

# EXPERIENCES OF TORTURE AND TRAUMA:

PSYCHOLOGICAL AND PHYSICAL EFFECTS,  
MANAGEMENT AND PSYCHOLOGICAL APPROACHES

AUSTRALIAN  
**REFUGEE  
HEALTH**  
PRACTICE GUIDE



Primary care for people from refugee backgrounds

# ABOUT THE AUSTRALIAN REFUGEE HEALTH PRACTICE GUIDE

The Australian Refugee Health Practice Guide aims to support doctors, nurses and other primary care providers to deliver comprehensive on-arrival and ongoing care for people from refugee backgrounds, including people seeking asylum.

The Australian Refugee Health Practice Guide comprises the following resources:

- Desktop guide
- Booklets on key topics
- Website: [refugeehealthguide.org.au](http://refugeehealthguide.org.au).

The Australian Refugee Health Practice Guide is an updated version of *Promoting Refugee Health: A guide for doctors and other healthcare providers caring for people from refugee backgrounds* (2012) and *Caring for patients in general practice: a desktop guide* (2012) and their previous editions.

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# EXPERIENCES OF TORTURE AND TRAUMA: PSYCHOLOGICAL AND PHYSICAL EFFECTS, MANAGEMENT AND PSYCHOLOGICAL APPROACHES

Knowledge about torture or other traumatic events and its physical and psychological effects on people from refugee backgrounds, including people seeking asylum, is important for several reasons:

- Such information is integral to assessment and diagnosis, and planning treatment and follow-up.
- A person's history of torture or other traumatic events may have an impact on a health professional's capacity to elicit accurate information for assessment, diagnosis, and follow-up care and treatment.
- Special care needs to be taken, as a health consultation may be a source of anxiety for a person who is traumatised.
- Psychological recovery is assisted by attention to a person's particular needs, referrals for counselling and other forms of specialised care.
- Where suitable, a health practitioner can provide direct psychological support, counselling and other treatment.

## EXPOSURE TO TRAUMATIC EVENTS

People from refugee backgrounds will almost certainly have been exposed to traumatic events. These may have included:<sup>1-3</sup>

- threats to their own lives or those of their family or friends
- death squads
- witnessing of mass murder and other cruelties inflicted on family or other people
- disappearances of family members and friends
- perilous flight or escape
- separation from family members
- forced marches
- extreme deprivation: poverty, unsanitary conditions, lack of access to health care
- persistent and long-term political repression, deprivation of human rights and harassment
- removal of shelter, forced displacement from their homes
- refugee camp experiences involving prolonged squalor, malnutrition and a lack of personal protection
- privation of personal space with consequent disruption to personal and intimate relationships
- interrupted or lack of education.

Reported prevalence of torture and war-related potentially traumatic experiences varies and it is difficult to generalise across groups. A 2016 systematic review reported that prevalence of torture among participants from refugee backgrounds ranged between 1–76% (median 27%).<sup>2</sup>

The United Nations High Commissioner for Refugees (UNHCR) estimates that 80% of refugee women have experienced some kind of sexual abuse or torture. The high incidence of rape of East African women refugees is now well documented,<sup>4-6</sup> as is the systematic use of rape by the Burmese military.<sup>7,8</sup>

Exposure to torture or other traumatic events is not confined to adults. Many children from refugee backgrounds have witnessed horrific events and have suffered the effects of dislocation and deprivation. In some regimes, children have been the specific targets of torture.<sup>9,10</sup>

The word 'torture' is usually associated with the detention and brutal abuse of the individual. However, torture is also a strategy used by oppressive regimes and groups to destroy communities. Many different methods have been used, and they continue to be refined in ways that maximise terror.<sup>11</sup>

