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DISSERTATION

Improving Mental Health of Refugees in the Post-migration and Pandemics Context

Verbesserung der psychischen Gesundheit von Geflüchteten im Kontext von Postmigration und Pandemie

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List of abbreviations

C-19-A Covid-19-Anxiety Questionnaire

DALYs Disability Adjusted Life Years

EMs Explanatory Models

IPSO International Psycho-Social Organisation

MEHIRA Mental Health in Refugees and Asylum Seekers

NGO Non-Governmental Organization

P2P Peer to peer

PHC Primary Health Care

PHQ-9 Patient Health Questionnaire

PHQ- 4 Patient Health Questionnaire

PTSD Post Traumatic Stress Disorder

SCCM Stepped-Care and Collaborative Model

TAU Treatment As Usual

WHO World Health Organisation

Abstract

Refugee movements and migrations are considered global phenomena worldwide. Germany, specifically, is one of the most receiving host countries for refugees and migrants in Europe. Since 2015 and after the Syrian war, people from diverse linguistic and cultural backgrounds fled to Germany. Refugees are at high risk of developing symptoms of general mental disorders such as depression, anxiety and PTSD. However, the mental health care system in Germany was not well prepared and several barriers prevented refugees from using its services, including cultural misunderstanding, language and administrative barriers. In addition, in March 2020, the WHO declared the COVID-19 outbreak in Wuhan, China as a pandemic and various strict measure had to be taken by the governments worldwide. This led to the exacerbation of mental illnesses in the general population, especially in disadvantaged groups such as refugees.

With the 1978 Alma Ata declaration, community participation and empowerment were brought to the forefront as a key component of PHC. Therefore, such empowerment interventions offered in the early stages of refugee resettlement were developed to help refugees arriving in Germany.

The aim of this dissertation, within the framework of three publications was first to assess a cost-effective, cultural compatible P2P self-help intervention for refugees that was established at the Charité. This intervention was administered to refugees suffering from depression and was related to other help initiatives such as that from the Civil Society Engagement. Secondly, the dissertation shed light on the impact of the COVID-19 disease on the mental health status of refugees, aiming to improve interventions during the present pandemic and beyond.

The results of the three publications suggest that integrating culturally sensitive interventions in mental health services and primary care is an important step to achieve better health outcomes among refugees. Integrating mental health care and empowerment in PHC are two important approaches in health care as regards to prevention of mental illnesses, promotion, access and quality of care delivered. These observations are relevant to the discussion on improving care for disadvantaged refugee groups and must be properly considered by the German health care system.

Zusammenfassung

Flüchtlingsbewegungen und Migrationen gelten weltweit als globale Phänomene. Deutschland im Speziellen ist eines der am meisten aufnehmenden Gastländer für Geflüchtete und Migranten in Europa. Seit 2015 und nach dem Syrien-Krieg sind Menschen mit unterschiedlichen sprachlichen und kulturellen Hintergründen nach Deutschland geflohen. Geflüchtete haben ein hohes Risiko, Symptome allgemeiner psychischer Störungen wie Depressionen, Ängste und PTBS zu entwickeln. Das psychische Versorgungssystem in Deutschland war jedoch nicht gut vorbereitet und mehrere Barrieren hinderten Geflüchtete daran, die Angebote zu nutzen, darunter kulturelle Missverständnisse, sprachliche und administrative Barrieren. Hinzu kam, dass die WHO im März 2020 den COVID-19-Ausbruch in Wuhan, China, zur Pandemie erklärte und verschiedene strenge Maßnahmen von den Regierungen weltweit ergriffen werden mussten. Dies führte zu einer Verschärfung der psychischen Erkrankungen in der Allgemeinbevölkerung, insbesondere bei benachteiligten Gruppen wie Geflüchteten.

Mit der Alma-Ata-Deklaration von 1978 wurde die Beteiligung und Befähigung der Bevölkerung als Schlüsselkomponente von PHC in den Vordergrund gerückt. Daher wurden solche Empowerment-Interventionen, die in der frühen Phase der Flüchtlingsansiedlung angeboten wurden, entwickelt, um den in Deutschland ankommenden Geflüchteten zu helfen.

Ziel dieser Dissertation war es, im Rahmen von drei Publikationen zuerst eine kosteneffektive, kulturkompatible P2P-Selbsthilfe-Intervention für Geflüchtete zu evaluieren, die an der Charité etabliert wurde. Diese Intervention wurde bei an Depressionen erkrankten Geflüchteten durchgeführt und mit anderen Hilfsinitiativen, z.B. aus dem zivilgesellschaftlichen Engagement, in Beziehung gesetzt. Zum anderen beleuchtete die Dissertation die Auswirkungen der COVID-19-Erkrankung auf den psychischen Gesundheitszustand von Geflüchteten mit dem Ziel, Interventionen während der aktuellen Pandemie und darüber hinaus zu verbessern.

Die Ergebnisse der drei Publikationen legen nahe, dass die Integration von kultursensiblen Interventionen in die psychische Gesundheitsversorgung und die Primärversorgung ein wichtiger Schritt ist, um bessere gesundheitliche Ergebnisse bei Geflüchteten zu erzielen. Die Integration von psychischer Gesundheitsversorgung und Empowerment in der PHC sind zwei wichtige Ansätze in der Gesundheitsversorgung im

Hinblick auf die Prävention von psychischen Erkrankungen, die Förderung, den Zugang und die Qualität der erbrachten Leistungen. Diese Beobachtungen sind relevant für die Diskussion über die Verbesserung der Versorgung von benachteiligten und geflüchteten Gruppen und müssen vom deutschen Gesundheitssystem angemessen berücksichtigt werden.

1 Introduction

Refugees are ordinary people in extraordinary circumstances. (Barbara Harrell-Bond, Founder Refugee Studies Centre, University of Oxford)

A Brief History on Mental Health

The 1978 Alma Ata declaration confirmed the WHO's holistic definition of health as a state of complete physical, mental and social well-being, and not merely the absence of disease. Health is a fundamental human right and achieving the highest possible level of health is a highly important world-wide social goal (World Health Organization, 1978). WHO has also proposed that mental health is more than the absence of mental illness, it is rather a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (World Health Organization, 2001).

Although mental and emotional disorders are major health problems, the history of mental health care reveals stigmatization of persons with mental disorders (Mundt et al., 2015). For example, many believed that people who are mentally ill, should be killed to save health care costs, the euphemism “euthanasia” was used to refer to the killings (Torrey & Yolken, 2010). Also, many considered that the mentally ill should not have children, which has often led to their eugenic sterilization (Seeman, 2014), and others were placed in prisons and asylums due to their disorders (Mundt et al., 2015). In the 1960s, the number of psychiatric beds decreased substantially in South America; a study done of Mundt et al. explored the association between decreased bed numbers and number of prisoners and found out that each removed bed was equivalent, on average, to 5.18 more prisoners (Mundt et al., 2015). This finding suggests that lack of care can lead to severe forms of social isolation.

Neuropsychiatric conditions account for 13% of the total DALYs lost, and five of the ten leading causes of disability and premature death worldwide are psychiatric conditions, with unipolar depression alone accounting for 5.7% of DALYs. (World Health Organization, 2004a). Therefore, priority should be given to prevention and promotion of mental health to reduce the increasing burden of mental disorders (World Health Organization, 2004a).

Figures about Refugees

According to the United Nations Report on Refugees, the world is currently experiencing the highest levels of refugees on record. As a result of persecution, conflict, violence, or human rights violations, almost 79.5 million people around the world have been forced to flee their homes; among them are nearly 26 million refugees, around half of whom are under the age of 18 (UNHCR, 2020) and this is the highest number seen since UNHCR was founded in 1950 after the Second World War (UNHCR, 2020).

In 2014 alone, 19.5 million people were refugees and 1.8 million people were asylum seekers; 42,500 individuals per day were forced to flee their home in comparison with 32,200 in 2013 and 10,900 per day in 2010 (Dapunt et al., 2017).

Germany recorded the highest level of immigration since 1950, registering a net immigration gain of 1,139,000 people in 2015 and it was considered the top receiving country among industrialised nations (Dapunt et al., 2017). At the end of 2019, Syrians continued to be by far the largest forcibly displaced population worldwide (13.2 million), among them 6.6 million refugees and more than 6 million internally displaced people (UNHCR, 2019).

Migration and Mental Illnesses

Evidence suggests that refugees are more prone to experience a substantial level of psychological stressors and traumatic events, and thus are at a high risk of developing mental disorders (Kirmayer et al., 2011). A systematic review about the prevalence and risk factors for common mental health problems among refugees found that the prevalence of specific types of mental problems can be attributed to migration trajectories: premigration (economical, occupational, and educational burdens in country of origin), migration (exposure to harsh conditions and violence), and postmigration (loss of social status, unemployment and language difficulties, uncertainty about the refugee status, worries about family back home, and difficulties in acculturation and adaptation) factors play a role (Kirmayer et al., 2011).

Research shows that refugees have numerous needs that are often unmet, such as food, housing, medical and mental care (Bartolomei et al., 2016). Despite the significant levels of mental disorders, refugees rarely seek help from professionals, which is mainly due to the negative portrayal of psychiatry, fear of being stigmatized by one’s community and

the lack of information concerning the available psychiatric services (Bartolomei et al., 2016).

If left untreated, refugees with mental health issues could face chronic illnesses that result in social withdrawal, unemployment and the inability to integrate into the host society. In addition to that, restricted access to mental health care can lead to increased costs of care (Nesterko et al., 2019). Consequently, there is an urgent need for early assessment and screening of common mental disorders in refugees that can detect and reduce symptoms at an early stage, support access to specialised mental health care, and lower the risk of chronic trajectories of mental disorders (Nesterko et al., 2019).

