, and uncertainty about whether or not asylum will be granted and how the procedure is developing are only a few examples of the stress they suffer. Rijnders (2002) named this kind of stress "current stress" and described the associated symptoms as Current Stress Disorder: "The refugee finds himself in an urgent situation marked by a high degree of social insecurity. A Current Stress Disorder may manifest itself as a psychiatric illness, such as anxiety, depression, psychosis, behavioral, adjustment disorder, substance dependency" (p. 171). It is important to be aware of current stress in addition to psychiatric illnesses because of the risk that the problems of refugees will be individualized rather than viewed within the wider social, economic, and political contexts in which the psychiatric problems of these refugees arise (Laban, Komproe, Gernaat, & de Jong, 2008).

Respondents reported that they felt embarrassed about the fact that they received psychiatric care and were often hurt by the lack of understanding. Problems with sleeping, re-living the trauma, nightmares, and (trauma-related) psychotic symptoms occurred frequently (Hamner et al., 2000). The use of public transport proved to be another trauma-related problem for many. It induced fear of travel in them and limited their freedom of movement.

The strength of this investigation lies within the combined methods that were used to identify the range and detail of the health and social needs of adult traumatized refugees and asylum seekers. Five limitations were identified:

1. Selection bias is possible because a number of scheduled interviews could not be conducted. Also there is no absolute certainty that the sample was representative of the entire group of refugees under psychiatric treatment.
2. The use of interpreter services may have influenced the reliability of the research results. Despite explicit instructions to translate as literally as possible, the interpreter may have chosen words that altered the messages of the respondents.
3. The CAN was not designed for use with refugees and asylum seekers. However an earlier performed literature study on needs assessments showed that the CAN was the most appropriate instrument at that time (Strijk et al., 2006). The CAN includes domains that received relatively low scores in this study, for example Safety to Others and Drugs. However, there is practical evidence that the participants have problems in these domains. There are other CAN domains that are taboo topics among the respondents, such as Sexual Expression and Intimate Relationships. Additionally, sleep problems were described during the interviews but this topic is not included in the CAN. This leads to the question, "Are the CAN scores reliable in such situations"? The merit of the CAN is that it serves as a starting point; however, the in-depth

questions in the qualitative interviews were necessary for an adequate identification of the range of problems and needs.

4. Furthermore, the number of respondents was rather small. A more extensive and large-scale study is needed to obtain a full picture of the problems and care needs of refugees.

5. Finally, the research was conducted in the Netherlands, but the Dutch situation is not always comparable to those in other countries. Some of the problems reported by the refugees were specific to the Dutch situation; obviously, this limits the external validity of the research results.

### Implications for Nursing Practice

The major significance of these findings for nursing practice is that they demonstrate the need for nurses to listen attentively and with an open mind to the stories that refugees have to tell. When one listens intently, then potential language and cultural barriers can be minimized. For instance, if the nurse thinks that certain answers are being given out of cultural politeness or the existence of (mutual) embarrassment about discussing a specific topic, then open communication without judgment or bias on the part of the nurse is crucial. It is important that nurses are readily available for their patients, but nurses must also be patient and refrain from being intrusive whenever sensitive topics are, or appear to be, at issue.

Another practice implication concerns the frequently recurring need of refugees and asylum seekers to be heard and have their plight acknowledged. This is associated with respect, and some refugees may require the existence of a relationship built on trust before they can talk about their problems and needs. Continuous focus should be placed on establishing respect, not only between nurses and refugees, but also among the refugees themselves. Irritation and discrimination are a source of vexation among residents of centers for asylum seekers. Respect provides the basis and room for refugees to work on other problems. Clearly, whenever a difficult or vital discussion will take place, a professional interpreter should be present to prevent communicative or cultural misunderstandings (Watters, 2001).

Moreover, nurses may be able to stimulate patients to pursue and find meaningful daytime activities. This can contribute to minimizing boredom and loneliness as well as reducing excessive brooding. It is important that nurses are aware of the fusion of psychological distress and the current situation of being an asylum seeker with the actual trauma, which brings psychiatric complaints as well (Fazel et al., 2005; Knipscheer, Drogendijk, Gülsen, & Kleber, 2009). When the nurse focuses only on trauma, then the actual health and social problems caused by the stress of the current burdensome situation of the asylum seeker may be overlooked. Of great importance is that nurses carry out tailored interventions to promote coping

skills in the refugee regarding his current stressful life situation.

Another important aspect of nursing care is the provision of information to close relatives and friends, specifically about psychiatric symptoms and treatment options. In this regard, nurses also can play an essential part in providing information to other care providers who are less familiar with the problems of refugees. In view of the frequent occurrence of sleeping problems, a routine nursing responsibility should be to provide useful information about normal day and night routines and specific sleeping advice. Finally, special attention should be given to the task of counseling and supporting refugees in using public transport in order to enhance their independence and radius of activities.

