Psychological distress in refugee survivors of torture and trauma

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Refugees can be exposed to trauma, either through persecution in the countries they are fleeing or displacement from their homes to refugee camps and asylum countries. Treatment requires trauma-informed and culturally competent strategies.

Refugees may have experienced the most horrific types of torture and trauma in the countries they are fleeing (Box 1).[1,2] Victims that have been exposed to severe, repetitive and prolonged trauma suffer severe and complex physical and mental health problems. Clinical and cultural complexities require systemic and specialised psychological, medical and social treatments. This article aims to reflect experiences from clinical practice.

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Refugee experiences – when horror becomes reality

War is considered to be one of the most horrific life experiences. Perpetrators of war have no fear of social consequences and legal sanctions, so human brutality escalates beyond comprehension. This can result in massive and systemic persecution on the basis of race, nationality, religion or social affiliations.

In the midst of massive violent conflicts, traumatising events occur in many forms that are usually unimaginable in a time of peace (Box 2). Children from some refugee groups are forced into heavy labour, sexual trafficking and severe crimes at an early age.

People fleeing war and persecution are, by the very nature of their unsecure status and limited resources, susceptible to further traumatising events in the refugee camps and asylum countries where they resettle. Those who survive these tragic accounts face countless and unbearable losses and an uncertain future.

Epidemiology

Refugee trauma is distinctively characterised as severe, complex, prolonged, repetitive and multiple traumas perpetrated by humans. Trauma exposure can prevail for decades with no recovery phases, resulting in deeply engraved psychological symptoms. The more severe and prolonged the exposure to trauma, the more severe the person's distress pattern will be.

Clinical practice suggests that trauma caused by human events is more likely to cause profound psychological damages than traumatic events occurring beyond human control, such as natural disasters. The systemic nature of refugee trauma impacts the entire sociocultural context of a person, developing catastrophic perceptions of the world, humankind and the future.

It is important to note that the prolonged absence of immediate and adequate treatment significantly increases the risk of a person developing chronic or life-lasting damages.

1. DEFINITION OF TRAUMA AND TORTURE

Trauma
Experienced, witnessed or confronted events involving an actual sense of extraordinary danger and threat to the physical and psychological integrity of a person, followed by extreme emotions of powerlessness, horror and fear of existential disintegration.[1]

Torture
An act of intentionally inflicted physical, sexual or psychological harm, pain and suffering.[2]

2. TRAUMATISING EVENTS EXPERIENCED BY REFUGEES

- Multiple losses
- Imprisonment
- Severe and repetitive physical, sexual or psychological torture
- Combat exposure
- Brutal massacres of civilians
- Forced resettlement and family separations
- Prolonged and profound deprivation of basic human needs

Memory deficit

From early development, human beings process and memorise both conscious and unconscious life stimuli and integrate life experiences into meaningful and well-organised memory structures. This primary memory matrix forms the basis of a person's thoughts, emotions, beliefs and behaviours. New experiences are in turn expected to fit with already existing predictable memory organisation.

However, incomprehensible trauma experiences involving horror, extreme fear and powerlessness do not fit into the belief system and consequently stay cognitively unprocessed and disconnected from a person's memory organisation. Trauma experiences appear to be explicitly amnestic, symbolic or fragmented in nature, and the person is not able to provide a coherent narrative of the traumatic event.

From a psycho-physiological perspective, abnormal amygdala-mediated fear conditioning and emotionally stimulated overactivity of the limbic system during traumatic exposure reciprocally exercise inhibited or diminished neocortical cognitive activity and normal memory processing.[3]

Psycho-physiological legacy of trauma

Trauma experience is unconsciously recorded as full memory material involving associated emotions, images, smells, sensory symbols and meanings. Due to the split between explicit and implicit memory, free-floating and timeless trauma material constantly intrudes the walls of unconsciousness causing involuntary recollections of a traumatic past event in the form of thoughts, images, flashbacks and nightmares, which appear vividly as if the trauma is occurring in the present. The very unstable nature of unconscious trauma memory can be autonomously triggered and cumulatively recalled at any time if a survivor of trauma is exposed to stimuli associated with the horrific past.

Impact of migration

Migration to another country is considered to be a significant life change that involves stressful or traumatic responses. Although migration brings about long-desired safety and security for refugee survivors, adjustment to unfamiliar sociocultural contexts and linguistic barriers may result in an over-perceived sense of danger triggering prior psycho-physiological hypersensitivity and impeded mechanisms of adaptation.

Health, financial, professional or family problems that would normally cause distress in any person might cause cumulative and disproportional reactivity in victims of severe trauma.

Trauma responses and presenting issues

Trauma challenges the concept of personal identity, belief systems and attachment bonding, causing significant changes to regular and predictable distress patterns and adaptive systems of a person. Affected individuals may present with the following issues.

