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From the Editor's desk

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Apples, refugees & emotions

The Syrian refugee crisis is a reminder that conflict and war have consequences of immense public health importance. Professor Hans Rosling has produced a simple but incisive account of the scale of the problem facing Europe (https://www.youtube.com/watch?v=-uljFaRuJ68&spfreload=10). If an apple represents 1 million Syrian people, 20 apples represent the Syrian population, 12 apples represent displaced populations, 4 of which are external to Syria. A quarter of an apple represents asylum seekers coming to the EU. The disproportionate burden of immediate and long-term health consequences falls on Syria and surrounding nations such as Lebanon and Turkey. Not only is there loss of life due to war and direct actions and injuries, political persecution by state or non-state forces leads to mass migrations of people seeking safety, security, and a future for themselves and their children. The tragic images of a 3-year-old boy, Alan Kurdi, lying on a Turkish beach after failing to survive a sea crossing, have sparked a rethink among world leaders. What should be their response to humanitarian crises and asylum seekers?

Migrants can seek asylum only once they have entered the destination country, so explaining why so many people travel surreptitiously, risking their lives. The response of the EU countries has been less than optimal, although a mechanism for processing applications from the refugee camps close to their homelands is now being enacted as a safer, more managed process. At the same time, there is concern that existing EU economies are unable to provide or afford the refuge and asylum that is needed. The health burdens, individual and societal, can be compounded by the handling of asylum cases, for example, by detention[1] or when cases for residency are rejected.[2] Trauma, persecution and torture, multiple loss events, and migration are known to be associated with a higher risk of mental illnesses, depression, psychosis, post-traumatic stress disorders and suicide attempts,[3] as well as poor physical health including short-term malnutrition,[4] and longer-term cardiovascular disease[5] and cancer.[6] Yet we also hear of remarkable stories of resilience and survival among traumatised populations.[7] For mental health practitioners, there are significant diagnostic challenges including the use of interpreters, negotiating culturally shaped explanatory models of mental disorders, and identifying and treating co-occurring psychiatric disorders. These include elements of extreme stress, grief, psychosis, abnormal mood and emotional dysregulation.

Adult mental illnesses and emotional dysregulation are well-established consequences of childhood adversity.[8,9] Few studies have investigated emotional dysregulation among victims of torture, mass migration and political persecution. Childhood maltreatment has biological, psychological and interpersonal impacts and emotional and mood dysregulation are core features irrespective of the overarching diagnosis.[10] Emotional dysregulation is thought to be mediated by fronto-limbic circuits, with heightened activity in the amygdala and impaired inhibitory control from the prefrontal cortex; such a process is found in suicidal thinking and borderline personality disorders, as well as mood disorders.[11,12]

Studies of emotional dysregulation offer an opportunity to connect neurobiology and social and environmental stressors (see Broome *et al*, pp. 283–285). Such approaches will help with greater precision in definitions of mental illness and offer new therapeutic targets. Emotional dysregulation may explain how sleep disturbance leads to self-harm, independent of mood (Hysing *et al*, pp. 306–312), and why such a high proportion of self-harming adolescents are assessed to have a personality disorder (Ayodeji *et al*, pp. 313–319). Gambling is more common in people with bipolar disorders, especially where there is rapid cycling and unstable mood disturbance (Jones *et al*, pp. 328–333). Although there is a careful distinction to be made between emotional dysregulation as a reactive state and mood instability as setting the tone for a whole range of emotions and cognitions, the psychosocial morbidity associated with mood symptoms in borderline disorders is as great as that found in people with bipolar disorder (Zimmerman *et al*, pp. 334–338), suggesting that emotional and mood dysregulation mediate psychosocial morbidity and may be equally distressing. Eating disorders are also characterised by emotional dysregulation with poor impulse control, yet behaviours and cognitions may be patterned by gender (Micali *et al*, pp. 320–327). The role of emotional dysregulation may explain a number of other health consequences, for example, eating disorders lead to poorer dental health (Kisley *et al*, pp. 299–305). Personality disorders are associated with a higher mortality (Björkenstam *et al*, pp. 339–345) perhaps mediated by impulsivity and emotional dysregulation impacting on relationships and sources of social support and employment.

Employment is an important resource for refugees and people more generally coping with mental illnesses.[2] New research shows that shorter versions (9 months) of employment support programmes are just as effective as a fuller programme lasting 18 months, for people with severe mental illnesses (Burns *et al*, pp. 351–356). In the US armed forces there is a gap between reports of mental health problems and treatment-seeking. In a study among military personnel, Adler *et al* (pp. 346–350) found that avoidance of help-seeking is not always indicative of stigma, but shows a positive desire to invoke personal coping resources. Thus, clinicians should support self-management more actively for superior outcomes.

Questioning the prevailing evidence is part of the scientific method and necessary when there are new social and systems contexts, as illustrated by controversies about the place of early intervention (Castle/Singh, pp. 288–292) and worrisome findings that few research studies announcing new mental health interventions are ever replicated (Tajika *et al*, pp. 357–362). Returning to the plight of refugees and mental health research, we need critical and strategic studies testing integrated preventive policies and health interventions throughout the asylum journey. There is fierce debate about the sustainability of health and social systems in countries receiving refugees, and more studies are necessary. The historical contributions of refugee populations to host nations are receiving recognition (www.refugeecouncil.org.uk/policy_research/the_truth_about_asylum/facts_about_asylum_-_page_3; www.bbc.co.uk/worldservice/people/highlights/refugees.shtml) and so more welcoming attitudes offer hopeful futures both to refugees and to all citizens in the countries providing refuge.

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