# Trauma and Migration

## Cultural Factors in the Diagnosis and Treatment of Traumatised Immigrants

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# Foreword

Many migrants experience traumatisation when leaving their countries and moving to a new location. This is particularly true for refugees. However, different factors including discrimination and social exclusion can traumatise all migrants, including those who have a secure legal status. This book focuses on these various ways in which refugees and migrants can be traumatised, describes the epidemiology of post-traumatic stress disorders among refugees and migrants, discusses challenges in cross-cultural diagnosis and communication and elucidates the role of stigmatisation on the one hand and resilience on the other, which impact on the ability of refugees to cope with the challenges of migration and social exclusion. A special focus is given to gender issues and challenges of specific settings and experiences such as torture and incarceration. Finally, specific treatment issues are discussed and include a description of the relevance of cultural competence, the need to orient towards resilience and coping capacities of migrants and to integrate such approaches in best practice models for traumatised refugees.

Altogether, this book gives an excellent overview over the epidemiology and relevance of the topic, shows ways how to diagnose trauma in different cultural and social settings and discusses best practice approaches for treating traumatised migrants. This topic is highly relevant given the increasing number of racist attacks on refugees, but also in view of the changing landscape of legal requirements and border policies in Europe and other parts of the world. Meryam Schouler-Ocak, the head of the outpatient unit of the Department of Psychiatry and Psychotherapy of the Charité, St. Hedwig Hospital, Berlin, managed to bring together an excellent group of experts in epidemiology, diagnosis and treatment of trauma among refugees and other migrants. The book includes views and voices from Turkey and Israel, Canada, Sweden, Denmark, the Netherlands, Germany and Spain and thus spans northern and southern, eastern and western regions of Europe and its neighbouring regions and links them with a global perspective. European societies dedicated to humanitarian ideals have to respond to the question how to adequately deal with the weakest members of society. Traumatised refugees and other migrants are among these subjects, which deserve special attention and care. May this book help to provide them with the best available support!

Berlin, Germany — Andreas Heinz

# Contents

**Part III Trauma and Migration: Treatment Issues**

# Part I

# Trauma and Migration: Epidemiological and Conceptual Issues

# Introduction: The Relevance of Trauma Among Immigrants

1

Meryam Schouler-Ocak

According to the United Nations High Commissioner for Refugees (UNHCR), a global total of 15.4 million refugees sought asylum in 2012 (UNHCR 2013). From a global perspective, 48.9 % of all asylum applications were made within the European Union (Eurostat 2014), the majority of these in Germany, France, Sweden, the UK and Italy (UNHCR 2014). Whether in crisis areas in their native countries, during the journey of migration itself or on arrival in their host countries, most of these people have had experiences which may result not only in adjustment disorders, but also in chronic psychiatric disorders such as anxiety, depression and somatoform disorders (Lindert et al. 2009; Hansson et al. 2012).

Wirtgen (2009) reports that the majority of refugees and asylum seekers are in a very poor physical and mental condition when they arrive in the host country (Wirtgen 2009). Various studies point out that the rate of post-traumatic stress disorder (PTSD) is around ten times higher among refugees and asylum seekers than among the general population of the host country (Fazel et al. 2005; Crumlish and O'Rourke 2010). Statistics on PTSD are very high, with studies reporting an incidence of anything between 3 and 86 %. Commonly mentioned causes are escape from crisis areas, physical and sexual violence, torture, loss of family members and persecution. One meta-analysis described the rate of mental illness as being twice as high among refugees and asylum seekers compared to those who migrated for economic reasons (40 % vs. 21 %) (Lindert et al. 2009).

Moreover, various authors (Laban et al. 2004; Porter and Haslam 2005; Hallas et al. 2007) report that the prevalence of mental disorders and physical health problems increases in proportion to the length of the asylum procedure, while their quality of life and satisfaction decrease accordingly (Laban et al. 2004, 2005, 2007,

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2008). It would appear that their resources are not activated; this process is characterised by a lack of access to healthcare, the low quality of life in the institutions which receive them, perceived discrimination and stigmatisation, and the absence of permission to work, hindering both the acquisition of financial resources and the basic structuring of everyday life. The related financial worries have a heavy impact on the overall situation (Laban et al. 2004; Noh et al. 1999).