Some common forms of torture are:<sup>12,13</sup>

- severe beatings
- falanga: prolonged and severe beating of the soles of the feet
- deprivation of sleep and sensory stimulation
- misuse of psychotropic drugs
- electric shock: electrodes are placed on the body's sensitive areas such as the tongue, gums, fingertips, genitals and nipples
- burning with cigarettes, hot irons, burning rubber, welding torches, corrosive liquids
- mutilation: extraction of hair or nails, cutting with knives, amputation of body parts, insertion of objects under nails
- suspension: hanging by arms or legs for extended periods of time
- isolation and solitary detention
- sexual violence and rape of women, men and children: includes molestation, stripping, touching, gang rape, rape by animals, insertion of objects into the vagina or rectum
- starvation and exposure to heat and cold

- sham executions
- water or submarine torture: the head of the victim is forced under water usually containing faeces or urine until near suffocation; a break is then allowed and the process is repeated many times
- being forced to maintain abnormal body positions for long periods
- forcing victims to witness the torture of others, including loved ones.

As for other traumatic events, torture rarely occurs as a single event. It is important to consider that the traumatic nature of a horrific event lies in its meaning for individuals, families and communities. Understanding the helplessness, isolation, humiliation and degradation caused by torture is as important as knowledge of techniques used to inflict torture.

### **PHYSICAL EFFECTS OF TORTURE AND TRAUMA**

The physical effects of torture are as varied as the methods of torture practised and are too numerous to document here. References in this guide provide more detailed information for health practitioners on physical effects and appropriate management.

Some common effects may include:

- brain damage
- chronic pain and poor mobility (can be due to fibromyalgia syndrome)
- missing teeth
- impaired hearing (which may result from beating or electrical torture)
- difficulties in walking (can result from falanga)
- bronchitis (can result from submarine torture)
- mutilation of body parts
- scars and disfigurement
- sexual and gynaecological dysfunction – pain from the testes, anal itching, fissures, fistulas and haemorrhoids, damage to cervix and uterus and other internal injuries and sexually transmitted infections.

Many survivors do not have enduring physical effects but the lack of visible signs should not be taken to mean that physical torture has not occurred. Some forms of torture leave few visible signs.<sup>14</sup>

### **PSYCHOLOGICAL EFFECTS OF TORTURE AND TRAUMA**

Most people from refugee backgrounds in Australia will not have experienced one single traumatic event, but rather have been exposed to a prolonged climate of political and civil repression, armed conflict and dislocation. The loss of loved ones in violent circumstances, the prohibition of cultural practices, prolonged deprivation of human rights and dislocation from one's community are commonly present.

There is now a large body of evidence demonstrating that people who are exposed to horrific, life-threatening events may experience psychological symptoms long after the event has taken place.<sup>15,16</sup> One constellation of symptoms, described in the *Diagnostic and Statistical Manual* (DSM 5) as post-traumatic stress disorder (PTSD),<sup>17</sup> is exhibited by survivors of torture or other traumatic events. Depressive disorders and anxiety disorders are also common.

Prevalence rates vary enormously between studies. Turrini et al. (2017) identified prevalence rates for PTSD of between 0–86%, rates of depression of between 2–100% and rates of anxiety between 4–90%.<sup>18</sup> See Turrini et al. (2017) for further details.<sup>18</sup>

It is not uncommon for survivors of torture or other traumatic events to somatise their psychological stress, with patterns of somatisation varying among cultural groups.

People from refugee backgrounds also experience the psychological problems of any population. This needs to be considered in any assessment process.

## Key symptomatic features of post-traumatic stress disorder

The symptom clusters described below are those that form the diagnostic criteria for PTSD according to DSM 5. The fourth symptom cluster is new to the diagnosis and, along with existing criteria, is arguably considered to capture characteristics of complex trauma.<sup>19</sup>

1. The traumatic event is persistently re-experienced: recurrent and intrusive recollections of traumatic event, recurrent distressing dreams, acting or feeling as if the traumatic event is recurring, intense distress in response to reminders, physiological reactivity to cues reminiscent of event.
2. Persistent avoidance of stimuli associated with the traumatic event, including avoidance of external reminders.
3. Persistent symptoms of increased arousal and reactivity: difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance, exaggerated startle response.
4. Negative alterations in cognitions and mood associated with the traumatic event, including negative beliefs about oneself and the world, self-blame and blaming of others, persistent negative emotional state, feelings of detachment, loss of interest in significant activities.

