

Acute Stress Disorder, Posttraumatic Stress Disorder and Complex PTSD



Specific Populations and Trauma Types Refugees and asylum seekers

This *Refugees and asylum seekers* information sheet addresses background issues and provides presentation, assessment, and treatment advice for practitioners working with refugees and asylum seekers.

Forcibly displaced populations, such as refugees and asylum seekers, leave their homes to escape conflicts, violence, and prosecution and seek long-term resettlement in countries such as Australia. In this process, they are often exposed to potentially traumatic events, loss and adversities. Nevertheless, a person's legal status as a refugee or asylum seeker does not in itself provide any direct information about their mental health needs (although it does signify the person is in a high risk group for mental illness). Mental health needs can only be established by assessing their personal experiences and symptoms.

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

Refugees' psychological distress should be evaluated in the context of their cultural background, which offers an understanding of what has happened, and what is happening, to them.¹ A range of cultural factors influence the individual's decision to seek treatment including beliefs about the causes of mental problems, treatment preferences, stigma attached to mental illness, and the place of family in healthcare.

Practitioners need to be informed about and to respect the cultural beliefs and practices of individuals from differing cultures.

A practitioner's own culture and ethnocentricity is another important contextual factor. Practitioners need to be culturally informed and 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 the client's values and those of the dominant culture, and the ability to understand and choose an appropriate treatment approach.

Finally, the host society provides the context in which subsequent treatment of refugees and asylum seekers occurs. Government policy, community attitudes, and media coverage can have a direct impact on the mental health of refugees, creating a welcoming or hostile environment, or indirect impact,

potentially influencing public attitudes. For asylum seekers, government policies relating to detention, visa restrictions, and access to economic and social rights and entitlements such as access to medical care, work rights, and income support have the potential to significantly influence mental health and wellbeing. Practitioners need to have an understanding of all of the above factors at both the societal 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.

Exposure to potentially traumatic experiences

The experiences that cause people to become refugees or asylum seekers render them susceptible to experiencing mental health problems. These experiences are of three main types.

1. Traumatic exposure to warlike situations and to situations where they or someone close to them has been threatened, injured, raped, or tortured, or they have witnessed the death of others.
2. Loss of family members, friends, relatives, possessions, livelihood, status, or country.
3. Deprivation of basic human rights (e.g., religion, safety or security) or needs (e.g., food, water, shelter, education, and medical attention), that for asylum seekers may continue in the host country while refugee claims are assessed.²

Forced migration involves three phases, during which different factors are at play, predisposing individuals, and whole displaced populations, to higher risk for mental health problems.

The factors experienced during the **pre-migration phase** may involve:

- torture and repeated and/or prolonged extreme forms of violence
- challenge to identity and the breakdown of families and communities
- 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, the targeted harming of children, the violation of sacred values, betrayal, and the weakness of restorative justice
- deliberate erosion of personal integrity (e.g., invasion of privacy or physical boundaries, control of basic functions such as eating and sleeping) and the creation of impossible choices (e.g., choosing who should die or who should be left behind).²⁻⁴

During the **peri-migration phase**, factors associated with the transition process from the country of origin to the country of resettlement become important. These can relate to:

- long and dangerous routes often involving unsafe means (e.g., journeys across the seas in overcrowded, unsafe boats)
- temporary and unsafe residence in so-called countries of transit
- separation from immediate family during flight
- unsafe conditions of refugee camps which may involve deprivation of basic needs such as food, shelter, safety, education, medicine, etc.^{5,6}

Finally, in the **post-migration phase**, members of the displaced populations are faced with chronic daily stressors, loss of their own culture, and the need to adapt to the new culture. These factors continue to

impact upon the mental health of refugees and, in some cases, may be more salient to the development or presentations of symptoms:

- loss of or separation from family and friends, including concern about the safety of those remaining in the country of origin
- loss of social role and status
- difficulties in tasks of settlement such as learning a new language, and gaining employment and accommodation
- economic hardship and poverty
- isolation and lack of social support
- acculturation and inter-generational tensions related to conflict between cultural maintenance of the culture of origin versus acquisition of host culture and identity
- discrimination, racism, and social exclusion in the host community relating to cultural or religious beliefs
- minority status and potential marginalisation in the dominant Australian culture
- in the case of asylum seekers, policies such as mandatory or indefinite detention and temporary protection (see additional issues specific to this group below).⁷⁻¹¹

Understanding the impact of individual and contextual influences during all the phases of forced migration is pertinent to understanding the mental health of refugees and asylum seekers.

