PHOENIX AUSTRALIA | Centre for Posttraumatic Mental Health

Australian Guidelines for the Treatment of
Acute Stress Disorder and Posttraumatic Stress Disorder

Specific Populations and Trauma Types
Refugees, asylum seekers and PTSD

This *Refugees, asylum seekers and PTSD* information sheet addresses background issues and provides presentation, assessment and treatment recommendations for practitioners working with refugees and asylum seekers. These recommendations are based on the systematic review of the international literature, and the expert opinion and advice presented in the Specific Populations and Trauma Types chapter of the *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder*: www.phoenixaustralia.org/resources/ptsd-guidelines/.

Practitioners working with refugees and asylum seekers need to be aware of their own ethnocentricity, need to be culturally skilled and informed, and need to be open to different cultural perspectives on psychological problems. This includes awareness of differing values, avoidance of stereotyping, the capacity to respond to potential conflicts between traditional values and values of the dominant culture, and the ability to understand and choose an appropriate treatment approach. A range of cultural factors influence the individual's decision to seek treatment and subsequent engagement in therapy, including beliefs about the importance of family in healthcare, the cause of illness, and stigma attached to mental illness and treatment. Clinicians should also recognise that cultural factors interact with what are commonly termed social factors – region of origin, socioeconomic status, education, social status, rural or urban background – and these factors are equally found to predict PTSD symptoms.[1]

The following section outlines a range of general issues with which practitioners working with refugees and asylum seekers in Australia should be familiar. Detailed information about the specific background and experience of the individual is, of course, still required.

Background issues

There is an inevitable political context in which the traumatic experiences and subsequent treatment of refugees and asylum seekers occurs. Within Australia, as well as internationally, government policy, community attitudes, and media coverage of refugee and asylum seeker issues impact the mental health and wellbeing of this group. The impact can be direct, creating a welcoming or hostile environment, or indirect, potentially influencing public attitudes. For asylum seekers, government policies relating to detention, visa options, and fundamental rights and entitlements such as access to medical care have the potential to significantly influence mental health and wellbeing.

The traumatic experiences of refugees need to be understood also in the context of sociopolitical factors in their country of origin. It is helpful for the practitioner to have an understanding of these factors at both the macro level – the nature and history of the conflict and its impact on the individual, their family, and community over time – as well as at the level of the individual's experience.

There are three defining characteristics of the refugee and asylum seeker experience common to most, and based on deliberate and targeted prosecution against their ethnic, cultural, religious or political beliefs or values:

1. Trauma (experienced or witnessed situations where their lives have been threatened or people close to them have been threatened, injured, raped, tortured or killed).
2. Loss (of family members, friends and relatives, abduction of children, possessions, livelihood, country, status, etc.).
3. Deprivation (of basic human rights and needs such as food, water, shelter, education, and medical attention).

The frequency and nature of traumatic exposure inevitably varies, but the following experiences, designed to maximise psychic injury, are common:

- Extreme forms of violence that have been repeated and/or prolonged.
- Destruction of identity and the breakdown of families and communities, which may occur deliberately through the systematic disruption of core attachments to families, friends, and religious and cultural systems.
- Conditions of inescapability and unpredictability, maximising the experience of helplessness.
- Loss under violent circumstances with consequences such as prolonged grief.
- Witnessing atrocities such as mass killings, rape, torture, children targeted for violence and death, the violation of sacred values, betrayal, and the weakness of restorative justice.
- Deliberate erosion of personal integrity – physical boundaries invaded, the right to privacy violated, basic functions of eating and sleeping closely controlled, confronted with impossible choices, such as choosing who should die or who should be left behind.

The practitioner should also be aware that, once in Australia, there are several stressors that can continue to impact upon the mental health of refugees and, in some cases, may be more salient to the development of psychopathology than pre-migration trauma exposure.[2] Post-migration stressors underlie the extent to which refugees and asylum seekers continue to maintain their culture or heritage and the degree to which they decide to adapt and interact with the new host society.[3,4] These factors may include:

- Concern about the safety of relatives and friends remaining in the country of origin when conflict is ongoing.
- Loss of, or separation from, family and friends.
- Difficulties in tasks of settlement such as learning a new language, gaining employment and accommodation.
- Isolation and lack of social support.
- Acculturation (e.g., ethnic and religious identity; inter-generational tensions associated with changes relating to the cultural, linguistic and social domains).
- Discrimination, racism and social exclusion in the host community relating to economic, social, cultural or religious beliefs.
- Minority status and potential marginalisation in dominant Australian culture, loss of social status and poverty. In the case of asylum seekers, environmental and policy factors such as mandatory or indefinite detention and temporary protection (see additional issues specific to this group below).

