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Abstract: *Refugees suffer from a higher rate of mental health symptoms than the general population since they have experienced extreme suffering and the accumulated effects of trauma. Because of the diversity of regions from which refugees originate, there is a need to understand some of the unique experiences that are specific to each sub-groups of immigrants. The purpose of the present study was to explore mental health symptoms in Iraqi refugee clients who immigrated to the United States after the Gulf War of the early 1990's. As part of a larger study, 116 adult Iraqi immigrants to the United States (46 male, 70 females) who were seeking mental health services completed measures of anxiety, depression, and posttraumatic stress disorder. As expected, the majority of refugees reported intense anxiety and depression, and many met the DSM IV criteria for posttraumatic stress disorder. Like refugees from other countries-of-origin, Iraqi refugees are in need of culturally sensitive assessment and mental health treatment. The results are discussed in light of the treatment needs of Iraqi refugee clients, their resilience and motivation for a better life, and the ways that health professionals can assist in optimizing their adjustment.*

Key Words: *Posttraumatic Stress Disorder, Iraqi,Rrefugees, Arab American, Trauma*

MENTAL HEALTH SYMPTOMS IN IRAQI REFUGEES: POSTTRAUMATIC STRESS DISORDER, ANXIETY, AND DEPRESSION

Between the Persian Gulf War of 1991 and the year 2000 approximately 40,700 Iraqi immigrants settled in the United States (Cainkar, 2000), and of these 29,076 qualified as refugees (U.S. Committee for Refugees, 2000). Given that the plight of refugees continues to be a worldwide problem into the 21st century (U.S. Committee for Refugees, 2004), health professionals are increasingly likely to be faced with the task of treating refugees who have been victims of torture and displacement due to political upheaval (Marotta, 2003). Thus, it is important for health professionals to enhance their understanding of the factors affecting refugees that may impact upon routine clinical assessments, diagnoses, and treatment protocols.

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Recent studies on refugees from Europe, Africa, the Middle East, South America, and Asia , have demonstrated that refugees often suffer from more symptoms of depression, anxiety, and posttraumatic stress disorder, and more health problems than people who immigrate for other reasons (e.g., Ai, Peterson, & Ubelhor, 2002; Bhui et al., 2003; Hondius, van Willigen, Kleijn, & van der Ploeg, 2000; Jamil, Hakim-Larson, Farrag, Kafaji, Duqum, & Jamil, 2002; Keyes, 2000; Steel, Silove, Phan, & Bauman, 2002). It has been argued that past and ongoing social, political, and economic factors play a key role in the life experiences and adaptation of refugees; thus, psychiatric classification and treatment of their difficulties is likely insufficient in addressing all of the refugees' underlying needs, including those involving safety and preservation of basic human rights (e.g., Gorman, 2001; Watters, 2001). However, community health agencies are nonetheless faced with the task of providing help to individuals with traumatic histories, and of

assessing their state of mental health for the purpose of optimizing their treatment services and outcomes. On the basis of her review of empirical studies conducted on refugees from many different cultural backgrounds in the 1980's and 1990's, Keyes (2000) suggested that clinicians incorporate refugee-specific assessment and treatment practices into their repertoire of clinical skills. While many responses to the refugee experience may be universal, others vary by culture.

In the early 1990's, mental health therapists in Europe and the United States who work with immigrants from the Middle East noticed an influx of refugees from Iraq who were seeking services for symptoms related to their traumatic histories (e.g., Gorst-Unsworth & Goldenberg, 1998; Takeda, 2000). The refugees from Iraq suffered "cumulative trauma" before their immigration since they experienced the effects of the 1980s war with Iran as well as the Persian Gulf War of the early 1990s (Kira, 1999). After the Persian Gulf War, large Arab settlement regions in the United States such as in Michigan and Ohio noticed an increase in the Iraqi immigrant population, many of whom have suffered a series of traumas such as multiple relocations, unsanitary refugee camps, poor nutrition, and the torture and/or death of family and friends (e.g., Via, Callahan, Barry, Jackson, & Gerber, 1997). In the Metropolitan Detroit area, estimates of Iraqi refugees and immigrants range from about 5,000 (Weinstein, 2001) to about 25,000 (Arab Community Center for Economic and Social Services, 2004) with variations in estimates occurring due to moves between the states. Post-migration stresses involving the demands of acculturation and continued tensions and upheaval in their country-of-origin are thought to also exacerbate the already high level of stress experienced by immigrants (e.g., Berry, 1991). Clinicians who have worked with Arab American mental health clients have noted high levels of depression, anxiety, somatization of symptoms, and posttraumatic stress disorder (e.g., Nassar-McMillan & Hakim-Larson, 2003). Physical health symptoms and high levels of anxiety, depression, and posttraumatic stress disorder have also been found in refugees from Europe, Asia, Africa, as well as the Middle East (e.g., Keyes, 2000). Keyes (2000) has recommended the need for refugee-specific assessment to further clarify and address their physical and mental health needs.