Refugees crave for a world that no longer exists. They wish they could change their histories and turn back the clock. Nurses and patients can work together to find strategies that enable patients to accept that the clock cannot be turned back. Equally important, nurses can help these patients to see the possibilities of alleviating their mental agony, treating the psychiatric symptoms, and working on a new future within the existing social and legal framework. In nursing care, it is important to have a broad focus on the individual situation and on the existing problems and needs of the patients. A comprehensive needs assessment—with full recognition of the lived experiences of the refugees—is required for good quality of care.

One research priority is validation of the CAN for refugees and asylum seekers. Further development of the CAN for use with this vulnerable group is important for subsequent research purposes and for use in clinical practice. A modified CAN can be used in nursing practice to assess the comprehensive and specialized needs of refugees. As a research tool, a modified CAN is needed to increase knowledge about the care needs of these patients at the population level. Another research priority concerns the similarities and discrepancies between care needs from the perspectives of patients, professionals, and informal caregivers. Exploration of the care needs of patients from different perspectives can contribute to the grounded development and utilization of nursing interventions for this extremely vulnerable group of patients.

### References

- Burnett, A., & Peel, M. (2001). Health needs of asylum seekers and refugees. *British Medical Journal*, 322(7285), 544–547.
- Centrum '45 (2003). *Zorgprogrammering: Zorg voor volwassen getraumatiseerde vluchtelingen en asielzoekers* [Care for adult traumatized refugees and asylum seekers]. Oegstgeest, the Netherlands: Author.
- Dirkzwager, A. J., van der Velden, P. G., Grievink, L., & Yzermans, C. J. (2007). Disaster-related posttraumatic stress disorder and physical health. *Psychosomatic Medicine*, 69, 435–440.

- Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorders in 7000 refugees resettled in western countries: A systematic review. *Lancet*, 365, 1309–1314.
- Gangsei, D., & Deutsch, A. (2007). Psychological evaluation of asylum seekers as a therapeutic process. *Torture*, 17, 79–89.
- Hamner, M. B., Frueh B. C., Ulmer H. G., Huber, M. G., Twomey, T. J., Tyson, C., & Arana, G. W. (2000). Psychotic features in chronic posttraumatic stress disorder and schizophrenia: Comparative severity. *Journal of Nervous and Mental Disease*, 188, 217–221.
- Herman, J. (1998). *Trauma en herstel: de gevolgen van geweld—van mishandeling thuis tot politiek geweld* [Trauma and recovery: The consequences of violence] (6th ed.). Amsterdam: Wereld Bibliotheek.
- Hollifield, M., Warner, T. D., Lian, N., Krakow, B., Jenkins, J. H., Stevenson, J., . . . Kesler, J. (2002). Measuring trauma and health status in refugees: a critical review. *Journal of the American Medical Association*, 288(5), 611–621.
- Knipscheer, J. W., Drogendijk A. N., Gülsen C. H., & Kleber R. J. (2009). Differences and similarities in posttraumatic stress between economic migrants and forced migrant: acculturation and mental health within a Turkish and a Kurdish sample. *International Journal of Clinical and Health Psychology*, 9(3), 373–391.
- Laban, C. J., Komproe, I. H., Gernaat, H. B., & de Jong, J. T. (2008). The impact of a long asylum procedure on quality of life, disability and physical health in Iraqi asylum seekers in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology*, 43(7), 507–515.
- Jongedijk, R. A., & Hoekstra, M. J. (2006). GGZ voor asielzoekers: teveel, voldoende of te weinig? [Mental health care for asylum seekers: too much, sufficient or too little?] *Cultuur Migratie Gezondheid*, 3(3), 148–159.
- McCrone, P., Leese, M., Thornicroft, G., Schene, A. H., Knudsen, H. C., Vazquez-Barquero, J. L., . . . Griffiths, G. (2000). Reliability of the Camberwell Assessment of Need—European Version. EPSILON Study 6. European Psychiatric Services: Inputs Linked to Outcome Domains and Needs. *British Journal of Psychiatry. Supplement*, 39, 34–40.
- Rijnders, R. J. P. (2002). De rol van de therapeut in de behandeling van getraumatiseerde asielzoekers en vluchtelingen [The therapist's role in treatment of traumatized asylum seekers and refugees]. In E. van Meekeren, A. Limburg-Okken, & R. May (Eds.), *Culturen binnen psychiatrie-muren. Geestelijke gezondheidszorg in een multiculturele samenleving* [Cultures in psychiatry: Mental health in a multicultural society] (pp. 167–176). Amsterdam: Uitgeverij Boom.
- Strijk, P., Meijel, B., & De Vree, W. (2006). Problematiek en zorgvragen van vluchtelingen [Problems and needs of refugees]. *TvZ: Tijdschrift voor Verpleegkundigen*, 116(11/12), 57–60.
- Watters, C. (2001). Emerging paradigms in the mental health care of refugees. *Social Science and Medicine*, 52(11), 1709–1718.