Accumulation of Trauma

In December 2019, a local outbreak of pneumonia-like symptoms of a new disease (COVID-19) caused by a previously unknown virus (SARS-CoV-2) was detected in Wuhan city, China (Dong et al., 2020). On 11 March 2020, the WHO announced the outbreak as a pandemic, with currently (29 January 2021) 100,819,363 confirmed cases of COVID-19, including 2,176,159 deaths, reported to WHO (World Health Organisation, 2021).

The novel coronavirus disease is a public health concern that poses a profound burden on both the physical and the psychological health (Liu & Heinz, 2020). Even though the WHO has set a series of preventive measures to protect individuals from being infected with COVID-19 (World Health Organization, 2020), not all persons are privileged enough to be able to abide by the recommended safety measures, especially refugees who are often socially excluded and stigmatized, have limited access to the healthcare system and often experience crowded and substandard living conditions (Lau et al., 2020). Refugees are in fact the most disadvantaged population facing the COVID-19 pandemic, who already face the cumulative trauma they have been exposed to due to various adversities in the course of the flight from their country. Also, they have to face disadvantages as services consumers due to language limitations and poor orientation in the host society, thus an exacerbation of pre-existing psychological illness due to fear and uncertainty is likely to occur.

1.1 Statement of the Problem

In Germany, a treatment gap was detected in the healthcare system; the needs of the rather high number of newly arriving refugees since 2014 were not met. Of an estimated

379,848 refugees in need of mental health care in 2015, only about 5% received some kind of treatment (BafF- National Association of Psychosocial Centers for Refugees and Victims of Torture, 2018). This gap in mental health care is a consequence of multi-component barriers that limit the initiation and continuation of treatments among individuals with mental disorders (Böge et al., 2019).

Barriers to mental health services can include lack of knowledge and information about mental health, in addition to language, administrative and financial barriers. These barriers are often related to limited use of preventive care, as well as the stigma of mental health and feelings of shame or fear of what the community might think about a mentally ill person (Nazzal et al., 2014). An additional barrier is the inequity in treatments and interventions, as apparent throughout the history of pandemics, where vulnerable groups such as refugees and immigrants are at a higher risk of developing more severe physical and mental illnesses (Kuy et al., 2020). We therefore need an immediate call to action by targeting interventions that protect the most vulnerable from COVID-19.

When designing interventions that are addressed to refugees, it is important to take cultural practices as well as the migration or refugee narrative and experiences into consideration (Kirmayer et al., 2011). Diversity of cultures as well as the individual migration narrative can significantly influence every aspect of illness, including interpretations of the symptoms, coping, help seeking and adhering to treatments, in addition to relationships between patients, their families and health care providers (Kirmayer et al., 2011; Penka et al., 2008). Patients in primary care with mental health problems often lack knowledge about mental health conditions and often seek help with ‘physical’ rather than ‘mental’ complaints such as somatic symptoms including musculoskeletal pain, that can lead to under-recognition of common mental disorders (Kirmayer et al., 2001). Moreover, in many cultures, depression and anxiety are viewed as sociomoral problems who are to be openly addressed only among family members, elder people, spiritual or community leaders, or someone else who is familiar with their cultural context (Kirmayer et al., 2011; Kleinman, 1980). Other factors such as fatalism - the acceptance of one's situation and reliance on God - is likely to affect the extent to which one seek mental health help when needed (Hsu et al., 2004).

Clinical practice is often not well equipped to cope with cultural and social diversity, due to the inability to provide translators and cultural interpreters in health care settings, who

are important when it comes to avoiding misunderstandings based on divergent explanations of diseases (Heinz & Kluge, 2012; Penka et al., 2012).
Due to all these hurdles and barriers, it is essential that mental health care systems serving refugees in Germany become better equipped to outreach to and support refugee communities in order to mitigate mental health complications in a community and culturally compatible fashion.

1.2 Theoretical Background: Empowerment Theory and Empowerment-based Interventions

“Empowerment is a construct that links individual strengths and competencies, natural helping systems, and proactive behaviours to social policy and social change” (Rappaport, 1981) (pp. 1-25). Empowerment is a vision or a philosophy that includes activities directed to enable people to increase control over their own lives (Swift & Levin, 1987). As stated by Funnell and Anderson (Funnell & Anderson, 2003) (pp. 454-464): “It is the discovery and development of one’s inherent capacity to be responsible for one’s own life”. To be empowered is not only to be involved in, but also to be able to make decisions (Swift & Levin, 1987).
Empowerment connects mental health to mutual help and focuses on capabilities rather than identifying risk factors and it explores environmental influences on social problems instead of “blaming the victims” (Perkins & Zimmerman, 1995). In other words, people are not regarded as powerless victims, but rather as individuals who are able to identify solutions for their own problems and their own well-being. At the community level, empowerment refers to collective actions to improve the quality of life in a community and the connections among community organizations (Perkins & Zimmerman, 1995).
In health care, patients are empowered when they have enough knowledge, skills and self-awareness, which are necessary to guide their behaviours, to cope with everyday stress and to improve the quality of their lives (Funnell & Anderson, 2003). The concept requires the awareness of one’s own empowerment deficits and the mobilization of resources to move from the disempowered to the empowered state (Swift & Levin, 1987). The patient empowerment approach differs from traditional patient education. It does not aim at improving compliance with the recommendations of health-care professionals. Instead, patient empowerment means possessing knowledge for decision making and not just to be recipient of professional knowledge. It aims to maximize the knowledge

regarding self-care, skills, self-awareness, and sense of personal autonomy of patients to enable them to take charge of their own wellbeing (Anderson et al., 1991).

Empowerment education is organized to be an effective health education and prevention model that leads to health promotion. The model proposes that participation of people in groups and dialogues enhances control and beliefs in the ability to change one's own lives, and reduces the patient provider hierarchy (Wallerstein & Bernstein, 1988).

Also from a public health perspective, empowerment programs, social support and community networks are recognized by the WHO as macro-preventive and protective strategies that aim at improving the determinants of mental health and happens when people start believing they can identify solutions to problems and create change (World Health Organization, 2004b).

The intervention presented in this dissertation is based on the empowerment theory. In the following sections, the dissertation will first separately review the multifaceted literature on civil society involvement and self-help groups for empowerment-based approaches in refugee support.

Civil Society

In Germany, civil society volunteers developed a 'welcome culture' ('Willkommenskultur') to help the state in its social and administrative work (Funk, 2016). Organisations working with refugees estimated an average increase of 70% of interest in volunteering for refugees since 2015. Volunteers were predominantly female, between twenty to sixty years old, and often had a migrant background themselves. They were more often nonreligious than the societal average (Karakayali & Kleist, 2016). Volunteers played a crucial assistance role for refugees, helped them overcome the bureaucratic hurdles, taught them German language, invited them to stay at their places or helped them search for accommodation, and organized many social activities like cultural events and festivals. However, it was observed that civil society often acted *for* refugees rather than *empowering* them (Funk, 2016). Volunteers offer refugees the chance to take an active part in shaping their integration process; however, refugees' first priority is often to start their new lives as soon as possible, which for them meant learning the language and finding a paid job (Ghorashi & Rast, 2018).

Previous research showed that the number of people who were willing to volunteer exceeded the actual number of refugees within the community even in rural areas. The phones of volunteer agencies at city administrations "did not stop ringing", and many

volunteer initiatives were unable to cope with the sheer number of people willing to support and help (Fleischmann & Steinhilper, 2017). However, it is important to state that the motives and reasons for civil society engagement are always multifaceted and complex and are not only limited to the will to help refugees. The so-called “refugee crisis” in Germany is described by some as perhaps the first political and societal situation in which many volunteers felt called upon to do something because politics alone would not master the situation.

The events that happened in Cologne on New Year’s Eve 2015/2016, represented a turning point about refugees in Germany. After the sexual assaults that hundreds of women experienced, what was once considered a welcome culture *“Willkommenskultur”* changed into discussions about dangers of “political correctness”, too liberal immigration policies, and the general danger of “Muslim patriarchy”. Such discussions often emphasized the German values of gender equality and tended to portray refugees as a threat to these values (Boulila & Carri, 2017).

Also, on 19th of December 2016 in Berlin, a truck crashed into a busy Christmas market next to the Kaiser Wilhelm Memorial Church, at Breitscheidplatz in the heart of City West. Nine people were immediately killed, and another three later died in hospital suffering from their injuries. The driver entered Germany in 2015 as an asylum seeker and was in connection with the terrorist organisation Islamic State (IS) (Berliner Morgenpost, 2016). Numerous similar incidents took place in Germany and were attributed to refugees, thus substantially altering public opinion and turning a large part of the population against the “welcome culture” (Steinberg, 2017).

The perceived image of a refugee as a threat to national security and culture and/or as a “weak victim” can both feed the `self-other´ gap between volunteers and refugees, reproduce the problem of exclusion, and allow power-based relationships to take place. A study of Larissa Fleischmann shows that many volunteers have clear opinions regarding those who “deserve” to receive help, for example Syrians with a good “Bleibeperspektive” (perspective of staying), particularly, women and children, while rejecting the asylum claims of refugees from African countries or single young men who are often perceived as not deserving help (Fleischmann, 2017).