Use of interpreters

In working with refugees and asylum seekers, interpreters are often involved. Practitioners should be mindful of the following issues when working with interpreters. First, with regard to perceptions of confidentiality, interpreters should not be known to clients. In small migrant communities, interpreters are frequently educated members of the community, often community leaders. People may feel that their confidentiality is compromised when they have to disclose their experiences through known members of their own community. Secondly, when interpreters are used for specific interventions such as imaginal exposure, it is important that the interpreter understands the procedure as well as the underlying rationale and potential client responses, so that the intervention is not unintentionally compromised. Clear roles should be established for therapist and interpreter,[5] ensuring that all parties, including the client, understand these roles. Finally, practitioners should be aware of the potential negative emotional impact on interpreters of retelling the client's traumatic experiences. Regarding the potential for all practitioners in the field of posttraumatic mental health to be adversely affected by the work, the possibility that the interpreter has had similar traumatic experiences of their own needs to be considered. Appropriate preparation, debriefing and clinical supervision may help mitigate any distress experienced by interpreters.[5]

Presentation

As noted above, refugees and asylum seekers have typically been exposed to prolonged and repeated traumatic experiences. While there are likely to be some differences in presentation (e.g., somatisation, spiritual interpretations such as loss of soul), the construct of PTSD is broadly applicable across cultures.[6-9] Around 10 per cent of adult refugees are estimated to have PTSD,[10] however, this percentage increases to almost 25 per cent in those who have experienced torture,[11] with many of those experiencing comorbid problems such as:

- anxiety, depression, substance abuse, compulsive gambling and brief reactive psychoses
- interpersonal difficulties associated with mistrust, fear, anger, and withdrawal
- high-risk and maladaptive behaviours
- grief responses such as numbing, anger, hopelessness, and meaninglessness
- family conflict, family breakdown, and domestic violence
- physical illness and somatic complaints.

In addition, language difficulties, availability of interpreters, culturally sensitive information about treatment, stigma, and other service barriers often prevent refugees and asylum seekers from accessing the right services. Hence, the utilisation of mental health services is often below the population average in the first years of resettlement and due to these barriers refugees and asylum seekers may not present until much later, when severely distressed or disordered.[12]

In seeking to understand refugees and asylum seekers with PTSD, the potential existential impact of this particular type of traumatic experience needs to be recognised. Interventions should go beyond assessment and treatment of PTSD to address other forms of distress that may have resulted from either daily stressors, or exposure to war-related violence and loss.[13] For example:

- Violence and uncertainty experienced during trauma may lead to anxiety, fear, and helplessness.
- Forced impossible choices, and experiences of humiliation experienced, may lead to feelings of guilt and shame.
- Disruption of relationships, separation, and isolation may lead to grief, depression, and altered interpersonal relatedness (e.g., fear of relationships, dependency or extreme self-sufficiency).
- Shattered values of human existence resulting from trauma may lead to a loss of faith in humanity, distrust, sensitivity to injustice, and idealisation and devaluing of others.
- Anger and potentially aggressive behaviour can result from low frustration tolerance, protest about loss, reaction to injustice and betrayal, and as a defence against shame and guilt.

It is also important to recognise that individual strengths can emerge in the face of trauma with resilience and posttraumatic growth as an outcome which also presents itself in those patients who have PTSD symptoms. Human beings are often remarkably resilient and it is important that clinicians are able to identify and build upon those strengths in treatment.

Assessment

As a general rule, standardised assessment measures are appropriate for use with refugee and asylum seeker clients, bearing in mind the need for culturally sensitive administration and interpretation of results. Adequate psychological and social support during the initial phase is of utmost importance. In addition, it is recommended to undertake a rapid and contextually grounded assessment of the daily stressors, that is, post-migration stressors mentioned in the above section, which may be pertinent and particularly salient to an individual's daily functioning, and the resolution of which may have a direct influence on mental health symptoms.

A framework for assessment that covers the multiple potential contributing factors to a refugee or asylum seeker's PTSD and related problems is critical. The following table summarises the information that should be collected for a comprehensive assessment.

