

A Call Unanswered: PTSD in Refugee Populations

Ben Davis, MD
June 7th, 2019
R3 Talks



Pre-Flight

Flight

Resettlement

7-15 Traumatic Events

Up to 54% experience torture

Marshall, G.N., Schell, T.L., Elliott, M.N., Berthold, S.M. & Chun, C.A. (2005) Mental health of Cambodian refugees two decades after resettlement in the United States. *JAMA: Journal of the American Medical Association*, 294, 571–579.

Mollica, R.F., McInnes, K., Sarajlic, N., Lavelle, J., Sarajlic, I. & Massagli, M. P. (1999) Disability associated with psychiatric comorbidity and health status in Bosnian refugees living in Croatia. *JAMA: Journal of the American Medical Association*, 282, 433–439.

Mollica, R.F., McDonald, L.S., Massagli, M.P. & Silove, D.M. (2004) Measuring Trauma, Measuring Torture: Instructions and Guidance on the Utilization of the Harvard Program in Refugee Trauma's Versions of the Hopkins Symptom Checklist (HSCL-25) & The Harvard Trauma Questionnaire (HTQ). Cambridge, MA: Harvard Program in Refugee Trauma.

ACLU sues Trump administration for denying bond hearings to asylum seekers

"Trump's true motives are clear — to deter asylum seekers and punish people who apply for protection under our laws."

ELHAM KHATAMI  MAY 3, 2019, 11:32 AM

...igration plan

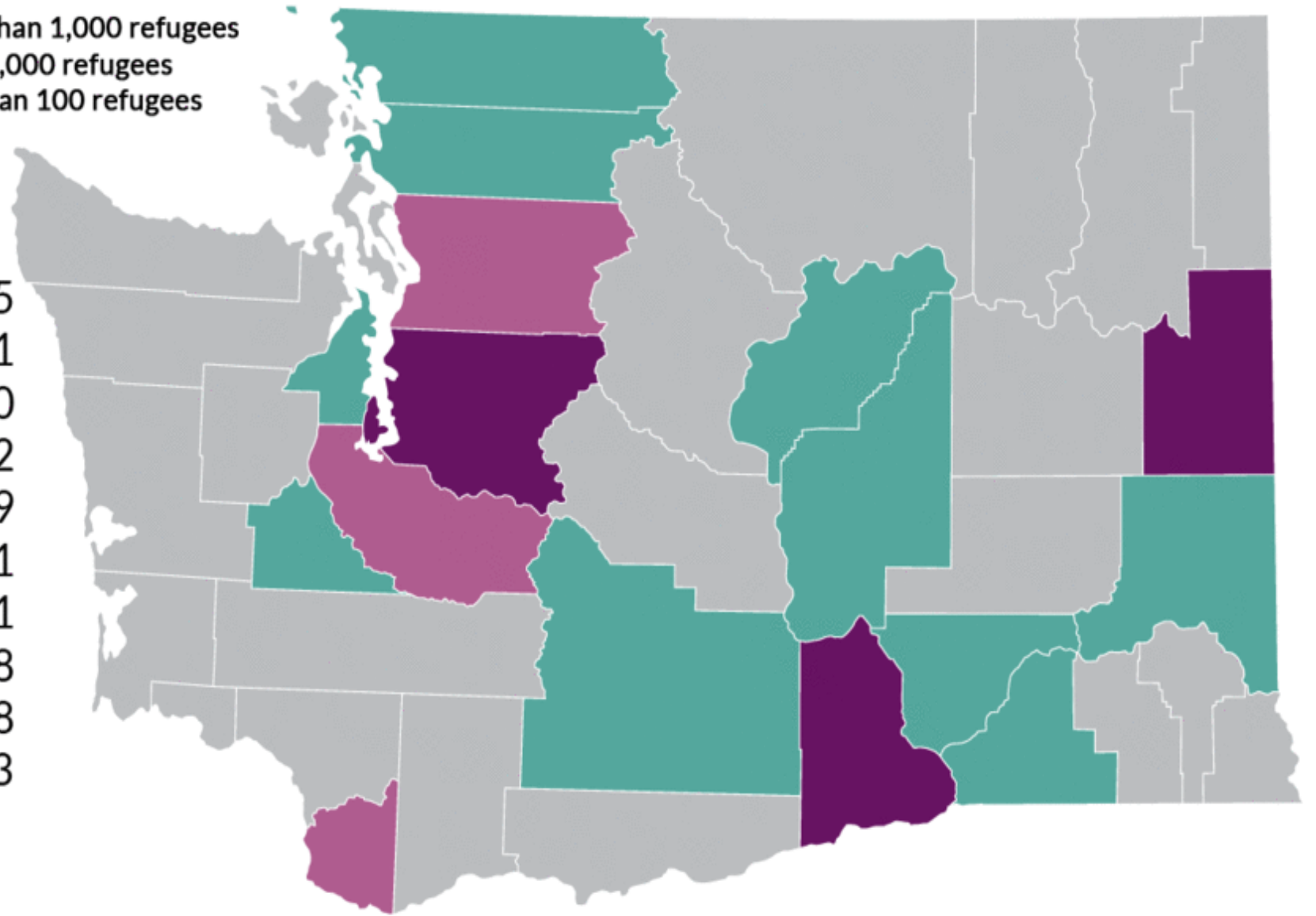
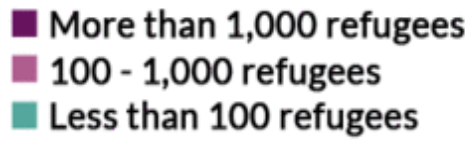
...als with his

