
The assessment of traumatized refugees: clinical practices at the Cultural Psychiatry Outpatient Clinic

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Abstract

The number of asylum seekers and refugees is rapidly increasing in Finland. Many refugees have trauma-related and other health problems and continue to have a stressful life situation even after resettlement. Cultural competence and preparedness to support refugee patients is needed in all psychiatric services. A comprehensive, multi-professional assessment that takes refugee trauma and cultural factors into account contributes to an effective and appropriate treatment plan. An assessment can and should be carried out in all psychiatric units, but a specialized clinic can be helpful in supporting them and in developing the assessment and treatment methods that are the most suitable in a Finnish context.

Introduction

There is an urgent need to develop psychosocial services to respond to the needs of immigrants from unstable societies. In Finland, the proportion of foreign-born citizens has been very small, but since the 1990's it has steadily increased and in 2014 it was 5.9% (1). The most common reasons for immigration have been family relationships, studying or work (2). However, the rapid increase in the number of asylum seekers in 2015 (2) changed the picture and brought new challenges to many sectors of society.

Traumatic experiences among asylum seekers and refugees are very common. In a small Finnish study conducted in a reception centre for asylum seekers, 57% of adults reported that they had experienced torture and 12% had been victims of other violent actions (3). In a large population-based study conducted among people who already

have a residence permit in Finland, 78% of Kurdish, 57% of Somali and 23% of Russian respondents reported a significant traumatic experience (4). Having been tortured was most common among Kurdish respondents. This was reported by one third of Kurdish men (4). These two studies, conducted among non-clinical samples (3, 4) and a study conducted among patients at the Centre for Torture Survivors (5), showed that symptoms of anxiety, depression and post-traumatic stress disorder (PTSD) are highly prevalent among asylum seekers and refugees in Finland. The prevalence of PTSD diagnosis among refugees in Finland has not been studied, but studies conducted in other countries have suggested that it is around 9% among refugees who have resettled in Western countries (6).

The well-being and early integration of recently arrived immigrants is important from ethical, public health and economic perspectives and therefore the adjustment of working methods in Finnish public services is necessary. Even though non-medical interventions such as access to employment, language studies, prevention of discrimination and social participation play a role in the prevention of mental health problems (7) and may sometimes be sufficient even for people who have had serious traumatic life events, there should be competence at all levels of the healthcare system to assess the needs of asylum seekers and refugees. The most severely traumatized immigrants often need psychiatric services and therefore psychiatric units should have the knowledge and skills for assessing and treating this population. So far the use of mental health services among immigrants has been less frequent than expected considering the frequency of psychiatric symptoms they report and the use of mental health services by the Finnish-born population (4, 8). It has been found that many immigrant populations in Europe use more psychiatric emergency care, but less psychotherapy and rehabilitation, than natives (9). Factors that may decrease the use of mental health services include language barriers and other communication problems as well as insufficient knowledge about the service system, the lack of health-related information and the fear of stigmatization among immigrants, and discriminatory practices or lack of cultural competence among health professionals (9-11).

The treatment strategy of a traumatized refugee should be individually planned and based on careful assessment. The aim of this review is to describe the factors that should be taken into account when assessing traumatized adult refugees, provide suggestions for conducting assessments and to describe the working model of the Cultural Psychiatry Outpatient Clinic (*Kulttuuripsykiatrian poliklinikka*) at the Helsinki University Hospital. The term refugee in this review also refers to immigrants who have been granted a residence permit on the basis of subsidiary or humanitarian protection.

Understanding refugee trauma

The nature of the traumatic experiences of refugees is often very different from what trauma professionals in Finland and other stable high-income areas are used to evaluating and treating. The experiences are usually significantly more severe and they are typically multiple, long-lasting traumatic events (12, 13). The traumatic events have often been intentionally inflicted, which is associated with worse long-term prognosis (14). Torture is particularly harmful because the perpetrator actively seeks to dehumanize, humiliate and degrade the victim (12). Shame, persistent anger and distortions in sense of identity are common and assumptions about the trustworthiness of the world and people are often shattered (12). It has been suggested that survivors of torture or other repeated interpersonal violence in adulthood can have complex PTSD similar to those who have experienced childhood abuse (15). Furthermore, refugees who have experienced both childhood adversities and war and human rights violations in later life may be the ones at highest risk of mental health problems (16).