Self-help P2P Groups

Peer support and the integration of P2P interventions into healthcare is a concept of central significance to health practitioners today, as the focus shifts from treatment to

health promotion and PHC (Dennis, 2003). By definition, P2P is a term used to describe the diverse range of practices that provide different systems of support where people with shared experiences can aid each other in well-being by creating support networks (Flegg et al., 2015). P2P programs are considered valuable means to complement the psychosocial care systems. They are usually conducted by peers who share a common cultural background, language, and knowledge about the problems that their community/group experiences (Webel et al., 2010). Peer-led interventions have been effective in improving a variety of health issues including heart disease, diabetes, bipolar disorders, schizophrenia, substance abuse and sexual behaviours (Deitrick et al., 2010; Im & Rosenberg, 2016). Recently, P2P and self-help programs have also been introduced to help refugees and asylum seekers to overcome their physical and mental health problems (Burnett & Peel, 2001). People seeking asylum are not a homogeneous group and their needs vary widely. Coming from different cultural backgrounds and countries and having different experiences has an impact on the expectations and acceptance of healthcare. Studies found that one in six refugees has a physical health problem that is serious enough to affect his/ her life, and two thirds have experienced anxiety, depression, and PTSD (Burnett & Peel, 2001; Fazel et al., 2005; Kirmayer et al., 2011). Literature suggests that P2P helps refugees in: getting out of isolation, providing a place to talk about problems and to receive support, learning about one`s rights, finding friends, getting advice, and learning about the receiving community (Behnia, 2003; Block et al., 2018; Wöller, 2016; Wollersheim et al., 2017). At the Charité, a P2P self-help empowerment-based intervention (Study 2) was introduced and aimed at providing a space to share challenges and experiences and to reduce isolation.

1.3 Aims

The peer reviewed publications presented in this dissertation aim at:

a) providing qualitative data elucidating volunteer-refugee interactions, misunderstandings and conflicts that might arise in the refugee-volunteer relationship (Study 1).
b) assessing a peer-centred and culturally competent intervention offered to the refugees after their arrival to Germany and describing the variables that predict the success in such groups (Study 2).

c) assessing the mental health and psychosocial impact of the COVID-19 pandemic on refugees aiming at improving interventions for future pandemics (Study 3).

2 Methods

Study 1 (Abi Jumaa, Mehran, et al., 2020)

This project was funded by the Federal Government Commissioner for Migration Refugees and Integration and it was part of a research intervention cluster that is composed of 14 projects.

To conduct the field research, five refugee accommodations and three volunteering initiatives were involved. The explorative field study was carried out at those eight institutions and initiatives. Structured interview guidelines based on field insights and theoretical considerations were developed. Altogether, 16 interviews with German female volunteers and 16 interviews with refugee women; 8 Arabic speaking from Syria, Iraq and Lebanon, and 8 Farsi speaking from Afghanistan were conducted in the mother tongue of the interviewees (German, Arabic and Farsi). The structured interview guidelines comprised the following topics: the expectations of refugee women towards female volunteers – and of volunteers towards refugee women, the ways in which female volunteers dealt with emotional stress regarding their engagement with refugee women, the conflicts that arised in the encounters and within the relationships due to discrimination, prejudice etc. and possible solutions. Socio-demographic questionnaires informed consent materials in German, Arabic, and Farsi were developed. Theoretical sampling was carried out (Gentles et al., 2016). All the interviews were recorded, translated into English and transcribed. They were then imported to ‘MAXQDA standard’. A qualitative content analysis was conducted in three-level coding (Hsieh & Shannon, 2005). For each interview, there were two members of the team conducting the analysis to include neutral and wider perspectives. Thereby, we included different cultural points of views in the analysis. In the first level, codes were formulated without any interpretation, quoted and condensed directly from the text. Each interview was analyzed separately, independent of the others. In the second level, the codes from the first level were abstracted and categorized based on their frequency and relatedness to each other. Finally, in the third level, the codes from the second level of all 32 interviews were combined by comparing and developing major categories. At this level, the codes were interpreted and highlighted into new final codes by all team members. The interviews were analyzed qualitatively by “an intercultural analytical group” based on comparative interpretations of the different project members.

Study 2 (Abi Jumaa, Kluge, et al., 2020)

This project was part of a broader project MEHIRA that involved six German university hospitals including Berlin, Aachen, Marburg, Mannheim, Munich, and Ulm. The project aimed at overcoming the mental health care barrier by developing and implementing a set of interventions within a SCCM for refugees with clinical depression, which has the potential to improve the efficiency of psychological therapy provision (Bower & Gilbody, 2005). The interventions at each step range from Step 1: watchful waiting, Step 2: self-management and support through a smart-phone-based application and Peer-to-Peer Support groups (P2P), Step 3: expert intervention and Step 4: structured therapy through psychiatrist and psychotherapists.

Participants of MEHIRA were screened at the beginning of the project and were randomized to either SCCM or TAU. PHQ9 was used to assign patients to their appropriate intervention. With the help of social workers working in different emergency centres in Berlin, participants falling in Step 2 were recruited. The sample included 9 potential peer trainers (5 women and 4 men). The trainers had to be between 18 and 64 years old, possessed interpersonal skills, and could speak either English or German. These peers completed two intensive peer workshops and were trained by psychiatrists and psychotherapists during a period of 12 weekly supervision sessions where a training manual was discussed and developed. The supervision sessions were conducted in English and translated into Arabic or Farsi when needed by the moderators. The topics of the manual included the following: Stress and its symptoms, breathing relaxation, progressive muscular relaxation techniques, vulnerability and resilience factors, opportunities to improve integration, and strategies for resolving conflicts and cultural misunderstandings in Germany. After completion of the workshops, the trained peers were able to recruit 17 participants from three shelters in Berlin (9 males and 8 females), who were from Syria and Afghanistan. These participants created 4 groups, each led by two native peer trainers of their own language. On a weekly basis, a total of 6 sessions with a duration of 90 minutes took place. The group size had to be at least two persons excluding the peer trainers. The topics of the group discussions were identical to those of the supervised peer trainings. The sessions were not recorded, but after each session, protocols were taken. An eight-item semi-structured interview guide invited 10 participants (excluding the peer trainers), who agreed to take part, to describe their experiences with the intervention including the perceived support from peer group

facilitators and from other refugees. They were also asked to share their expectations and outcomes, in addition to their satisfaction and preferences regarding the topics and recommendations for improvement. Interviews were conducted with the participants after 3 months from the beginning of the intervention and lasted for about 40 minutes.
All participants were at least six times present in the peer group. Interviews were conducted in Farsi and Arabic and translated back to English by the authors. After transcription and translation, interviews were added and coded in MAXQDA software program. Thematic analysis was used to analyse the data (Hsieh & Shannon, 2005). Two level coding was conducted, where the first level was descriptive and close to the text. In the second level, categories were generated based on the recurring themes and the structured questionnaire.

Study 3 (Abi Jumaa et al., 2021)

This research project used a mixed methodology for collecting and analyzing the data. For the quantitative part, an online questionnaire, which was designed by the research group of Anxiety Disorders at the Charité University Medicine Berlin, was translated into Arabic and distributed among Arabic speaking refugees and migrants in Germany. The minimum age of participation was 18 years. The questionnaire included questions concerning demographic information, the perceived risk of being infected with the Coronavirus, the daily average amount of hours spent thinking about the Coronavirus, hours spent on media news, as well as the PHQ-4 and C-19-A questionnaires, and specific phobia related questions. The questionnaires were accessible via the platform SoSci Survey and data was analyzed using IBM SPSS Statistics Version 26.
For the qualitative part, ten semi-structured interviews were conducted (three men and seven women). The semi-structured interview guideline comprised of the following topics: What do refugees know about the Coronavirus, how did they feel when they first knew about it, in case they got infected: do they have enough information on where to go, how do they describe their feelings comparing between flight fear vs. COVID-19 fear. All the interviews were conducted by telephone due the lockdown and were recorded, translated and transcribed into English. They were then imported to ‘MAXQDA standard’. A thematic analysis was conducted using three-level coding.

3 Results

Results of Study 1 (Abi Jumaa, Mehran, et al., 2020) generated two main categories:

1. Uncertainty regarding the definition of "volunteering"

Results showed that neither volunteers nor refugees had a clear understanding of the concept of volunteering. Reasons and motivations for volunteering differed among the volunteers, this resulted in different roles volunteers adopt and different ideas and visions were negotiated between them through their engagement. For example, re-awakening of civil responsibility, a high emotional impact of media coverage and efforts to dispel the fears and resentments about refugees played a central role in the engagement of the large number of volunteers.

Additional findings declared that volunteers related their own engagement to their respective families' social engagement or their interest in foreign cultures. For many, a self-understanding as a liberal and open person is the initial trigger for their volunteer engagement. Other volunteers explicitly decided to offer volunteer work only to refugee women, and this was due to the assumption that refugee women have a special need for protection.

There seems to be a solidarity of women for women due to an awareness about universal sexism and gender-specific discrimination and also the oppression of women within their relationships and marriages. This attitude indicated that one of the motivations for female volunteers to engage with refugee women are experiences from their own social relations and encounters to overcome societal prejudices against refugees.

On the other hand, refugee women perceived that the volunteers' motivation to help was a humanitarian action. This perception of volunteers as helpful, efficient facilitators of care structures sometimes led to an idealizing image of volunteers in the eyes of refugees. The actual possibilities and spheres of influence of volunteers in providing concrete help to refugees were sometimes overestimated.

Refugee women were often unable to distinguish between paid staff in the accommodations and volunteers working free of charge. There were strong fluctuations among volunteers including lack of continuity of their presence (mostly caused by semester breaks and holidays), changes in their positions, and sometimes ending up as paid staff in the accommodation. These fluctuations increased the already existing uncertainties in demanding requests from volunteers. The unannounced absence of the

helpers or other forms of discontinuity of contact were felt by many women as sad and painful.

Some volunteers who had professional backgrounds had uncertainties about the delimitation between their professional role and their volunteer role. While some volunteers expressed a clear wish to maintain a certain fixed role in their contact to refugee women, they expressed the concern of raising false expectations or getting caught in time-consuming activities that would prevent them from focusing on their original tasks. Other volunteers expressed the exact opposite wish by wanting personal contact and friendship with refugee women.