In the present study we were interested in assessing refugees from Iraq who were seeking mental health services at a community health center by using reliable, valid questionnaires that had been used with refugees from other ethnic backgrounds. We were interested in providing further descriptive information about the nature of the trauma suffered by these immigrants, and in exploring the nature of the symptoms experienced in relation to demographic characteristics such as gender. In keeping with past studies of refugees with traumatic histories, we anticipated that many of the participants would display symptoms of depression and anxiety in addition to meeting the criteria for posttraumatic stress disorder. The primary goal of the present study was to better understand the extent and severity of the problems experienced by the Iraqi refugees to assist in effective planning for their health care.

METHODS

Participants

After ethical clearance was obtained by the authors' respective academic institutions, Iraqi refugees were recruited from mental health clients at a community agency. Both current clients who had already started treatment as well as new incoming mental health clients were recruited. Some participants were referred for a mental health assessment by local physicians, community agencies, religious centers, or by their family members. In total, the data used for the present analyses were obtained from 116 adult Iraqi immigrants (46 male, 70 female) who were seeking or already receiving outpatient services ($n = 87$) or treatment in a partial hospitalization program ($n = 29$). Table 1 displays the background demographics of the sample broken down by gender. Most participants were in the age range of 30 to 50 years of age, married, and had either no formal education or less than a high school degree. In addition, the majority reported no current employment ($n = 100$), or a disability ($n = 8$). The mean number of years since immigration at the time of testing was 5.18 ($SD = 3.17$) and did not differ by participant gender, t (97) = 1.69, *ns*.

Measures

All measures were translated into Arabic by the second author who is a native speaker of Arabic. Back translation was used to insure accuracy and equivalence. This study is part of a larger project on the medical and psychological health and well-being of immigrants from Iraq. Although data were also collected on participants'

Table 1. Background Demographics by Gender

Demography	Male $n=46$	Female $n=70$	Total $N=116$
Age (years)			
19-29	4 (8.7)	17 (24.3)	21 (18.1)
30-39	19 (41.3)	26 (37.1)	45 (38.8)
40-49	16 (34.8)	19 (27.1)	35 (30.2)
50-75	7 (15.2)	8 (11.4)	15 (12.9)
Marital Status			
Married	29 (63.0)	54 (77.1)	83 (71.6)
Single	12 (26.1)	2 (2.9)	14 (12.1)
Divorced	2 (4.3)	3 (4.3)	5 (4.3)
Separated	2 (4.3)	7 (10.0)	9 (7.8)
Widowed	1 (2.2)	4 (5.7)	5 (4.3)
Education *			
No formal education	9 (19.6)	16 (23.2)	25 (21.6)
Less than high school degree	22 (47.8)	34 (49.3)	56 (48.7)
High school degree	8 (17.4)	12 (17.4)	20 (17.2)
Some college or college degree	4 (8.7)	7 (10.0)	11 (9.5)
Other	3 (6.5)	0	3 (3.5)

* Total does not add to 116 cases due to missing data.

general physical health and medical complaints, the current study focuses specifically on describing the traumas experienced by the refugees and on their specific symptoms of anxiety and depression.

Anxiety and Depression Measure: The measure used to assess anxiety and depression was the Hopkins Symptom Checklist-25. Richard Mollica and his colleagues have used this measure as a screening instrument for psychiatric problems in refugees (e.g., Mollica, Wyshak, deMarneffe, Khuon, & Lavelle, 1987). In 1999, the second author translated the scales of the Hopkins Symptom Checklist-25 into Arabic for use in clinical research. Participants rate themselves on ten anxiety symptoms such as "suddenly scared for no reason" and on fifteen depression symptoms such as "crying easily" using a four point scale. The scores are 1: Not at all, 2: a little, 3: quite a bit and 4: extremely. Both anxiety and depression scale scores are created by taking the total of each person's responses across ten items for anxiety and across fifteen items for depression, and then computing the averages. For the present sample, both scales were internally consistent and thus reliable; Cronbach's alpha coefficients were .95 for anxiety (n = 116) and .88 for depression (n = 116).

