Mental health work with traumatized refugee patients

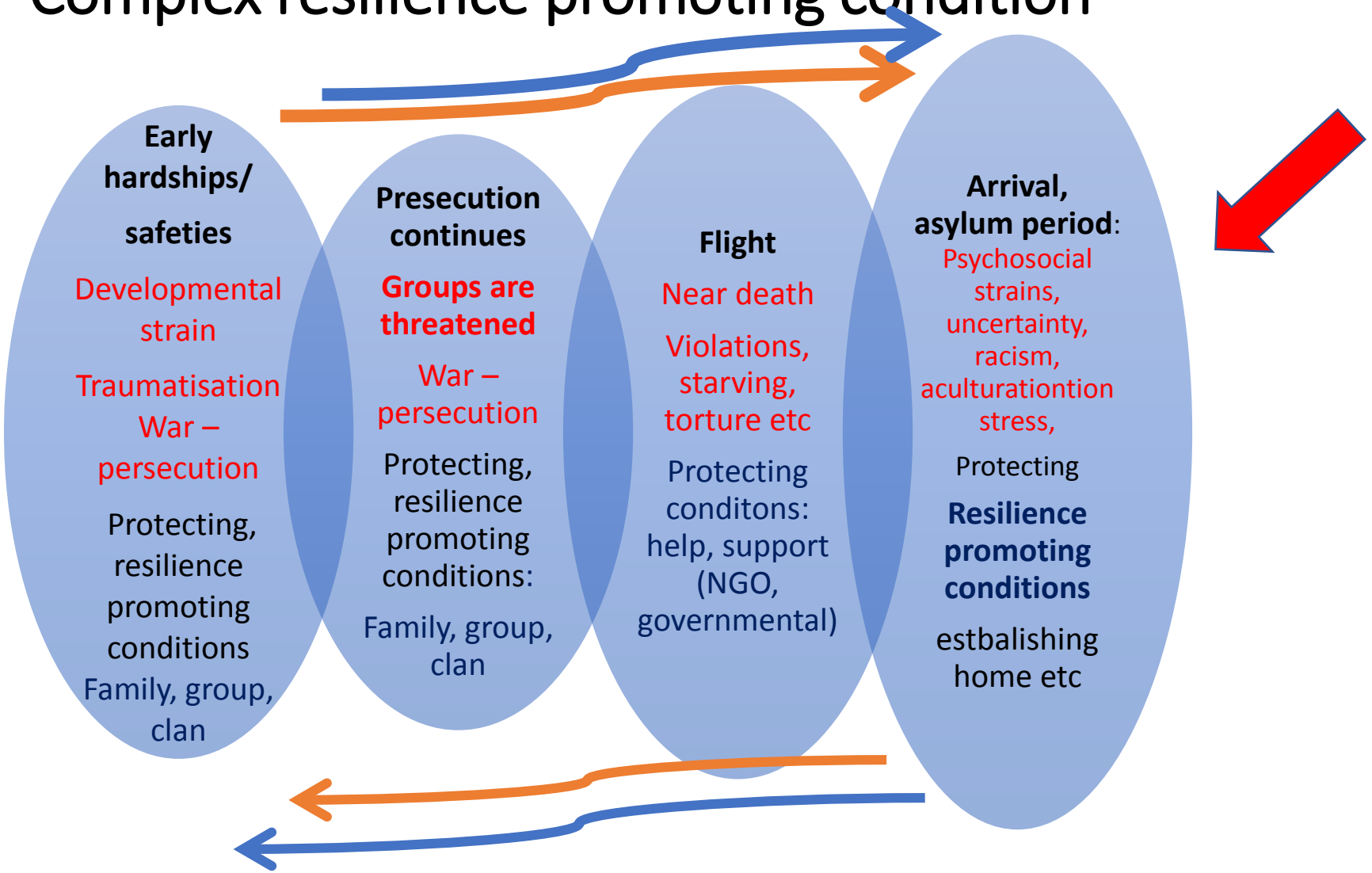
Sverre Varvin

Professor

OsloMet – Oslo Metropolitan University

Norwegian psychoanalytic Society

Complex, sequential challenges
Complex resilience promoting condition



Persecution and flight: destabilizing relations

- ***Attachment***

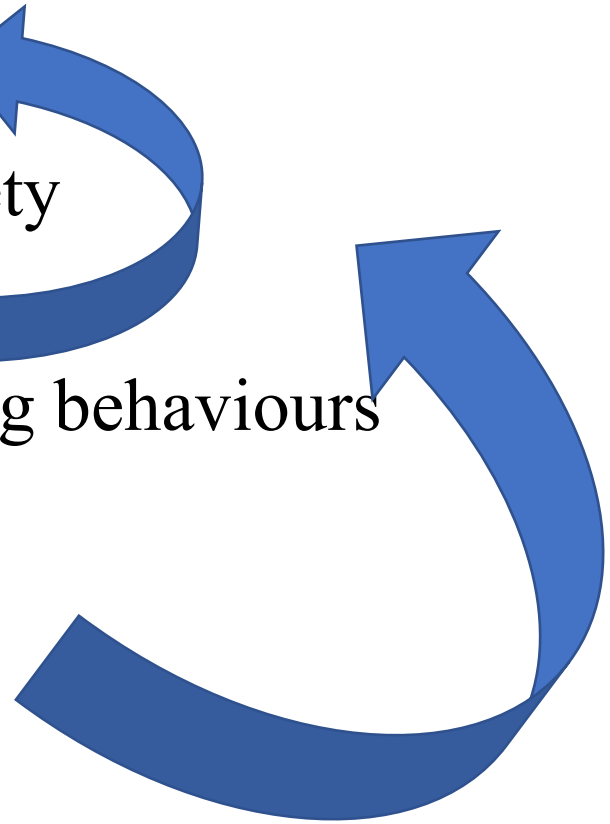
  - attachment system activates during danger(unsafety

- ***Family/group destabilizes***

  - safety systems in danger: children's safety seeking behaviours made difficult

Anchoring in culture and traditions weakened

- The meaning-producing function of culture weakened



Dehumanisation

To be treated as less worthy, someone who can be disposed and used

- Human rights violations causes dehumanisation:
  - torture, sexual assaults, persecution
  - Concertation camps
  - Left to human smugglers
  - Detention camps
  - Genocide

Potential for demoralising and self defeating psychic consequences

Traumatisation

- Overwhelming experiences that set ways of coping, manage and defend out of function to different degrees
- The person's subjective experience of the overwhelming events is decisive
- Clinically we see the person's reaction to and attempt to cope with and defend against changes resulting from the overwhelming experience
- Many aspects of personality functions may be involved
- Complex traumatisation involves as a rule disturbance in development (development as a life-long process)

The Mechanisms of Psychosocial Injury Following Human Rights Violations, Mass Trauma, and Torture. Nickerson et al 2014

The pervasive negative impact of human rights violations (HRVs) on psychological functioning has been well documented.

What are the mechanisms that mediate the link between exposure to HRVs and various mental and behavioral health outcomes?

Three theory- and evidence-based pathways by which HRVs may lead to psychosocial impairment may be:

disruptions in interpersonal processes

decreased perceptions of control

the denigration of individual and group identity.

post-HRV environment moderates each of these pathways,

Acculturation Model: John Berry 2003

-

Integration → Good for mental health

Separation → Not bad for mental health

- Assimilation → Not necessarily good for mental health

- Marginalisation → Bad for mental health

Acculturation Model: John Berry 2003

Societal response: choice or policy imposition?