By CAITLIN OPRYSKO | 05/17/2019 07:55 AM EDT





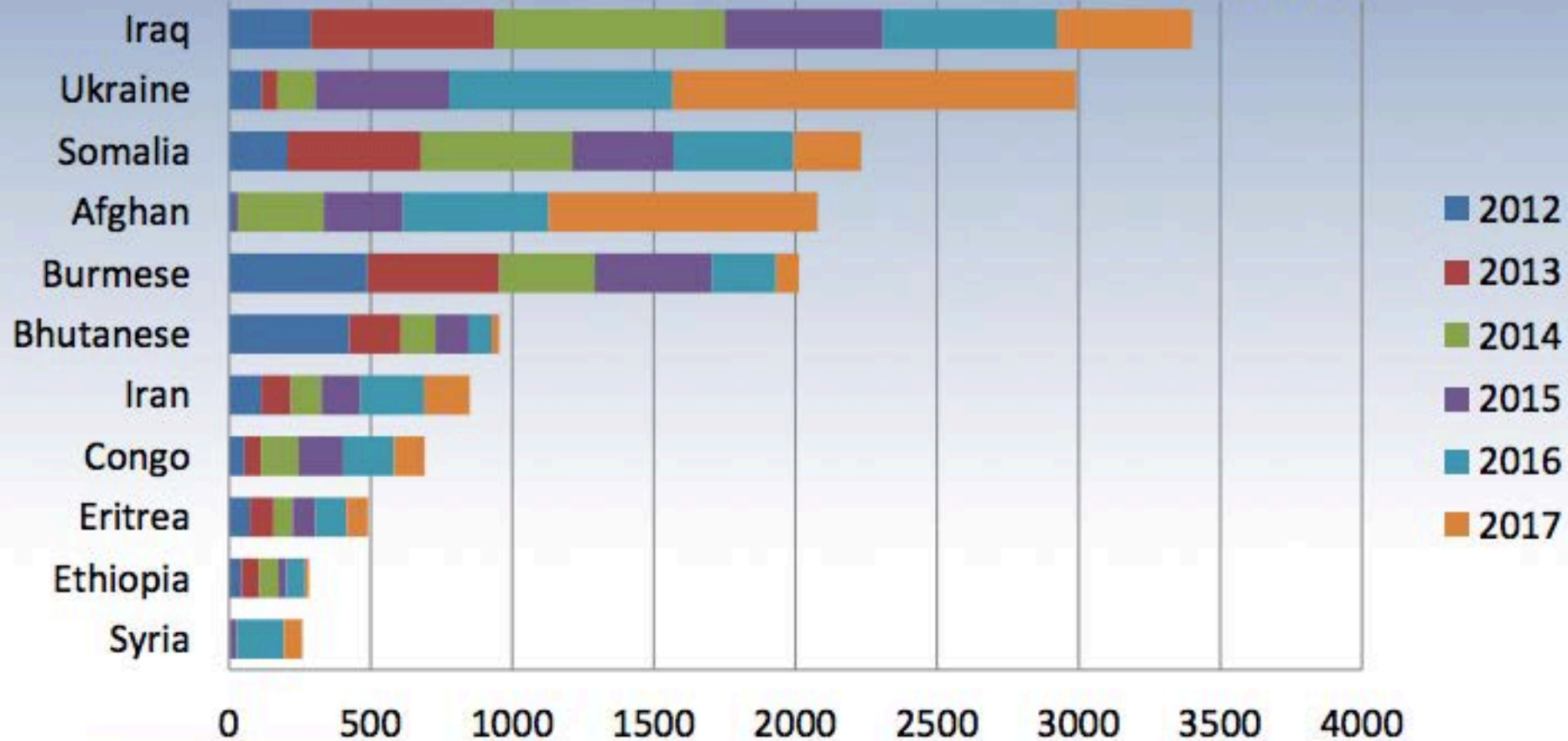




1. SEATTLE (King)	5,665
2. KENT (King)	3,331
3. SPOKANE (Spokane)	2,810
4. VANCOUVER (Clark)	992
5. RICHLAND (Benton)	639
6. KENNEWICK (Benton)	521
7. TUKWILA (King)	521
8. TACOMA (Pierce)	268
9. RENTON (King)	228
10. EVERETT (Snohomish)	203

Top Countries of Refugee Arrivals 2012-2017

Transforming
Lives



THE RELATIONSHIP BETWEEN TRAUMA, POST-MIGRATION
PROBLEMS AND THE PSYCHOLOGICAL WELL-BEING OF
REFUGEES AND ASYLUM SEEKERS

KENNETH CARSWELL, PENNIE BLACKBURN & CHRIS BARKER

Table 3
Post-migration problems reported as serious or very serious and mean scores for problem groups

Problem	<i>n</i>	(%)
Residency determination		
Fears of being sent home	23	49
Conflict with immigration officials	12	26
No permission to work	15	32
Healthcare, welfare and asylum		
Poor access to healthcare	8	17
Poor access to counselling services	4	9
Delays in processing your application	19	40
Threat to family		
Separation from family	36	77
Worries about the family at home	27	57
Adaptation difficulties		
Not being able to work	36	77
Poverty	32	68
Loss of culture and support		
Loneliness and boredom	26	55
Isolation	29	62
Poor access to the foods that you like	14	30
Post-migration problem group		
	Mean	<i>SD</i>
Residency determination	1.4	1.6
Healthcare, welfare and asylum	0.9	0.9
Threat to family	2.8	1.3
Adaptation difficulties	2.9	1.1
Loss of culture and support	2.2	1.18

Comparing Trauma Exposure, Mental Health Needs, and Service Utilization Across Clinical Samples of Refugee, Immigrant, and U.S.-Origin Children