Assessment domain	Implications
Country of origin and date of arrival	This information alone alerts the assessor to: • region-specific physical health problems • nature and duration of violence and hardship • access to healthcare.
Visa status	Visa status is critical to understanding rights and entitlements and thereby the stresses of the client's everyday environment.
Language	Check preferred language and country of origin of interpreter as some prefer that the interpreter does not come from their country.
Cultural background	Cultural notions of causal attributions, stigma, help-seeking behaviour, and concepts of healing are important to assess, as well as familiarity with systems in Australia. A cultural, ethnic or religious group is very diverse; generalisations need to be cautious. Some may wish to involve other family members in healthcare decision-making.
Extent of exposure to violence and other traumatic events (e.g., child abuse, intimate partner violence, etc.)	A 'thumbnail' sketch is sufficient for the assessment process and provides an indication of likely physical and psychological health sequelae.
Family functioning and social support	Children and adolescents have usually been directly affected through the experience and/or witnessing of violence, disrupted schooling and ongoing loss or separation from important caregivers. Ascertaining whether children and other family members require support involves proactive and sensitive exploration, particularly in the context of domestic violence.
Post-migration circumstances including housing, employment, language barriers, social isolation, etc.	Potential sources of stress or strength.
Legal-immigration situation regarding refugee determination or family sponsorship	Sponsorship issues and refugee determination processes are major sources of stress and mental health problems.
Physical health screening	Considerations include: • physical injuries or pain which are the result of torture/physical trauma • somatisation of a psychological problem • dental care • in women, reproductive health-related problems • in children, health consequences of neglect, abandonment, domestic violence.

A comprehensive assessment should go beyond the Diagnostic and Statistical Manual of Mental Disorders (fourth edition; DSM-IV) diagnosis of PTSD to include comorbidity and broader psychosocial factors. In refugees and asylum seekers, particular attention should be paid to: indicators of family breakdown, behavioural problems, quality of daily functioning, socially disruptive, aggressive or withdrawn behaviour, and physical symptoms. In undertaking the assessment and planning treatment, for people with PTSD arising from prolonged and repeated trauma, apply. The following additional considerations are recommended for refugees and asylum seekers with PTSD.

- Trust and rapport are very important. First appointments often need to be longer and/or several appointments may be needed for a comprehensive assessment.
- Refugees need to be seen in a safe place which does not trigger traumatic memories of overly officious, authoritarian behaviour.

- Awareness that medical settings may act as reminders of torture, and that some refugees may have a fear of intrusive investigative procedures.
- Gender of the therapist can be especially important for survivors of sexual assault.
- Understanding that a person's hostility may be a reaction to fear and uncertainty.
- Information provision (e.g., on the purpose of the assessment and use of information once disclosed) and encouraging the person to ask questions promotes a sense of control. However, practitioners need to be aware that in some cultures such practices are unfamiliar and may require extra encouragement and multiple checks on behalf of practitioners.
- Explanations of the meaning of confidentiality, privacy and consent are helpful.
- Factors affecting 'non-compliance' are important to anticipate, such as cultural beliefs about damaging effects of investigations such as taking blood, attitudes to medication and misunderstanding of side-effects, and suddenly stopping medication.

Treatment

Limited treatment research has been conducted with this population, although the available evidence supports the relevance of standard treatment guidelines for PTSD. The key recommendations, graded A through D depending upon the strength of the evidence, are:

Psychological interventions for adults

- For adults exposed to a potentially traumatic event, a one-session, structured, psychological intervention in the acute phase, such as psychological debriefing, should not be offered on a routine basis for the prevention of PTSD. **Grade B**
- For adults displaying symptoms consistent with acute stress disorder (ASD) or PTSD in the initial four weeks after a potentially traumatic event, individual trauma-focussed cognitive behavioural therapy, including exposure and/or cognitive therapy, should be considered if indicated by a thorough clinical assessment. **Grade C**
- Adults with PTSD should be offered trauma-focussed cognitive behavioural interventions or eye movement desensitisation and reprocessing. **Grade A**

Pharmacological interventions for adults

- For adults exposed to a potentially traumatic event, drug treatments should not be used for all those exposed as a preventive intervention. **Grade D**
- The routine use of pharmacotherapy to treat ASD or early PTSD (i.e., within four weeks of symptom onset) in adults is not recommended. **Grade C**
- Drug treatments for PTSD should not be preferentially used as a routine first treatment for adults, over trauma-focussed cognitive behavioural therapy or eye movement desensitisation and reprocessing. **Grade B**
- Where medication is considered for the treatment of PTSD in adults, selective serotonin reuptake inhibitor antidepressants should be considered the first choice. **Grade C**

In treating refugees and asylum seekers with PTSD, the practitioner is faced with a number of complex factors over and above the individual's traumatic experiences, including language, ethnocultural, sociopolitical, and community issues, as well as the person's current clinical and psychosocial situation. It is not uncommon for practitioners to feel overwhelmed by these cultural and clinical complexities. In some cases this can lead the practitioner to being immobilised for fear of making mistakes, and in other cases it can lead to practitioners ignoring the complexities completely and proceeding as though they did not exist. Either response is unlikely to result in effective treatment. The middle ground in which the practitioner is mindful of ethnocultural issues, but does not attempt to deal with them as the end in itself, is ideal. The practitioner's genuine interest and respect are the most effective tools for building trust and the positive therapeutic relationship needed to help the individual recover from their traumatic experience.