A full list of diagnostic criteria can be found at National Center for PTSD: [www.ptsd.va.gov/professional/ptsd-overview/dsm5\\_criteria\\_ptsd.asp](http://www.ptsd.va.gov/professional/ptsd-overview/dsm5_criteria_ptsd.asp).

For more information about mental health effects see Department of Mental Health and Substance Dependence, World Health Organization (WHO) (2003) *Mental Health in Emergencies: Mental and Social Aspects of Health of Populations Exposed to Extreme Stressors*, WHO, Geneva: [http://www.who.int/mental\\_health/emergencies/MSDMER03\\_01/en](http://www.who.int/mental_health/emergencies/MSDMER03_01/en).

Psychological effects go beyond the symptomatic. The psychological effects of torture or other traumatic events can be far more pervasive than those captured by diagnostic categories.<sup>1,19,20</sup>

Grief is the normal response to loss and is not considered a mental health problem. Nevertheless, grief can affect everyday functioning to a debilitating extent and needs to be considered in assessment and treatment planning.

A consideration of the following highlights the far-reaching effects of the response to torture or other traumatic events:

- Ability to carry out everyday tasks and attend to basic needs can be seriously impaired by feelings of powerlessness and lack of connection to others.
- Learning ability, which is crucial to adjustment in a new country, is seriously disrupted by poor concentration, memory impairment and sleep disturbance.
- Pain, whether caused by injuries or psychosomatic in nature, can be debilitating.
- Relationships are affected by distrust or loss of faith in people.
- Survivor guilt and guilt about choices that had to be made can prevent people from enjoying life, and they may expiate guilt through self-destructive behaviour.
- Anger and aggressive behaviour can result from low frustration tolerance as a result of stress and lack of sleep, as a protest against loss, as a response to injustices, and as a reaction to shame and guilt.

It is important to emphasise that there is a wide range of reactions to traumatic events. Whereas, for some, the psychological effects can persist over a lifetime and be debilitating, for other people from refugee backgrounds, adverse effects may not impact on their daily functioning. Others may overcome such effects with family and community support, favourable social and economic circumstances, and through their personal resources.

The key symptoms, signs and behavioural changes that may be exhibited by survivors of torture or other traumatic events are outlined in Table 1.

**Table 1: Torture or other traumatic events: key psychological effects**

KEY PSYCHOLOGICAL EFFECTS OF TORTURE OR OTHER TRAUMATIC EVENTS	MANIFESTATIONS <i>Italicised symptoms and signs are included in diagnostic category post-traumatic stress disorder (PTSD) in DSM 5.</i>
Anxiety and helplessness	<p>Panic attacks, pain, psychosomatic symptoms, startle reaction</p> <p><i>Poor concentration and memory, confusion, apprehension, hypervigilance, excessive worrying, anticipating the worst, intrusive memories of traumatic events, over-reaction/phobic perception of stimuli reminiscent of the traumatic events, flashbacks, nightmares, sleep disturbance, constricted receptivity to information, dissociation</i></p> <p>Avoidance and escape behaviour of potentially fear evoking situations, passivity, withdrawal, detachment from others, impulsive behaviour, aggressive behaviour</p> <p>Poor sense of agency or internal locus of control</p>
Loss	<p>Grief reaction – numbness, denial, yearning, and preoccupation with loss, emptiness, apathy and despair, anger, risk-taking behaviours</p> <p><i>Changes to relationships – dependency, overly self-sufficient, guardedness, suspicion, withdrawal, fear of renewed loss, fear of intimacy, fear of tainting others with death</i></p>
	<p><i>Depression – pessimism, hopelessness, loss of interest, lack of energy, sleep disturbance, appetite disturbance, self-degradation, self-blame, suicidal thoughts and plans</i></p>
Shattered core assumptions of self, others and life	<p>Loss of trust, sense of betrayal, ready idealisation and devaluation of others, loss of meaning of human existence, loss of future orientation</p> <p>Sensitivity to injustice, moral concepts affected, loss of continuity of self, loss of identity</p>
Guilt and shame	<p>Preoccupation with feelings of having failed to do something more to avert violence</p> <p>Use of fantasy to repair damage incurred during traumatic events</p> <p>Self-destructive behaviour to expiate shame</p> <p>Avoidance of others or aggression due to shame</p> <p>Experience of pleasure inhibited</p> <p>Self-derogatory comments, overly deferential behaviour</p>

