

Understanding and Treating the Deleterious Effects of Refugee Trauma on Health

EVALUATING AND CARING FOR SURVIVORS OF TORTURE

CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

Chronic disease is highly prevalent in traumatized communities. Resettled refugees, IDP's, immigrants, and asylum seekers who have experienced extreme violence and torture are now demonstrating serious chronic illness such as diabetes, heart disease, hypertension, and stroke in resettlement countries. The experience of extreme violence plants the seed of poor health in the survivor, which will blossom into debilitating illnesses over time. Prevention strategies early on in this process are therefore a top priority.

GENERAL PRINCIPLES

Understand that recounting the events of abuse can be extremely stressful and potentially re-traumatizing for the survivor.

- Utilize active listening
- Acknowledge the difficulties of talking about traumas
- Know that listening to accounts of trauma can also be stressful for the interviewer
- Acknowledge that establishing a rapport and eliciting a thorough history can take time
- Understand that there is variability in the manner in which torture victims conduct themselves in this process
- *Be aware that health professionals may have participated directly or indirectly in the individual's abuse*

TIP: Provide multidisciplinary care by engaging members of your referral network, not just other medical doctors!

COMMON MEDICAL PROBLEMS AMONG REFUGEE SURVIVORS OF TORTURE

Physical

- ◆ Musculoskeletal
 - Fractures, chronic pain, pain on walking from "Falanga" (beatings on soles of feet)
- ◆ Neurological
 - Headaches, visual/hearing loss, vertigo, cognitive impairments
- ◆ Dermatological
 - Scars, keloids, ulcers
- ◆ Infectious Diseases
 - Tuberculosis, parasitic infections, sexually transmitted diseases
- ◆ Urological/Gynecological
 - High prevalence of sexual assault among both men and women
 - Increased rates of depression/PTSD among sexually assaulted individuals
- ◆ Dental
 - Poor dentition as a result of beatings, malnutrition, inadequate access to dental care
- ◆ Gastrointestinal

Psychological

- ◆ Depressive symptoms
 - Sadness, hopelessness, shame, difficulty concentrating, sleep difficulties
- ◆ Anxiety symptoms
 - Nervousness, intrusive memories, nightmares, sleep difficulties, startle response, irritability
- ◆ PTSD
 - Comorbidity of depression/PTSD is common
- ◆ Cognitive Deficits
 - Traumatic brain injury (TBI) is prevalent following torture
 - TBI is correlated with cognitive deficits and depression

Social

- ◆ Withdrawal
- ◆ Isolation
- ◆ Mistrust
- ◆ Substance Use

ANCILLARY TESTS

Be mindful of cultural issues and the potential for re-traumatization, in particular with blood drawing, ECG, and CT Scan/MRI

PHYSICAL EXAMINATION

- ◆ Start with less intrusive elements of physical exam
- ◆ Avoid prolonged nakedness
- ◆ Explain each step as you go
- ◆ Know that physical findings may or may not be present – a “normal” physical exam does not negate allegations of torture
- ◆ Be familiar with the cultural health practices that might be discovered on physical exam that are not a result of torture or physical abuse (e.g. cupping, coining)

SOMATIC EFFECTS OF TRAUMA

Brain Differences:

- ◆ People with PTSD have significantly smaller amygdala, anterior cingulate cortices, and frontal lobes.
- ◆ People with trauma exposure, regardless of PTSD symptomatology, have significantly smaller hippocampi.¹⁷

Cardiovascular Illness:

- ◆ Chronic PTSD, when controlling for age, smoking, body mass index (BMI), substance use, and other factors, is associated with electro cardiogram (ECG) abnormalities, atrioventricular defects, hypercoagulability, and infarctions.³
- ◆ Witnessing a traumatic event leads to long-term changes in systolic blood pressure, which precipitate atherosclerotic plaque formation.¹⁸
- ◆ Acute stress induces cardiac mast cell activation and elevates serum histamine and IL-6, increasing the risk of acute coronary events.²²

Changes in Immune Functioning:

- ◆ Acute stress activates and elevates the immune system. Continued exposure to stress, however, leads to immunosuppression, increasing vulnerability to infectious disease; it can also lead to autoimmunity that causes organ systems to deteriorate.¹⁸
- ◆ Stress increases natural killer (NK) cells and cytotoxic T cells during exposure to the stressor. Following the stressor, those immune cells decrease to below baseline levels.⁸ Afterward, the immune system has a blunted response to new stressors.
- ◆ Increased plasma IL-6, IL-1 β , and C-reactive protein follow exposure to acute stress which predict hypertension, coronary heart disease, and cardiac mortality.²¹