Note that refugees may have differing interpretations of the cause of their current difficulties, with treatment expectations varying accordingly. Many will take a Western view of mental health problems, seeing them as disorders that will improve with appropriate treatment. Others may feel that their problems are a natural consequence of chronic exposure to inhuman conditions and will not respond to treatment, or that their difficulties will subside naturally over time, and thus treatment is unnecessary.[14] Yet others will attribute their traumatic experiences to supernatural or religious reasons, presenting a potential difficulty for treating practitioners as to how to present and explain trauma-focussed treatments of PTSD. Regardless of their views on the importance of treatment and the likelihood of success, refugees will often have a poor understanding of what the treatment

process will involve.[14] Clearly, the provision of a clear explanation of assessment findings, as well as a description and rationale for the proposed treatment, is crucial.

A small number of studies suggest that culturally-adapted cognitive behavioural therapy (CBT) (including exposure) may be effective for refugees with trauma-related disorders.[15] There is a need, however, to define more clearly who needs specific psychological (specifically CBT) interventions and/or pharmacological interventions over and above the general psychosocial assistance and counselling that is given in contemporary programs provided by torture and trauma services. Little research has investigated the use of interpreters in the delivery of trauma-focussed therapy, although there is some indication that interpreter-mediated and standard therapy result in equivalent treatment gains in refugees with PTSD.[16] If an interpreter is required, it is recommended that therapist and client use shorter 'chunks' of speech during exposure therapy in order to ensure appropriate monitoring of the client's narrative and levels of distress.[5]

It is essential that a therapeutic relationship and conditions of trust and safety are established in working with refugees and asylum seekers. In addition, the clinician should consider the following issues:

- the need for a holistic framework for treatment, which parallels the holistic framework for assessment
- recognising the value of different levels of intervention – individual, family, community, and important settings such as schools, cultural and religious associations
- being aware of coping strategies that may have developed in response to situations of chronic violence and extensive losses – such as denial, withdrawal, and anger – and their protective value for the person
- the critical role of guilt and shame in maintaining health problems.

In working with a refugee or asylum seeker, treatment goals need to extend beyond PTSD. Of uppermost importance for refugees and their families is usually the rebuilding of their lives through a successful settlement process. The practitioner should facilitate opportunities for retraining, employment, recovery of status, and establishing connections. Where this is beyond the scope of the individual provider, the person should be linked in with appropriate services to address those issues. Attention also needs to be paid to physical health, as the alleviation of physical health problems can be a pathway to mental health wellbeing.

Finally, it needs to be recognised that mental health problems in refugees are the result of systematic violation of their human rights. Restoration of faith in human beings, the right to health, the right to protection from human rights violations, and restoration of justice are part of the process of healing for refugee survivors of torture and trauma. Services which address the mental health needs of survivors must respect and reinforce the concept of human rights as expressed in various international charters and agreements.[17]

Additional issues specific to asylum seekers subject to mandatory detention and temporary protection

Australia's policies of mandatory detention and temporary refugee protection have been implicated as predictors of PTSD in refugees in Australia. Steel and colleagues[18,19] report extremely high incidence of PTSD in temporary visa holders and asylum seekers in detention, as well as in the years after release. This group is also more likely to experience ongoing language difficulties, social isolation, and increasing anxiety and depression over time, compared to refugees granted permanent protection.[20] In addition, asylum seekers in detention are at significant risk of suicidal behaviour, with rates of approximately 41 and 26 times the national average for men and women, respectively.[21]

The particular difficulties of working with this group of asylum seekers should be noted. Asylum seekers subject to mandatory detention or temporary protection often have difficulty engaging in therapy to address their trauma, as their traumatic experiences are, in many cases, ongoing. Most have a history of pre-migration trauma, followed by a dangerous and traumatic flight to safety and finally prolonged and indefinite detention in penal-like institutions, where they are faced with loss of control, long-term separation, and uncertainty about their family members left behind in the country of origin. These factors exacerbate the impact of war-related traumas, and coupled with long periods in detention are associated with worse mental health outcomes.[19,22] Such experiences are then followed by limitations of the temporary visas (employment restrictions, reduced access to settlement services and welfare benefits) that cause severe distress to many.

