

Working with Refugees with PTSD

Post Traumatic Stress Disorder (PTSD) is one of the most common mental health issues which refugees face as a result of experiencing trauma. The DSM5 defines PTSD as a disorder lasting more than one month following a trauma and is characterized by 4 types of symptoms:

- Re-experiencing the event
- Negative changes in mood or thought
- Avoidance of reminders of the event
- Hyper arousal of the nervous system

Trauma is direct exposure to actual or threatened death, serious injury, or sexual violation as a victim, witness, or perpetrator

Refugees Suffering from PTSD May Experience:

- Insomnia
- Excessive watchfulness
- Poor concentration
- Jumpiness
- Nightmares
- Intrusive thoughts or images of events
- Flashbacks
- Physical panic
- Emotional distress
- Negative changes in moods and thoughts
- Self-blame
- Memory loss of the trauma

Traumatic Events Predisposing Refugees to PTSD:

- Torture
- Exposure to war
- Human trafficking
- Exposure to state-sponsored violence and oppression
- Life in refugee camps
- Internal displacement
- Loss of family members and prolonged separation
- Stress of adapting to a new culture or environment
- Unemployment
- Low socioeconomic status

Misdiagnosis of PTSD

PTSD is often co-occurring with other disorders or misdiagnosed. PTSD may present similar to Traumatic Brain Injury, Bi-Polar Disorder, Depression, Addiction, and other anxiety or depressive disorders. ^{6,8,10,11,13}

Considerations for your Work

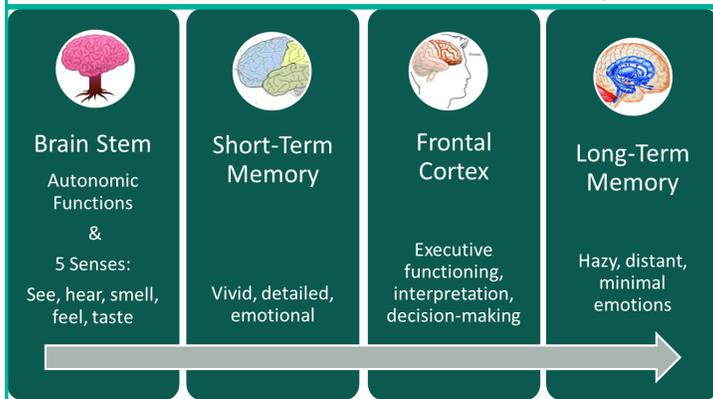
- *The relationship with the provider is the single best predictor of treatment outcomes*
- Trauma is healed only in relation to others
- Communicate thoroughly and openly in order to clear up potential misunderstandings, to minimize escalation from mood swings, and to demonstrate trustworthiness
- Normalize symptoms and reassure patients by reducing distress through modeling self-calming
- During times of psychological distress, silence can be a good tool to acknowledge validity and feelings
- Gently change the subject if appropriate
- Don't challenge unrealistic thoughts too directly because it can be invalidating for patients
- Be especially respectful of personal space
- Staying in situations where one feels powerless can prolong suffering because there is no opportunity to confront feared situations
- Support clients to mediate the impact of PTSD
 - Avoidance can prolong symptoms
 - Meeting basic needs may decrease stressors
 - Strengthening support systems improves resiliency
- Create community groups (dance, art, cooking, knitting) where clients can socialize
- Highlight even the smallest successes to assist clients in overcoming the symptoms of PTSD
- Remind yourself of the life experiences of clients with PTSD to better understand their symptoms and remain compassionate
- There is a higher occurrence of domestic violence and substance abuse in clients with PTSD; therefore, be prepared to refer appropriately

Cultural Barriers

- There can be a stigma against mental health and its legitimacy
- Understand the metaphorical language cultures use when discussing mental health
 - Some cultures may describe spirit or demon possession
 - Many cultures will describe somatic rather than psychological symptoms
- Clients may want more prescriptive approaches; therefore, basic relaxation exercises may be helpful