There may be cultural variation in the responses to traumatic events. In fact, the universality and cross-cultural validity of PTSD has been criticized by anthropologists and other researchers that represent relativist perspectives and emphasize the importance of cultural context in understanding people's values, beliefs and practices (17). In their comprehensive review, Hinton and Lewis-Fernandez did not deny the applicability of PTSD diagnosis in any setting, but they concluded that its expression is not identical across the globe and provided several examples of cross-cultural variation (18). These included, for example, the relative salience of the avoidance/numbing cluster and of somatic symptoms in some cultural settings, the variation in the content of nightmares and the impact of the meaning of trauma on PTSD severity and symptom expression (18).

In addition to PTSD, the prevalence of other psychiatric disorders and somatic health problems is high. At least in clinical populations, most refugees with PTSD also suffer from depression (6, 19). In addition, it is relatively common that traumatized refugees experience at least transient periods of psychotic symptoms even though they do not suffer from a psychotic mood disorder or schizophrenia spectrum disorder (19, 20). Furthermore, dissociative symptoms, which are common among traumatized patients,

can be similar to psychotic symptoms, leading to possible misdiagnosis (20, 21). The prevalence of pain symptoms is extremely high. In clinical samples of traumatized refugees in Norway (22) and Denmark (19) practically all patients reported chronic pain. Often there are also other treated or untreated somatic health problems (19, 23, 24). In addition to impairing quality of life, physical complaints and symptoms may function as triggers for intrusions. Physical injuries and most importantly self-reported head injuries are very common amongst refugees (19, 25, 26), and they correlate with the findings of magnetic resonance imaging (MRI) (25).

In addition to the burden caused by past traumatic events and current health problems, refugees often have continual challenges in adjusting to their new living environment. The stress experienced by asylum seekers is particularly high because: they have an ongoing fear of being repatriated, they have barriers to work and to health and social services, they are separated from families and they have to go through the very stressful asylum interviews (13, 27). However, many refugees with a residence permit have stressful living conditions as well. Problems such as economic uncertainty, poor language proficiency, problems with accommodation and ethnic discrimination are known to impair their mental health (28-30).

Assessing refugee trauma

Building the relationship

A prerequisite for an assessment is sufficient trust and understanding in the relationship between the patient and the clinician. For severely traumatized patients several meetings may be required to build even the minimum level of trust. It is challenging, especially for those patients who come from an environment in which health professionals are regarded as part of the authority that is guilty of mistreatment. Informing the patient about the Finnish healthcare system, and issues related to confidentiality, and arranging a peaceful physical environment are important but not sufficient actions. Often therapeutic approaches including stabilization and psychoeducation need to be included early in the assessment process. Trust is also facilitated by an active interest in the patient's story with particular attention to language and culture.

Assessing a patient without a common language is probably more difficult in psychiatry than in any other medical specialty. Even though there are multiple sources of miscommunication and distortion when working with a professional interpreter, it is still the most reliable way of conducting a psychiatric assessment if the clinician and patient do not have a common language that both speak fluently (31, 32). Specifically, a study of asylum seekers in Switzerland showed that traumatic events were more likely to be detected when a professional interpreter was used than when no interpreter or a non-professional interpreter was used (33). Working with a refugee client is often a special challenge for an interpreter as well. More effort is needed to build trust, clients may expect interpreters to help them in other areas of life and sometimes interpreters themselves share a similar traumatic history with their clients (34). In addition to language interpreters some healthcare units use cultural interpreters or culture brokers who are professionals in interpreting the cultural meaning of illness and healing (35). Culture brokers can be, for example, social scientists, bilingual/bicultural health practitioners or people representing community groups, who are employed in healthcare institutions to mediate cultural differences (35).