Gastrointestinal Illness:

- ◆ Acute stressful events and psychological stress (including PTSD) precipitate gastro-intestinal (GI) disorders, including irritable bowel syndrome.
- ◆ Psychological and physical stressors are associated with altered contractile responses of the colon.¹⁵

Reproductive Illness

- ◆ Trauma is associated with chronic pelvic pain, sexual problems, infertility and miscarriage, preterm delivery, and low birth weight.⁶

Musculoskeletal Problems/Chronic Pain:

- ◆ Trauma increases the risk of fibromyalgia.¹³

HEALTH SCREENING

- ◆ Tuberculosis (chest x ray for any patients with pulmonary symptoms or positive PPD)
- ◆ HIV and syphilis
- ◆ Hepatitis
- ◆ Stool for ova and parasites
- ◆ Measles, mumps, rubella antibody titres
- ◆ General primary care screening
- ◆ Blood pressure (HTN), lipids
- ◆ Vaccinations
- ◆ Routine labs (Complete Blood Count, basic chemistries)

TIP: Prioritize attending to these patients' basic, as well as medical needs, as patients may be more concerned with safety, food, and clothing than with the providers' agenda.⁵

GOOD DOCUMENTATION

Refer to the [Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment](#)

- International guidelines for medical legal investigation and the documentation of torture and ill treatment,
- Adopted by the UN as the gold standard for such evaluations



Understanding and Treating the Deleterious Effects of Refugee Trauma on Health

The best therapeutic approach is holistic, and considers the interrelationship of the individual, family and community, as well as the interconnection of physical, psychological and social problems and the influence of trauma. Therefore, Primary Care Physicians (PCPs) and other health professionals play an important role in promoting the health and well-being of survivors of torture and refugee trauma.

EPIDEMIOLOGY

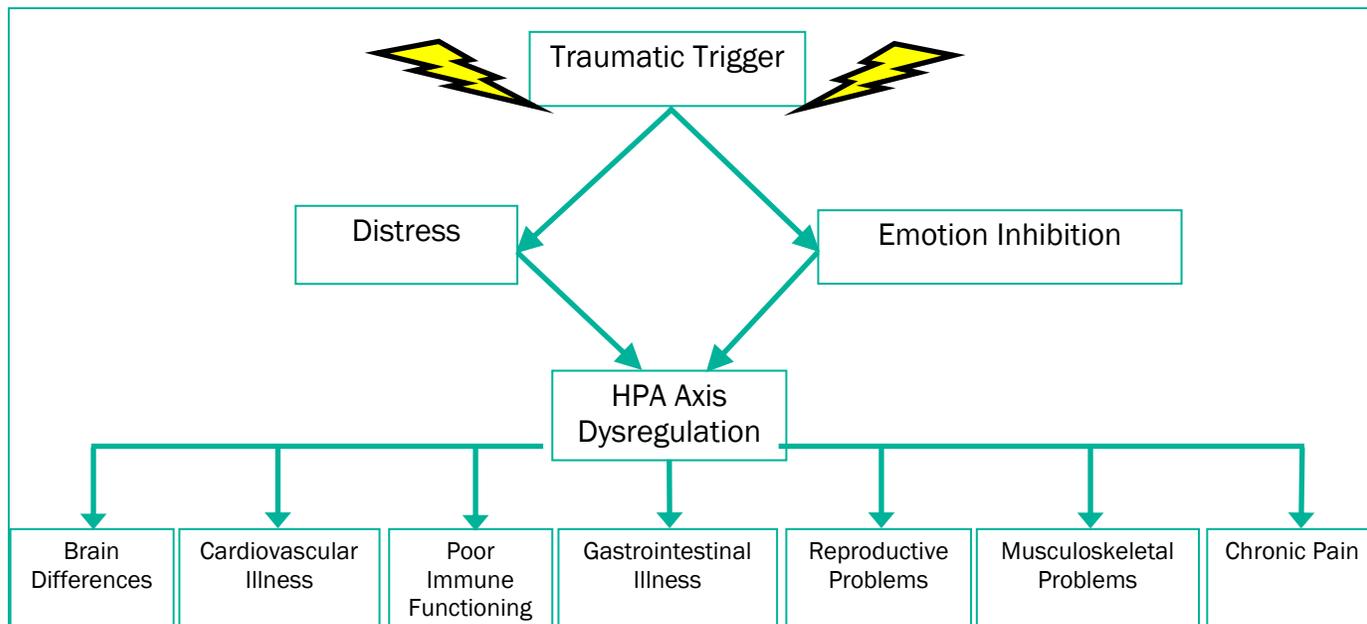
7-11% of immigrant patients in the primary care setting have endured torture.^{4,9,10} Many more have likely experienced traumatic human rights abuses. Nonetheless, few, if any, individuals report their history of torture/trauma to their physician, nor are they asked about it. 85% of patients will not suffer from serious mental illness and will benefit from counseling on the nature of their symptoms and coping techniques. 15% will develop a specific psychiatric disorder, including: complex grief reaction; generalized anxiety disorder; chronic insomnia; depression and Post Traumatic Stress Disorder (PTSD).