Theresa S. Betancourt,¹ Elizabeth A. Newnham,^{2,3} Dina Birman,^{4,5} Robert Lee,⁶ B. Heidi Ellis,⁷ and Christopher M. Layne⁸

Table 2
Type of Trauma Exposure for Refugee, U.S.-Origin, and Immigrant Samples

Trauma exposure	Refugee (N = 60) ^a		U.S.-Origin (N = 140) ^a		Immigrant (N = 143) ^a	
	n	%	n	%	n	%
Number of trauma types ^{b, c}	5.43	2.46	3.79	2.39	3.63	2.03
Sexual maltreatment/abuse ^c	4	7.3	17	12.7	27	19.1
Sexual assault/rape	10	18.2	20	14.8	26	18.8
Physical maltreatment/abuse	19	33.9	44	32.1	46	33.6
Physical assault	12	23.1	21	15.7	19	14.0
Emotional abuse/ psychological maltreatment	18	31.6	51	37.2	46	33.3
Neglect	13	22.8	30	21.9	21	14.9
Domestic violence	21	40.4	66	49.3	50	36.8
Illness/medical	11	19.6	29	20.9	25	17.5
Serious injury/accident	10	17.5	15	11.0	23	16.4
Natural disaster	6	10.7	17	12.4	15	10.8
Kidnapping	2	3.6	4	2.9	2	1.4
Traumatic loss or separation	36	62.1	64	47.4	72	50.3
Forced displacement ^{b, c}	32	53.3	2	1.4	4	2.8
Impaired caregiver ^c	19	35.2	59	43.1	23	16.5
Extreme interpersonal violence	6	11.5	12	8.8	19	13.5
Community violence ^b	25	46.3	35	25.7	46	32.4
School violence	10	18.9	24	17.4	28	19.6
Other trauma	11	20.8	17	13.3	24	19.5

Note. ^aSample sizes vary due to listwise deletion. Superscripts ^b and ^c indicate a statistically significant bivariate relationship between variables and refugee status at $p < .05$ level according to χ^2 or likelihood ratio tests with refugee status comparisons defined as ^b U.S.-origin versus refugees, and ^c immigrants versus refugees.