Presentation

The construct of PTSD appears to be broadly applicable across cultures.¹²⁻¹⁵ Empirical research demonstrates a well-established association between the extent or dose of trauma exposure and higher risk of PTSD among refugees and asylum seekers.^{12,13,16,17} It is particularly important to note the heightened prevalence of torture among refugee populations, and its associated higher risk for the development of PTSD.¹⁶ Special note should also be made of the use of sexual violence against both women and men in the context of war and organised violence.¹⁸

Research evidence also offers preliminary support for Complex PTSD among culturally-diverse conflict-exposed communities.^{19,20,21}

A large body of research with refugee and asylum seekers has focussed on PTSD, however, refugees and asylum seekers are at risk of comorbid problems, such as:

- anxiety disorders, depression, and mood disorders
- substance abuse
- secondary reactive psychoses and psychotic features
- chronic pain associated with torture and assault
- interpersonal difficulties associated with mistrust, fear, anger, and withdrawal
- difficulties with emotional regulation and reactivity
- high-risk and maladaptive behaviours, including suicidality

- grief responses such as numbing, anger, hopelessness, and meaninglessness
- family conflict, family breakdown, and domestic violence
- reduced physical activity, physical illness, and somatic complaints
- impairments in cognitive functioning including in relation to attention, working memory, and autobiographical memory. ^{4,16,22-27}

Together with the accurate identification of mental disorder among refugee clients, the existential effect of their traumatic histories should be recognised. 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.⁶ For example:

- prolonged exposure to a violent and unpredictable environment may lead to chronic anxiety, fear, helplessness, and reduced stress tolerance
- forced impossible choices and experiences of humiliation may lead to feelings of guilt and shame
- disruption of relationships, separation, and isolation may lead to grief, depression, and altered relationships (e.g., fear of intimacy, 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. 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 rule, standardised assessment measures are appropriate for use with refugees and asylum seekers, bearing in mind the need for culturally sensitive administration and interpretation of results. Where possible, symptom and other self-report measures should be administered within the preferred language of the refugee, although using an interpreter does not demonstrate negative effect on psychological assessments or treatments.²⁸

There are a range of clinician- and self-rated measures that have been adapted and translated for assessment of:

- PTSD diagnosis (e.g., Clinician Administered PTSD scale for DSM-5)
- traumatic exposure and PTSD symptoms (e.g., self-rated measures include International Trauma Questionnaire; Harvard Trauma Questionnaire; Impact of Event Scale)
- psychiatric disorders (e.g., Structured Clinical Interview for the DSM; Mini-International Neuropsychiatric Interview; WHO Composite International Diagnostic Interview)
- anxiety, distress, depression symptoms (e.g., Refugees Health Screener; Symptoms Check List; PTSD/MDD Screener for non-mental health professionals (STAR-MH²⁹))

- post-migration stressors (e.g., Post Migration Living Difficulties Scale)
- Cognitive impairment (e.g., Rowland Universal Dementia Assessment Scale).

Multi-Adaptive Psychological Screening Software (MAPSS), an Audio Computer-Assisted Self-Interview Software (ACASI) for touchscreen devices, is a cost-effective, flexible and valid alternative to interpreter-based psychometric screening and mental health assessment in refugees and asylum seekers.³⁰

However, a comprehensive assessment should go beyond the Diagnostic and Statistical Manual of Mental Disorders (fifth edition; DSM-5) diagnoses and include broader assessment of psychological and social factors. The following table summarises the information that should be collected for a comprehensive assessment.

Assessment domain	Implications
Migration history	
Country of origin and date of arrival	Alerts to: <ul style="list-style-type: none"> • region-specific physical health problems • nature and duration of violence and hardship • access to healthcare
Visa status	Critical to: <ul style="list-style-type: none"> • understanding rights and entitlements • associated everyday stresses
Language	Check preferred language and ethnicity as these can be indicators of possible traumatic experiences. When working with interpreters, be aware that the client may/may not prefer an interpreter from their country or ethnic background. Furthermore, inter-country variation in accent and vocabulary may also need consideration.
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 made with caution. Some may wish to involve other family members in healthcare decision-making or utilise assessment tool (e.g., DSM-5 Cultural Formation Interview and Cultural Awareness Tool).
Social history	
Post-migration stressors including housing, employment, education, language barriers, social isolation, etc.	Post-migration stressors have been found to be an independent contributor to rates of PTSD, depression, and functional impairment in the recovery environment. Post-migration living difficulties inventories have been developed to assist with the assessment of these stressors.
Legal-immigration situation	Refugee determination processes and sponsorship of family members to come to Australia are major sources of stress and mental health problems, especially among asylum seekers.

