Addressing Mental Health, PTSD, and Suicide in Refugee Communities

Kristin L. Towhill, LCSW
Clinical Supervisor
Florida Center for Survivors of Torture
July 31, 2014
Training Objectives

Enhance the capabilities of providers in recognizing and meeting refugee mental health needs

Assist social service providers in responding to recent increases in suicide attempts in the refugee community

Present prevalence, indicators, and warning signs of PTSD, depression, somatization and suicidal ideation

Present evidence-based interventions for addressing PTSD, depression, somatization and suicide
Outline

I. Definitions of torture and PTSD
II. Prevalence of depression, PTSD and torture
III. Depression, explained
   A. Background
   B. Warning signs
IV. PTSD, explained
   A. Background
   B. Warning signs
   C. Treatment best practices
V. Somatization
VI. Suicide
   A. Rates
   B. Risk factors
   C. Culturally-sensitive response & prevention
VII. Best practices for trauma-informed care
   A. Examples
VIII. Questions
Torture

Prevalence of refugees in US who are torture survivors: 5%-35%

- 50% to 67% PTSD
- 33% depression
- 10% generalized anxiety disorders
- 10% other psychiatric diagnoses
- 40% to 70% chronic pain or somatoform disorders
  - Recurrent, complex, or unexplained pain – Screen for torture (Wenzel et. al., 2007; Modvig and Jaranson 2009)
According to the Centers for Disease Control & Prevention (CDC)

Post-traumatic stress disorder (PTSD), depression, panic attacks, somatization, and traumatic brain injuries are prevalent in refugees (CDC 2012)
Prevalence Rates

<table>
<thead>
<tr>
<th>PTSD: 4% - 86%</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Children and adolescents 50%-90% (Refugee Health Technical Assistance Center, ND)</td>
</tr>
<tr>
<td>• Non-Western, collectivist cultures</td>
</tr>
<tr>
<td>• Lower PTSD, higher somatization and psychosis (Schubert &amp; Punamaki, 2011)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Torture</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Designed to affect whole person and community, impact not fully captured by PTSD criteria (Williams &amp; Merwe, 2013)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Depression: 5% - 31%</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Children and adolescents 6%-40% (Refugee Health Technical Assistance Center, ND)</td>
</tr>
</tbody>
</table>
Warning Signs – Depression
(Refugee Health Technical Assistance Center, 2010)

Normalize as state of “energy depletion” and demoralization

- Lethargy
- Fatigue
- Drowsiness
- Hypersomnia

- Aches and pains
- Chest pains
- Feeling absent
- Poor concentration or memory

Avoid “Mental Health” or Diagnoses

- Refer to specific symptoms (Regester, Parcells & Levine (2011))
Symptom Severity & Chronicity

Mental health symptoms
• Increase during the first 2 years of resettlement
• Then gradually decline
  (Beiser, 1988; Tran, Manalo, & Nguyen, 2007)

Distress still chronic
• 45% in one study still met clinically significant distress 5 years later
  (Ater, 1998)

Greater levels of trauma = greater risk
• Psychological disorders, physical illnesses, and chronic pain long after resettlement
  (Steel, Silove, Phan, & Bauman, 2002)
According to the Diagnostic & Statistical Manual (DSM-5)

PTSD
A disorder lasting more than one month following a trauma, characterized by 4 types of symptoms

1. Re-experiencing the Event
2. Avoidance of Reminders of the Event
3. Negative Changes in Mood or Thoughts
4. Hyper-arousal of the Nervous System

Trauma
Direct exposure to actual or threatened death, serious injury or sexual violation (American Psychiatric Association, 2013)

As a victim, witness, or at times, even a perpetrator
Some risk factors predisposing refugees to PTSD

Exposure to war

State-sponsored violence and oppression

Torture

Internment in refugee camps

Human trafficking

Physical displacement outside one's home country

Loss of family members and prolonged separation

The stress of adapting to a new culture

Low socioeconomic status

Unemployment (CDC, 2012)

Persecution and discrimination in new country

Long-term effects of physical trauma and hardships before fleeing or in camps
6 Steps to PTSD

