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Mental Health of Refugees and Asylum Seekers: Assessment and Intervention

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Santé mentale des réfugiés et des demandeurs d'asile: évaluation et intervention

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Abstract

With unprecedented numbers of displaced persons worldwide, mental health clinicians in high-income countries will increasingly encounter refugee and asylum-seeking patients, many of whom have experienced significant adversity before and after their migration. This paper presents a summary of the recent evidence on the assessment and treatment of refugees across the lifespan to inform clinicians' approaches to care of refugee patients in mental health care settings. Assessment and interventions for refugees are grounded in an ecosystemic approach which considers not only pre-migratory trauma, but social, familial, and cultural determinants of mental health in the host country. Evidence for psychotherapy and pharmacological treatments are reviewed, highlighting promising interventions while acknowledging that further research is needed. Ultimately, serving refugees necessitates a biopsychosocial approach that engages clinicians as medical experts, therapists, and advocates.

Abrégé

Avec des nombres sans précédent de personnes déplacées dans le monde entier, les cliniciens de la santé mentale des pays à revenu élevé rencontreront de plus en plus des patients réfugiés et demandeurs d'asile, dont beaucoup ont connu une adversité significative avant et après leur migration. Cet article présente un résumé des données probantes récentes sur l'évaluation et le traitement des réfugiés de durée de vie afin d'éclairer l'approche des soins des cliniciens aux patients réfugiés dans des contextes de soins de santé mentale. L'évaluation et les interventions pour les réfugiés sont ancrées dans une approche écosystémique qui tient compte non seulement du traumatisme pré-migratoire, mais aussi des déterminants sociaux, familiaux et culturels de la santé mentale au pays d'accueil. Les données probantes des traitements de psychothérapie et de pharmacologie sont examinées, démontrant qu'il y a des interventions prometteuses mais qu'il faut plus de recherche. Finalement, servir les réfugiés nécessite une approche biopsychosociale qui demande aux cliniciens d'être à la fois experts médicaux, thérapeutes et défenseurs des droits.

Keywords

refugees, PTSD, adults, children, post-migratory stress, Common mental disorders

Introduction

Refugees and asylum seekers arrive in destination countries having faced a range of profound stressors, such as armed conflict, loss or murder of family members, torture, arbitrary imprisonment, and sexual and other forms of violence. Prevalence rates of mental disorders in resettled refugees vary from 4% to 40% for anxiety, 5% to 44% for depression, and 9% to 36% for post-traumatic stress disorder (PTSD).[1] Previous systematic reviews have noted that methodological differences account for much of this variation: high-quality studies estimate lower prevalence rates, while individual factors and post-migratory stressors can also impact the

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variability.[2] Overall, it is suggested that greater than 20% of refugees suffer from anxiety, depression, or PTSD.[2] A recent review of 42 studies on refugee children suggests the rates of PTSD among refugee children have ranged from 40 to 63% (but have also been as low as 5% in one study), and that depression rates also range from 25 to 50%.[3]

Despite the high rates of pre-migratory trauma and significant psychiatric difficulties, it is striking that most refugees with a secure status adapt well, as shown in longitudinal Canadian studies.[4,5] The emphasis on refugee pathology may be understood as a consequence of a literature which tends to focus on disorder and disease rather than resilience and post-traumatic growth.[6] Research over the past decade has refined our understanding of the complex factors impacting well-being, recovery, and mental health difficulties in refugees, pointing to the importance of reducing stress in the post-migratory context, the promotion of resilience and the adverse effects of trauma during and prior to migration.[2,7-9]

This paper presents a summary of the recent evidence on the assessment and treatment of refugees across the life span to inform clinicians' approaches to the care of refugee patients in mental health settings. We focus on refugees resettled to high-income countries and include evidence pertaining to both refugees and refugee claimants (asylum seekers), often referring to both as refugees. The clinical approach may also apply to some failed refugee claimants, whom, as evidence suggests, may warrant refugee protection, as the decision processes in Canada are vulnerable to error.[10-12]

Assessment

The literature suggests several principles important to the quality of mental health assessments of refugees.