The two groups of volunteers and refugees had different approaches in their relationship. Some volunteers wished to overcome the cultural differences between them and refugee women by formulating implicit or explicit educational instructions, e.g. by imparting German customs and values to the refugee women. They claimed that their own lifestyle and appearance as modern women should be respected. Refugee women, on the other hand, decisively rejected this educational approach and wished for a mutual process in negotiating values and norms. They appreciated German women's freedom but wanted to decide on what to adopt from the host culture. Refugee women's wish for bilateral relationship with volunteers came along with interest in learning more about the volunteers' life stories and not only sharing their own personal stories one-sidedly.

2. Misunderstandings and imbalances in the relationship volunteers and refugee women

Some volunteers mentioned feelings of suspicion and mistrust towards the refugee women, which was not communicated in their interactions. Differences between the two groups were especially apparent in the context of practicing religion. Some volunteers even concluded that the cultural/religious differences between Germans and Muslim refugees were too big to enable integration and solve the "refugee crisis." The volunteers claimed that refugee women did not participate in the offered activities despite significant and diverse efforts to involve them, and they also did not communicate concrete reasons for their absence. This fact caused feelings of frustration and helplessness among many volunteers, as well as speculations about refugee women's lack of reliability and willingness. Refugee women on the other hand explained their low participation by the lack of offers for childcare in parallel to activities and the little support in transportation. Further obstacles in accessing activities were the high costs for materials, e.g., cooking

equipment. The special needs and requirements for their participation could not be communicated because of the language barrier. Both groups perceived the language barrier as the biggest obstacle in the process of creating relationships.

According to the interviews, only a few close relationships are formed between refugee women and female volunteers, and the interactions were more prone to keep a distance. Usually, refugee women who did not establish any relationship with volunteers, interacted with other refugee women inside the accommodations. Establishing a relationship and contact with people from a similar linguistic and cultural context was easier and was more often preferred. Higher German skills were necessary for them to be able to build up more intimate relationships, whereas the volunteers assumed that cultural differences were the reason for experiencing a personal distance.

Refugee women rarely shared their personal traumatic experiences to avoid criticism and because of fear that shared information would not be confidentially treated and might harm the volunteer's feelings. Also, volunteers were afraid of triggering refugee women's emotions by inappropriately questioning them about the experienced events during their flight. They also did not feel confident to deal with the resulting situations which might include intense reactions of their counterparts.

Experiences of discrimination in the accommodations based on ethnic origins or nationality were also displayed in the interviews. Tensions between Farsi- and Arabic-speaking people are created mainly due to the different chances in the asylum-seeking process. Non-inclusive offers by volunteers were interpreted by the disadvantaged refugee group as an act of discrimination. Even when interpreters were involved, the interviewed women reported that they mistrust them because they often had the impression that they are censored. A clarification of refugee women's needs, concerns and the assumptions of volunteers rarely took place in a dialogical way.

- Results of **Study 2** (Abi Jumaa, Kluge, et al., 2020) generated two main categories:

1. Benefits of the P2P program

Refugees mentioned the following benefits of the peer groups: they considered it a safe place where they can share their mutual experiences. It was possible for them to make new friends from the same culture and to try to find common solutions together. It decreased their loneliness and feelings of being the only ones in this situation. Building a safe place to share experiences and trust between the group members helped in providing them with some skills to accept and listen to each other. On the one hand,

exchanging experiences offered them ideas for possible solutions. And on the other hand, the person who shared the experiences felt good by assisting others in finding solutions to problems. Refugees often reported feelings of guilt and shame because they were not telling their families back home about their real situation, feelings of powerlessness, helplessness, and low self-esteem. However, they felt safer once they openly shared these feelings and realized that they were mutual.

As mentioned by some refugees in the intervention, peer groups were perceived more beneficial than individual psychotherapy, as it helped him to sleep and to study better without any medication. Treatment that was only based on drugs was perceived by some refugees as ineffective. Also, the long waiting times for individual psychotherapy appointments were annoying, some of them had to wait for at least three months for an appointment, thus P2P was considered a more available option.

2. Variables that contribute to the success of a P2P group

Refugees preferred the content of the sessions to be more flexible and personalized. For them, these sessions were a place to share their experiences and stories. They would like to talk about their everyday struggles and experiences rather than general fixed (and oftentimes perceived as unimportant) topics. Some refugees would have preferred that they had an idea about the content of the further sessions, because they needed time to think about the themes that were going to be discussed. Regarding the gender of the group, gender homogeneity was mainly requested by female refugees. As explained by them, this was related to the cultural practices back home in the Middle East, where males and females are usually separated and sometimes not allowed to be together in public events and gatherings. Bigger groups' size facilitated gender heterogeneity, but it was recommended that the number of women and men in the group should be balanced to prevent domination of any group.

On the other hand, age range was favoured to be homogeneous. Refugees wanted the group members to be of the same age and mindset. Different ages might bring conflicting perspectives and uncommon problems. The size of the group played a role on the participants' feeling of security. When the group is small, it was easier to notice when someone is absent, which had a negative effect on the group dynamics. That is why the participants preferred bigger groups where the fluctuation would not be very visible. In addition to that, it was repeatedly stated by the refugees that extremely sad and depressed people in the group increased their own sadness and lowered their mood.

Since they are searching for a safe and happy place, they would prefer not to encounter severe sadness in the sessions. It was expected that the group leader should be “happy”, talkative, energetic and a positive person. Moreover, the group leader was perceived more knowledgeable, mature, and experienced than other members of the group. Having different cultural backgrounds might lead to misunderstanding and confusion in the group. Therefore, it was regarded as ideal when the group leader was from the same cultural and language background as the participants.

- Results of **Study 3** (Abi Jumaa et al., 2021) generated the following outcomes:

Findings from this study were compared to the general German population, who also had access to the German version of the questionnaire. Our sample included 85 participants, 77 provided information about their legal status in Germany: 20.8% were refugees, 48.3% were migrants with a residence permit and 31.2% were migrants with a German passport. Our results from the ultra-brief screening scale of the PHQ-4 scale showed that there was a high level of depressive and anxiety symptoms during the COVID-19 pandemic among both the participants and the German population. The mean PHQ-4 total score was 4.05. There was no difference in the median PHQ-4 score between men and women ($\tilde{x}$ = 4.00, SD = 2.98). The median total PHQ-4 score for refugees was the highest when compared to the migrants without and those with a German passport ($\tilde{x}$ = 5.4).

32.7% of the participants indicated severe COVID-19-Anxiety symptoms based on the modified Specific-Phobia Scale C-19-A, with an average score above 2.5. Likewise, the score was highest for the refugee group ($\tilde{x}$ = 2.4) when compared to migrants ($\tilde{x}$ = 2.0) and holders of German passport ($\tilde{x}$ = 1.8)

54.5% stated to be afraid to become infected with COVID-19; 76.4% reported to be afraid of the consequences for the health of their relatives, and 56.4% stated to be afraid of the economic consequences on their life.

Social media platforms were the main source of information, whereas it was official websites of the government or health authorities for the German speaking one. Participants spent approximately 98 minutes per day on media.

Qualitative results also showed that the mental health status of the refugees was worsened in the face of the COVID-19 pandemic. All ten except one participant reported that the pandemic reminded them of the past experiences; war in the home country threatened to end their lives, and now the Coronavirus also posed an imminent danger to their health and lives. What worsened the situation is the fact that they had no

independent information on where to get medical help, in case they were infected, and were very much dependent on the translators. Also, due to the strict lockdown and restrictions, refugees experienced boredom, anger, frustration and irritability. Their German classes as well as their foreign office appointments were postponed, all increasing the feelings of instability, and fear of deportation. As the result of the low SES, some refugees still lived in small rooms in overcrowded refugee shelters, and some had to go to work to earn a living even during the lockdown.

4 Discussion

Due to the large number of refugees that arrived in Germany in 2015, and the lack of qualified personnel who could offer psychotherapeutic and psychological help, a need arose for organizing and carrying out innovative mental health interventions such as training of non-professionals to be able to offer some help. Support from trained individuals and nonprofessional volunteers aimed at preserving their mental health and empowering them to overcome the burdens (Abi Jumaa, Kluge, et al., 2020).

Results from this dissertation show that the different experiences that refugees pass through, and feelings of being stuck in hopeless and instable situations, which were very high during the pandemic, put a huge psychological burden on refugees and amplified the demands on the mental health system. Refugees however could regain their ability to better function through well-structured talks in safe places (i.e. peer support groups), which allow them to self-explore and understand their own situation (Abi Jumaa, Kluge, et al., 2020).

Our results (Abi Jumaa, Kluge, et al., 2020; Abi Jumaa, Mehran, et al., 2020) also show that refugees are already a vulnerable group who already experienced stressful situations in their home country, during the flight as well as related to the lengthy and unpredictable asylum seeking processes and challenges in regards to integration in a new country. These experiences were especially exacerbated during the pandemic that caused further uncertainty in their legal and administrative processes, boredom, fear and anxiety (Abi Jumaa et al., 2021).

