Refugee Services
National Partnership
for Community Training
Gulf Coast Jewish Family & Community Services

Addressing Mental Health, PTSD, and Suicide in Refugee Communities

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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

PTSD: 4% - 86%

- Children and adolescents 50%-90% (Refugee Health Technical Assistance Center, ND)
- Non-Western, collectivist cultures
  - Lower PTSD, higher somatization and psychosis (Schubert & Punamaki, 2011)

Torture

- Designed to affect whole person and community, impact not fully captured by PTSD criteria (Williams & Merwe, 2013)

Depression: 5% - 31%

- Children and adolescents 6%-40% (Refugee Health Technical Assistance Center, ND)

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

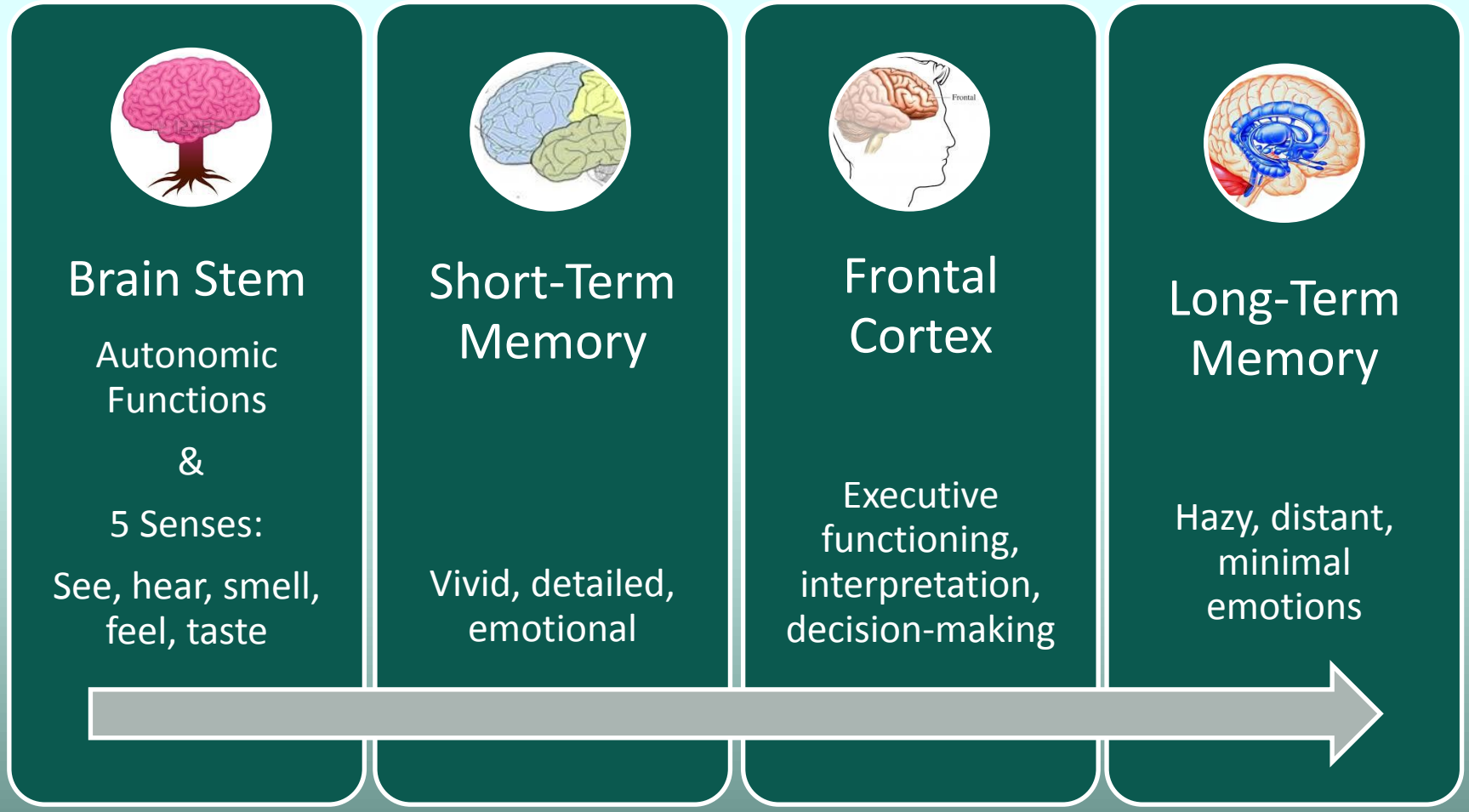
Exposure to war	State-sponsored violence and oppression	Torture	Internment in refugee camps
Human trafficking	Physical displacement outside one's home country	Loss of family members and prolonged separation	The stress of adapting to a new culture
Low socioeconomic status	Unemployment *(CDC, 2012)*	Persecution and discrimination in new country	Long-term effects of physical trauma and hardships before fleeing or in camps