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Components of PTSD

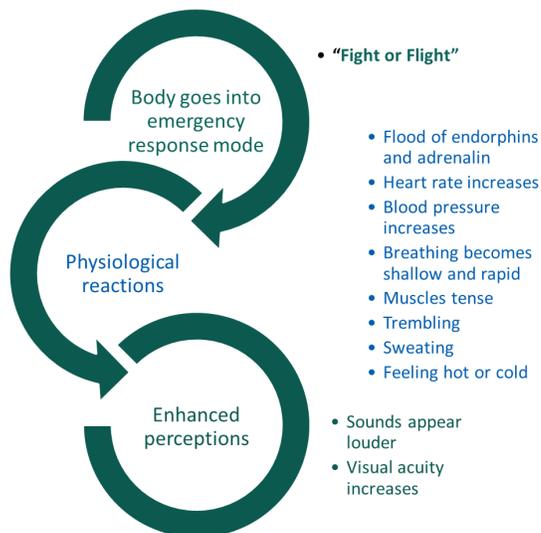


Adaptive Information Processing

The system of how information flows through the brain normally shuts down during a traumatic event leading to the panic response.

The Panic Response

When in danger, the body goes into “fight or flight” mode, resulting in physiological reactions such as an increase in endorphins, adrenaline, and heart rate, and tensed muscles in order to give the body the best chance of survival.



Self disconnects to avoid the oncoming expected pain

Normal information processing disrupted
(Shapiro, 2001)

If still aware

Short-term memory

If fight or flight doesn't work

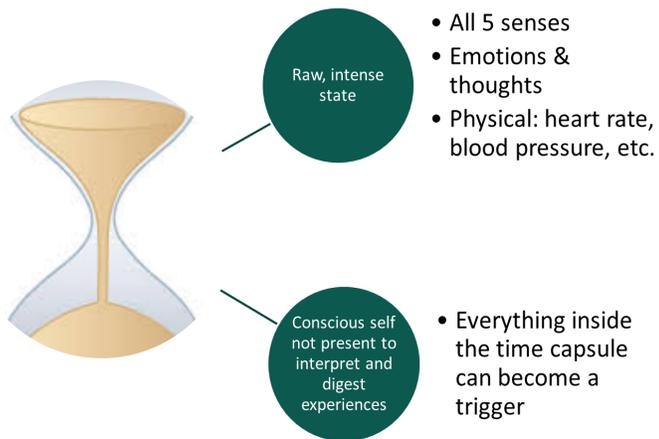
Freeze
Brain stem (amnesia)

Dissociation in Panic

Self disconnects in order to avoid oncoming expected pain. It is a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment. Dissociation occurs on a continuum.

Time Capsules (Memory Networks)

Extreme forms of dissociation can cause clients to “freeze”. Incoming information is stalled in the brain stem, resulting in potential amnesia. All five senses are trapped in their raw state because the conscious self is not present to interpret and process experiences.



When all 5 senses, emotions and thoughts, and physiological state are “frozen” together as a result of a severe traumatic experience, a trigger is created.



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Post Traumatic Stress Disorder

4 Symptom Clusters

1. **Re-experiencing** the trauma occurs when time capsules are activated by triggers or the mind's natural process of trying to digest information resulting in:
 - Nightmares
 - Intrusive thoughts or images of events
 - Flashbacks
 - Physical panic
 - Emotional distress
2. **Avoidance** of triggers can result in re-experiencing trauma so people try to avoid the internal and external
 - Internal - thoughts, feelings
 - External - conversations, situations, people, media
3. **Hyper-arousal** of the nervous system (body is "stuck" in panic or a semi-panic state)
 - Irritability and angry outbursts with little or no provocation
 - Reckless or self-destructive behavior
 - Excessive watchfulness
 - Jumpiness
 - Poor concentration
 - Insomnia
4. **Negative changes** in thoughts and mood are attempts by the mind to reduce conflict between beliefs and trauma, or to avoid emotional pain
 - Inability to remember an important aspect of the trauma
 - Exaggerated negative beliefs or expectations about oneself, others, or the world
 - Distorted thoughts about the cause of the trauma that lead the individual to blame self or others
 - Persistent strong negative emotions
 - Loss of interest in significant activities
 - Feelings of detachment or estrangement from others
 - Inability to experience positive emotions

Specifiers - some individuals with PTSD may exhibit:

- **Dissociative symptoms** that continue to occur after the trauma results in:
 - De-personalization: Feeling detached from oneself
 - De-realization: Feeling like everything is unreal
- **Delayed expression**
 - Most symptoms don't start until at least 6 months after the event
 - Delayed expression frequently occurs when:
 - There are prolonged periods before the person is completely safe, such as living in a refugee camp or living "on the run"
 - There is a new significant life stressor or trauma