Family and Systemic Approach

Individual patients should be assessed in the context of their family, community, and larger social milieu. This follows an "ecological framework" that attends to microsystems (attachment, social support, caregiver mental health), mesosystems (schools, neighbourhoods), and macrosystems (political policies, regional host culture).[9,13] Including family members in the assessment can help facilitate the development of a trusting relationship with the clinician, and is especially crucial as war and other forms of organized violence tend to implicate the entire family, rather than just one individual.[14] The identified patient may therefore represent only one face of the family's difficulties, and, further, enforcing ties between family members may be protective to vulnerable family members.[15] When family members are present for interviews, the clinician should be mindful of confidentiality in general and within the family's specific ethno-cultural community.[14]

Separation from family members during migration causes suffering both because of loss but also because of fear for the safety of the absent family members if they remain in peril in the country of origin.[15] As one study showed,[16] children separated from their parents for over 2 years had greater rates of depression and anxiety than non-separated children. Diagnostically, attending to family separation is also important, as fear for a family member's safety may aggravate mental health problems, especially PSTD, where threat is perceived as ongoing.

At the systemic level, post-migratory stressors are strongly linked with poor psychological outcomes (see Hynie, in this issue). A significant body of research has examined how factors within the host country, such as socioeconomic stress, social and interpersonal difficulties, and the challenges inherent in the immigration process, contribute to poor mental health.[7-9,17] Refugees with access to housing, for example, have better mental health outcomes than those without access.[18] While several factors were correlated to changes in PTSD symptoms, a recent study examining a cohort of 195 adult trauma-affected refugees in Denmark showed that secure employment was particularly associated with improvements in PTSD.[19] Regarding the immigration process, Canadian research has shown an increase in psychiatric disorders among detained asylum seekers as compared with an equivalent group of refugee claimants living in the community.[20] In both children and adults, having precarious status is associated with PTSD.[3,8,21-23] A recent review suggests that 94% of unaccompanied refugee minors experienced traumatic or stressful events during migration or during the resettlement processes.[24] The level and amount of emotional support received after resettlement predicts the course of depressive symptoms, post-traumatic stress symptoms, and anxiety level, as does the warmth of the host country.[24] It is therefore critical that clinicians attend to these post-migratory determinants of refugee mental health, particularly because patients may feel these fundamental stressors are not appropriate to speak about with physicians.[14,25]

Interpreters and Cultural Brokers

A systematic review[26] found improved clinical care when interpreters were used for all patients speaking a non-dominant language. Other research has suggested that interpreters can increase the level of disclosure in clinical encounters.[27] Canadian guidelines recommend that lay interpreters and family members should not be used.[14] Although many hospitals may rely on allied health professionals to interpret, there is a risk that, in trying to be helpful to their colleague, these interpreters may gloss over patient's hesitations or organize content which may be relevant to the mental status exam. When children are used as interpreters, parents may not disclose traumatic material or, inversely, children could be exposed to traumatic content. A practical approach to working effectively with interpreters has been outlined in the Canadian Guidelines for Immigrant Health[14] and Leanza et al have developed guidelines for clinicians as

well as institutions.[28] When institutions fail to provide access to professional interpreters, refugee patients are at risk of receiving substandard care.[29]

Cultural brokers can also be useful in the clinical evaluation of refugees. Their role is to facilitate the interpretation and negotiation of non-linguistic cultural content and differences.[28,30]

Screening

Refugees with trauma-related disorders, including depression and anxiety, often differ from other populations with PTSD. Some of the differences include a history of multiple traumatic events, the impossibility of returning home to safety, being identified as a racialized minority, socioeconomic stress, or fractured communities and social networks.[31] Diagnostic assessment and screening therefore requires a specialized approach. Canadian guidelines emphasize the imperative to avoid over-diagnosis and medicalization of suffering,[32,33] and thus recommend against routine screening in the primary care setting to avoid false positives.[34]