Posttraumatic Stress Disorder Measures: Prior to the decisions about the questionnaires to be used in the current study, the Bilingual PTSD Scale created by the second author had been used with clients who had already started treatment. This measure is a symptom checklist based on the Diagnostic and statistical manual of mental disorders-4th edition (DSM-IV; American Psychiatric Association, 1994) criteria and was used to assist in diagnosing PTSD; 17 of the 116 participants in the current study completed this measure. Sixteen of the 44 items were symptoms related to the DSM-IV diagnosis of posttraumatic stress disorder.

For the remaining 99 of the 116 participants, a bilingual interviewer verbally administered the Posttraumatic Stress Diagnostic Scale (PDS; Foa, 1995). The PDS is also based on the DSM-IV diagnostic criteria of posttraumatic stress disorder, is a published measure, and has evidence for its reliability and validity. Participants are asked whether or not a series of traumatic events happened to them or were events that they had witnessed; for example, the events include accidents, disasters, assaults, as well as war traumas. The measure includes the Symptom Severity Score based on 17 symptoms from the DSM-IV criteria for posttraumatic stress disorder. FOA reported that in her sample, the Cronbach alpha reliability coefficient of the scale was .92 and the test-retest reliability of the scale was .83. In the present study, we obtained a similar Cronbach's alpha coefficient of .94 for the Symptom Severity Score scale (n = 99). Validation studies reported by Foa (1995) showed a high correlation between the scale and the psychiatric diagnostic criteria. The PDS also showed consistent correlations with other measures that tapped different aspects of PTSD. Overall, the PDS appears to be a reliable and valid measure of PTSD.

Procedure: Questionnaires were administered verbally in an interview format by one of two bilingual interviewers (Arabic and English). A male Masters level licensed professional counselor and a female Masters level graduate student therapist conducted all interviews. The study was conducted in 2001 and 2002, with eighty percent (n = 93) of the participants completing the questionnaires after September 11, 2001. Potential participants were first screened during a psychosocial assessment to see if they qualified for the study as refugees from Iraq. Participants were then given an informed consent form to sign and were given a $15.00 gift certificate for their participation. Interviews lasted approximately 45 minutes.

RESULTS

Diagnostic Classification of Participants

Mental health diagnoses were available from the medical records of 77 (66.4%) of the participants. More than half of the men in the sample (n = 25, 54.3%) and less than one-fifth of the women (n = 8, 11.4%) received the single diagnosis of PTSD (i.e., no comorbid condition noted). In contrast, more than one-third of the women (n =24, 34.3%) and only 2 of the men (4.3%) were diagnosed with a depressive disorder with no comorbid condition noted. Other diagnostic classifications including comorbid diagnoses (e.g., PTSD and a depressive disorder, bipolar disorder, schizophrenia) were given to 6 men (13.0%) and 12 women (17.1%). The diagnosis was classified as unknown if it was not available from the medical record, or if the participant did not follow-up and return for the intake and treatment (men: n = 13, 28.3%; women: n = 26, 37.1%). A 2 (gender) by 4 (diagnostic group) Pearson chi square statistic was computed and revealed a significant association, suggesting a significantly different diagnostic pattern for men and women, χ^2 (3) = 30.03, $p < .0001$; Cramer's $V = .51$, $p < .0001$.

Anxiety and Depressive Symptoms

The findings from the *Hopkins Symptom Checklist* 25 suggest that more than 80% of the participants at the time of their interview had recently experienced intense symptoms of anxiety (e.g., faintness, dizziness, weakness, trembling, headaches, spells of terror or panic) and depression (e.g., crying easily, feeling low in energy, feeling hopeless, having difficulty falling asleep and sleeping). Symptoms of anxiety (M = 3.64, SD = .55) and depression (M = 3.45, SD = .42) for the past week including the day they were administered the interview were typically endorsed at either 3, which is 'quite a bit' or 4, which is 'extremely'. Although these symptoms were high for both men and women for both anxiety and depression, the average depression rating for women (M = 3.51, SD = .37) was slightly higher than for men (M = 3.35, SD = .49), t (114) = -2.03, $p < .05$, two-tailed. There was no difference between men (M = 3.64, SD = .63) and women (M = 3.63, SD = .49) for reported symptoms of anxiety.