## THE SETTLEMENT PROCESS AND ITS PSYCHOSOCIAL EFFECTS

People from refugee backgrounds, including people seeking asylum, may be exposed to further negative influences on their psychological health in the process of settling in a new country and may have limited access to those resources known to protect and promote their health, such as social support, employment and income.<sup>21,22</sup>

Serious threats can persist once people have arrived in Australia, particularly when family members remain exposed to danger in the country of origin or transit. Countries from which refugees come often continue to be war zones or areas of systematic persecution. Characteristically, other significant family members have been left behind. Anxiety about their welfare continues, and can maintain a sense of helplessness and powerlessness. Other people from refugee backgrounds who are from the same culture can provide support, but they can also remind the person of earlier trauma as well as represent an ongoing threat if they are perceived as being linked to perpetrators. An unfamiliar environment and the disruptive effect of symptoms, where they occur, can create anxiety about ever gaining control.<sup>23</sup>

Separation from family members, and dislocation from culture and tradition, can contribute to a sense of ongoing loss. Exposure to encounters with people who have little or no understanding of their backgrounds maintains distrust and isolation. On the other hand, the possibility of a new life can restore a sense of purpose and meaning, and can mitigate loss.

Guilt and shame can persist if new humiliations from racial prejudice occur. It is particularly important to consider the impact of guilt that results from having left relatives behind in precarious circumstances. Such guilt commonly manifests as difficulty eating and serious concerns for being able to save enough money to send to relatives and loved ones.<sup>24</sup>

In summary, there are a number of experiences and influences in the settlement environment that may exacerbate the effects of traumatic events. These can include:

- concern about the safety of friends and relatives facing ongoing conflict and deprivation in countries of origin
- ongoing loss of, or separation from, family and friends
- difficulties in accomplishing the tasks of settlement (e.g. learning a new language)
- lack of understanding, discrimination and hostility in the host environment
- minority status in the dominant Australian culture
- difficulties understanding income and other entitlements.

For individuals granted a protection visa in Australia (i.e. those who sought asylum via onshore processing), the effects of long-term detention and a protracted refugee determination process have a bearing on settlement outcomes.<sup>25,26</sup>

## PSYCHOLOGICAL IMPLICATIONS OF UNCERTAIN MIGRATION STATUS

People seeking asylum face particular stresses owing to their uncertain migration status, limitations on their access to benefits and, in some cases, experiences in detention centres. Recent studies indicate that this group is vulnerable to being retraumatised and has particularly poor physical and mental health.<sup>25,27-29</sup>

Typical stresses faced by people seeking asylum include:

- a limited capacity to plan for their future, develop social connections and feel a sense of belonging in Australia
- detention centre experiences that may compound a sense of injustice and loss of control, and can serve as reminders of persecutory practices in countries of origin
- perceptions that they are not being believed by the Australian Government and being treated in a punitive fashion
- feelings of powerlessness
- exposure to unsympathetic or hostile attitudes in the media and the wider community (a particular concern for people who have arrived by boat)
- no or uncertain access to family reunion provisions, resulting in limited access to the protective effects of family relationships and support and unresolved anxiety about the safety of loved ones still in dangerous circumstances overseas
- limitations on their access to the resources required for positive mental health (e.g. English language tuition, secure housing).