Complex Trauma

- Occurs when there have been extended or repeated traumas where the person has little control such as
 - Prolonged imprisonment or torture
 - Prison of war or refugee camps
 - Childhood sexual abuse
- Can cause long-lasting personality changes and a disruption in the basic sense of self
 - Rapid mood swings
 - Unstable relationships
 - Impulsivity
 - Repeated failures of self-protection
 - Search for rescuer
 - Sense of helplessness or paralysis of initiative
 - Hallucinations

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Information Guide Working with Refugees with PTSD

References

1. American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.
2. Arditto, R., Rabellino, D. (2011). Therapeutic alliance and outcome of psychotherapy: Historical excursus, measurements, and prospects for research. *Frontiers in Psychology*, 2: 270. doi: 10.3389/fpsyg.2011.00270
3. Centers for Disease Control & Prevention (2012). Guidelines for mental health screening during the domestic medical examination for newly arrived refugees. Retrieved from <http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/mental-health-screening-guide-lines.html>
4. Eades, D. (2013). Resilience and refugees: From individualized trauma to post traumatic growth. *M/C Journal*, 16(5). Retrieved from <http://journal.media-culture.org.au/index.php/mcjournal/article/viewArticle/700/0>
5. Foa, E., Hembree, E., & Rothbaum, B. O. (2007). Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences therapist guide (treatments that work). Oxford: Oxford University Press.
6. Hall, R. C. W., & Hall, R. C. W. (2007). Detection of malingered PTSD: An overview of clinical, psychometric, and physiological assessment: Where do we stand? *Journal of Forensic Science*, 52(3), 717-725.
7. Herman, J. L. (1992). Trauma and recovery. New York, NY: Basic Books.
8. Hernandez, J. M., Cordova, M. J., Ruzek, J., Reiser, R., Gwidowski, I. S., Suppes, T., & Ostacher, M. J. (2013). Presentation and prevalence of PTSD in a bipolar disorder population: A STEP-BD examination. *Journal of Affective Disorders*, 150(2), 450-455.
9. Modvig, S., & Jaranson, B. (2004). In J. Wilson & B. Drozdek (Eds.), *Broken Spirits: The treatment of traumatized asylum seekers, refugees, war and torture victims* (609-36). New York, NY: Brunner-Routledge Press.
10. Salzbrenner, S., & Conaway, E. (2009). Misdiagnosed bipolar disorder reveals itself to be post traumatic stress disorder with comorbid pseudotumor cerebri: A case report. *Psychiatry (Edgmont)*, 6(8), 20-32. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2743211/>
11. Sbordone, R. J., & Ruff, R. M. (2010). Re-examination of the controversial coexistence of traumatic brain injury and post traumatic stress disorder: Misdiagnosis and self-report measures. *Psychological Injury and Law*, 3(1), 63-76.
12. Shapiro, F. (2001). Eye movement desensitization and reprocessing (EMDR): Basic Principles, Protocols, and Procedures (2nd Ed.). New York, NY: The Guilford Press.
13. Sumpter, R. E. & McMillan, T. M. (2005). Misdiagnosis of post-traumatic stress disorder following severe traumatic brain injury. *The British Journal of Psychiatry*, 186, 423-426.
14. Van der Kolk, B. (1994). The body keeps the score: Memory & the evolving psychobiology of post traumatic stress. *Harvard Review of Psychiatry*, 1(5), 253-265.
15. Van der Veer, G. (1998). Counseling and therapy with refugees and victims of trauma: Psychological problems of victims of war, torture, and repression (2nd ed.). Chichester, West Sussex: John Wiley & Sons.
16. Weine, S., Kuluzovic, Y., Klebic, A. (2008). Evaluating a multiple-family group access intervention for refugees with PTSD. *Journal of Marital and Family Therapy* April 2008, Vol. 34, No. 2, 149-164.
17. Wilson, J. & Drozdek, B., Eds. (2004). *Broken Spirits: The Treatment of Traumatized Asylum Seekers, Refugees, War, and Torture Victims*. New York: Brunner-Routledge.

This information guide is based on an NPCT webinar on this topic presented by the Florida Center for Survivor of Torture's Clinical Supervisor, Kristin L. Towhill, LCSW. The webinar is archived on our website, www.gcjfc.org/refugee under Webinars.

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