Studies report on the multiple and highly complex stressors with which refugees are often faced and which are at risk of having a lasting impact on their mental health (Bhugra et al. 2014). These might be experiences of traumatisation before, during and after the actual journey of migration. If they succeed in leaving the crisis area, this journey is often a long and tortuous one on which they may be exposed to other traumatic events. When they finally arrive in the host country that they may have long been yearning for, they usually have to deal with sharing cramped accommodation, often with very poor sanitary facilities, next door to strangers from other cultures and unable to make themselves understand (Wirtgen 2009). A lack of future perspectives exacerbates the situation.

Access to the healthcare system varies greatly between countries. In Germany, the current Law on Benefits for Asylum Seekers only enables medical treatment for acute symptoms or life-threatening cases (Wirtgen 2009). The pressure and stress that refugees and asylum seekers are exposed to in the host country have the effect of complicating or delaying recovery (Porter and Haslam 2005; Silove et al. 1997; Momartin et al. 2006). Although numerous studies have shown that precisely this difficulty in gaining access to healthcare contributes to further deterioration in general health and especially in mental disorders among refugees and asylum seekers (Laban et al. 2004, 2005, 2007, 2008; Bhui et al. 2006; Gerritsen et al. 2006), no uniform solution has been found so far.

In addition, in most countries, especially in psychiatric care for refugees and asylum seekers, linguistic and culture-related factors that have a significant influence on diagnosis and treatment also form significant barriers to entry (Tribe 2002; Priebe et al. 2013; Penka 2013; Heinz and Kluge 2011). Other barriers to access constitute discrimination motivated by racism, with adverse effects on physical health (Pascoe and Smart Richman 2009; Williams and Neighbors 2001) and especially mental health (van Dijk et al. 2010; Igel et al. 2010; Pascoe and Smart Richman 2009).

Indeed, in a study conducted in Germany, Igel et al. (2010) demonstrated that 43.4 % of immigrants were frequently exposed to experiences of discrimination, regardless of their specific country of origin. At the same time, in the group of migrants originating from the former states of the Soviet Union, the researchers found a relationship between these experiences of discrimination and mental health (Igel et al. 2010).

Lederbogen et al. (2011) report that stigma and social exclusion also affect the recovery process and social participation itself, including in the healthcare system (Lederbogen et al. 2011). Other major barriers to access include cultural misunderstandings (Heinz and Kluge 2011; Penka 2013; Penka et al. 2012), different expectations and explanatory models (Heinz and Kluge 2011; Penka et al. 2008; Kleinman

1980) and diagnostic blurriness arising in the course of using psychiatric instruments and during verbal communication (Heinz and Kluge 2011; Penka 2013; Penka et al. 2012; Haasen et al. 1999).

As a consequence of these barriers, refugees and asylum seekers are likely only to be offered an appointment with a general medical practitioner, even if they have mental health problems (Fenta et al. 2007), meaning that they often only reach crucial professional treatment after much delay (Laban et al. 2004, 2005, 2007, 2008). Laban et al. report that this is also commonly caused by a lack of knowledge within the medical institutions, not only about culture-specific variations in the presentation of symptoms, but also about the basic symptoms of common mental disorders ('health literacy') such as depression or post-traumatic stress disorder (Laban et al. 2004, 2005, 2007, 2008). The authors also report that refugees and asylum seekers are very unlikely to have access to social networks and therefore to the kind of social support that could help them to overcome the barriers to accessing mental health services.

Bhugra et al. (2014) emphasise that refugees and asylum seekers constitute one of the highest-risk groups in terms of developing mental disorders and are one of the most vulnerable groups in society. Although the worldwide numbers of refugees and asylum seekers show an upward trend and, as already mentioned, the proportion of traumatised people with a serious mental disorder is very high, the available healthcare systems are not prepared for this specialised group of traumatised migrants.