Based on the data obtained from the *PDS: Posttraumatic Stress Diagnostic Scale* ($n = 99$), Table 2 shows the frequency and percentage of men and women in the study that reported that the different types of traumas happened to them or were events that they had witnessed. Ninety percent of the women and 92 percent of the men reported having lived through wartime trauma, which was the largest category endorsed. Separate Pearson chi square statistics were computed to see if there was an association between the trauma endorsed and the participant's gender. Men were significantly more likely to report the events of imprisonment and torture than women. However, it is important to note that a high number of both men and women were affected. Over 85% of the men and one third of the women reported the events of imprisonment and torture.

The PDS also assessed 17 PTSD symptoms. The average number of symptoms endorsed was 16.24 ($SD = 2.11$) with a range of 3 to 17 symptoms. The Symptom Severity score was also calculated based on how often participants rated themselves as experiencing the symptoms with scores ranging from a possible 0 to 51. The average in the current study was 43.84, $SD = 8.79$, with a range of 6 to 51 ($n = 99$). In her normative sample, Foa (1995) reported that participants who met the criteria for PTSD in the *SCID: Structured Clinical Interview for DSM-III-R* endorsed a mean of 14.6 symptoms, ($SD = 2.81$) and had a mean symptom severity score of 33.59 ($SD = 9.96$). Thus, in the present study, both the mean number of symptoms and the mean symptom severity score exceed the means in Foa's sample with over 90% of the participants (92 out of 99) reporting symptom severity scores of 33 or higher.

Finally, the PDS also assesses which areas of a person's life have been affected by the symptoms that they reported. These eight areas are: work, household chores and duties, relationships with friends, fun and leisure activities, schoolwork, relationships with family, sex life, and general satisfaction with life. Seventy-six of the 99 participants (66% or two-thirds) endorsed all eight areas as being affected by their symptoms.

Table 2. Frequency and Percentage of Participants by Traumatic Events Reported

Traumatic Event	Men n=39	Women n=60	Total N=99
Accident, fire, explosion	7 17.9%	19 31.7%	26 26.3%
Natural Disaster (hurricane, storms, flooding)	5 12.8%	5 8.3%	10 10.1%
Non-sexual assault by family member/ acquaintance	0	3 5.0%	3 3.0%
Non-sexual assault by a stranger	1 2.6%	6 10.0%	7 7.1%
Sexual assault by family member/ acquaintance	0	1 1.7%	1 1.0%
Sexual assault by a stranger	1 2.6%	1 1.7%	2 2.0%
Combat or a war zone	36 92.3%	54 90.0%	90 90.9%
Sexual contact under age 18 with someone 5 or more years older	0	0	0
Imprisonment a***	34 87.2%	21 35.0%	55 55.6%
Torture b ***	35 89.7%	20 33.3%	55 55.6%
Life-threatening illness	4 10.3%	2 3.3%	6 6.1%
Other traumas	1 2.6%	5 8.3%	6 6.1%
a*** Pearson Chi Square : $\chi^2(1) = 26.06$, $p < .0001$			
b *** Pearson Chi Square : $\chi^2(1) = 30.46$, $p < .0001$			

DISCUSSION

These findings suggest that the problems experienced by Iraqi refugees who are seeking or considering treatment are quite pervasive and affect their everyday lives. As we expected, the data collected for this study has confirmed that many of the refugees seeking treatment do indeed meet the qualifications for the diagnosis of posttraumatic stress disorder using measures that have some evidence for their reliability and validity. Symptoms of anxiety and depression were found to be prominent in both men and women, with slightly more depressive symptoms in women. This finding is not surprising given that the DSM-IV notes that more than twice as many women than men have been found to suffer from depressive episodes (American Psychiatric Association, 1994). Consistent with the findings of Hondius et al. (2000) who studied refugees in the Netherlands, men and women in the present study differed in the kinds of traumatic events reported, with men being significantly more likely to include imprisonment and torture in their list of traumatic events. In addition, among those for whom a diagnosis was available, women were more likely to receive a depressive disorder diagnosis than men, and men were more likely to receive a PTSD diagnosis than women.

Consider the following two case studies of refugees from Iraq, both of which illustrate the findings for male and female refugees, respectively.