Results of Study 3 (Abi Jumaa et al., 2021) revealed refugees´ concerns in regards to COVID-19 and the cumulative trauma they experienced having been exposed to various adversities in the course of the flight from their country. Also, it explored their disadvantages as services consumers due to language limitations and poor orientation in the host society. Refugees regularly lack suitable accommodation, employment, and access to the health care system, which make them one of the weakest populations dealing with COVID-19. If there are no measures taken in order to improve their conditions, the risk increases for an outbreak of COVID-19 among refugee groups. In fact, morbidity and mortality are not simply based on infections or other biological reasons (Braveman & Gottlieb, 2014): there are underlying social, economic, and cultural factors, which in turn, condition the biological, physical and chemical factors so as to cause the

disease (Braveman & Gottlieb, 2014). It appears that COVID-19 has evolved into a worldwide social disease subsequent to infectious diseases such as tuberculosis and HIV/AIDS that are also associated with social factors. Considered from this point of view, social determinants of health are linked to the prevalence of infection. Moreover, viewed from the consequences of the infection and with respect to public health measures, the social effects of the pandemic manifest itself more distinctively in disadvantaged groups such as refugees.

Rudolf Virchow, father of social medicine, revealed during the typhus epidemic (1848) the importance of social factors in the emergence and spread of epidemics, and concluded that despite the biological causality, the underlying causes of epidemics are problems in political and social structuring. He also observed that disadvantaged groups are particularly vulnerable to these problems and the epidemics themselves. Virchow introduced the term “artificial epidemics” to point out that inadequate social conditions increase the population's susceptibility to the infectious agents (Waitzkin, 2006). In the current COVID-19 pandemic, we clearly see this, as most countries are experiencing such “artificial epidemics” among disadvantaged groups.

One of the aims of the dissertation is to relate self-help interventions with help from the civil society upon refugees´ arrival in the host country. Study 1 (Abi Jumaa, Mehran, et al., 2020) showed that the relationship between refugees and volunteers had several complications such as: the inability to form close relationships and friendships due to language and cultural barriers, rarely sharing traumatic experiences with volunteers, volunteers imparting German customs, perceived unappealing offers from the volunteers by refugees and lack of continuity of volunteers presence. Therefore, the limits and capabilities of voluntary work in context of assisting refugee women must be clearly defined and it should be communicated transparently with refugee women and the management of accommodation shelters. Also, results (Abi Jumaa, Mehran, et al., 2020) show that the psychosocial needs of refugee women are complex and require gender-sensitive and qualified support offers. However, low-threshold psychosocial group services for refugees are still lacking (Abi Jumaa, Kluge, et al., 2020; Abi Jumaa, Mehran, et al., 2020). These intervention services should be more present to create safe places that help refugees talk about themselves and speak about their concerns. They should be thematically open and regarded as non-pathologizing interventions. Therefore, the P2P intervention (Abi Jumaa, Kluge, et al., 2020) is considered a promising solution to

provide these spaces and to fill in the gap of increased demand for mental health services and the decreased resources of supply and delivery. The non-pathologizing P2P approach was meaningful for the participants who suffered from mental health symptoms due to the disrupted social environment and the exposure to a high level of stress in everyday life (Abi Jumaa, Kluge, et al., 2020; Abi Jumaa, Mehran, et al., 2020).

Our results were in alignment with Missmahl (2018) who states that empowering rather than diagnosing or pathologizing is crucial as it allows people suffering from mental health symptoms to influence the social situation that had given rise to the symptom and enable them to better cope with psychosocial stressors (Missmahl, 2018). Self-efficacy, based on one's own values, plays an important role to determine the success of the intervention (Bandura, 2010; Missmahl, 2018). Many patients from non-Western countries are not able to be compatible or to attend as many sessions as needed within a Western psychiatric treatment model [64]. It is interesting to mention that almost all theories and data of modern psychiatry and psychology come from Western populations (e.g. European, American, and Australian), yet 70 percent of humans live or come from non-western societies.

Furthermore, most of the psychiatric studies are carried out on clinical populations and transferred to other continents, thus ignoring the social processes that select patients appropriate for the Western treatment model (Gozdziak, 2004). Murray et al (2010) noted that diagnostic classifications of psychotherapy are often not applicable for refugees coming from different cultures such as the Middle East and that the Western psychotherapeutic methods are not always applicable to the psychosocial and cultural situation of the local context (Murray et al., 2010).

Peer support groups (Study 2) were sometimes more beneficial to refugees than individual psychotherapy, especially that it did not involve any medications and was focused on actively listening, empowering and sharing relevant problems. The involvement of medications to treat their psychological problems was one of the most frequent concerns of the refugees. Previous research about medicalization of various social and mental problems have been conducted. "Medicalization" refers to the way in which many social problems and behaviours, previously not defined as medical issues are now defined, diagnosed and "treated" as medical conditions (Conrad, 1992). It has been claimed that the Western psychiatric models are inappropriately applied in situations where problems are moral rather than medical, that can objectify human suffering and

lead to the inappropriate prescription of a “pill for every ill” (Summerfield, 2004). Likewise, Gozdziak (2004) explained that as a result of medicalization, suffering which was an inherently moral category is now transformed into a psychiatric condition (Gozdziak, 2004). This indeed weakens the capacity of human beings to deal with anxiety and suffering, denies their resilience, and makes them dependent on external factors for their psychosocial survival as only professionals medical or mental health care providers can analyse and discuss it (Gozdziak, 2004).

Our results highlight the advantages of nonmedical approaches through increasing resilience and individual empowerment that help people from different cultures to build social networks, to share their distress, and to allow them have control on their own decisions. Indeed, in both Western and non-Western societies between 70 and 90% of sickness is managed solely within the family context and social network and community activities (Kleinman, 1978).

Within an analysis of psychotherapy outcome research, it was found that almost 40% of improvement in clients mental health status resulted mainly from extra-therapeutic factors such as supportive structures in the environment, active participation in community, healthy living conditions, and satisfying work (Kleinman, 1978). Summerfield (2004) also describes that in many cultures the harmony of the family or group matters more than the self or the individual, who is not regarded as a free-standing unit (Summerfield, 2004). In Arab cultures for instance, family is one of the most important pillars for coping with psychological distress, and this is expressed by participants in study 2 (Abi Jumaa, Kluge, et al., 2020) and study 3 (Abi Jumaa et al., 2021). They voiced a call for greater empathy and understanding of culture from the German mental health providers by stating that sometimes spiritual support is needed rather than just giving diagnosis and treating symptoms.

On another aspect, it is important to note that the symmetrical relationship as equals (between the peer group leader and participants) appears to be of critical importance (Cvengros et al., 2009). Research shows that when patients perceive limited control over their healthcare, they may attempt to regain this control by not abiding with the provider recommendations (Cvengros et al., 2009). Such concerns are addressed in P2P, as it is not considered a teaching unilateral approach, but rather a bilateral one.

Regarding culture sensitive interventions, culture can profoundly influence every aspect of illness and adaptation (Kleinman, 1980; Murray et al., 2010). Results from paper 3 (Abi

Jumaa et al., 2021) confirm the need of more targeted, culturally sensitive interventions, which concentrate on vulnerable populations. Self-help and self-care interventions should focus on personal empowerment, providing valid information about health care options, and relaxation exercises to decrease levels of stress and anxiety during pandemics. Efforts to develop effective treatments and vaccines should be coupled with efforts to support the psychological needs of the public, and particularly to infected patients and to vulnerable populations such as refugees and migrants.

Results of the culturally sensitive support groups (Abi Jumaa, Kluge, et al., 2020) showed that P2P provided social support for the participants. Simich et al. (2004) emphasized that social support is a key determinant of health, and it is as vital as having shelter, food and income for the well-being of individuals. Studies on social support show that it buffers the effects of stress and acts a coping resource (Simich, 2004). However, it was found that many interventions are deficient in cultural sensitivity and language proficiency, and failed to utilize social networks in the community (Simich et al., 2003). The formation of refugee communities can help to rebuild and reinforce a sense of belonging for people whose lives have been disrupted by exile and can play an important role in empowering the members of the community. This is highlighted in the recent studies (Simich et al., 2003)showing that emphasis on practical needs such as employment, healthcare, transportation, finances, language, education, and security usually attained through social networks can help in reducing mental health matters (Simich et al., 2003).

Conversely, the lack of social support have negative impacts such as feelings of isolation and being “in limbo”, discouragement in seeking help, and loneliness (Simich, 2004). As observed in Study 3 (Abi Jumaa et al., 2021), qualitative interviews suggested that high levels of loneliness, boredom and social isolation from the community can contribute to heightened distress during quarantine and strict lockdown. Therefore, interventions that can safely enhance social connection while maintaining social distance are necessary. Social bonds have long been considered essential for healthy functioning, and the absence or disruption of social bonds is in itself a cause of emotional distress (Durkheim & Simpson, 1951; Rook, 1985).

On another level, refugees emphasized the importance of the reciprocity- the need of receiving and giving something back. This was achievable in P2P; they felt they were doing something helpful to the others and at the same time to themselves. However, this reciprocity was not conceivable with the volunteers (Abi Jumaa, Mehran, et al., 2020).

Some German volunteers wanted to impart and teach refugee women their German values; this approach irritated some refugee women who wished for mutuality in their relationship. They wanted to share and give something back to the volunteers; they would have liked to keep some of their values and learn something new from the Germans. This created a power imbalance between the two groups. It is important here to mention that empowerment denotes a positive activity in which power is balanced between groups. Empowerment is about power, and when power conflicts emerge, they should not be avoided but rather be resolved by re-balancing the powers (De Vos et al., 2009).

Also results from Study 1 (Abi Jumaa, Mehran, et al., 2020) show that volunteers, due to uncertainty in their roles, and due to lack of continuity of their presence provided casual acquaintances or “weak ties”, that could provide instrumental resources for long-term social integration, but could not serve the immediate needs of refugees such as the emotional needs that affect their health and well-being and the recognition of their legal status. Therefore, it is important to clearly distinguish newly arrived refugees’ motives from others who arrived in Germany several years before in order for the interventions to provide the most needed offers.