In addition, during the processing time, asylum seekers face further distressing events – interviews to apply for permanent protection, the frequent rejections of their application, the appeals to the Refugee Review Tribunal and other courts of appeal. Many report that their intense intrusive and disturbing thoughts and nightmares are about being arrested by detention guards and returned to detention or being deported – they experience 'flash-forwards'. McInerney and Kaye[23] argue that standard diagnostic categories and individual therapy in these conditions may be inadequate to address these complexities that have such a devastating impact on asylum seekers' lives.

Treatment of PTSD therefore needs to consider providing care in the context of the traumas experienced, current living circumstances, and asylum seekers' cultural beliefs and values. There is some evidence to suggest that refugees on temporary protection visas experience improved mental health on receipt of permanent residency,[24] however, harmful effects can remain despite initial improvements due to release from detention, and further research is required to assess

the long-term impact of detention and subsequent acculturation stressors.

There are significant challenges in the application of these treatment recommendations to refugees and asylum seekers. In addition to the complexity and severity of their traumatic experience, ongoing trauma of detention and ongoing stressors of resettlement, asylum seekers are generally detained in geographically remote areas with limited or no access to appropriately trained mental health practitioners, thus presenting considerable additional barriers to the delivery of effective care for their posttraumatic mental health needs.

Working with children

Children make up almost half the refugee population worldwide, and represent approximately one-third of asylum seekers.[25] Around 11 per cent are likely to develop PTSD.[10] As with adults, a range of pre-, peri- and post-migration stressors put refugee children and adolescents at increased risk of developing mental health problems. Estimates of the prevalence of PTSD in this group vary widely but are generally well above the rates seen in non-refugee children.[26] The available literature indicates a strong association between prolonged immigration and detention and mental health problems in children and adolescents, with reported difficulties including:

- attachment issues, developmental, emotional and behavioural delays[27]
- depression, anxiety, and behavioural problems, which may be early indicators of the subsequent development of PTSD[28]
- self-harm and suicidal ideation[29]
- separation anxiety, sleep disturbance, disruptive conduct and somatic symptoms.[29,30]

In addition to the experience of trauma, flight and displacement, children also experience disruptive schooling and many are separated or lose their parents or caregivers. Evidence suggests that unaccompanied refugee children and adolescents are at greater risk of psychological distress than those who are accompanied by a parent or guardian.[26,31] On the other hand, children's experiences and wellbeing are mediated by their parents' mental health, and thus accompanied children whose parents experience mental health problems may be more likely to develop significant levels of distress themselves.[22]

In general, however, refugee children and adolescents tend to be more resilient than adults, and find it easier to adapt to life in a new country. Younger children in particular are less likely to feel guilt at leaving friends and family behind, and may feel more excited than afraid of starting a new life.[32] Nonetheless, children's adaptability can create additional stressors, such as a change in family dynamics as they become more fluent in their new language and are required to act as 'interpreters' for parents. With the loss of identity and social roles, families are exposed to further tensions which can cause widening of the cultural gap between family members and can lead to conflict and anger. While the literature suggests that anger experienced as a part of a PTSD diagnosis is often directed towards a spouse, recent research suggests that anger towards children is also very common, and a linguistic gap experienced between parents and children may contribute to generating this conflict and anger.[33] However, there is a lack of systematic studies investigating the effect of anger on children and the impact on the family unit as a whole.

Limited research has investigated the assessment and treatment of trauma-related mental health problems in refugee children.[34,35] In the absence of conflicting evidence, judicious application of the suggestions for working with refugee adults (above), and with non-refugee children is recommended.

Recommended reading

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Source and Contributors

This information was taken from the Refugee and Asylum Seekers section (p.139-145) of the Specific Populations and Trauma Types chapter of the *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder* www.phoenixaustralia.org/resources/ptsd-guidelines/. The Refugee and Asylum Seekers section was developed by Phoenix Australia in collaboration with Professor Derrick Silove, Psychiatrist, Director, Psychiatry Research & Teaching Unit, University of New South Wales; Mr Mariano Coello, Research Coordinator, Service for the Treatment and Rehabilitation of Torture and Trauma Survivors; Dr Ida Kaplan, Clinical Psychologist, Direct Services Manager, Victorian Foundation for Survivors of Torture; and Associate Professor Harry Minas, Psychiatrist and Director, Victorian Transcultural Psychiatry Unit.

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