6 Steps to PTSD

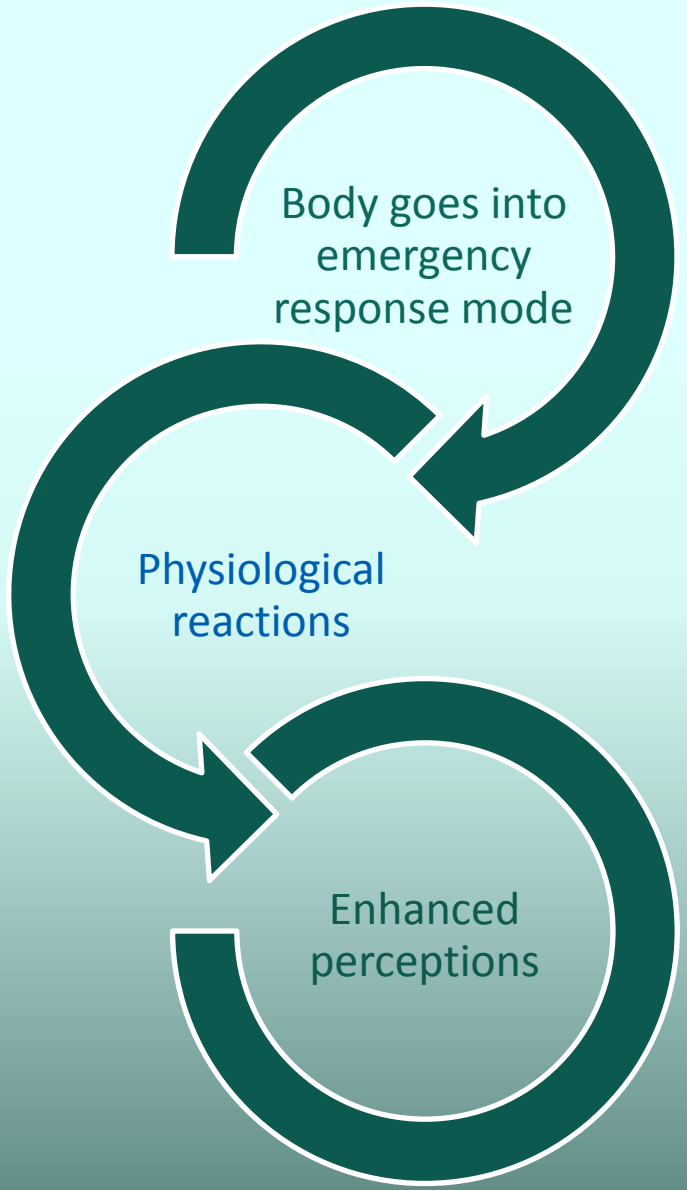
- Information Processing Theory
- The Panic Response
- Dissociation in Panic
- Time Capsules
- PTSD
- Complex PTSD

1. Information Processing Theory

Normal Flow of Information *(Shapiro, 2001)* :