Cultural competence can be defined as the ability to work and communicate effectively and appropriately with people from culturally different backgrounds, and its most important elements are often termed cultural awareness, cultural knowledge and cultural behaviour (36). Further, in the field of psychiatry, cultural competence may also include characteristics such as flexibility in establishing a mutually acceptable mode of interaction with the patient, ability to adjust communication to patient preferences, openness to discussing cultural differences, anthropological orientation in learning the meaning of the presented symptoms, and creativity in making biomedical treatment culturally acceptable to the patient (10, 37). Sometimes patients present religious reasons, moral codes and values for resisting treatment recommendations. Asking questions about spirituality and world view can improve a treatment alliance, because patients would then feel that important aspects of their existence are understood. Furthermore, understanding of the patient's world view may be a critical component in suicide assessment and prevention (38). To emphasize the need for a respectful attitude and the understanding of power issues in health care in addition to technical competence, the terms "cultural responsiveness", "cultural safety" and "cultural humility" have also been used (39). Promoting cultural competence in general may be more useful than aiming at ethnic matching between a clinician and patient (39, 40), which in many cases is practically impossible.

A practical tool that may provide a clearer understanding of the patient's own views of his/her health problem and related cultural issues, enhance diagnostic validity and improve the relationship between the patient and the clinician, is cultural formulation, which was published as part of DSM-IV in the form of Outline for Cultural Formulation and further developed to Cultural Formulation Interview (CFI) in DSM-5 (41, 42). It is a set of semi-structured interviews that cover themes such as cultural definition of the problem, cultural identity, spirituality and patient/clinician relationship. One of the supplementary interviews is aimed at refugees and immigrants in particular. It has been shown that the use of cultural formulation is useful in identifying traumatic life events and it improves the diagnostic accuracy of PTSD among immigrants (43, 44).

Assessment methods

When the above-mentioned factors related to trust, culture and language are taken into account, a general psychiatric assessment of a refugee patient is not very different from an assessment of a Finnish-born patient. Observing a patient during an interview follows the same principles as usual although special attention needs to be paid to the emotional and physiological state of the patient, because traumatized patients often have self-regulation problems, which may be provoked during an interview (45). Sensitivity is needed when collecting information about life history and flexibility is often necessary in phrasing questions about current psychiatric symptoms, but both should be included. It has to be taken into account that the patient's history may be fragmented and appear illogical because of the nature of traumatic memories (46, 47). Even when it is evident that the patient has had traumatic experiences, the assessment should not only focus on typical trauma-related symptoms, but comorbid or alternative problems should be considered as well.

Assessment methods that aim at measuring traumatic events and related symptoms have limitations in refugee populations. Very few instruments have been adapted for refugees, and even the ones that have been developed specifically for refugees have problems with both validity and reliability (48). The availability of questionnaires and interviews in different languages, including Finnish, is limited. In addition, the use of self-report questionnaires in particular is often complicated by patients' illiteracy and inexperience in completing written forms. The Structured Clinical Interview for DSM Disorders (SCID) with an interpreter was used in an immigrant and refugee population in a Swedish study, but it was found that many patients had trouble

understanding the questions and did not report traumatic events or PTSD symptoms even though they did so when the Cultural Formulation Interview was used (43). Patients may be reluctant to reveal the details of traumatic experiences, and it may be too painful for them without an established therapeutic contact. For diagnostic purposes, determining if a trauma occurred, its general type, and if any recent events have led to symptom exacerbation is often sufficient (49). However, for the victims of torture in particular, the identification and more detailed documentation of traumatic events and their consequences is important for treatment planning and for the fulfilment of human rights. Clinicians should be prepared to document the possible signs of torture according to the Istanbul Protocol (50, 51). This is important especially for asylum seekers who may be granted asylum if there is evidence of torture.