- Integration → Good for mental health

Multicuturalism

- Separation → Not bad for mental health

Forced segregation

- Assimilation for → Not necessarily good mental health

Melting pot

- Marginalisation → Bad for mental health

Forced exclusion

Growing xenophobia

Last years migration of refugees has created generalised anxiety in many European countries.
National identity seems threatened: a need for national unity, ethnic uniformity, return to the presumed safety of ”how it was before”.
Foreigners are devalued – own culture idealised

Structural Violence

2015: Europe received around 0,03% of its total populations as refugees/asylum seekers

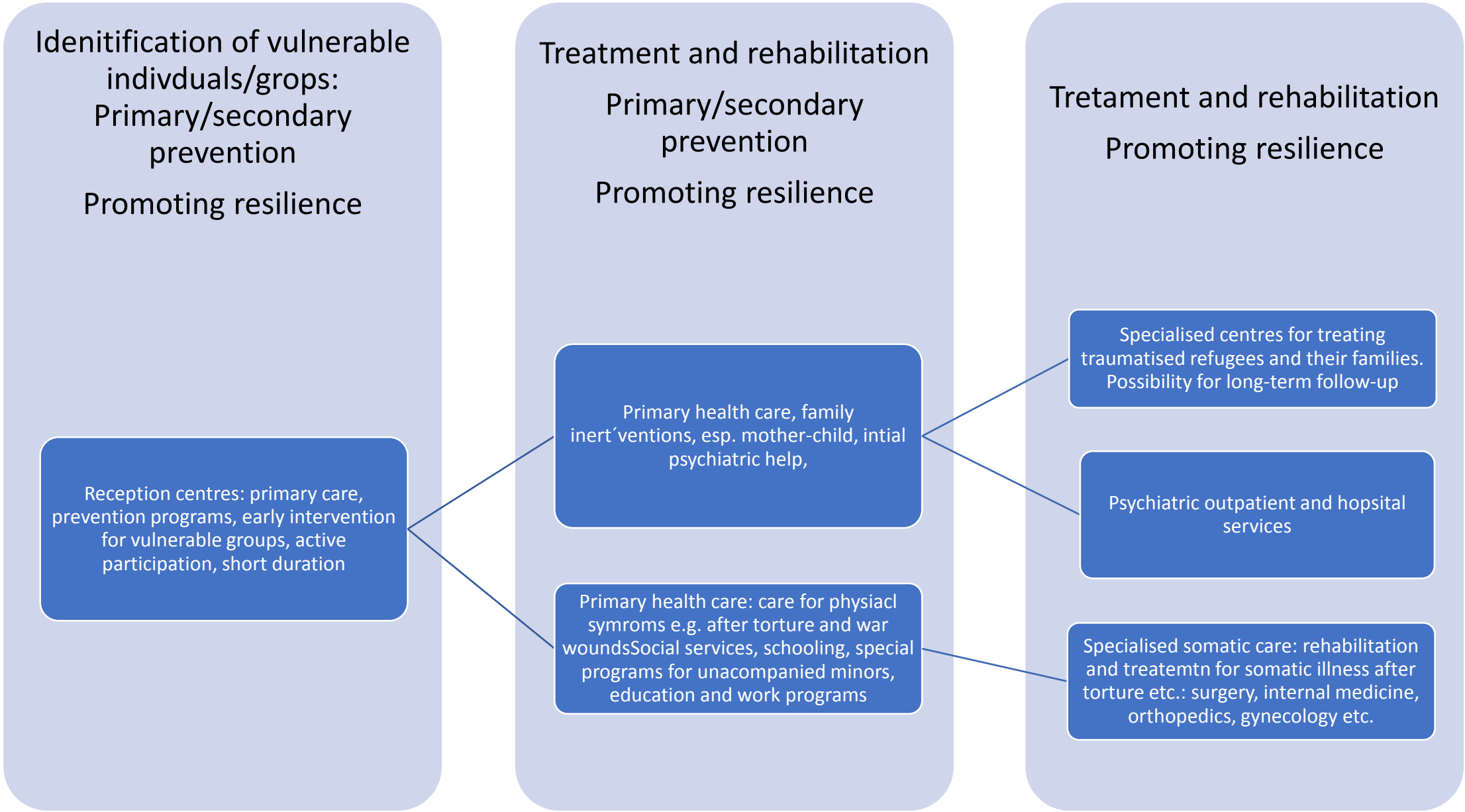
Who are they?