There are still significant access barriers and those working in the healthcare systems are on the whole inadequately trained and are unqualified to diagnose and treat traumatised refugees and asylum seekers. Both the WPA (Bhugra et al. 2011) and the EPA (Bhugra et al. 2014) have published guidelines for the treatment of mentally ill migrants, including refugees and asylum seekers.

The precarious situation which many of the afflicted find themselves in means that it is even more important to bring refugees and asylum seekers under the spotlight of diagnostic and therapeutic attention (Schouler-Ocak et al. 2015). This is exactly what this book is for. The title *Trauma and Migration* refers here primarily to people who were exposed to a traumatic event before, during or after migration, and refugees and asylum seekers are focussed on in particular.

The book gives an overview on how traumatised migrants are dealt with in various different contexts. Authors from various countries, namely, Germany, the Netherlands, Denmark, Spain, Sweden, Turkey, Israel and Canada have contributed to the book. In addition to epidemiological data and conceptual considerations, the focus is on diagnostic and therapeutic approaches to the treatment of refugees and asylum seekers.

The first group of topics presents an introduction to the subject, illustrating its relevance in today's psychiatry and psychotherapy; an emphasis is laid on the necessity to rethink healthcare for traumatised migrants and ensure the provision of additional resources for the care and treatment of refugees and asylum seekers. In his chapter *Rethinking Trauma as a Global Challenge*, Duncan Pedersen focusses on our current concept of trauma and raises questions pertaining to this.

Marion C. Aichberger offers an overview in her article *The Epidemiology of Post-Traumatic Stress Disorder – a focus on refugee and immigrant populations.* Sofie Baarnhielm and Mike Mosko report on *Cross-cultural Communication with Traumatised Immigrants*, while Levent Küey's chapter, *Trauma and Migration*: *the Role of Stigma*, elaborates on the importance of stigma in this context. Antonio Ventriglio and Dinesh Bhugra emphasise the relevance of *Trauma, Migration and Resilience*.

In the section on diagnostic features, Ibrahim Özkan and Maria Belz's contribution on *Clinical Diagnosis of Traumatised Immigrants* and Ferdinand Haenel's *Special problems in the assessment of psychological sequelae of torture and incarceration*. Inci User's chapter illuminates the relationship between *Gender and Trauma*. In their contribution *Forced Migration to Israel*: *Exposure to Trauma, Mental Health and Acculturation*, Ido Lurie and Ora Nakash offer an insight into the treatment of migrants who emigrated involuntarily to Israel. In the section on *Therapeutic Aspects*, Adil Qureshi, Irene Falgas, Khalid Ghali and Francisco Collazos focus on the subject of *Cultural Competence in Trauma*, while Meryam Schouler-Ocak introduces a special method of therapy for traumatised migrants in her chapter on *Intercultural Trauma-Centered Psychotherapy and the Application of the EMDR Method*. Cornelis J. Laban presents features of *Resilience-oriented Treatment of Traumatized Asylum seekers and Refugees*, followed by Johanna Winkler with her report on *Traumatised Immigrants in an Outpatient Clinic* and Ljiljana Joksimovic, Monika Schröder and Eva van Keuk with their contribution on *Psychotherapy with Immigrants and Refugees from Crisis Zones*. Finally, Marianne C. Kastrup and Klement Dymi finish the book with their manuscript on a *Therapy Model for Traumatised Refugees in Denmark*.

The authors bear responsibility for their own chapters.

It is my hope that this book will help bring the subjects of trauma and migration, traumatised migrants and in particular refugees and asylum seekers increasingly to our attention and that this very vulnerable group will be treated with due sensitivity. The book contains not only scientific contributions, but also contributions from practice, particularly examples of 'good clinical practice'. It also recounts specific features in the diagnosis and treatment of traumatised migrants in the hope that it can be of assistance in therapeutic work with this group of the population.

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