2. Panic



- **“Fight or Flight”**

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

- Sounds appear louder
- Visual acuity increases

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)*

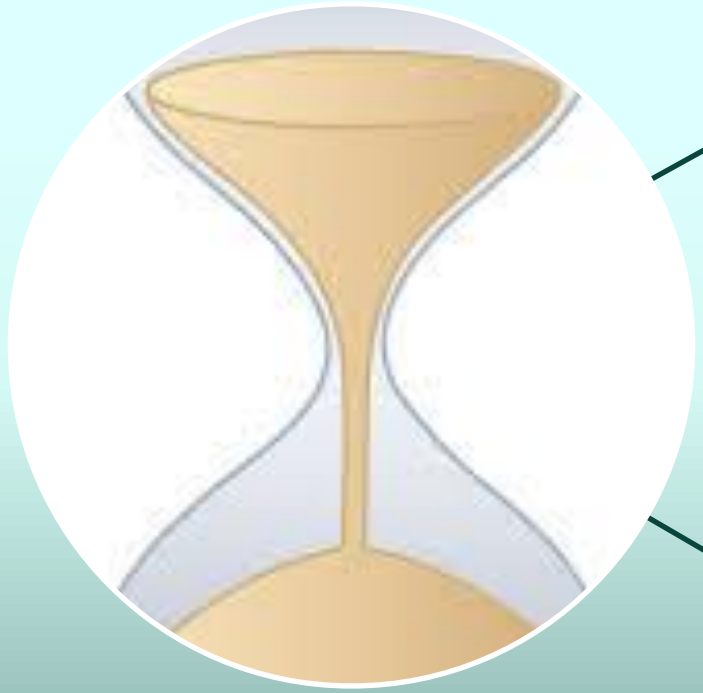
If still aware

- Short-term memory

If fight or flight doesn't work

- Freeze
- Brain stem (amnesia)

4. Time Capsules



Raw, intense state

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

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**

Significant overlap with symptoms of depression and the freeze response

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

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)

Unexplained physical complaints

- Fear of heart attacks
- Fear of stroke or passing out
- Pseudoseizures
- Unexplained pain from reexperiencing physical sensations of trauma

Local examples (Vargas, 2007)

- Latin American
  - "Nervios"
- Vietnamese
  - "Think-too-much"
- Ethiopian
  - "Tight in neck"
  - "Burning all over"
  - "Insects under skin"

Common stress-related illnesses

- Diabetes
- Back problems
- Heart problems
- Genitourinary/ reproductive
- Gastrointestinal distress
- Muscle tension
- Sleep problems

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

Prolonged Exposure therapy (PE)	• Most evidence for PTSD in the US • Tested with torture survivors and different cultures (Foa, 2009)
Eye Movement Desensitization and Reprocessing (EMDR)	• More tolerable than PE (ISTSS, 2009)
Narrative Exposure Therapy	• Culturally-relevant exposure • Latin American practice of sharing testimonials • Multiple other story-telling traditions (Neuner, et. al., 2004; Murray, et. al., 2010; Merwe & Williams, 2009) • Last stage of healing trauma as action step

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”