## THE IMPACT OF LONG-TERM DETENTION

*“Nothing stays in my memory. Nothing. I must try ten times, twenty times, and in the end, I forget it all again.”*

– Tertiary-qualified person from refugee background on long-term impact of detention.<sup>26</sup>

An Australian study on the long-term mental health problems faced by people from refugee backgrounds formerly detained in Australian detention centres demonstrates that prolonged detention has long-term deleterious effects on psychological functioning.<sup>25</sup> It was reported that participants suffered poor concentration and memory, an ongoing sense of insecurity and injustice, difficulties with relationships, profound changes to view of self and poor mental health. Depression, demoralisation and persistent anxiety were also very commonly reported.<sup>25(p2070)</sup>



Children and adolescents who have experienced immigration detention are at high risk of mental health problems. Australian immigration detention has a negative impact on child mental health, parenting and family functioning.<sup>25,29-32</sup>

It is important that people from refugee backgrounds are assisted to understand that, as with physical fitness, their mental fitness can be restored over time, given appropriate stimulation, time and opportunities for autonomous decision-making and problem-solving. Ensuring accessible pathways to service provision and supportive communities can optimise the potential for recovery.

### **APPROACHES TO ASSESSMENT OF TRAUMA**

*Should you ask if a person is a survivor of torture or other traumatic events?*

In practice, people from refugee backgrounds infrequently disclose traumatic experiences. However, an understanding of the extent to which the person has experienced violence or torture and witnessed horrific events is relevant to diagnosis, management, treatment and making referrals.

The extent to which you actively enquire about this information will depend on your professional role and whether you have established rapport with the person.

Awareness that the person has come from a 'refugee-like' situation will often be sufficient to tailor care to their needs, and specific details will not be required. Knowing the country of origin and country or countries of transit will give you considerable information about the experiences people from particular regions are likely to have endured.

The more information you have about a country and its political, economic and social conditions, the easier it is to 'read between the lines' and ask appropriate questions.

Some people will disclose readily, especially if they sense that the health professional is knowledgeable about their previous and current circumstances. Providing the opportunity to discuss traumatic experiences in a sensitive and supportive environment can have a powerful therapeutic effect. For some people it may be the first time someone has shown an interest in the experiences they have endured, and may bring a sense of great relief. Many survivors have been told by their torturers that no-one will ever believe them. Listening and responding sensitively to their experiences can help to reduce feelings of isolation and counter the destructive messages of the torturer.

The questions below are not intrusive and allow people to elaborate if they should wish. They can assist in establishing a history of traumatic events, displacement and significant losses. The questions can be used in addition to those that appear in the health assessment. See 'Refugee health assessment', Australian Refugee Health Practice Guide: <http://refugeehealthguide.org.au/refugee-health-assessment>.

### **Questions to establish a history of trauma and displacement**

- When did you leave your country?
- Were you forced to leave? What were the circumstances which led you to leave?
- Which countries have you lived in before coming to Australia? How were conditions in those countries? Have you spent time in a refugee camp? How were conditions in those countries?
- Terrible things have often happened to people who have been forced to leave their countries. I do not need to know the details about what you have been through, but have you had any terrible experiences that might be affecting you now?

### **A COMPREHENSIVE PSYCHOSOCIAL ASSESSMENT**

A comprehensive psychosocial assessment consists of several parts and includes:

- trauma history
- client information: country of origin, countries of transit, date and means of arrival, and preferred language
- family composition, genealogy, whereabouts of close family members, and quality of family functioning
- extent of pre-arrival exposure to extreme circumstances, human rights violations and violence (trauma history)
- current stresses associated with settlement
- social resources and support
- psychological health.

Table 2 summarises the reasons for eliciting information about these key areas.