To summarise key interventions that aim at reducing post-migration stressors and better coping strategies during pandemics should target the following:

- Linguistically and culturally appropriate health education and risk communication
- Ensuring universal health coverage including full access to services
- Effective outreach approaches (community/refugee leader, cultural mediators, mHealth technologies especially during pandemics)
- Decreasing stigma and discrimination and empowering refugees in self-organized groups
- Increasing community participation
- Increasing intersectoral collaboration for more holistic, interconnected and gender sensitive health policies and practices

5 Conclusions

This dissertation investigated the various stressors that refugees experienced after migration and during the COVID-19 pandemic. It provides qualitative data supporting the need for transition programs that are peer-centred and sensitive to the diverse cultural backgrounds. Results confirm that mental health interventions (such as P2P) that do not focus on specific diagnosis and individual treatment, but instead enhance personal adaptive strengths, are highly appreciated by refugees. These approaches, rather than to emphasize on their weaknesses and failures, tend to take advantage of individual's resources that promote their well-being. Sharing information from others with similar experience is not only instrumental but also helps refugees imagine the possibility of security and well-being in their lives ahead. These shared experiences are of utmost importance that help newly arriving refugees integrate in the society.

There is a need for increased training opportunities and funding to implement interventions that work together with refugees through their stages of resettlement and to evaluate the effectiveness of these interventions with them, not only in reducing mental health symptoms but also in promoting their social and health well-being.

The dissertation also shows that inequities as well as previous trauma can further exacerbate the impact of COVID-19 on refugees. Refugees' mental health should be on the agenda of policy makers and practitioners for a more comprehensive and effective pandemic response.

COVID- 19 has clearly demonstrated how the world is interconnected and has showed that refugee migration policies and public health policies should be protective and inclusive and improve access to health services, otherwise they will not reach their aims. Refugee migration is not a problem to be solved, but rather a human reality that needs to be managed.

Reference List

Abi Jumaa, J., Bendau, A., Heinz, A., Ströhle, A., Betzler, F., & Petzold, M. (2021). Psychological Distress and Anxiety in Arab Refugees and Migrants during the COVID-19 Pandemic in Germany. *Transcultural Psychiatry*.

Abi Jumaa, J., Kluge, U., Weigold, S., Heinz, E., & Mehran, N. (2020). Peer-to-Peer Self-help Interventions for Refugees: A Pilot Study. *Fortschritte Der Neurologie Psychiatrie*, *88*(2), 89–94. https://doi.org/10.1055/a-1011-4232

Abi Jumaa, J., Mehran, N., Hertner, L., Von Bach, E., Valensise, L., Strasser, J., & Kluge, U. (2020). Exploring the relationship between refugee women and female volunteers. *Fortschritte Der Neurologie Psychiatrie*, *88*(2), 76–81. https://doi.org/10.1055/a-1041-3225

Anderson, R. M., Funnell, M. M., Barr, P. A., Dedrick, R. F., & Davis, W. K. (1991). Learning to empower patients: Results of professional education program for diabetes educators. *Diabetes Care*, *14*(7), 584–590. https://doi.org/10.2337/diacare.14.7.584

BafF- National Association of Psychosocial Centers for Refugees and Victims of Torture. (2018). *Report on the Psychosocial Care of Refugee and Torture Victims in Germany, 3rd Edn.* http://www.baff-zentren.org/veroeffentlichungen-der-baff/versorgungsberichte-der-baff/.

Bandura. (2010). Self-Efficacy. *Wiley Online Library*. https://onlinelibrary.wiley.com/doi/abs/10.1002/9780470479216.corpsy0836

Bartolomei, J., Baeriswyl-Cottin, R., Framorando, D., Kasina, F., Premand, N., Eytan, A., & Khazaal, Y. (2016). What are the barriers to access to mental healthcare and the primary needs of asylum seekers? A survey of mental health caregivers and primary care workers. *BMC Psychiatry*, *16*(1), 336. https://doi.org/10.1186/s12888-016-1048-6

Behnia, B. (2003). Refugees' convoy of social support: Community peer groups and mental health services. *International Journal of Mental Health*, *32*(4), 6–19. https://doi.org/10.1080/00207411.2003.11449595

Berliner Morgenpost. (2016). *Timeline of the truck attack in Berlin*. https://interaktiv.morgenpost.de/breitscheidplatz/index_en.html

Block, A. M., Aizenman, L., Saad, A., Harrison, S., Sloan, A., Vecchio, S., & Wilson, V. (2018). Peer Support Groups: Evaluating a Culturally Grounded, Strengths-Based Approach for Work With Refugees. *Advances in Social Work*, *18*(3), 930–948. https://doi.org/10.18060/21634

Böge, K., Karnouk, C., Hahn, E., Schneider, F., Habel, U., Banaschewski, T., Meyer-Lindenberg, A., Salize, H. J., Kamp-Becker, I., Padberg, F., Hasan, A., Falkai, P., Rapp, M. A., Plener, P. L., Stamm, T., Elnahrawy, N., Lieb, K., Heinz, A., & Bajbouj, M. (2019). Mental health in refugees and asylum seekers (MEHIRA): study design and methodology of a prospective multicentre randomized controlled trail investigating the effects of a stepped and collaborative care model. *European Archives of Psychiatry and Clinical Neuroscience*, *270*(1), 95–106. https://doi.org/10.1007/s00406-019-00991-5

Boulila, S. C., & Carri, C. (2017). On Cologne: *Gender* , migration and unacknowledged racisms in Germany. *European Journal of Women's Studies*, *24*(3), 286–293. https://doi.org/10.1177/1350506817712447

Bower, P., & Gilbody, S. (2005). Stepped care in psychological therapies: Access, effectiveness and efficiency. Narrative literature review. In *British Journal of*

Psychiatry (Vol. 186, Issue JAN., pp. 11–17). https://doi.org/10.1192/bjp.186.1.11

Braveman, P., & Gottlieb, L. (2014). The Social Determinants of Health: It's Time to Consider the Causes of the Causes. In *Public Health Reports* (Vol. 129).

Burnett, A., & Peel, M. (2001). Asylum seekers and refugees in Britain: Health needs of asylum seekers and refugees. In *British Medical Journal* (Vol. 322, Issue 7285, pp. 544–547). BMJ Publishing Group. https://doi.org/10.1136/bmj.322.7285.544

Conrad, P. (1992). Medicalization and Social Control. *Annual Review of Sociology*, *18*(1), 209–232. https://doi.org/10.1146/annurev.so.18.080192.001233

Cvengros, J. A., Christensen, A. J., Cunningham, C., Hillis, S. L., & Kaboli, P. J. (2009). Patient Preference for and Reports of Provider Behavior: Impact of Symmetry on Patient Outcomes. *Health Psychology*, *28*(6), 660–667. https://doi.org/10.17077/qwzn-8rw8

Dapunt, J., Kluge, U., & Heinz, A. (2017). Risk of psychosis in refugees: a literature review. In *Translational psychiatry* (Vol. 7, Issue 6, p. e1149). Nature Publishing Group. https://doi.org/10.1038/tp.2017.119

De Vos, P., Malaise, G., De Ceukelaire, W., Perez, D., Lefèvre, P., & Van der Stuyft, P. (2009). *Participation and empowerment in Primary Health Care: from Alma Ata to the era of globalization | De Vos | Social Medicine*. *4*(2), 7. https://www.socialmedicine.info/index.php/socialmedicine/article/view/269/633

Deitrick, L. M., Paxton, H. D., Rivera, A., Gertner, E. J., Biery, N., Letcher, A. S., Lahoz, L. M., Maldonado, E., & Salas-Lopez, D. (2010). Understanding the role of the promotora in a latino diabetes education program. *Qualitative Health Research*, *20*(3), 386–399. https://doi.org/10.1177/1049732309354281

Dennis, C. L. (2003). Peer support within a health care context: A concept analysis. *International Journal of Nursing Studies*, *40*(3), 321–332. https://doi.org/10.1016/S0020-7489(02)00092-5

Dong, E., Du, H., & Gardner, L. (2020). An interactive web-based dashboard to track COVID-19 in real time. In *The Lancet Infectious Diseases* (Vol. 20, Issue 5, pp. 533–534). Lancet Publishing Group. https://doi.org/10.1016/S1473-3099(20)30120-1

Durkheim, É., & Simpson, G. (1951). *Suicide: a study in sociology*. Glencoe, IL: Free Press. http://web.stanford.edu/class/polisci100a/durkheim.pdf

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: A systematic review. *Lancet*, *365*(9467), 1309–1314. https://doi.org/10.1016/S0140-6736(05)61027-6

Flegg, M., Gordon-Walker, M., & Maguire, S. (2015). Peer-to-peer mental health: a community evaluation case study. *Journal of Mental Health Training, Education and Practice*, *10*(5), 282–293. https://doi.org/10.1108/JMHTEP-04-2015-0019

Fleischmann, L. (2017). The Politics of Helping Refugees Emerging Meanings of Political Action around the German 'Summer of Welcome''.' *MONDI MIGRANTI*, *3*, 53–73. https://doi.org/10.3280/mm2017-003003

Fleischmann, L., & Steinhilper, E. (2017). The myth of apolitical volunteering for refugees: German welcome culture and a new dispositif of helping. *Social Inclusion*, *5*(3), 17–27. https://doi.org/10.17645/si.v5i3.945

Funk, N. (2016). A spectre in Germany: refugees, a 'welcome culture' and an 'integration politics.' *Journal of Global Ethics*, *12*(3), 289–299. https://doi.org/10.1080/17449626.2016.1252785

Funnell, M. M., & Anderson, R. M. (2003). Patient empowerment: a look back, a look ahead. *The Diabetes Educator*, *29*(3), 454–464. https://doi.org/10.1177/014572170302900310