Whereas refugees typically experience high rates of pre-migratory trauma, mental health professionals should avoid urging disclosure of trauma, especially in the preliminary encounter, because of the risk of inducing trauma, stigma, and the impact of such disclosure on families and communities.[33] When trauma is disclosed, practitioners should take an empathic and supportive stance,[15] especially given that refugees may face incredulity in other contexts, such as at the refugee hearing.[35]

Diagnosis

Refugees who are referred to mental health services from the community may be more likely to have psychiatric disorders than those in primary care settings; however, clinicians should remain cognizant that reactions to traumatic disclosures may incite referrals, rather than signs of a disorder itself. In other words, there may be various reasons why refugees find themselves in specialized mental health settings, and distress and social suffering—individual and collective suffering resulting from socially generated ills[36]—should be distinguished from disorder.[37]

Diagnosis is further complicated by research evidence that stress-related disorders in refugees may present with unique symptomatology not necessarily captured in ICD-10 or DSM-5 criteria.[31,6] For example, a Swiss study of severely traumatised refugees and asylum seekers suggests that the severity of PTSD symptoms is predicted by somatisation and anger.[17] There is much research to support the notion that distress may be expressed through physical symptoms.[14] Dissociation, brief reactive psychoses, psychotic depression, and conversion symptoms, though rare, could also be associated with PTSD or a post-traumatic presentation.[15]

Culture can influence all aspects of the illness experience and the expression of distress. It is therefore important to consider the patient's culturally specific explanatory models for their difficulties to promote cultural safety and to ensure that interventions will address the true concerns of the patient.[14,32,38] The Cultural Formulation Interview (CFI), included in the DSM-5, may help to elicit refugees' cultural identity, their illness narrative(s), cultural elements of their psychosocial environment, and mechanisms for coping and adaptation.[39,40] Patients may be reticent to discuss their ethnocultural background with clinicians, especially if they have been previously persecuted or stigmatized based on identity. Thus, clinicians should communicate how such information can be supportive of assessment and treatment.[41]

Special Considerations in the Assessment of Refugee Children

The assessment of refugee children and youths should follow the ecological approach described above, attending to the child as an individual, and within the contexts of family, community, and the broader sociocultural system. Likewise, as in adult populations, clinicians should avoid medicalization of difficulties, given that, despite significant adversity, some research shows that refugee children may have better mental health outcomes than host country children.[13,42,43]

Cumulative traumatic exposure may increase the risk of psychopathology,[13] and post-migratory stressors are associated with an increased risk,[9] with some evidence that, in youths, exposure to post-migratory stress is a stronger predictor of psychological problems than pre-migratory trauma.[44] Being a recipient of an attack or observing violence towards others, specifically witnessing a mother's torture or experiencing the violent death of a family member were shown to be predictors of PTSD in young resettled refugees.[3] The challenges of reunification after long absence from family members should be explored, because such family transformations come with the redefinition of family roles, that pose challenges and conflict.[15] There is also research with refugee children confirming that parental psychopathology increases the risk of child psychiatric problems,[43] and thus care or treatment for parents is often a central part of a child's intervention.

Children may present with concerning symptoms, such as sleep disturbance, nightmares, grief reactions, inattention, withdrawal, somatization, and disruptive behaviours yet not meet the criteria for PTSD.[13] All these symptoms should alert mental health professionals to a possible disorder, although assessment must consider the level of impairment and distress.[15]

Treatment

At the foundation of all interventions for refugees is clinician empathy, emotional support, and advocacy to reduce social

adversity.[32] As in assessment, the family, community, and larger social context should be targets for intervention.