- Information Processing Theory
- The Panic Response
- Dissociation in Panic
- Time Capsules
- PTSD
- Complex PTSD
1. Information Processing Theory

Normal Flow of Information (Shapiro, 2001):

- **Brain Stem**
  - Autonomic Functions
  - &
  - 5 Senses: See, hear, smell, feel, taste

- **Short-Term Memory**
  - Vivid, detailed, emotional

- **Frontal Cortex**
  - Executive functioning, interpretation, decision-making

- **Long-Term Memory**
  - Hazy, distant, minimal emotions
2. Panic

- "Fight or Flight"

Body goes into emergency response mode

- Flood of endorphins and adrenalin
- Heart rate increases
- Blood pressure increases
- Breathing becomes shallow and rapid
- Muscles tense
- Trembling
- Sweating
- Feeling hot or cold

Physiological reactions

- Sounds appear louder
- Visual acuity increases

Enhanced perceptions
3. Dissociation

**Dissociation**: A disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment *(APA, 2013)*

- **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)
4. Time Capsules

- All 5 senses
- Emotions & thoughts
- Physical: heart rate, blood pressure, etc.

Raw, intense state

Conscious self not present to interpret and digest experiences

- Everything inside the time capsule can become a trigger
5. PTSD – 4 Symptom Clusters (APA, 2013)

1. Re-experiencing: Time Capsules are activated by triggers or the mind’s natural process of trying to digest information
   - Nightmares
   - Intrusive thoughts or images of events
   - Flashbacks
   - Physical panic in response to reminders
   - Emotional distress in response to reminders
5. PTSD – 4 Symptom Clusters

2. **Avoidance** of triggers that could result in re-experiencing trauma
   - Internal – Thoughts, feelings
   - External – Conversations, situations, people, media

3. **Hyper-arousal** of the nervous system
   Body “stuck” in panic/semi-panic state
   - Irritability and angry outbursts with little or no provocation
   - Reckless or self-destructive behavior
   - Excessive watchfulness
   - Jumpiness
   - Poor concentration
   - Insomnia
5. PTSD – 4 Symptom Clusters

4. Negative changes in thoughts and mood

Attempts by the mind to reduce conflict between beliefs and traumas, or avoid emotional pain

• Inability to remember an important aspect of the trauma(s)
• Exaggerated negative beliefs or expectations about oneself, others, or the world
• Distorted thoughts about the cause of the trauma(s) that lead the individual to blame self or others
5. PTSD – 4 Symptom Clusters

4. Negative changes in thoughts and mood

- Persistent strong negative emotions
- Loss of interest in significant activities
- Feelings of detachment or estrangement from others
- Inability to experience positive emotions

Significant overlap with symptoms of depression and the freeze response
6. Complex PTSD *(Herman, 1992)*

Extended trauma where the person has little control, can cause long-lasting personality changes:
- Prolonged imprisonment and torture
- Prisoner of war or refugee camps
- Childhood sexual abuse

Disruption of 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
### Warning Signs – PTSD
(Refugee Health Technical Assistance Center, 2005)

<table>
<thead>
<tr>
<th>Unexplained physical complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Fear of heart attacks</td>
</tr>
<tr>
<td>• Fear of stroke or passing out</td>
</tr>
<tr>
<td>• Pseudoseizures</td>
</tr>
<tr>
<td>• Unexplained pain from reexperiencing physical sensations of trauma</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Local examples (Vargas, 2007)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Latin American</td>
</tr>
<tr>
<td>• “Nervios”</td>
</tr>
<tr>
<td>• Vietnamese</td>
</tr>
<tr>
<td>• “Think-too-much”</td>
</tr>
<tr>
<td>• Ethiopian</td>
</tr>
<tr>
<td>• “Tight in neck”</td>
</tr>
<tr>
<td>• “Burning all over”</td>
</tr>
<tr>
<td>• “Insects under skin”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Common stress-related illnesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diabetes</td>
</tr>
<tr>
<td>• Back problems</td>
</tr>
<tr>
<td>• Heart problems</td>
</tr>
<tr>
<td>• Genitourinary/reproductive</td>
</tr>
<tr>
<td>• Gastrointestinal distress</td>
</tr>
<tr>
<td>• Muscle tension</td>
</tr>
<tr>
<td>• Sleep problems</td>
</tr>
</tbody>
</table>
Best practices for treating PTSD in individual therapy