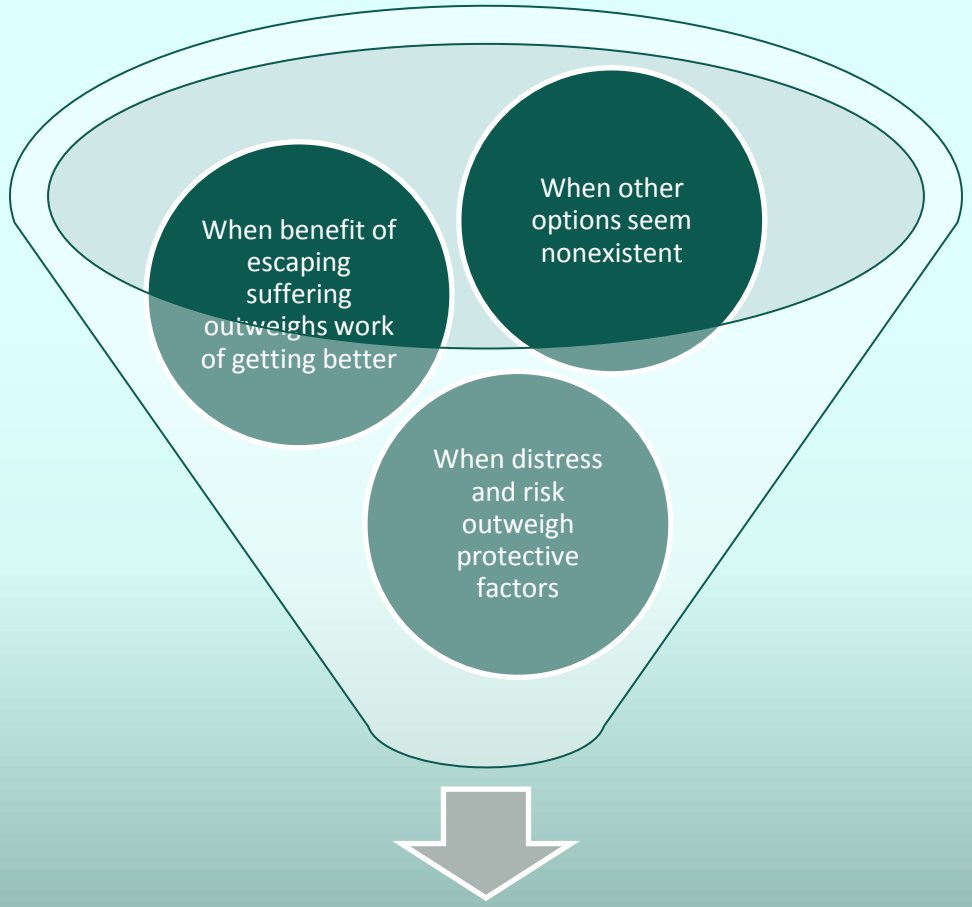
Western medicine only practice that separates

- 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

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)

Support, satisfying social life	Family, friends, and other significant relationships	Responsibility to others, especially children
Religious, cultural, and ethnic beliefs against suicide	Religious, cultural, and ethnic beliefs in support of healing	Community involvement, social integration
Employment	Constructive use of leisure time	Access to mental health care and services

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

Bhutanese

- Karma
- Witchcraft
- Disturbed ancestors
- Spirits
- Loss of soul
- Diet or environment out of balance (Maxym, 2010)

Hmong

- Soul loss due to:
  - Injury or anesthesia
  - Sadness or fear
  - Loneliness
- Symptoms
  - Weakness or tiredness
  - Fever or headache
  - Thirst or loss of appetite
  - Insomnia
  - Dreams of being in a strange place with a stranger
- Soul caller/shaman (Owens, 2007)

Ethiopian

- Traditional
  - Mental and physical illness from spirits
- Christian
  - Punishment from God
- Treated with prayer (Molakign, Brandon, Duncan, Hayden, 1996)

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*

Best practices for refugee mental health interventions in groups (Murray et. al., 2010; CVT, 2005)

Homogenous groups	• Four times improvement over mixed-culture groups
Not symptom-focused	• Psychosocial, family, community, expressive arts
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
- Cultural Orientation Resource Center http://www.culturalorientation.net
- Dignity – Danish Institute Against Torture http://www.dignityinstitute.org
- Ethnomed Cross-Cultural 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
- Harvard Program in Refugee Trauma http://hprt-cambridge.org

Resources

- Harvard and Hopkins – 300pg manual http://hprt-cambridge.org/screening/simple-depression-screen/measuring-trauma-measuring-torture/
- Heal Torture http://www.healtorture.org/content/provider-resources
- International Rehabilitation Council for Torture Victims (www.IRCT.org)
- International Society for Traumatic Stress Studies http://www.istss.org/TreatmentGuidelines/6797.htm
- National Center for PTSD http://ptsd.va.gov
- National Consurtium of Torture Treatment Programs http://www.ncttp.org

Resources

- Refugee Health Technical Assistance Center Suicide Prevention Toolkit (Individualized for Bhutanese refugees)http://refugeehealthta.org/physical-mental-health/mental-health/suicide/suicide-prevention-toolkit/
- Trauma-Focused Cognitive-Behavioral Therapy (free online implementation course) http://tfcbt.musc.edu
- VA/DOD Clinical Practice Guidelines http://www.healthquality.va.gov/guidelines/MH/ptsd/
- World Health Organization (ND). Preventing suicide: a resource series http://www.who.int/mental_health/resources/preventingsuicide/en/

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