Traumatised refugees are a heterogeneous group:

a. Different symptoms and personality characteristics (syphilis of psychiatry)
b. Many different diagnoses: PTSD, Eating disorders, Personality disorders, dissociative disorders, depression, anxiety disorders etc.
c. Traumatisation happens at different developmental stages – consequences for symptoms and problems

d. Additional problems.

- Poverty
- Broken families
- Somatic illness
- Acculturation stress


Idenitification of vulnerable indivduals/grops: Primary/secondary prevention
Promoting resilience
Reception centres: primary care, prevention programs, early intervention for vulnerable groups, active participation, short duration
Treatment and rehabilitation
Primary/secondary prevention
Promoting resilience
Primary health care, family inert´ventions, esp. mother-child, intial psychiatric help,
Primary health care: care for physiacl symroms e.g. after torture and war woundsSocial services, schooling, special programs for unacompanied minors, education and work programs
Tretament and rehabilitation
Promoting resilience
Specialised centres for treating traumatised refugees and their families. Possibility for long-term follow-up
Psychiatric outpatient and hopsital services
Specialised somatic care: rehabilitation and treatemtn for somatic illness after torture etc.: surgery, internal medicine, orthopedics, gynecology etc.

An integrated, sequential response to refugees' mental health problems should be resilience oriented, as continuous as possible and geared towards longstanding principles of social medicine: early detection, primary, secondary and tertiary prevention

Interventions:

Family oriented, Long-term, Psychotherapy

Organisation

Need for specialised centres with competence in transcultural psychiatry/psychology and severe traumatisation

Early interventions: what do we know?

- Few studies: difficult to compare. Different foci: attachment, education, social skills, psychological functioning

- Studies assessing psychological symptoms consistently found reduction in symptomatology of the participants

- Example with long-term follow-up:
- Drožđek and colleagues (2013 a, b) found significant declines over course of the treatment for anxiety, depression and PTSD ($p < .001$). Post-treatment PTSD symptoms were even under the cutoff score whereas symptoms of anxiety and depression diminished, but remained above cutoff scores. Decreases in PTSD, anxiety, and depression symptoms remained up to 5 years (60 months) post-treatment before all symptoms began to worsen. Nevertheless, 7 years (89 months) post-treatment, all symptoms were at lower levels than at baseline

The need for individualised and coordinated treatment

- Traumatised patient have as a rule complex conditions with multi-layered aetiology and often difficult social situation
- Families are affected and there is high frequency of transgenerational problems: this has often resulted in insufficient early care taking for the patient and sometime childhood traumatisation

Aims of treatment and rehabilitation

- Personality functions: e.g. Self esteem
- Relational functions: self-object relations
- Specific symptomatology: e.g. posttraumatic: avoidance, re-experiencing. Anxiety, depression, somatisation, psychotic symptoms etc.
- Family relations: children, parents, extended family
- Social problems
- Somatic problems

The therapeutic setting

- A safe place where psychic material may be projected: a projective space
- Safety:
  - regular times
  - stability
  - therapeutic attitude: containing vs exploring

Conclusion

Massive traumatisation creates destabilisation of the basic structures of human relationships:

- on the level of intimate relationships where intrapsychic and interpersonal functions concern regulations of emotions, primary care, basic identity and so forth

- on the level of the individual relations to the group where identity and developmental task are negotiated

- on the cultural or discourse level, where different discourses are established that give meaning to and stabilises relations and developments on the individual and group levels.