Psychological history	
Exposure to pre-migration violence and torture, and other traumatic events (e.g., child abuse, intimate partner violence)	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.
Physical health	<ul style="list-style-type: none"> • All clinicians should be aware of the close connection between physical activity and mental health and undertake an assessment of levels of physical activity and evidence of physical health morbidity and risk factors. • The assessing physician should be aware of the range of medical conditions for which a person of the refugee's background should be screened. Some of these conditions may cause or exacerbate psychological problems. In addition, both the physician and treating clinicians should be alert to the possibility of the presence of the following conditions which have been found to be of raised incidence in many refugee populations: <ul style="list-style-type: none"> ◦ physical injuries or pain which are the result of torture/physical trauma ◦ traumatic brain injury ◦ somatisation of a psychological problem ◦ dental problems ◦ infectious diseases, nutritional deficiencies, undiagnosed congenital or chronic diseases may impact on psychological presentation.
Children and adolescents	
Physical health and development	In addition to the above, the assessment should include growth, development, education history, peri- and post-natal history, health consequences of neglect, abandonment, domestic violence, parental traumatic experience, and mental health problems.
Women's health	
	In addition to the above, the assessment should include sexual/reproductive health, female circumcision/traditional cutting, and intimate partner violence.

Facilitating engagement

In undertaking the assessment and planning treatment for people with PTSD arising from prolonged and repeated trauma, the following additional considerations are recommended.

- First appointments often need to be longer and/or several appointments may be needed for a comprehensive assessment.
- The refugee needs to feel they are in a safe environment. Building trust and rapport are essential. There should be an absence of conduct by the clinician, or environmental stimuli, which inadvertently precipitate traumatic responses. Practitioners should also be aware that medical settings may act as reminders of torture, and that some refugees may have a fear of intrusive investigative procedures.
- The gender of the therapist can be especially important for survivors of sexual assault.
- Information provision (e.g., on the purpose of the assessment and use of information once disclosed) and encouraging the client to ask questions promotes a sense of control. However, practitioners need to be aware that in some cultures such practices are unfamiliar and the client may require extra encouragement.
- Explanations of the meaning of confidentiality, privacy and consent are helpful, especially when using professional interpreters.
- Factors affecting lack of engagement in assessment and treatment are important to anticipate. The disclosure of personal and emotionally challenging experiences may be an entirely culturally unfamiliar approach to addressing psychological problems. Cultural beliefs about medical investigations such as taking blood, attitudes to medication, and misunderstanding of side-effects may result in lack of adherence to treatment.

Barriers to access for mental health care

Despite the relatively high prevalence of mental disorders in refugee populations, many do not receive timely treatment. Language difficulties, availability of interpreters, culturally sensitive information about treatment, stigma, and other service barriers (such as homelessness or poverty) 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.^{31,32}

Working with interpreters

The involvement of an interpreter is essential to providing mental health assistance to refugees whenever the clinician and client do not share a language in which they are both fluent. The Australian Government provides a free Translating and Interpreting Service (TIS) to eligible private practitioners to assist communication with clients from culturally and linguistically diverse backgrounds. Interpreting services are provided free of charge to anyone who is eligible for Medicare. Even when there is a shared language, for example when the refugee speaks English well, there may be a good reason to work with an interpreter, for example, because the refugee feels more in tune with their emotions in their first language or otherwise prefers to speak in their native tongue.

Practitioners should be aware of a number of 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 disclose their experiences through known members of their own community. Issues of confidentiality around interpreter use are particularly relevant in small language populations. To improve confidentiality it is often possible to request an interstate telephone interpreter via TIS, or avoid disclosing the client's name. Secondly, the interpreter should have a broad understanding of the rationale for and direction of the treatment, particularly when an intervention might rouse strong or painful emotions in the client. This allows the interpreter to prepare themselves and conduct the session knowing where it is heading. Thirdly, clear roles should be established for the clinician and interpreter,³³ ensuring that all parties, including the client, understand these roles. Finally, practitioners should be aware of the effect on interpreters of retelling the client's traumatic experiences. Despite the interpreter's capacity for a degree of professional emotional detachment, the material may still be disturbing for them, and this effect may be magnified if the interpreter has similar traumatic experiences in their own background. Interpreters working in the field of posttraumatic mental health should receive appropriate supervision and access to debriefing.³³