Gentles, S. J., Charles, C., & Ploeg, J. (2016). Sampling in Qualitative Research: Insights

from an Overview of the Methods Literature. In *The Qualitative Report* (Vol. 20, Issue 11). https://nsuworks.nova.edu/tqr/vol20/iss11/5

Ghorashi, H. ;, & Rast, M. C. (2018). Dancing with “The Other”: Challenges and Opportunities of Deepening Democracy through Participatory Spaces for Refugees. *Social Inclusion*, *6*(1), 188–198. https://doi.org/10.17645/si.v6i1.1300

Gozdziak, E. M. (2004). Training Refugee Mental Health Providers: Ethnography as a Bridge to Multicultural Practice. *Human Organization*, *63*(2). https://www.questia.com/library/journal/1P3-658746991/training-refugee-mental-health-providers-ethnography

Heinz, A., & Kluge, U. (2012). Mental health in different groups of migrants and ethnic minority within Europe and beyond: Regional and cross-national challenges and approaches in research, practice and training. In *European Psychiatry* (Vol. 27, Issue SUPPL.2, p. S1). Elsevier Masson SAS. https://doi.org/10.1016/S0924-9338(12)75700-0

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, *15*(9), 1277–1288. https://doi.org/10.1177/1049732305276687

Hsu, E., Davies, C. A., & Hansen, D. J. (2004). Understanding mental health needs of Southeast Asian refugees: Historical, cultural, and contextual challenges. *Clinical Psychology Review*, *24*(2), 193–213. https://doi.org/10.1016/j.cpr.2003.10.003

Im, H., & Rosenberg, R. (2016). Building Social Capital Through a Peer-Led Community Health Workshop: A Pilot with the Bhutanese Refugee Community. *Journal of Community Health*, *41*(3), 509–517. https://doi.org/10.1007/s10900-015-0124-z

Karakayali, S., & Kleist, O. (2016). *Volunteers and asylum seekers | Forced Migration Review*. https://www.fmreview.org/sites/fmr/files/FMRdownloads/en/destination-europe/karakayali-kleist.pdf

Kirmayer, L., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., Hassan, G., Rousseau, C., & Pottie, K. (2011). Common mental health problems in immigrants and refugees: General approach in primary care. In *CMAJ* (Vol. 183, Issue 12, pp. E959–E967). Canadian Medical Association. https://doi.org/10.1503/cmaj.090292

Kirmayer, Nutt, Lecrubier, Lepine, & Davidson. (2001). Cultural variations in the clinical presentation of depression and anxiety: Implications for diagnosis and treatment. In *Journal of Clinical Psychiatry* (Vol. 62, Issue SUPPL. 13, pp. 22–30).

Kleinman, A. (1978). Concepts and a model for the comparison of medical systems as cultural systems. *Social Science and Medicine. Part B Medical Anthropology*, *12*(C), 85–93. https://doi.org/10.1016/0160-7987(78)90014-5

Kleinman, A. (1980). Patients and Healers in the Context of Culture. In *University of California Press*. https://books.google.de/books/about/Patients_and_Healers_in_the_Context_of_C.html?id=ZRVbw6-UyucC&redir_esc=y

Kuy, S., Tsai, R., Bhatt, J., Chu, Q. D., Gandhi, P., Gupta, R., Gupta, R., Hole, M. K., Hsu, B. S., Hughes, L. S., Jarvis, L., Jha, S. S., Annamalai, A., Kotwal, M., Sakran, J. V., Vohra, S., Henry, T. L., & Correa, R. (2020). Focusing on Vulnerable Populations during COVID-19. In *Academic Medicine* (pp. E2–E3). Lippincott Williams and Wilkins. https://doi.org/10.1097/ACM.0000000000003571

Lau, L. S., Samari, G., Moresky, R. T., Casey, S. E., Kachur, S. P., Roberts, L. F., & Zard, M. (2020). COVID-19 in humanitarian settings and lessons learned from past epidemics. In *Nature Medicine* (Vol. 26, Issue 5, pp. 647–648). Nature Research. https://doi.org/10.1038/s41591-020-0851-2

Liu, S., & Heinz, A. (2020). Cross-Cultural Validity of Psychological Distress

Measurement during the Coronavirus Pandemic. In *Pharmacopsychiatry* (Vol. 53, Issue 05, pp. 237–238). Georg Thieme Verlag. https://doi.org/10.1055/a-1190-5029

Missmahl. (2018). Value-based counselling: Reflections on fourteen years of psychosocial support in Afghanistan. *Intervention*, *16*(3), 256–260. https://doi.org/10.4103/INTV.INTV_15_18

Mundt, A. P., Chow, W. S., Arduino, M., Barrionuevo, H., Fritsch, R., Girala, N., Minoletti, A., Mitkiewicz, F., Rivera, G., Tavares, M., & Priebe, S. (2015). Psychiatric hospital beds and prison populations in South America since 1990 does the Penrose hypothesis apply? *JAMA Psychiatry*, *72*(2), 112–118. https://doi.org/10.1001/jamapsychiatry.2014.2433

Murray, K. E., Davidson, G. R., & Schweitzer, R. D. (2010). Review of refugee mental health interventions following resettlement: Best practices and recommendations. In *American Journal of Orthopsychiatry* (Vol. 80, Issue 4, pp. 576–585). NIH Public Access. https://doi.org/10.1111/j.1939-0025.2010.01062.x

Nazzal, K. H., Forghany, M., Geevarughese, M. C., Mahmoodi, V., & Wong, J. (2014). *An Innovative Community-Oriented Approach to Prevention and Early Intervention With Refugees in the United States*. https://doi.org/10.1037/a0037964

Nesterko, Y., Jäckle, D., Friedrich, M., Holzapfel, L., & Glaesmer, H. (2019). Prevalence of post-traumatic stress disorder, depression and somatisation in recently arrived refugees in Germany: An epidemiological study. *Epidemiology and Psychiatric Sciences*, *29*, e40. https://doi.org/10.1017/S2045796019000325

Penka, S., Heimann, H., Heinz, A., & Schouler-Ocak, M. (2008). Explanatory models of addictive behaviour among native German, Russian-German, and Turkish youth. *European Psychiatry*, *23*, 36–42. https://doi.org/10.1016/S0924-9338(08)70060-9

Penka, S., Schouler-Ocak, M., Heinz, A., & Kluge, U. (2012). Interkulturelle aspekte der interaktion und kommunikation im psychiatrisch/psychotherapeutischen behandlungssetting: Mögliche barrieren und handlungsempfehlungen. *Bundesgesundheitsblatt - Gesundheitsforschung - Gesundheitsschutz*, *55*(9), 1168–1175. https://doi.org/10.1007/s00103-012-1538-8

Perkins, D. D., & Zimmerman, M. A. (1995). Empowerment theory, research, and application. *American Journal of Community Psychology*, *23*(5), 569–579. https://doi.org/10.1007/BF02506982

Rappaport, J. (1981). In praise of paradox: A social policy of empowerment over prevention. *American Journal of Community Psychology*, *9*(1), 1–25. https://doi.org/10.1007/BF00896357

Rook, K. S. (1985). The Functions of Social Bonds: Perspectives From Research on Social Support, Loneliness and Social Isolation. In *Social Support: Theory, Research and Applications* (pp. 243–267). Springer Netherlands. https://doi.org/10.1007/978-94-009-5115-0_14

Seeman, M. V. (2014). Sterilization of the Mentally Ill During the Years of World War II in Finland. *International Journal of Mental Health*, *36*(1), 58–66. https://doi.org/10.2753/IMH0020-7411360105

Simich, L. (2004). Meanings of Social Support, Coping and Help-seeking Strategies Among Immigrants and Refugees in Toronto. In *CERIS-The Ontario Metropolis Centre*. Joint Centre of Excellence for Research on Immigration and Settlement. https://books.google.de/books/about/Meanings_of_Social_Support_Coping_and_He.html?id=ix2lSgAACAAJ&redir_esc=y

Simich, L., Beiser, M., & Mawani, F. N. (2003). Social support and the significance of shared experience in refugee migration and resettlement. In *Western Journal of Nursing Research* (Vol. 25, Issue 7, pp. 872–891).