Client #1

Client #1 is a 35 year old Iraqi male refugee who is single and unemployed. He had worked in the field of communications in Iraq before he was imprisoned and tortured. His torture included beatings, electric shot, hot and cold water baths, hanging by the shoulders, and cigarette burns to his body. After his release, he fled to another Middle Eastern country, where he lived for several years before coming to the United States as a refugee in the year 2000. As a result of the torture

and trauma, he suffered depressive symptoms including suicidal behavior, anxiety attacks, hallucinations, and PTSD symptoms (nightmares, flashbacks). He was referred for mental health treatment by a friend of his (another refugee). His range of social services included case management for referrals to community welfare agencies and referral to a crisis phone line. Psychotherapy services included individual sessions, psychiatric evaluation, and medication management. With ongoing treatment, the client has been able to make alternative plans for his life, thus reducing suicidal ideation, isolation, and hopelessness. He continues to acquire social skills and has improved relationships with friends and others in the community. His self-esteem and self-efficacy have also improved. It is anticipated that he will need to be involved in the treatment program for a total of 3-4 years. Upon continued attendance at the program, he is expected to remain stable on medication, and to continue to gain the insight and the skills required to improve his social interactions. It is also anticipated that he will continue to learn effective ways to cope with the traumatic events he suffered, thus contributing to his ability to become a productive citizen of American society.

Client #2

Client #2 is a 36 year old Iraqi female refugee who is married and has school-age children. She was physically and emotionally abused as a child, and was married in Iraq to a soldier. In Iraq, her brother-in-law was arrested and executed in front of her, and her husband was imprisoned and tortured for several months. After her husband's release, he escaped. As his wife, she was then arrested, interrogated, and tortured with beatings and electric shock while she was pregnant. She was forced to witness the gruesome effect of other women being tortured by having their heads dipped in acid. After being bailed out by her father, she continued to be interrogated and to have her children removed from her home and returned periodically. Eventually, she was able to meet up with her husband in the countryside and they planned their family's escape to another Middle Eastern country. From there, they applied for refugee status and came to the United States. Once settled in the United States, she initiated contact at the local Arab American community center for mental health services with her husband's approval and initial involvement, as is customary for the culture. Her symptoms included nightmares, flashbacks, crying spells, poor concentration, intense anxiety when she saw police officers, and insomnia. She had intense feelings of sadness, a depressed mood, feelings of hopelessness, and remained isolated from community activities. Her physical symptoms for which no medical basis could be found included headaches, chest pains, and numbness in the hands and legs. Her diagnosis included the comorbid conditions of PTSD and Major Depression. Treatment goals included helping to educate her about the rules and guidelines of her new country, learning new coping skills, and new relaxation techniques. She was encouraged to use metaphors and sayings from her native language to express herself during individual therapy. Because of her traditional religious background, religious language was sometimes used (e.g., "Inshallah" or "If God is willing"). In addition, she was referred to a psychiatrist for medication to address the symptoms of anxiety and depression. To address feelings of isolation, she was referred to a women's group where she met new friends, and started to make crafts. After several months of treatment, she began to sleep better and have fewer symptoms. She was referred to a case manager and received outside services such as English as a Second Language. Her children were enrolled in relevant youth programs. An holistic approach was taken to empower her and to strengthen the identity of the whole family. Current events such as the attacks of September 11th, the Palestinian-Israeli conflict, the regime change in Iraq, and the ongoing suffering of the Iraqi people continue to remind her of her past traumas, provoke stress, and a need for support in order to cope. Her treatment is ongoing and includes individual therapy, participation in the women's group, and medication reviews. She would like to visit family in Iraq sometime again in the future and wishes to raise her children to cherish their culture and religious values. She places great importance on helping other people in need and has donated time and goods to others in spite of her own financial difficulties. She wants to work and improve her financial situation so she can help the needy overseas including her own family.

Currently, there are no known studies on mental health treatment efficacy with refugees from Iraq. However, there is a large and growing literature on various treatment issues with refugees and victims of torture (e.g., Bemak & Chung, 2002; Kira, 2002; Prendes-Lintel, 2001) including some review articles on refugees from specific cultural backgrounds (e.g., Brune, Haasen, Krausz, Yagdiran, Bustos, & Eisenman, 2002; De Vries, 2001; Nassar-McMillan & Hakim-Larson, 2003; Powell, Rosner, Butollo, Tedeschi, & Calhoun, 2003; Weine, Kuc, Dzudza, Razzano, & Pavkovic, 2001; Ying, 2001). As can be seen from the case studies presented above and as Kira (2002) notes, many refugees, including those from the Middle East, have suffered the most severe forms of cumulative trauma and torture, and our currently available measures may not adequately assess the relevant symptoms. A recent review of the literature suggests that there is a dearth of information on the psychological treatment of severely traumatized refugees, although the studies that are available suggest that some innovative treatment approaches with refugees have been effective (Nicholl & Thompson, 2004).