Table 3
Clinical Problems by Refugee, U.S.-Origin, and Immigrant Samples

Clinical Issue	Refugee (N = 60) ^a		U.S. Origin (N = 140) ^a		Immigrant (N = 143) ^a	
	N	%	N	%	N	%
Acute stress disorder	12	21.8	33	25.8	30	21.3
Posttraumatic stress disorder	37	66.1	78	60.5	92	65.2
Traumatic complicated grief ^b	26	46.4	37	28.7	57	40.1
Dissociation ^b	28	50.0	26	20.2	52	36.9
Somatization ^b	24	42.9	31	24.2	46	32.6
Generalized anxiety	35	62.5	66	51.6	68	48.2
Separation disorder	14	25.0	20	15.6	19	13.5
Panic disorder	2	3.6	3	2.3	11	7.8
Phobic disorder ^{b, c}	4	7.1	1	0.8	2	1.4
Obsessive compulsive disorder	3	5.4	3	2.3	4	2.8
Depression	29	51.8	75	59.1	86	61.0
Attachment problems	24	42.9	55	43.0	57	40.1
Sexual behavioral problems ^b	5	8.9	24	18.8	10	7.1
Oppositional defiant disorder ^b	8	14.5	42	32.8	23	16.3
Conduct disorder	3	5.4	17	13.3	11	7.8
General behavioral problems	22	39.3	69	53.9	51	36.2
Attention deficit hyperactivity disorder	11	19.6	35	27.3	19	13.5
Suicidality	3	5.4	12	9.3	22	15.6
Substance abuse ^b	2	3.6	17	13.3	12	8.5
Sleep disorder	15	26.8	29	22.5	22	15.6

Note. ^aSample sizes vary due to listwise deletion. Superscripts ^b and ^c indicate a statistically significant bivariate relationship between variables and refugee status at $p < .05$ level according to χ^2 or likelihood ratio tests with refugee status comparisons defined as ^b U.S.-origin versus refugees, and ^c immigrants versus refugees.

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and Christopher M. Layne⁸

Table 4
Services Utilized for Refugee, U.S.-Origin, and Immigrant Samples

Health service	Refugee (<i>N</i> = 54) ^a		U.S.-Origin (<i>N</i> = 139) ^a		Immigrant (<i>N</i> = 141) ^a	
	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%
Inpatient psychiatric unit	1	1.9	1	0.7	4	2.8
Residential treatment center	3	5.6	8	5.8	5	3.6
Detention center, jail, or prison	1	1.9	7	5.1	3	2.1
Group home	–		1	1.4	2	1.4
Treatment foster care	1	1.9	3	2.2	2	1.4
Probation officer or court counselor ^b	1	1.9	14	10.2	3	2.1
Day treatment program	2	3.7	3	2.2	1	0.7
Case management or care coordination	23	42.6	41	29.5	43	30.5
In-home counseling ^c	6	11.8	9	6.5	5	3.6
Outpatient therapy	15	28.3	42	30.7	24	17.0
Outpatient treatment from a psychiatrist	5	9.4	16	11.6	9	6.4
Primary care physician, pediatrician ^c	10	23.3	16	11.9	8	5.8
School counselor, psychologist, or social worker	14	29.8	36	26.9	28	20.1
Special class or special school ^b	22	41.5	25	18.2	39	27.9
Child Welfare or Department of Social Services ^b	8	16.0	43	31.6	27	19.6
Foster care	3	5.6	12	8.7	13	9.2
Therapeutic recreation services	4	7.4	7	5.0	6	4.3
Hospital emergency room	2	3.8	8	5.8	12	8.6
Self-help groups (e.g., Alcoholics Anonymous, Narcotics Anonymous)	–		3	2.2	1	0.7

Note. ^aSample sizes vary due to listwise deletion.

Superscripts ^b and ^c indicate a statistically significant bivariate relationship between variables and refugee status at *p* < .05 level according to χ^2 or likelihood ratio tests with refugee status comparisons defined as ^b U.S.-origin versus refugees, and ^c immigrants versus refugees.