With Cognitive Behavioral Therapy (CBT) adapted to culture
(Murray, et. Al., 2010)

With exposure component  (ISTSS, 2009; VA/DOD, 2010; Murray, et. al., 2010)

With medication enhancing efficacy  (VA/DOD, 2010; Murray, et. al., 2010)

SSRI’s: Paroxetine and sertraline
Prazosin: Beta-blocker for nightmares
Benzodiazepines: Contraindicated
Best practices for treating PTSD in individual therapy

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prolonged Exposure therapy (PE)</td>
<td>• Most evidence for PTSD in the US&lt;br&gt;• Tested with torture survivors and different cultures (Foa, 2009)</td>
</tr>
<tr>
<td>Eye Movement Desensitization and Reprocessing (EMDR)</td>
<td>• More tolerable than PE (ISTSS, 2009)</td>
</tr>
<tr>
<td>Narrative Exposure Therapy</td>
<td>• Culturally-relevant exposure&lt;br&gt;• Latin American practice of sharing testimonials&lt;br&gt;• Multiple other story-telling traditions (Neuner, et. al., 2004; Murray, et. al., 2010; Merwe &amp; Williams, 2009)&lt;br&gt;• Last stage of healing trauma as action step</td>
</tr>
</tbody>
</table>
### Best practices for PTSD and special populations in individual therapy

| Complex PTSD | • Before: Add stabilization and skill building before  
|             | • After: Add reinforcement of treatment gains  
|             | (ISTSS, 2009; Herman, 1992) |
| Comorbidity | • Depression, panic disorder, anxiety and others improve with PTSD treatment alone |
| Substance abuse | • Co-occurring treatment with PTSD (ISTSS, 2009) |
| Children and youth | • Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) (Pottie, et. al., 2011)  
| | • Adapted EMDR  
| | • Individual treatment better for kids (Murray, 2010) |
Best practices for PTSD: Some considerations

CBT limitations

- Individual-based - may not resonate with more collectivist cultures
  - Focus on behavior and ability to fulfill role for family or community

Internet-based therapies found effective for torture and chronic pain (Carinci, et al, 2010)

- Better than no therapy for PTSD, but not as good as in person (VA/DOD, 2010)

- Viable if needed for native language
“Somatization”

Western medicine only practice that separates

- Body
- Emotional
- Spiritual
- Interpersonal

Mind/body/spirit/community

- Feelings in the body: Normal process of expressing distress in ALL cultures
- Somatization = Pathologizing (Harvard Program in Refugee Trauma, 2010)
Suicide

Then, those suffering from trauma, depression, or PTSD are at risk of suicide.

- When benefit of escaping suffering outweighs work of getting better.
- When other options seem nonexistent.
- When distress and risk outweigh protective factors.
Suicide rates per 100,000 (CDC, 2013)

- **Global:** 16
- **US:** 12.4
- **Bhutanese refugees:** 20.3 in US
  - 20.7 in refugee camps
  - 31.5 in one study
- No marked difference in rates of other refugee groups from the general population
- For every completed suicide (in the world), there are 20 attempted
Suicide Risk Factors Specific to Refugees

Impaired judgment, lack of impulse control, and self-destructive behaviors (World Health Organization (WHO) 2006)

Shame (from torture or sexual assault), guilt (from survivor guilt, depression or PTSD), history of perpetration (Murray, et. al., 2010)

Unresolved asylum cases, fear of being discovered or deported or tortured again (Center for Victims of Torture, 2011)
Other Suicide Risk Factors

