

13. Post-traumatic stress disorder

A large proportion of new immigrants to Canada come from countries experiencing social turmoil, and some are directly affected by protracted conflicts or war.⁴²⁰ Refugees and others who face significant trauma and loss are at risk for mental health consequences, including post-traumatic stress disorder. For three main reasons, primary care practitioners play a key role in the recognition and management of post-traumatic stress disorder in immigrants and refugees. First, immigrants and refugees underutilize formal mental health services.⁴²⁰ Second, an integrated treatment approach is often needed for extreme traumas, common in refugees, such as torture and rape, which have severe and long-lasting consequences for both physical and mental health.⁴²¹ Third, a family perspective is essential because trauma stemming from organized violence tends to affect the whole family, particularly children, who may not display dramatic or easily recognizable symptoms. We conducted an evidence review to determine the burden of post-traumatic stress disorder within immigrant and refugee populations, to evaluate the effectiveness of screening and treatment, and to identify barriers for primary care. The recommendations of the Canadian Collaboration for Immigrant and Refugee Health on post-traumatic stress disorder are outlined in Box 13A.

Box 13A: Recommendations from the Canadian Collaboration for Immigrant and Refugee Health: post-traumatic stress disorder

Do not conduct routine screening for exposure to traumatic events, because pushing for disclosure of traumatic events in well-functioning individuals may result in more harm than good.

Be alert for signs and symptoms of post-traumatic stress disorder, especially in the context of unexplained somatic symptoms, sleep disorders or mental health disorders such as depression or panic disorder, and perform clinical assessment as needed to address functional impairment.

Basis of recommendation

Balance of benefits and harms

Many persons who have been exposed to trauma do fine once they find safety and social supports. Brief screening instruments overestimate the rate of disease because they focus on symptoms and do not measure functional impairment. Detailed inquiry and pushing for disclosure without indications of distress or disorder could be harmful. There are no clinical trials demonstrating the benefits of routine screening for post-traumatic stress disorder.

Quality of evidence

Low (evidence available for refugee populations)

Values and preferences

The committee attributed more value to preventing potential harms from routine screening in the absence of clear evidence of benefits and determined that post-traumatic stress disorder was best dealt with through primary care practitioners remaining alert for signs and symptoms of this condition and performing clinical assessment to address functional impairment.

Methods

We used the 14-step method developed by the Canadian Collaboration for Immigrant and Refugee Health¹⁶ (summarized in section 3 of this article, above). We considered the epidemiology of post-traumatic stress disorder in immigrant populations and defined clinical preventive actions (interventions), outcomes and key clinical questions. We searched MEDLINE, Embase, CINAHL, PsychLIT, the Cochrane Library and other sources from Jan. 1, 2002, to Dec. 31, 2010. Detailed methods, search terms, case studies and clinical considerations can be found in the complete evidence review for post-traumatic stress disorder (Appendix 11, available at www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.090313/-/DC1).

Results

We identified 16 systematic reviews relevant to immigrants and refugees and five guidelines. We selected the 2005 guidelines commissioned by the National Institute for Clinical Excellence for the management of post-traumatic stress disorder in primary care,⁴²² but none of the selected intervention studies in those guidelines provided evidence for immigrants or refugees. We also selected four Cochrane reviews on treatment of post-traumatic stress disorder,^{423–426} the practice guidelines from the International Society for Traumatic Stress Studies⁴²⁷ and a systematic review on treatment of this condition in refugees and asylum seekers.⁴²⁸

What is the burden of illness of post-traumatic stress disorder in immigrant populations?

Most persons who experience traumatic events have a favourable mental health prognosis.⁵³ When symptoms of post-traumatic stress disorder or acute stress disorder develop, there is, in most cases, substantial natural recovery (estimated at about 80%). However, those in whom post-traumatic stress develops may remain symptomatic for years and are at risk of secondary problems, such as substance abuse.⁵⁴ A meta-analysis of studies involving adult refugees resettled in developed countries reported a 9% prevalence of post-traumatic stress disorder, and 5% had major depression. Among refugees with major depression, 71% also had post-traumatic stress disorder. Conversely, 44% of refugees with post-traumatic stress disorder also had major depression.⁵¹ Studies of child refugees report 11% prevalence of post-traumatic stress disorder.^{429,430} Symptoms may be reactivated when faced with new traumas, particularly if reminiscent of earlier traumatic experiences.⁴³¹ Torture and cumulative trauma are the strongest predictors of post-traumatic stress disorder and are associated with chronic physical and mental health problems.⁴³⁰ Fear of repatriation may exacerbate consequences of premigratory traumas.

Longitudinal studies from Canada indicate that most adults and children with refugee status adapt well, in spite of a high level of exposure to premigratory trauma.^{432,433} A population-based health survey from Quebec similarly found that non-refugee immigrants also experienced high levels of premigratory trauma, but that most immigrants were in good mental health.⁴³⁴

Does screening for post-traumatic stress disorder decrease morbidity and mortality?