**Table 2: Comprehensive psychosocial assessment: key areas and their rationale**

CONSIDER	MAY INDICATE
Country of origin	<ul style="list-style-type: none"> <li>• Nature and likely duration of exposure to hardship, privations, violence, conflict</li> <li>• Familiarity and previous availability of services</li> </ul>
Country (countries) of transit	<ul style="list-style-type: none"> <li>• As above</li> </ul>
Date of arrival	<ul style="list-style-type: none"> <li>• Likely settlement stresses</li> <li>• Need for orientation and information</li> <li>• Need for refugee health assessment</li> </ul>
Means of arrival	<ul style="list-style-type: none"> <li>• Traumatic journey to Australia</li> <li>• Asylum seeker and detention history</li> </ul>
Migration status	<ul style="list-style-type: none"> <li>• Benefits and entitlements available</li> <li>• Relevant services</li> <li>• Asylum seeker and detention history</li> <li>• Cultural backgrounds</li> </ul>
Preferred language	<ul style="list-style-type: none"> <li>• Interpreter requirements – dialect, ethnic group considerations</li> </ul>
Religion (preface with explanation for enquiry)	<ul style="list-style-type: none"> <li>• Beliefs and practices that need to be accommodated in care</li> </ul>
Family composition and family functioning	<ul style="list-style-type: none"> <li>• Family links</li> <li>• Missing family members</li> <li>• Stresses and psychological reactions can be anticipated regarding separation, death, concern for family members left behind</li> <li>• Emotional and practical support available</li> <li>• Need for referral for migration assistance, tracing services</li> <li>• Indicators to promote assessment of other family members</li> </ul>
Trauma history	<ul style="list-style-type: none"> <li>• Duration and severity of exposure to traumatic experiences and likelihood of psychological (and physical) effects</li> <li>• Importance of consideration of gender</li> <li>• Implications for family functioning and health of other family members</li> <li>• Need for referral(s)</li> <li>• Anxieties that may manifest in medical setting</li> </ul>
Current stresses	<ul style="list-style-type: none"> <li>• Need for settlement support and material needs – housing, economic concerns</li> <li>• Need for psychological support</li> <li>• Relevant referrals</li> </ul>
Social resources and support	<ul style="list-style-type: none"> <li>• Need for links to community/services</li> <li>• Need for one-to-one professional relationship</li> </ul>
Psychological health	<ul style="list-style-type: none"> <li>• Screening will indicate areas to follow up</li> <li>• Referrals for specialised assistance</li> <li>• Options for most appropriate response (including client’s interest in sharing psychological concerns)</li> </ul>

## MENTAL HEALTH/PSYCHOLOGICAL SCREENING

In the experience of torture and trauma services, the following areas to enquire about are usually acceptable, are not overly intrusive, and easily lead to further questions that can establish a diagnostic picture.

- Appetite (or weight change)
- Energy levels
- Daily activities
- Memory/concentration
- Sleep
- Mood/affect
- Bad memories
- Worries/too much thinking

### Resources

There are a number of screening tools available that have been designed for use in the primary healthcare setting. Their validity with different cultural groups varies. 'Practitioners are encouraged to take considerable care when administering any tool that was originally created and validated in English, to persons with a low level of English proficiency or limited experience of Australian culture. This caution applies equally when working with an interpreter to administer the English language version of a tool or a translated version.'<sup>33</sup>

There have been comprehensive reviews, commissioned by The Victorian Foundation for Survivors of Torture, of the Kessler Psychological Distress Scale (K10) and Strengths and Difficulties Questionnaire (SDQ) in cross-cultural settings.<sup>34,35</sup> These instruments have some validity as clinical screening tools but not across all populations and are not trauma sensitive.

Screening tools that have validity in cross-cultural settings include the Harvard Trauma Questionnaire Part 2 for trauma symptoms: <http://hprt-cambridge.org/screening/harvard-trauma-questionnaire> and Hopkins Symptoms Checklist for anxiety and depression: <http://hprt-cambridge.org/screening/hopkins-symptom-checklist>.