- Personal losses, especially bereavement in childhood
- Mental diagnoses: depression, PTSD, personality disorder, schizophrenia, substance abuse
- Low socioeconomic status or educational level; loss of previous status
- Discrimination, limited acculturation, isolation, language barriers
- Problems with family functioning, social relationships, and support systems
- Domestic violence
- History of previous attempts, especially immediately following discharge if hospitalized
- Single relationship status
- Physical illness, especially chronic or terminal illness, and chronic pain
- Exposure to suicide of other people
Protective factors that decrease suicide risk *(WHO, 2006)*

<table>
<thead>
<tr>
<th>Support, satisfying social life</th>
<th>Family, friends, and other significant relationships</th>
<th>Responsibility to others, especially children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religious, cultural, and ethnic beliefs against suicide</td>
<td>Religious, cultural, and ethnic beliefs in support of healing</td>
<td>Community involvement, social integration</td>
</tr>
<tr>
<td>Employment</td>
<td>Constructive use of leisure time</td>
<td>Access to mental health care and services</td>
</tr>
</tbody>
</table>
Responding to Suicide Risk

Suicide is not a diagnosis
- Response to suffering outweighs coping

Interventions
- Decrease suffering (Risk)
- Increase culturally relevant coping (Protective)
Suicide Prevention

World Health Organization (2006) recommends:

- Prevent or treat depression and substance abuse
- Use “gatekeepers” to engage in services
- Follow up with survivors after suicide attempt

Center for Disease Control (2013) recommends:

- Culturally-appropriate community-based suicide prevention
- Standard procedures for monitoring and reporting suicides and attempts
Culturally Sensitive Screenings

**Why:** doctors’ responsibility as first and only usual respondent

**Primary care**
- Refugee Health Screen (RHS-15)
- Personal Health Questionnaire (PHQ)
- Refer to MH or refugee services

**Social services**
- Refugee Health Technical Assistance Center Toolkits
- WHO Preventing Suicide Resource Series

**Trauma services**
- Harvard & Hopkins Assessments (HPRT)
- PTSD Checklist for the DSM-5 (National Center for PTSD)
## Culturally Specific Expressions of Distress

<table>
<thead>
<tr>
<th>Bhutanese</th>
<th>Hmong</th>
<th>Ethiopian</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Karma</td>
<td>• Soul loss due to:</td>
<td>• Traditional</td>
</tr>
<tr>
<td>• Witchcraft</td>
<td>• Injury or anesthesia</td>
<td>• Mental and physical illness from</td>
</tr>
<tr>
<td>• Disturbed ancestors</td>
<td>• Sadness or fear</td>
<td>spirits</td>
</tr>
<tr>
<td>• Spirits</td>
<td>• Loneliness</td>
<td>• Christian</td>
</tr>
<tr>
<td>• Loss of soul</td>
<td>• Symptoms</td>
<td>• Punishment from God</td>
</tr>
<tr>
<td>• Diet or environment out</td>
<td>• Weakness or tiredness</td>
<td>• Treated with prayer</td>
</tr>
<tr>
<td>of balance (Maxym, 2010)</td>
<td>• Fever or headache</td>
<td>(Molakign, Brandon, Duncan, Hayden,</td>
</tr>
<tr>
<td></td>
<td>• Thirst or loss of</td>
<td>1996)</td>
</tr>
<tr>
<td></td>
<td>appetite</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Insomnia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Dreams of being in a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>strange place with a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>stranger</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Soul caller/shaman</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Owens, 2007)</td>
<td></td>
</tr>
</tbody>
</table>
Responding to Suicidal Ideation

(Descending according to risk):

- Establish safety (police if needed)
- Contract for safety
- Mitigate risk factors
- Strengthen protective factors (enlist family)
- If unable to limit access or commit to safety, needs to be hospitalized
Strengths Orientation

All refugees have been through trauma

- Traumatic displacement
- Bereavement
- Loss of attachments
- War

Medicalizing trauma

- Diminishes resilience
- Makes dependent on external factors for survival
- Rather than internal or community (Murray, et. al., 2010)
Best practices for refugee mental health interventions (Murray et. al., 2010)

- Evidence-based practices tailored to each culture
  - Understand differences in meaning and distress
  - To foster appropriate coping with adversity