https://doi.org/10.1177/0193945903256705
Steinberg, G. (2017). *Islamist Terrorism in Germany: Threats, Responses, and the need for a Strategy*. http://www.aicgs.org
Summerfield, D. (2004). Cross-Cultural Perspectives on the Medicalization of Human Suffering. In *Posttraumatic Stress Disorder: Issues and Controversies* (pp. 233–245). wiley. https://doi.org/10.1002/9780470713570.ch12
Swift, C., & Levin, G. (1987). Empowerment: An emerging mental health technology. *The Journal of Primary Prevention*, *8*(1–2), 71–94. https://doi.org/10.1007/BF01695019
Torrey, E. F., & Yolken, R. H. (2010). Psychiatric Genocide: Nazi Attempts to Eradicate Schizophrenia. *Schizophrenia Bulletin*, *36*(1), 26. https://doi.org/10.1093/SCHBUL
UNHCR. (2019). *UNHCR*. Global Trends Forced Displacement in 2019. https://www.unhcr.org/globaltrends2019/
UNHCR. (2020). *UNHCR*. Figures at a Glance. https://www.unhcr.org/figures-at-a-glance.html
Waitzkin, H. (2006). One and a Half Centuries of Forgetting and Rediscovering: Virchow's Lasting Contributions to Social Medicine. *Classics in Social Medicine*. https://www.medicinasocial.info/index.php/socialmedicine/article/view/6/7
Wallerstein, N., & Bernstein, E. (1988). Empowerment education: Freire's ideas adapted to health education. *Health Education Quarterly*, *15*(4), 379–394. https://doi.org/10.1177/109019818801500402
Webel, A. R., Okonsky, J., Trompeta, J., & Holzerner, W. L. (2010). A systematic review of the effectiveness of peer-based interventions on health-related behaviors in adults. *American Journal of Public Health*, *100*(2), 247–253. https://doi.org/10.2105/AJPH.2008.149419
Wöller, W. (2016). Trauma-informierte Peer-Beratung in der Versorgung von Flüchtlingen mit Traumafolgestörungen. *PPmP Psychotherapie Psychosomatik Medizinische Psychologie*, *66*(9–10), 349–355. https://doi.org/10.1055/s-0042-114992
Wollersheim, D., Koh, L., Walker, R., & Liamputtong, P. (2017). (PDF) Happy, just talking, talking, talking: Community strengthening through mobile phone based peer support among refugee women in Melbourne, Australia. *The Journal of Community Informatics*. https://www.researchgate.net/publication/316452114_Happy_just_talking_talking_talking_Community_strengthening_through_mobile_phone_based_peer_support_among_refugee_women_in_Melbourne_Australia
World Health Organisation. (2021). *WHO Coronavirus Disease (COVID-19) Dashboard | WHO Coronavirus Disease (COVID-19) Dashboard*. WHO Coronavirus Disease (COVID-19) Dashboard | WHO Coronavirus Disease (COVID-19) Dashboard. https://covid19.who.int/
World Health Organization. (1978). Declaration of Alma-Ata. *International Conference on Primary Health Care, Alma-Ata*. https://www.who.int/publications/almaata_declaration_en.pdf
World Health Organization. (2001). *World Health Organization*. The World Health Report 2001 - Mental Health: New Understanding, New Hope; World Health Organization. https://www.who.int/whr/2001/en/whr01_en.pdf?ua=1
World Health Organization. (2004a). *Prevention of Mental Disorders*. https://apps.who.int/iris/bitstream/handle/10665/43027/924159215X_eng.pdf?sequence=1&isAllowed=y
World Health Organization. (2004b). *Promoting Mental Health*. https://apps.who.int/iris/bitstream/handle/10665/42940/9241591595.pdf?sequence=1&isAllowed=y

World Health Organization. (2020). *Coronavirus*. https://www.who.int/health-topics/coronavirus#tab=tab_2

Statutory Declaration

“I, Jinan Abi Jumaa, by personally signing this document in lieu of an oath, hereby affirm that I prepared the submitted dissertation on the topic: “**Improving Mental Health of Refugees in the Post-migration and Pandemics Context / Verbesserung der psychischen Gesundheit von Geflüchteten im Kontext von Postmigration und Pandemie**”, independently and without the support of third parties, and that I used no other sources and aids than those stated.

All parts which are based on the publications or presentations of other authors, either in letter or in spirit, are specified as such in accordance with the citing guidelines. The sections on methodology (in particular regarding practical work, laboratory regulations, statistical processing) and results (in particular regarding figures, charts and tables) are exclusively my responsibility.

Furthermore, I declare that I have correctly marked all of the data, the analyses, and the conclusions generated from data obtained in collaboration with other persons, and that I have correctly marked my own contribution and the contributions of other persons (cf. declaration of contribution). I have correctly marked all texts or parts of texts that were generated in collaboration with other persons.

My contributions to any publications to this dissertation correspond to those stated in the below joint declaration made together with the supervisor. All publications created within the scope of the dissertation comply with the guidelines of the ICMJE (International Committee of Medical Journal Editors; www.icmje.org) on authorship. In addition, I declare that I shall comply with the regulations of Charité – Universitätsmedizin Berlin on ensuring good scientific practice.

I declare that I have not yet submitted this dissertation in identical or similar form to another Faculty.

The significance of this statutory declaration and the consequences of a false statutory declaration under criminal law (Sections 156, 161 of the German Criminal Code) are known to me.”

Date: 07/09/2021 Signature

Declaration of any eventual publications

Jinan Abi Jumaa took part in the following publications to the extend stated below:

Publication 1: Abi Jumaa, J., Mehran, N., Hertner, L., Von Bach, E., Valensise, L., Strasser, J., & Kluge, U. (2019). Zur Beziehungsgestaltung zwischen geflüchteten Frauen und weiblichen Freiwilligen. *Fortschritte Der Neurologie · Psychiatrie*, *88*(02), 76–81.

Contribution in detail: I was responsible for conducting the Arabic interviews for the study as described on page 77 of the publication, the execution of the coding and thematic analysis, and the creation of the main themes (page 78).

My main responsibilities included: organization of data collection, recruitment of Arabic participants, conducting the Arabic interviews, data analysis of Arabic interviews and data maintenance. The writing, submission, and revision of the manuscript in the peer review process was done jointly with the fellow authors.

Publication 2: Abi Jumaa, J., Kluge, U., Weigold, S., Heinz, E., & Mehran, N. (2019). Peer-to-Peer Selbsthilfe-Interventionen für Geflüchtete-eine Pilotstudie Peer-to-Peer Self-help Interventions for Refugees: A Pilot Study. *Fortschritte Der Neurologie Psychiatrie*, *88*(02), 89– 94.

Contribution in detail: I was responsible for the qualitative data analysis of the study. Table 1 in the publication (page 92) was created on the basis of my analysis.

In this work, my main responsibilities included: Organization of the data collection, recruitment of the group participants, conducting the group sessions, developing the interview guideline, conducting the interviews, data maintenance, qualitative data analysis. Together with the authors, but in charge: writing, submitting, and revising the manuscript in the peer review process.

Publication 3: Abi Jumaa, J., Bendau, A., Heinz, A., Ströhle, A., Betzler, F., & Petzold, B. M., Psychological Distress and Anxiety in Arab Refugees and Migrants during the COVID-19 Pandemic in Germany, Transcultural Psychiatry, 2021

Contribution in detail: I was in charge of all the qualitative and quantitative data of the study. Figures 1 to 5 and table 1 in the publication were produced on the basis of my statistical evaluation.

I was responsible for: translation of the German version of the questionnaire into Arabic, setting up the questionnaire online on SoSci, organization of the data collection, developing the interview guidelines for the qualitative questionnaire, recruitment of the participants, conducting the interviews, data maintenance, qualitative and quantitative data analysis. Together with the authors, but in charge: writing, submitting, and revising the manuscript in the peer review process.

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Signature, date and stamp of first supervising university professor / lecturer

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Signature of doctoral candidate

Publication 1

Mehran, N., **Abi Jumaa, J.**, Hertner, L., Von Bach, E., Valensise, L., Strasser, J., & Kluge, U. (2020). Zur Beziehungsgestaltung zwischen geflüchteten Frauen und weiblichen Freiwilligen. *Fortschritte der Neurologie· Psychiatrie*, *88*(02), 76-81.

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Publication 2

Abi Jumaa, J., Kluge, U., Weigold, S., Heinz, E., & Mehran, N. (2020). Peer-to-Peer-Selbsthilfe-Interventionen für Geflüchtete–eine Pilotstudie. *Fortschritte der Neurologie· Psychiatrie*, *88*(02), 89-94.

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Publication 3

Jumaa, J. A., Bendau, A., Ströhle, A., Heinz, A., Betzler, F., & Petzold, M. B. (2022). Psychological distress and anxiety in Arab refugees and migrants during the COVID-19 pandemic in Germany. *Transcultural Psychiatry*, 13634615221122536.

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Curriculum Vitae

My curriculum vitae does not appear in the electronic version of my paper for reasons of data protection.

Publication List

Abi Jumaa, J., Bendau, A., Heinz, A., Ströhle, A., Betzler, F., & Petzold, B. M. (2021). Psychological Distress and Anxiety in Arab Refugees and Migrants during the COVID-19 Pandemic in Germany. *Transcultural Psychiatry*. **Impact Factor: 1.936 (2019)**

Abi Jumaa, J., & Heinz, A. (2020, July). Gender-Sensitive Peer Counselling Groups in Times of Conflict Reflections on a Self-Help Support Group in Berlin. In *Proceedings of the International Conference on Future of Women* (Vol. 3, No. 1, pp. 12-24).

Abi Jumaa, J., Kluge, U., Weigold, S., Heinz, E., & Mehran, N. (2019). Peer-to-Peer-Selbsthilfe-Interventionen für Geflüchtete-eine Pilotstudie Peer-to-Peer Self-help Interventions for Refugees: A Pilot Study. *Fortschritte Der Neurologie Psychiatrie*, *88*(02), 89– 94. https://doi.org/10.1055/a-1011-4232 **Impact Factor: 0.642 (2019)**

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Kluge, U., Rapp, M. A., Mehran, N., **Jumaa, J**., & Aichberger, M. C. (2019). Armut, Migration und psychische Gesundheit. *Der Nervenarzt*, *90*(11), 1103-1108.

Impact Factor: 0.824 (2019)

Kluge, U., **Abi Jumaa, J.**, Mehran, N., Valensise, L., Von Bach, E., & Strasser, J. (2017). "Solidarität im Wandel?"

Nassim, M., **Jinan, A.J.**, Felicia, L. *et al.* Spatiality of Social Stress Experienced by Refugee Women in Initial Reception Centers. *Int. Migration & Integration* (2021). https://doi.org/10.1007/s12134-021-00890-6

Impact Factor: 1.737 (2021)

Book chapter:

Heinz A., **Abi Jumaa J.**, Mehran N. Space, art, psyche In: POLLMANN, T. C. (2019). Visions4people: Artistic research meets psychiatry. Artbook d a p, [s.l.]. Jovis Verlag GmbH.

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20th World Congress of Psychiatry, Bangkok, Thailand “Corona-Related Anxiety Among Migrants and Refugees In Germany”

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