Experts suggest that war-affected adults and children receive intervention following a pyramidal structure that targets the basic social needs of larger populations initially and then focuses on the psychological needs of smaller groups.[13,45,46] At the base of the pyramid, interventions should support immediate safety and basic physical needs. The second layer of intervention aims to increase community and family support. The third layer represents focused but non-specialized support (for example, community-based support groups for female survivors of sexual violence). And fourth—for the smaller proportion of persons who require it—there is a focus on specialized mental health services. This approach coheres well with Silove's model, which identifies 5 pillars: 1) safety/security, 2) bonds/networks, 3) justice, 4) roles and identities, and 5) existential meaning. These 5 pillars need to be restored to allow for recovery following mass conflict.[46]

Specialized mental health treatment includes advocacy in collaboration with lawyers and non-governmental organizations. Interventions that support asylum seekers obtaining secure immigration status,[15] adequate housing, employment, and family reunification are often fundamental to patient recovery[7,47] and to the re-establishment of meaningful roles in the host country.[46] Connecting refugees with their ethnocultural or religious communities can help protect them from isolation and discrimination.[14] Although, it is important to understand patients' identity and affiliation, as not all will feel connected with their nationality or religious-based communities.

Types of Interventions

Psychotherapy. National Institute for Health and Care Excellence (NICE) guidelines recommend that healthcare professionals should consider providing trauma-focused psychological treatment when the sufferer considers it safe to proceed, pointing to the importance of a phased approach.[48] A phased approach also allows for a treatment course that does not focus solely on symptom reduction (often the clinician's concern) but rather on "restoring the continuity of life" through social integration, which is more often the patient's priority.[15]

A growing body of research is guiding psychotherapy treatment within refugee populations. A Cochrane review of torture survivors suggests that narrative exposure therapy (NET) and other forms of cognitive behavioural therapy (CBT) offer moderate benefits in reducing distress and PTSD but evidence was of low quality.[49] A more recent meta-analysis and systematic review examined 14 studies from Europe and the United States that focussed on NET and other trauma-focused therapies, including CBT variants.[50] For the primary outcome—reduction in PTSD symptoms—the analysis suggested that interventions are effective, with a number needed to treat (NNT) of 4.4. However, there was inadequate data to conclude if the benefits of the interventions were maintained at follow up, and the included studies were deemed to be of low or very low quality.[50]

Whereas trauma-focussed therapies, particularly NET, show promise, they are not yet widely available. Nonetheless, committed clinicians and community workers can provide a therapeutic space and instrumental support to refugee patients.[15] In fact, some refugee patients may resist structured therapies when they feel unready to reengage traumatic memories. Some research suggests that only a minority of refugee patients can tolerate direct exposure techniques, and that cognitive restructuring may also be deemed inappropriate by patients. Thus, manualizing therapies based on a flow-chart rather than predetermined sessions, can facilitate therapist flexibility in responding to patients' individual and cultural needs.[51]

Eye movement desensitisation and reprocessing (EMDR). There is limited experimental research on EMDR with refugee populations.[52-54] One randomised control trial (RCT) with Syrian refugees in refugee camps on the Turkish border found that refugees assigned to the EMDR group had significantly larger reductions in PTSD symptoms than the waitlist controls; although, the limitations of the study included a high drop-out rate.[52] A recent Dutch RCT found no difference between safety and the efficacy of EMDR intervention v. stabilization as usual. This is significant, as some[53] have hypothesized that EMDR might be harmful or unacceptable to refugees. Overall, while there is some promise in the use of EMDR within a refugee population, there is inadequate systematic research to draw conclusions.