- Acknowledge cultural differences and inherent strength and wisdom
  - Foster strength, capacity, resilience

- In native language
  - Twice as effective

- Reduce traumatic stress and anxiety
  - Most quality of life and symptom improvement
Holistic Treatment Plans

Harvard Program in Refugee Trauma (ND)

- Bicultural Providers and Diagnoses (Harvard, ND; CVT, 2005)
- DSM-5 and “Cultural Expressions of Distress” (CED)

Psychological /Emotional
- Stabilization
- Safety
- Trauma story
- Traditional healing for CED’s
- Mourning or remembrance
- Expressive arts
- Action steps
- Reconsolidating

Case management /Concrete needs
- Legal
- Finances
- Parenting
- Resident status
- Medical care
- Housing

Enrichment
- ESL
- Religion
- Work
- Social
- Community
- Expressive arts
- Altruism*

Harvard Program in Refugee Trauma (ND)
Bicultural Providers and Diagnoses (Harvard, ND; CVT, 2005)
DSM-5 and “Cultural Expressions of Distress” (CED)
## Best practices for refugee mental health interventions in groups (Murray et. al., 2010; CVT, 2005)

<table>
<thead>
<tr>
<th>Homogenous groups</th>
<th>• Four times improvement over mixed-culture groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not symptom-focused</td>
<td>• Psychosocial, family, community, expressive arts</td>
</tr>
</tbody>
</table>
| Reconnect         | • Improve acculturation and coping  
                    | • Directly address interpersonal nature of trauma |
| Avoids stigma     | • Related to mental health treatment |
Suggested for Bhutanese refugees
(by Maxym, 2010)

- Community garden
- Worship gatherings
- Cultural expression
- Elder services
QUESTIONS?
Resources

- The Center for Victims of Torture [http://www.cvt.org](http://www.cvt.org)
- Cultural Orientation Resource Center [http://www.culturalorientation.net](http://www.culturalorientation.net)
- Dignity – Danish Institute Against Torture [http://www.dignityinstitute.org](http://www.dignityinstitute.org)
- Ethnomed Cross-Cultural Health [https://ethnomed.org/clinical/mental-health/](https://ethnomed.org/clinical/mental-health/)
- Gulf Coast Jewish Family Services Refugee Programs: Screening and referral guidelines, support group guidelines, suicide prevention resources [http://gulfcoastjewishfamilyandcommunityservices.org/refugee/resources](http://gulfcoastjewishfamilyandcommunityservices.org/refugee/resources)
- Harvard Program in Refugee Trauma [http://hpert-cambridge.org](http://hpert-cambridge.org)
Resources


- Heal Torture [http://www.healtorture.org/content/provider-resources](http://www.healtorture.org/content/provider-resources)

- International Rehabilitation Council for Torture Victims ([www.IRCT.org](http://www.IRCT.org))

- International Society for Traumatic Stress Studies [http://www.istss.org/TreatmentGuidelines/6797.htm](http://www.istss.org/TreatmentGuidelines/6797.htm)

- National Center for PTSD [http://ptsd.va.gov](http://ptsd.va.gov)

- National Consurtium of Torture Treatment Programs [http://www.ncttp.org](http://www.ncttp.org)
Resources


• Trauma-Focused Cognitive-Behavioral Therapy (free online implementation course) [http://tfcbt.musc.edu](http://tfcbt.musc.edu)


References


References


http://fieldresearch.msf.org/msf/bitstream/10144/22352/1/Apr%204%207.pdf
References

https://ethnomed.org/culture/hmong/hmong-cultural-profile#section-16

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3168666/?report=classic#___sec160title

Refugee Health Technical Assistance Center (ND). Mental Health.
http://refugeehealthta.org/physical-mental-health/mental-health/

https://ethnomed.org/culture/iraqi


References


http://www.herebenhelp.bc.ca/visions/trauma-and-victimization-vol3/war-trauma-in-refugees


http://www.who.int/mental_health/resources/preventingsuicide/en/
Contact Information

www.gcjfcs.org
E: partnership@gcjfcs.org    T: 305-275-1930