Treatment

In treating refugees and asylum seekers with PTSD, the practitioner is faced with a number of considerations over and above the individual's traumatic experiences, including language, ethnocultural, sociopolitical, and community issues, as well as the person's current psychosocial situation. For asylum seekers there is the additional stressor of insecure residency status. It is not uncommon for practitioners to feel overwhelmed by these social-cultural complexities. In some cases, the practitioner may disregard the complexities and proceed as though they did not exist. This is unlikely to result in appropriate treatment or the establishment of a collaborative therapeutic relationship. The middle ground, in which the practitioner is aware of the contextual issues at each point in treatment and how they shape the client's experience, but is not diverted from delivering effective treatment, 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.

Mental health ethnographic work has documented that many communities including those from refugee backgrounds have differing interpretations of the cause of their current difficulties, with treatment expectations varying accordingly. Some 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 or irreparable losses and will not respond to treatment, or that their difficulties will subside naturally over time, and thus treatment is unnecessary.³⁴ Yet others will attribute their traumatic experiences to supernatural or religious causes, which may make explaining the rationale for a psychological or pharmacological treatment more challenging. Regardless of their views on the importance of treatment and the likelihood of success, refugees may sometimes have a limited understanding of what the treatment process will involve.³⁴ Assessment of the client's beliefs and expectations, the provision of a clear explanation of the assessment's findings, and a description of the rationale for the proposed treatment is crucial.

Recent decades have seen the publication of multiple clinical trials investigating the efficacy and effectiveness of a range of psychological and other interventions for refugees, asylum seekers, and conflict-affected populations. Recent systematic reviews and meta-analytic studies^{35,36} have documented consistent evidence that trauma-focussed psychological interventions are effective for refugees with trauma-related disorders. Some of these treatments such as trauma-focussed cognitive behaviour therapy

(CBT) have been adapted from interventions validated amongst non-refugee populations. Other treatments such as Narrative Exposure Therapy (NET) have been specifically developed to address the complex and often across-the-lifespan nature of refugee trauma. It should be noted that there are interventions that have been found to be effective for PTSD in general populations for which there is currently insufficient evidence that they will reliably assist refugees. For example, further research is needed in relation to the effectiveness of Eye Movement Desensitisation and Reprocessing (EMDR).³⁵ Other interventions, for example, Culturally Adapted CBT,¹⁵ have shown strong preliminary results but now need to be studied by other researchers in diverse refugee populations.

There is still much to be learnt about how to deliver effective treatments to refugees. It remains a matter of controversy as to whether refugees require a period of stabilisation of their mental state and psychosocial circumstances prior to engaging in trauma-focussed treatment (this is a matter of debate in other trauma-affected populations, but is particularly acute in treatment planning for asylum seekers and refugees who may be living in situations of protracted insecurity).

To date there has been little research that has examined the specific effectiveness of the general psychosocial assistance and counselling provided by torture and trauma services. More needs to be known about who benefits from such programs, who requires specific interventions, and whether the two kinds of assistance yield better outcomes in combination than alone. Based on what is known about the contribution of both pre-arrival trauma and current stressors to mental health outcomes, a plausible argument can be made that specific interventions targeting posttraumatic symptoms and programs of support to address contemporary stressors are both required.

Interpreters are an integral part of the work with many refugees. Delivering treatment through an interpreter, provided the interpreter is appropriately accredited and the clinician is skilled in working with interpreters, would appear to pose no barrier to effective treatment. There is some indication that interpreter-mediated and standard therapy result in equivalent treatment gains in refugees with PTSD.³⁷ In fact, clinical experience suggests that the presence of an interpreter is often a great asset in building rapport and in bringing a cultural understanding to the therapeutic relationship.

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

- the need for a holistic framework for treatment
- recognition of the value of different levels of intervention – individual, family, and 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 the potentially protective value these responses may have for the person
- the critical role that guilt, shame, and a sense of injustice have in maintaining health problems.