An assessment by a psychologist is often useful especially if there are many comorbid symptoms or diagnostic challenges in differentiating, for example, between dissociative and psychotic symptoms. It also gives important information about the patient's suitability and motivation to receive psychotherapy or other treatment options. A neuropsychological assessment may be particularly useful in differentiating psychiatric symptoms that are caused by psychological trauma from those that are secondary to the effects of traumatic brain injury (52). The most important part of the psychological assessment is the clinical interview in which the psychologist takes comprehensive psychosocial, trauma and medical history. Current psychosocial circumstances are also examined. A thorough assessment of functional capacity is useful when examining neuropsychological problems in particular. It is also important to be aware of the common customs and beliefs in the country of origin in order not to pathologize behaviour and thoughts that are normal in the refugees' culture.

Certain limitations have to be kept in mind when using psychological tests. There is a lack of assessment measures translated into refugees' native languages and sensitive to their cultural norms. Western-based intelligence quotient and ability tests cannot be used cross-culturally when the social conventions underlying those tests differ between the tester and the participant (53). The social conventions refer to the domains of values and meaning, knowledge and communication. Prerequisites for valid testing often depend on the degree of formal education and experience with the range of cognitive tasks that underpin test performance (52, 53). Testees may have little experience of using paper and pencils, they may not be literate in their own language or they may come from a culture with an oral tradition, in which characteristics of thinking are less linear and factual than those of written cultures. Multiple choice tests, for example, can never be universally culture-fair (53).

The use of an interpreter makes it often impossible to assess the actual wording or modulation of phrasing, which has an impact on the psychologist's ability to assess mood, affect, level of cooperation, and language itself. Interpreter use may also significantly affect scores for some tests commonly used in testing cognitive skills (54). This influence is greater for verbally mediated tests (54). The interpreter must be instructed on how to administer psychological measures. In addition, communication among strangers is not the norm in collectivist cultures and the psychologist may need to establish a personal relationship with the testee before a valid assessment can take place.

Some refugee patients feel more comfortable when they are assessed by an occupational therapist and involved in an activity instead of being interviewed in a standard medical setting. An occupational therapist may collect important information on issues related to immigration such as changes in roles, work, identity and well-being (55). She/he may also assess problems related to traumatization including abnormalities in sensory processing (56) and identify factors that promote resilience (57).

Traditional psychiatric assessment methods can also be complemented by an art therapy approach. Working with art materials has the potential to activate emotionally loaded images, whereas goal-oriented art expression in a therapeutic setting offers a means to express, understand and integrate them consciously (58). An art therapy interview is designed according to the clinical situation. It yields complementary information about the quality and severity of symptoms, coping mechanisms and resources of the patient and developmental level (59). Furthermore, culturally specific issues and values may become visible in the art therapy interview.

Physical health status may be insufficiently assessed especially among recently arrived refugees and sometimes referrals to other medical fields are needed during or after a psychiatric assessment. Collaboration with a neurologist is important when, for example, developmental problems or a traumatic brain injury are suspected or the differentiation between neurological and dissociative symptoms is challenging. MRI of the brain is often justified and an electroencephalogram (EEG) is needed particularly when epileptic or other seizures are suspected. In addition, collaboration with experts in pain medicine as well as physiotherapists is useful when evaluating patients with severe chronic pain.

If the patient has family members in Finland, it is essential to involve them in the assessment process if the patient is agreeable to it. Family members can provide information that helps in understanding the patient's situation and they may also themselves need information about mental health problems and the service system. However, if children are included in a meeting, caution should be taken in the disclosure of parents' traumatic experiences. Even though silencing or indirect referral to trauma history may confuse children, pushing direct disclosure may be even more harmful especially if children are young, they have been exposed to the traumatic events themselves or this type of communication is not culturally appropriate (60).