- Emotional difficulties involve an impaired ability to self-regulate mood affect and extreme emotions such as fear, anger, rage, powerlessness, desperation, guilt and shame. Even when external environmental factors are considered to be stable, personal resources to return to emotional homeostatic functioning are not available to the person.
- Psychological damage may include unbearable changes in the person's sense of self, others and the world (depersonalisation, derealisation).
- Diminished cognitive and mental capacities appear in the form of memory problems, significant lapses in concentration and attention, disorientation, learning difficulties and distorted executive functioning.
- Behavioural changes involve irritability, social withdrawal, relationship problems, aggression, substance abuse and domestic violence. Self-harming behaviour and suicidal tendencies could also be presented.
- Severe sleep disturbances in all phases of the sleep cycle, characterised by nightmares, restlessness, sweats and vocalisations are common.
- Trauma survivors experience multiple physical health problems resulting from prolonged psycho-physiological deregulations, injuries, lack of treatment and deprivation of basic human needs along the refugee journey.
- Significant psychosomatisation such as headaches, massive muscle pain and tension, and respiratory, cardiovascular and gastrointestinal problems could be presented more often in some cultural groups, due to the cultural stigma associated with psychological and emotional problems.

- Children who have experienced severe violence may suffer significant developmental problems. Exposure to cross-generational family trauma would have an additional negative effect.

Clinical features

Post-traumatic stress disorder (PTSD) is a psychiatric disorder defined in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (*DSM*-5) as a specific set of symptoms and clinical features following traumatic experiences.[4] The criteria apply to adults, adolescents and children older than 6 years. For children 6 years and younger, specific corresponding criteria apply.

A diagnosis of PTSD should be considered if three core sets of symptoms are presented:[5]

- memory recall deficit followed by intrusive recollections of trauma in memories, dissociations, imageries and nightmares
- actual or perceived avoidance of trauma-associated cues and an excessive need for control, predictability and safety
- increased psycho-physiological arousal and sensitivity.[6]

However, symptoms of extreme trauma in refugee populations significantly vary in onset, intensity and clinical configurations.[7] Many refugee victims present with symptoms that could not be considered as pathological enough to meet the diagnostic criteria of PTSD.[8] In my experience, people exposed to prolonged and massive trauma may develop strong defensive mechanisms that suppress and modify clinical features, which makes diagnostic procedures even more complex. Depression, other mood and anxiety disorders and comorbid substance abuse are common. PTSD complications may involve personality changes and hypersensitivity to repeated harm.

Cultural considerations

Individuals from different cultures hold various conscious and unconscious values, norms and beliefs that inevitably affect their conceptual understanding of health and wellbeing, medical conditions, causes of symptoms and healing opportunities.

From the perspective of Western biomedical health, some traditional concepts of health care would be disapproved of on clinical, ethical or cultural grounds. However, it is highly recommended to explore a patient's cultural beliefs and to assess whether these alternative approaches are contraindicated, or can safely coexist with biomedical practice. This approach makes diagnosis and treatment more valuable and more relevant to the patient, and reduces the risk of misdiagnosis or disengagement from therapy. The Health Explanatory Model proposed by Kleinman in 1978 outlines particular methods for medical practitioners to use when treating patients from different cultural backgrounds.[9]

Treatment strategies

The primary treatment goal is to reduce fear and treat the patient sensitively. A safe environment and trusting relationship will help the patient regain a basic sense of control and predictability. A sensitive approach and good communication skills that simplify medical terminology can be helpful.[10]

The services of professional interpreters should always be offered if appropriate and engaged when needed and if accepted by the patient. It increases a sense of mutual understanding and inclusion. Some patients may be more co-operative if accompanied by a trusted person. It is highly relevant to address the patient's history of trauma and areas of high sensitivity.

Provision of general information about the Australian health-care system, medical examinations, treatments and health outcomes can increase acceptance of recommended approaches. The patient should be provided with general empirical information about traumatic reactions and exacerbation of symptoms, which demystify and normalise their reactions and reduces the 'fear of madness' and incurability related to extensive psychosomatic complaints.

Patients may provide selective or limited information based on their own clinical frame of reference, so expanded assessment is required to examine beyond the presented issues. Patients may not report some health problems if not specifically asked.

Most patients will gain significant benefit from judicious use of medications.[11] Reluctance and ambivalence presented by some individuals and cultural groups can be reduced if simple pharmacological information is provided.

Culturally competent trauma counselling provided at specialised torture and trauma rehabilitation centres is a valuable resource. The Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) offers information and contact details of all trauma rehabilitation centres nationally (www.fasstt.org.au). Ongoing psychotherapy provides a better understanding and stabilisation of symptoms, increases coping strategies and prevents the re-occurrence of symptoms.

It is highly recommended to address settlement issues and current stressors with the patient. Referral to relevant social support services is helpful. Complex cases would require referral of the patient to a psychiatrist for initial or ongoing care. Co-ordinated practices and regular exchange of experiences and information among service providers will undoubtedly have a positive impact on patients' treatments and outcomes.

Conclusion

Severe and complex trauma experienced by refugees impacts the most personal and existential aspects of an individual. Clinical and cultural complexity requires specialised and systemic psychological, medical and social treatment and culturally and clinically integrated practice. MT

References

A list of references is included in the website version (www.medicinetoday.com.au) and the iPad app version of this article.

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