Screening

Several short screening instruments practical for primary care settings have been developed.⁴³⁵ The four-item primary care post-traumatic stress disorder screening scale⁴³⁶ and the Breslau seven-item screening scale (available at <http://ajp.psychiatryonline.org/cgi/content/full/156/6/908#T2>) are two simple means of identifying symptoms in primary care patients. In both cases, their cultural validity is unknown. Very few screening instruments have been tested for diagnostic accuracy among immigrants, refugees and asylum seekers. However, it may be reasonable to use questionnaires to assist in identifying symptoms, as part of a clinical assessment when addressing functional impairment.

Relative benefits and harms of psychological treatment (adults and children)

The systematic review and meta-analysis commissioned by the National Institute for Clinical Excellence⁴²² provided evidence that psychological treatments, including trauma-focused cognitive-behavioural therapy and eye movement desensitization and processing, reduce the symptoms of post-traumatic stress disorder. We rated the quality of this evidence as low because of study limitations and inconsistency of results. Two Cochrane reviews^{425,426} provided similar evidence of effectiveness. A recent systematic review⁴²⁸ showed that psychological treatments (cognitive-behavioural therapy and narrative exposure therapy) can reduce symptoms of post-traumatic stress disorder among refugees, but we rated this evidence as very low quality. Other authors have reported that patients may experience adverse effects with therapy, such as re-experiencing traumatic events, and rates of withdrawal from active therapy may approach 30%.⁴³⁷

Clinical considerations

What are the potential implementation issues?

Primary care practitioners need to be aware that immigrants and refugees may have been exposed to traumatic events. If a patient discloses a traumatic experience, it may be helpful to acknowledge the pain and suffering associated with the experience, to explain that a reaction is common for anyone who has undergone trauma and to offer empathetic reassurance that the situation is likely to get better. Several Canadian cities have centres and experts available to help care for survivors of trauma and torture.

Exploration of trauma and its consequences is not recom-

mended in the first meeting with a patient unless it is the patient's primary complaint. However, certain symptom presentations should alert clinicians to the need for assessment for post-traumatic stress disorder, including unexplained physical complaints, sleep disorders,⁴²² depression, panic disorder and somatoform disorder.⁵¹ Other presentations, such as severe dissociation mimicking brief reactive psychosis, dissociative disorders (amnesia and conversion) and psychotic depression, although less frequent, may also be related to post-traumatic stress disorder. Key elements of the assessment include level of psychological distress, the impairment associated with the symptoms in the patient and his or her family, substance abuse and suicidality.

Familiarity with the cultural background of the patient is recommended, and assessment should involve a professional interpreter if the patient's language ability is inadequate to express psychological distress and narrate the experience.⁴²² Disclosing traumatic experience through relatives, family members or, particularly, children can be traumatic.⁴³⁸

Although not supported by clinical trials, the National Institute for Clinical Excellence⁴²² recommends a phased intervention model, reflecting a pragmatic approach for refugees and asylum seekers who face the possibility of being returned to a traumatic environment. Phase I is defined as the period in which safety has not yet been established and during which intervention should focus on practical, family and social support. Phases II and III should focus on the patient's priorities, which may include social integration and/or treatment of symptoms. Unemployment, isolation and discrimination may overshadow the efficacy of mental health treatment in many patients,⁴³⁰ which suggests that multifaceted interventions that include primary care, community organizations and other social institutions may be effective.⁴³²

Recommendations of other groups

The UK National Institute for Clinical Excellence⁴²² recommends against routine systematic provision of brief, single-session interventions. It recommends that consideration be given to the use of a brief screening instrument to detect post-traumatic stress disorder among refugees and asylum seekers, but does not suggest any specific instrument for screening or provide evidence of effectiveness of treatment in refugees. It also recommends that children and youth with post-traumatic stress disorder be offered a course of trauma-focused cognitive behaviour therapy. For sleep disorders, the National Institute for Clinical Excellence recommends the short-term use of hypnotic medication for adults or, if longer-term treatment is required, the use of suitable antidepressants to reduce the risk of dependence. For significant comorbid depression or severe hyperarousal, the National Institute for Clinical Excellence recommends paroxetine and mirtazapine. The US Centers for Disease Control and Prevention state that, in general, the majority of people who experience reactions to stress after disasters and emergencies show resilience and do not go on to experience long-term psychopathology.⁴³⁹ Our recommendations highlight the paucity of evidence for routine screening and the potential for harms.

Take-home messages

- Forty percent of Canadian immigrants and refugees from countries involved in war or with significant social unrest have been exposed to traumatic events before migration.
- Most (estimated at 80%) individuals who experience traumatic events heal spontaneously after reaching safety.
- Empathy, reassurance and advocacy are key clinical elements of the recovery process.
- Pushing for disclosure of traumatic events by well-functioning individuals may result in more harm than good.

For the complete evidence review for post-traumatic stress disorder in immigrants, see Appendix 11, available at www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.090313/-/DC1.

More detailed information and resources for assessment and treatment of trauma and survivors of torture can be found at: www.mmhrc.ca.