Services at the Cultural Psychiatry Outpatient Clinic

Assessing refugee patients has become common practice in most psychiatric units in Finland. In addition there are some specialized units. A psychiatric outpatient clinic for immigrants in Tampere serves refugees living in Tampere. The Centres for Torture Survivors in Helsinki and Oulu are run by the Deaconess Institute and provide rehabilitation for the victims of torture nationally. These units have operated for more than 20 years. A more recent unit, and the only one providing services at a university hospital level, is the Cultural Psychiatry Outpatient Clinic at the Helsinki University Hospital. It was established in 2013 and provides services primarily in the Helsinki Metropolitan Area. Patients are referred to the clinic from specialized psychiatric services if their assessment or treatment is considered challenging due to cultural factors, or if there are problems in establishing a patient/clinician relationship. Most patients are refugees, but there are also immigrant patients who have migrated for other reasons.

The main focus at the Cultural Psychiatry Outpatient Clinic is on the assessment of immigrant and refugee patients, whilst the treatment is mostly carried out in other units. The clinic provides short consultations as well as more extensive, multi-professional assessments. Some modifications have been made compared with common practice. The appointment letter including an introduction of services has been translated into several languages. An interpreter is used with almost all patients, and if the patient has previously established a good relationship with a specific interpreter effort is made to continue this working relationship. The meetings last at least an hour and often longer. In some cases the assessment takes place at the patient's home or at a place easily accessible to him/her.

The initial assessment at the Cultural Psychiatry Outpatient Clinic usually includes a joint meeting with a nurse and a doctor. It is most often followed by a cultural formulation interview and a life history assessment by a nurse and a diagnostic evaluation by a doctor. The support of a social worker is often needed from the outset. The need for additional assessment methods is considered after the initial phase. In diagnostically or therapeutically complicated cases, a psychological assessment is often conducted. Neuropsychological assessment is requested in selected cases, for example, when a traumatic brain injury or other neurological or neuropsychiatric condition is suspected. If the functional capacity or working ability cannot be established by standard interviews and by obtaining information from the patient's closest informants and networks, an assessment by an occupational therapist is conducted as well. Occasionally a neurologist or other specialists are consulted. The recommendations based on the assessment are negotiated with the patient, sometimes with his/her family members, and preferably with the unit that takes responsibility for the treatment after the assessment. There is also frequent collaboration with primary care services, social services, employment services and non-governmental organizations.

Even though a comprehensive assessment with an interpreter is time consuming, the experiences at the clinic show that it often produces valuable information for treatment planning. An assessment that is conducted in a respectful way can also improve the patient's trust in the healthcare system and motivation for treatment. Most traumatized refugee patients have multiple problems in addition to PTSD, and therefore strictly following the treatment guidelines of PTSD may lead to unsatisfactory results. It has been found that traditional psychotherapy alone may not be sufficient, suitable or acceptable to all patients. Therefore, the availability of both specific evidence-based interventions, such as narrative exposure therapy (NET) and trauma-focused cognitive therapy (7, 61), and complementary treatment modalities, such as art therapy, physiotherapy or family therapy, tailored to refugees should be improved in Finland.

So far patients and the psychiatric units in the regions have given positive feedback about the services of the Cultural Psychiatry Outpatient Clinic, and the number of referrals has been steadily increasing. Even though it is impractical and unrealistic to assess all refugee patients in the region at one unit, and it is clear that cultural competence and knowledge about traumatized patients is needed in all

psychiatric services, there are some advantages in the centralization of services. In addition to providing clinical consultations to other units, personnel with more experience and knowledge of working with traumatized refugees contribute to the development of assessment methods and treatment strategies, train other professionals and collaborate with other specialists in the field locally, nationally and internationally.

Conclusions

The assessment of traumatized refugee patients requires special understanding of the nature of the traumatic events refugees may have experienced and of other challenges they typically face. The clinician should also be interested in each individual's cultural context and his/her understanding of their own problems. A comprehensive assessment may require more resources than usual, but it usually leads to obtaining much more information and therefore to a more efficient and accurate treatment plan. It is possible to conduct assessments at any psychiatric unit, but concentrating the most specialized services at a university hospital has proven to be a promising option, which can be recommended to other regions in Finland as well.

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