THE EMBODIMENT OF TRAUMA

The physical sequelae of trauma develop in two possibly overlapping scenarios:⁶

Scenario 1: Physical illness is generated by the triggering of traumatic associations and the distress that this cued reactivity causes

Scenario 2: Physical illness is generated by emotion inhibition via coping styles that serve to reduce stress but are physically taxing



HPA AXIS DYSREGULATION

People with PTSD have blunted cortisol stress responses but higher overall daily cortisol output. Even in the absence of PTSD, trauma exposure causes both too much and too little cortisol and therefore the health outcomes associated with these abnormalities.^{7,8} HPA axis dysregulation is theorized to be a primary biological mechanism in the pathway from stress to organic disease.¹²

EFFECTS OF TRAUMA ON HEALTH

Traumatic experiences have a dose-response relationship with negative health outcomes across multiple diagnoses, from psychiatric (depression, anxiety, substance abuse) to physical (diabetes, heart disease, and cancer).^{1,11} These outcomes appear to be independent of PTSD.²⁰ In patients with PTSD, although the psychological symptoms often lead to risky health behaviors, the negative impact of the disorder remains even when poor health behaviors are held constant. PTSD additively increases health burden.²



THE PATIENT HISTORY: ELICITING THE TRAUMA STORY

It is important for physicians to understand their patients' full trauma story. Details of refugee trauma may be suppressed for many years, and when physicians do not ask about trauma, patients may not believe it appropriate to initiate conversations about their experiences.¹⁹ Inviting patients to recount their story establishes trust and assists the physician in making an accurate differential diagnosis, as well as evaluating the patient's support systems to foster their recovery and well-being. Beware that refugee patients' pre-flight and flight trauma may be exacerbated by additional losses during resettlement in the host country associated with disconnection from cultural traditions, loss of language and communication skills, loss of career and social status, and marginalization in their host country.⁵

SAMPLE QUESTIONS FOR INQUIRING ABOUT TORTURE EXPERIENCES⁵

- ◆ Can you tell me what made you leave your home country?
- ◆ Have you ever had problems because of your culture or tribe? Your political beliefs? Your religion? Your gender?
- ◆ Have you ever been arrested or put in jail?
- ◆ Have you ever been beaten or attacked by soldiers, police, or rebel groups? Have you ever seen or heard this happen to others?
- ◆ What problems are you having now from these experiences?

CHALLENGES TO OBTAINING THE HISTORY²¹

- ◆ Lack of trust
 - Survivors of torture/refugee trauma may:
 - Fear receiving bills they are unable to pay
 - Perceive clinicians as agents of the government
 - Not understand the confidential nature of the doctor-patient relationship
 - Fear arrest or deportation if in the asylum process
- ◆ Inadequate communication
 - Patients with low English proficiency are more likely to report problems with care and are at greater risk of medical errors¹⁶
 - Federal law obligates physicians to use a professional interpreter under Title VI of the Civil Rights Act
 - However, interpreters may be members of the local community, and patients may fear stigmatization if torture/trauma/sexual history is discussed
- ◆ Cultural differences between clinician and refugee
 - Different ways of understanding illness and health care
 - Be sure to inquire about traditional medicines, fasting, and medical practices and be flexible about their incorporation into the treatment plan

This information guide is based on research and modules presented at NPCT trainings developed by Dr. Allen Keller, MD, the Director of the NYU/Bellevue Program for Survivors of Torture and Dr. Richard Mollica MD, Director of the Harvard Program in Refugee Trauma.

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