Pharmacotherapy. There is very limited evidence on the effectiveness of psychopharmacological interventions in refugee populations.[31] The literature also tends to focus on PTSD symptoms as defined by the DSM, rather than the broader range of trauma-related presentations, including depression and anxiety,[6] and there are no studies of antipsychotics in traumatized refugee populations.[31]

Sonne and colleagues[31] recently conducted a review of the pharmacological literature pertaining to refugee populations. They identified 11 studies on antidepressants, only 2 of which had an experimental design.[55,56] Because of significant methodological limitations, these studies do not provide conclusive evidence regarding the efficacy of antidepressant treatments for refugees.[31] Sonne and colleagues also identified 2 studies examining the use of prazocin (alpha-1-adrenergic receptor antagonist) for nightmares[57,58] and 2 observational studies of the use of clonidine in refugees.[59,60] There was, again, insufficient evidence to support the efficacy of either drug.[31]

NICE guidelines for adults suffering from PTSD recommend against the use of pharmacology as a first-line treatment.[48] Given the paucity of adequate evidence, clinicians should engage in pharmacological interventions only as a second line and with the knowledge that it is not supported by evidence.

Children and Youth

With children, as with adults, a pyramidal and phased approach is recommended.[13,45,46] Research has emphasized that schools, primary care physicians, and community workers are at the front line in providing support to asylum-seeking and refugee children and, as such, should be provided with resources and training.[13] Clinical models of service have been developed to help provide a multi-layered, multi-disciplinary, collaborative care that allows community-based professionals (for example, teachers, family doctors, social workers) to be linked with specialized mental health clinicians to guide interventions or intervene with a smaller percentage of children and families.[13,61,62]

Psychotherapy for children. There is limited research on psychotherapeutic interventions with young refugees. Robjant and Fazel[63] reviewed 6 studies of KIDNET (NET adapted for children), 5 of which were conducted in low- or middle-income countries. These studies show promising results, suggesting that KIDNET may reduce PTSD symptoms. There is some limited evidence for adapted CBT models for children with PTSD but, overall, more evidence is needed to support the use of psychotherapy for refugee children with PTSD.[34]

When undertaking supportive or structured therapies with children, consideration should be given to the potentially protective elements of avoiding traumatic material for some cultural communities.[13,64] A modulated approach to disclosure is recommended, as are non-verbal approaches to therapy, which do not take trauma as a focus and, rather, "work around" trauma.[13,64]

Pharmacotherapy for children. To our knowledge, there are no clinical trials of medication for refugee children with psychiatric disorders. Even for a non-refugee population, there is inadequate evidence to support pharmacotherapy for PTSD in children. The NICE guidelines recommend against pharmacotherapy in children as a first-line approach,[48] as do the Canadian Guidelines for Immigrant Health.[34]

Vicarious Traumatization and Vicarious Post-Traumatic Growth in the Clinician

While traumatology has historically focused on the risks of vicarious traumatization to the clinician, there is increasing research on more complex and bi-directional processes between patient and practitioner. Vicarious traumatization refers to the risk that therapists may become traumatized themselves through exposure to trauma narratives.[65] Researchers have acknowledged that the transmission of trauma also confers the possibility of post-traumatic growth and resilience to the clinician[65] and that, through bearing witness, the care provider is not just a recipient of vicarious harm but also the receiver of a "precious gift."[35] There is also clinicians' potential retaliation in the context of the transmission of trauma. Rousseau and Foxen[35] have documented this phenomenon in the setting of the refugee determination process, in which adjudicators respond to narratives of trauma with subtle forms of retaliation, such as avoidance or denial. Clinicians working with refugees should be aware of these possible reactions in themselves, recognizing both the opportunities for vicarious growth and the risks of unwitting participation in aggression toward our patients.[66]

Conclusion

With the highest numbers of displaced people on record,[67] mental health clinicians will increasingly encounter refugee patients. The root causes of refugee suffering are multiple and linked most closely to social adversity, both in their country of origins but also in their host societies. In addressing refugee mental health, clinicians must adopt a truly biopsychosocial approach that contextualizes patient distress in the broader family, social, and global perspectives. This demands medical and therapeutic expertise, as well as an engagement with our role as advocates.[68] Researchers must also grapple with the inherent challenges in conducting research with refugees while simultaneously heeding the imperative for evidence-based care models.

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