Clinical interventions

Trauma-focused cognitive behavior therapy (CBT) and eye movement desensitization and reprocessing (EMDR) have proven to be effective psychological interventions for Western clients who have experienced trauma but the evidence-based efficacy for refugees residing globally is in its infancy and is under-investigated (ter Heide et al., 2014; Drozdek et al., 2013; Yakushko et al., 2008). A growing number of researchers (e.g., Kruse et al., 2009; Drozdek et al.; ter Heide et al.) agree that trauma-focused, multimodal, multicomponent interventions that are also culturally adapted and linguistically appropriate, are proving to be effective for refugees experiencing complicated PTSD. Increasingly, Western psychologists are learning to appreciate the relationship between the collectivist nature of many of the refugees' cultures with designing and implementing intervention models. Most psychological interventions that are reported in the literature have occurred in settings in Western countries, after refugees have resettled permanently, rather than within the temporary confines of refugee camps. Drozdek et al. (2013) have used group interventions effectively while Kruse et al. (2009) and ter Heide et al. (2014) have experienced positive outcomes with individual interventions. We briefly discuss both types of interventions.

Individual interventions with refugees

Krause et al. (2009) used an individual psychotherapeutic intervention with Bosnian refugees while implementing seven core elements (i.e., treatment relationship, feelings of safety, psychoeducation, cognitive restructuring, progressive muscle relaxation, skill building/regulation of affect and self-perception/caring of oneself). ter Heide et al. (2014) report treatment success using EMDR on an individual basis with a refugee population, noting "EMDR may be a suitable approach for refugees because it does not include homework assignments, may minimize language issues because speech is not always necessary, and has been found efficacious with patients from non-Western cultural backgrounds" (p. 147). Otto and Hinton (2006) and Schulz, Resnick, Huber and Griffin (2006) have demonstrated the efficacy of CBT and adapted cognitive processing therapy with refugee populations.

Group interventions with refugees

In the Netherlands, Drozdek et al. (2013) used a group intervention model to treat Iranian and Afghan refugees in a long term day treatment program for PTSD. Clients ranged in age between 18 years and 70 years and spoke Farsi or Dari. Their treatment model incorporated components of CBT with imaginal exposure, empowerment and socially supportive interventions as well as exploration of coping styles. Psychotropic medication and non-verbal therapies (e.g., art therapy, music therapy) were incorporated as adjuncts to group therapy. The non-verbal therapies were effective with clients who experienced difficulty in the verbal expression of traumatic experiences. The short-term and long-term outcomes of this model were positive for the reduction of PTSD, depression and anxiety symptoms.

Effects of Trauma-Focused Psychotherapy Upon War Refugees

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Research Article |  Full Access |

Seven-Year Follow-Up Study of Symptoms in Asylum Seekers and Refugees With PTSD Treated With Trauma-Focused Groups

Boris Droždek , Astrid M. Kamperman, Wietse A. Tol, Jeroen W. Knipscheer, Rolf J. Kleber

First published: 18 September 2013 |
<https://doi-org.offcampus.lib.washingt>

Research Article

EMDR With Traumatized Refugees: From Experience- Based to Evidence-Based Practice

Heide, F. Jackie June ter
Mooren, Trudy T. M.
Knipscheer, Jeroen W.
Kleber, Rolf J.

Journal of EMDR Practice and Research Vol 8 Issue 3, DOI: 10.1891/1933-3196.8.3.147

Refugee

(Medicaid)