For many reasons, when working with a refugee or asylum seeker, treatment goals need to extend beyond PTSD. Firstly, as already discussed, similar to other traumatised populations, PTSD among refugees is typically concurrent with other disorders, most commonly depression and various disorders of mood, and anxiety disorders.³⁵ In providing a comprehensive treatment plan, PTSD will rarely be a single focus of clinical attention. Secondly, the client may regard social problems as of greater significance to their

wellbeing than their psychological state and specific disorder-related symptomatology. The refugee may also be afflicted by various trauma-related psychological problems, which are 'sub-clinical' but nonetheless, in the context of their lives, very distressing. For example, the inability to form secure attachments, to relate to their children, or to regulate their anger. Usually of utmost importance to refugees and their families is the rebuilding of their lives through a successful settlement process. The practitioner should be mindful of the need to 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. Thirdly, physical health must be addressed concurrently with treatment of PTSD. The refugee may suffer medical conditions that produce or maintain depressive and anxiety symptoms and which impede recovery from the sequelae of trauma. For some refugees the alleviation of physical health problems is the pathway to better mental health.

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.³⁸

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 among asylum seekers and refugees in Australia. Steel and colleagues^{39,40} report extremely high incidence of PTSD in temporary visa holders and asylum seekers in detention, as well as in the years after release. High prevalence of torture and interpersonal violence, especially in clinical populations and those exposed to long-term detention, is similarly related to higher prevalence of depression.¹⁸ 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.⁴¹ In addition, asylum seekers in detention are at significant risk of suicidal behaviour, with rates many times higher than the national average for men and women, respectively.⁴²

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 as they relate to 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 experiences exacerbate the impact of war-related traumas, and coupled with long periods in detention are associated with worse mental health outcomes.^{40,43} Such experiences are then followed by the limitations of the temporary visas (employment restrictions, reduced access to settlement services and welfare benefits) that cause severe distress to many.

In addition, during visa processing, asylum seekers face further distressing events – interviews to apply for a permanent visa, frequent rejections of their application, and then application for review at a Tribunal and then a Court, all of which can take many years. Finally, many asylum seekers face potential deportation to their countries of origin. During this time, many report an increased re-experiencing of trauma and fears of

being deported. It has been argued that standard diagnostic categories and individual treatment may be inadequate to address the devastating effect prolonged detention and the visa application process can have on asylum seekers' lives.⁴⁴ Some directions on how to provide psychosocial support to asylum seekers threatened with deportation have been developed in the Netherlands.⁴⁵

Treatment of PTSD therefore needs to consider providing care in the context of the kinds of traumas experienced, the various psychological and physical sequelae of trauma, 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.⁴⁶ In relation to immigration detention, while there are often initial improvements in mental state upon release, in some instances the psychological harm resulting from protracted detention does not remit. Further research is required to assess the long-term effect of detention on psychological wellbeing and adaptation.

Working with children

Children make up more than half of the 25.4 million refugee population worldwide, and represent approximately one-third of asylum seekers.⁴⁷ Around 16 per cent are likely to develop PTSD, with some variations according to type of trauma and gender,⁴⁸ but well above the rates seen in non-refugee children.⁴⁹

As with adults, a range of pre-, peri- and post-migration stressors, including prolonged immigration detention, put refugee children and adolescents at increased risk of developing mental health problems including:

- attachment issues, developmental, emotional, and behavioural delays⁵⁰
- depression, anxiety, and behavioural problems, which may be early indicators of the subsequent development of PTSD⁵¹
- self-harm and suicidal ideation²⁶
- separation anxiety, sleep disturbance, disruptive conduct, and somatic symptoms.^{26,52}

In addition to the experience of trauma, flight and displacement, children also experience disrupted schooling and many are separated from 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.^{49,53} On the other hand, children's experiences and wellbeing are mediated by their parents' mental health. Parental trauma history and post-migration difficulties are associated with harsher parenting styles, as well as higher levels of conduct problems, hyperactivity, emotional symptoms, and peer-related problems among children.⁵⁴

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. Young refugees who are permanently resettled in Australia demonstrate comparable or higher adjustment levels than generally seen in the community. This is particularly influenced by their better physical health and school achievements. On the other hand, refugee children report greater peer difficulties forming friendships, being generally liked, and being picked on, and have a preference for being on their own or with adults.⁵⁵

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.⁵⁶ 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.⁵⁷ 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.

Several individual trauma-focussed PTSD interventions have demonstrated effectiveness among children,^{58,59} including narrative exposure therapy for children⁶⁰ and CBT delivered in school and community-based settings.⁶¹ However, little is known about the long-term effects of trauma-focussed treatments, especially regarding group interventions.

Recommended reading

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Citation

Phoenix Australia - Centre for Posttraumatic Mental Health. Specific Populations and Trauma Types: *Refugee and asylum seekers* in Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder and Complex Posttraumatic Stress Disorder. Melbourne: Phoenix Australia; 2020

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