Kira (2002) has recommended a comprehensive assessment and treatment package using the wraparound approach to service provision with refugees from the Middle East. Based on comprehensive studies of the

needs and problems of torture victims, Farrag (2003) designed a psychosocial rehabilitation approach that aims at helping torture survivors from the Middle East restore and rebuild their social skills. In addition, this program provides specific treatment for posttraumatic stress disorder, and assists in meeting the other medical, social, legal, educational, and vocational needs of clients. Cumulative trauma in refugees is known to increase the risk of developing posttraumatic stress disorder symptoms, while having higher education, good language skills in the country of exile, and a strong religious or political belief system that lends meaningfulness to the trauma may lessen the risk and serve as a protective factor (e.g., Brune et al., 2002). While some individuals who have suffered moderate stress and trauma appear to note positive changes in themselves attributed to changes after the hardships (i.e., posttraumatic growth), it is unclear currently to what extent and under what conditions posttraumatic growth may occur in severely traumatized refugees, although younger refugees seem to fair better than older ones (Powell et al., 2003).

Weine et al. (2001) have suggested that primary medical care service providers need more education and training in helping to screen refugees for mental health services. Therapists who work with Arab Americans likewise see the need for collaborative efforts with medical service providers. Nassar-McMillan and Hakim-Larson (2003) conducted interviews with therapists who worked with Arab American clients including Iraqi refugees. One therapist described the postwar effects of trauma as "beyond PTSD". Therapists also described the impact as fostering the development and onset of depression, substance abuse, and other physical health problems. Providers may need to be alert for the possibility that typical assessment tools may be insufficient in capturing the experience of these clients. Careful interviews conducted by a bilingual professional or with the aid of an interpreter may be needed. Clinicians who have worked with Iraqi refugees have reported that many recent immigrants have broken family ties and have lost track of family members in their country-of-origin, thus leading to feelings of shame and fear. There may also be financial difficulties due to poverty, extreme feelings of distrust of others, and immediate crises in need of resolution. Clinicians have also noted the need for bilingual crisis counseling services and for collaboration with medical professionals (Nassar-McMillan & Hakim-Larson, 2003).

LIMITATIONS OF THE PRESENT STUDY AND DIRECTIONS FOR FUTURE RESEARCH

Additional studies are needed on the reliability and validity of the Arabic versions of the measures used in the present study so that norms can be created that are suitable for use with non-refugee Arab American immigrants and with refugees. As noted by other researchers working with refugees (e.g., Terheggen, Stroebe, & Kleber, 2001), it is important to include culture-specific items in non-Western samples along with the items standardized in Western samples. In addition to translating and back-translating measures into the language of the refugees, it may be important to modify the measures based on focus groups comprised of the refugees themselves in order to adequately tap the constructs of interest given cultural differences (e.g., Crescenzi, Ketzer, Van Ommeren, Phuntsok, Komproe, & de Jong, 2002).

With the information that would be available from such assessments, health professionals would be in a better position to measure the effectiveness of their treatments by comparing their clients on the measures before and after treatment relative to the functioning of the general Arab American population. Such an advance would be likely to result in improving overall treatment effectiveness in the long run. Thus, there is a clear need for both culturally sensitive assessment and for studies of clinical treatment outcome in the Arab American population.

Future studies with the Iraqi refugees will need to consider a number of factors regarding pre-migration functioning in the country-of-origin, the nature of the flight and first asylum, as well as adaptation to the host country (e.g., Bemak & Chung, 2002; Prendes-Lintel, 2001). As Hondius et al. (2000) note, many refugees also suffer ongoing sociopolitical strain that adds to the stress of their migration. Given the recent 2003 war in Iraq and the current changing political climate in the region, the mental health needs of Iraqi refugees are likely being affected by current events and personal experiences as well as by their past. Until we have more research on the long-term adaptation of refugees, clinicians will need to exercise caution in their interpretations. That is, they will need to be careful to not exaggerate, medicalize, or stigmatize survivors while at the same time optimizing care and empathic concern (Steel et al., 2002). In that sense, clinicians will need to make use of their best clinical skills and judgment as they help to promote well-being in their treatment of refugees (Marotta, 2003).

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