- ❖ SeaMar
- ❖ Valley Cities
- ❖ NAVOS
- ❖ Healthpoint

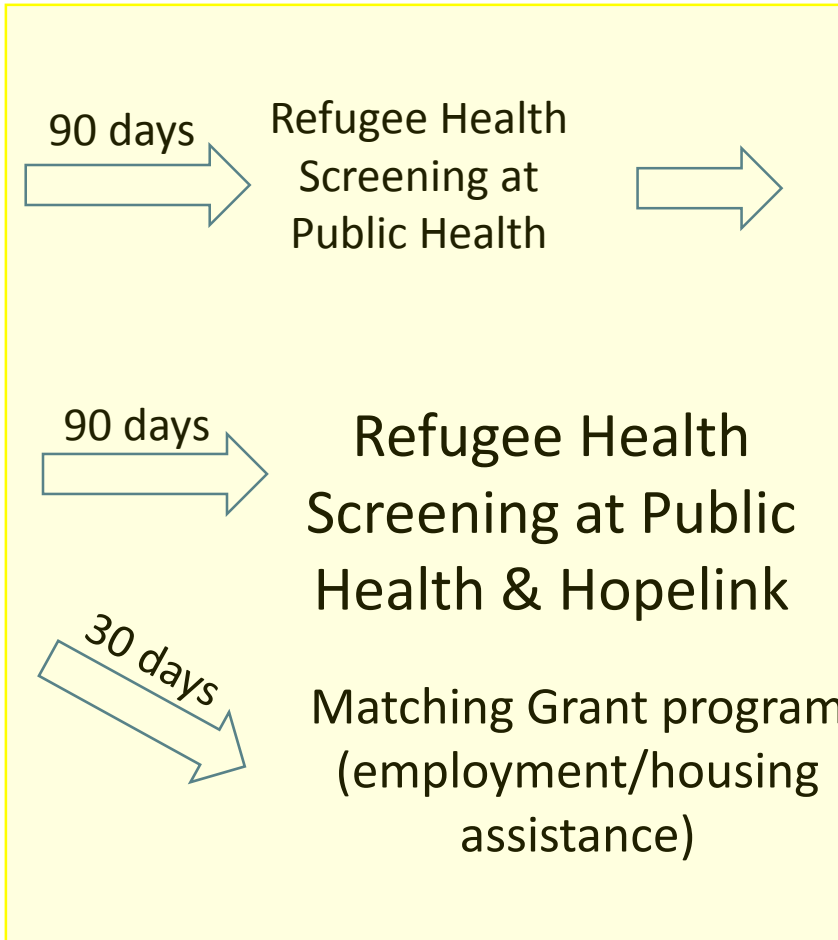
Asylum Seeker

(Uninsured)

- ❖ Refugees Northwest
- ❖ ACRS
- ❖ REWA
- ❖ Consejo
- ❖ SCS

Refugees/
Asylees

Asylum
Seekers



--8 months--
Refugee Medical Assistance (RMA) →

Outpatient:
Charity Care & Sliding Scale

Inpatient:
Asylee Detention Center or local ED/hospitals



NWHHR

A Systematic Review of Interventions to Improve Initiation of Mental Health Care Among Racial-Ethnic Minority Groups

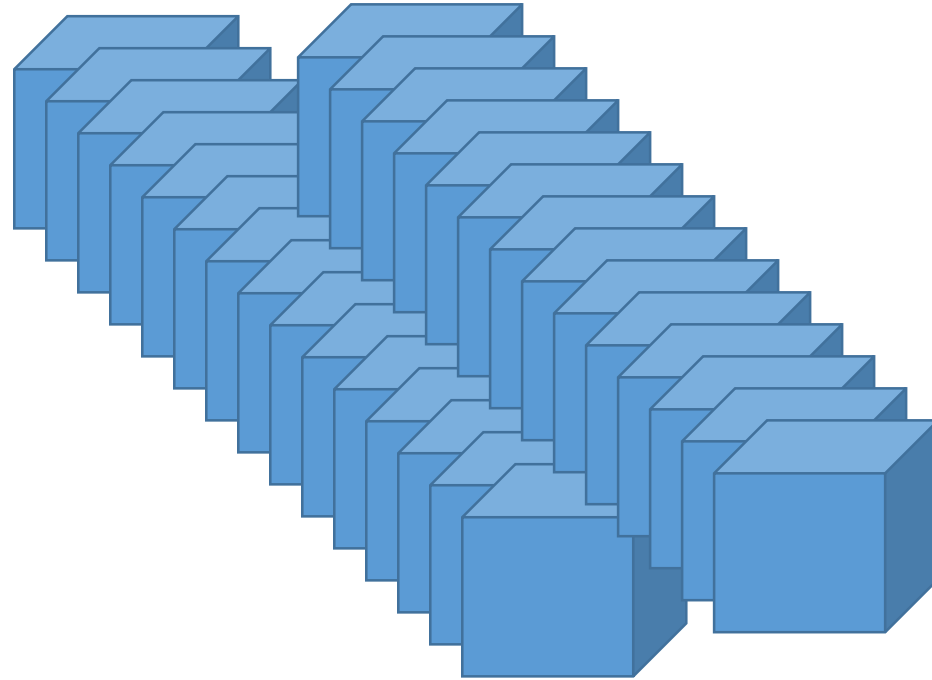
Su Yeon Lee-Tauler✉, Ph.D., John Eun, B.A., Dawn Corbett, M.P.H., Pamela Y. Collins, M.D., M.P.H.

Published Online: 2 May 2018 | <https://doi-org.offcampus.lib.washington.edu/10.1176/appi.ps.201700382>

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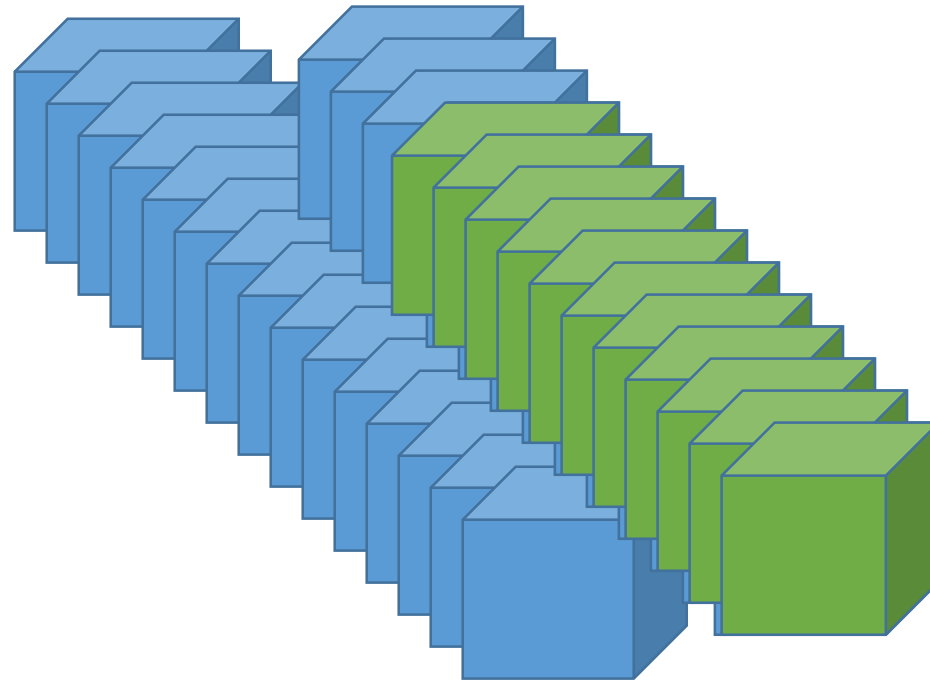
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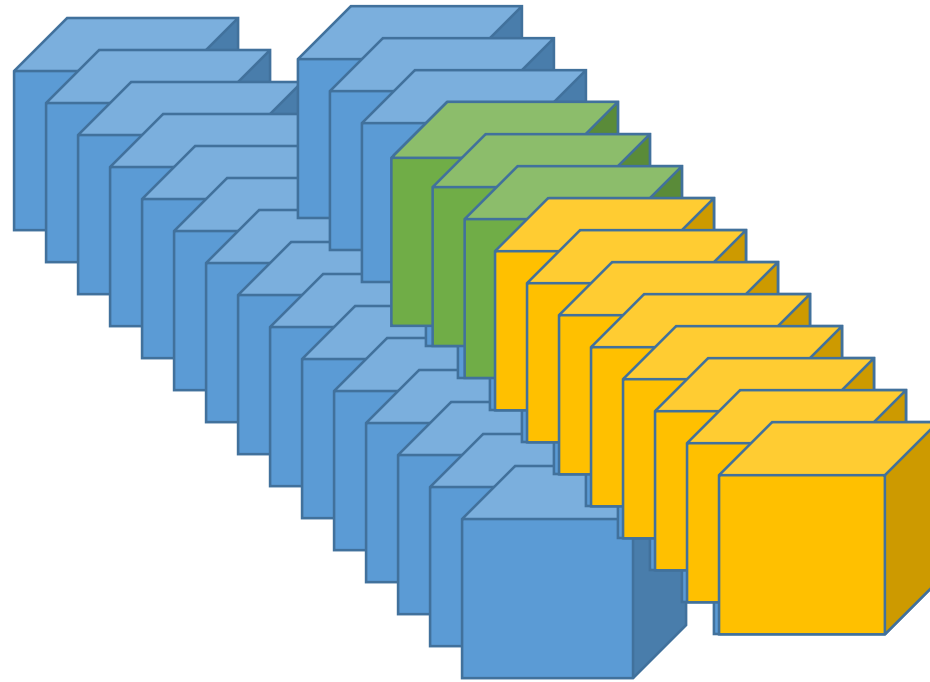
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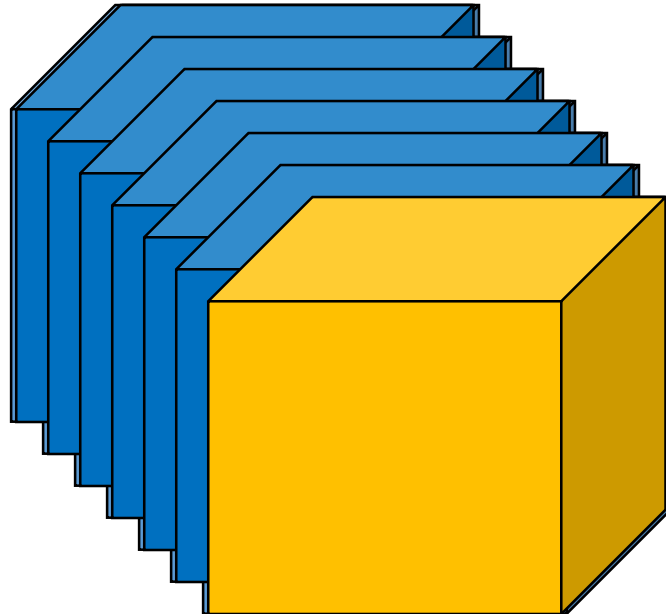
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❖ Integrated Primary Care

- ❖ Collaborative care interventions (4)
- ❖ Colocation of psychiatric care (2)

MENTAL HEALTH CLINICAL TOPICS

Articles and other information for health care providers about topics related to mental health and culture. Includes information about refugee mental health, select populations' cultural perspectives regarding mental illness, and teaching videos about providing culturally competent care and managing stigma.

Related content

[Mental Health Patient Education](#)

Walking Together

This free publication (114 pg, PDF) is designed for mental health professionals, clinicians and social workers who have the privilege of working with refugees. The Guide tackles important topics such as barriers to care, overcoming obstacles, clinical considerations in assessment, treatment planning, working with interpreters, medication adherence, and trauma. Produced by International Counseling and Community Services (SeaTac), a program of Lutheran Community Services Northwest.

Mental Health Issues of Resettled Refugees

An article with some general information for health care providers about mental health issues and refugees.

Necessary Steps to Neuropsychological Evaluation

Considerations and tips for primary care providers dealing with an individual patient suspected of cognitive difficulty that may prevent him/her from successfully taking the English language or U.S. civics and history tests in order to become a naturalized citizen.

Somali Mental Health

Article by David McGraw Schuchman, MSW, LICSW. The challenges facing Somali immigrants and refugees in the Twin Cities are complex and their needs are great. Besides facing enormous cultural and language differences, African immigrants and refugees contend with racism, often have limited literacy skills, and hold jobs where they barely earn minimum wage and have difficulty providing for their families. (Originally Published in Bildhaan – An International Journal of Somali Studies; 2004; reprinted with permission). See also [6 page PDF](#) version of article.

Somali Refugee Mental Health Cultural Profile

Information about depression, anxiety, and posttraumatic stress disorder (PTSD) within the Somali refugee community; information about common beliefs and traditional treatment for mental illness in Somalia, and advice for healthcare providers working with this refugee population.

Somali Depression Profile

Article about Somali culture and depression.

Adherence Barriers to Antidepressants among an Urban Female Latino Population

An article highlighting insights from providers and patients about risk factors, protective factors and interventions related to adherence barriers to antidepressants among urban Latinos.

Seeking Serenity in a Patch of California Land



Yer Vang in the Hmong Village Community Garden in Fresno. Jim Wilson/The New York Times

By Patricia Leigh Brown

May 25, 2013



PARADISE PARKING PLOTS COMMUNITY GARDEN





For these refugees, theater plays a 'vital role' in healing

May 13, 2019 6:25 PM EDT

May 13, 2019 6:25 PM EDT

For these refugees, theater plays a 'vital role' in healing

Thank you