## THE IMPACT OF TORTURE AND TRAUMA ON THE CONSULTATION

Experiences of torture or other traumatic events may impact on the consultation in the following ways:

- Anxiety, distress as the result of intrusive memories (sometimes triggered in the course of consultation), memory loss, confusion and inability to concentrate may interfere with the client's ability to 'hear' and understand questions and instructions.
- Some survivors may have incurred brain damage in the course of torture, and this may interfere with memory and concentration.
- The doctor's surgery and instruments used in the conduct of procedures may remind a survivor of their torture experience and reinforce a sense of helplessness and powerlessness, or induce anxiety, panic or avoidance of further consultations.
- Doctors and other health professionals may unwittingly invoke fear, as health professionals have been actively involved in perpetrating torture in some persecutory regimes.<sup>36</sup>
- Confusion and memory loss may result in inconsistencies in information provided by the client.
- Survivors may be particularly sensitive to unfamiliar situations and may exhibit signs of hypervigilance and startle reactions.
- Feelings of shame may make being physically approached and touched a disturbing experience. This may be particularly the case for survivors of rape and other forms of sexual torture.
- Anger, hostility and mistrust, particularly of authority figures, are not uncommon responses, and may interfere with obtaining information required for diagnosis and treatment.

Approaches to conducting a consultation with a person experiencing a trauma reaction are outlined in 'Approach to consultation and management', Australian Refugee Health Practice Guide: <http://refugeehealthguide.org.au/consultation-and-management>.

## THE ROLE OF HEALTH PROFESSIONALS IN PROVIDING PSYCHOLOGICAL SUPPORT

Some survivors will require counselling and psychotherapy, which should be provided by a professional with appropriate qualifications. Nevertheless, there is the potential to provide psychological support in the context of the assessment or diagnostic interview conducted by many health professionals (e.g. doctors, nurses, refugee health nurses, maternal and child health nurses).

Therapeutic ingredients of an interview include:

- establishing rapport and outlining the purpose of the contact
- gathering information, including assessment, problem definition and needs identification
- determining outcomes and ascertaining how the client wishes to proceed
- exploring alternatives and personal dynamics
- transferring learning to everyday life.

When well conducted, an interview can provide significant psychological benefits.

- Demonstrating understanding and a genuine caring approach can help to reduce the person's sense of isolation and reduce stigma about having difficulties.
- Providing the opportunity to share unbearable knowledge can provide relief, as you provide a witness to the person's experiences; experiences they sometimes cannot believe themselves.
- Listening to the person's feelings and relating them to past and current stressors can enhance their understanding of difficulties, enhance the person's capacity to problem-solve and take control themselves.
- Looking for and identifying strengths raises self-esteem.
- Seeds can be planted about what is needed for recovery.
- You can begin to influence and challenge central beliefs that maintain the reaction to trauma (e.g. self-perceptions of external isolation, weakness, low self-value, culpability and failure or perceptions of oneself as permanently damaged).
- Clarity about your availability and the length of the consultation will improve control and predictability.
- Ambivalence about disclosing torture is normal, and reflects the person's struggle to remember or forget the past. Sometimes a disclosure may be followed by a cancellation to control the level of disclosure.

## RESPONDING TO A DISCLOSURE

- Acknowledge the person's experience and its associated pain (e.g. 'That's a terrible thing you have been through.'). This will help to validate the person's reaction.
- Remind the person that their reaction is a characteristic response to their circumstances. For example, it is common for survivors to blame themselves – seeing their reactions as a sign that they are abnormal or weak.
- Avoid false reassurance, but instilling hope is important. Indicate that, with time and appropriate support, improvement can be achieved.
- Expect that the person who has disclosed a painful event one day may be unwilling to talk about it in subsequent consultations. Rather than pushing them to do so, talk about other things that may be troubling them in the 'here and now'.
- Expect inconsistencies in the person's retelling of their trauma history.
- In completing the interview, explain to the person how you are able to assist them.

*“... there is an opportunity to build dignity with every human encounter. Given that it is the human hand that has perpetrated violations it is the human hand that has the power to heal wounds.”*

– Ida Kaplan and Kim Webster<sup>20</sup>

## MANAGEMENT OF PSYCHOLOGICAL EFFECTS OF TORTURE OR OTHER TRAUMATIC EVENTS

Approaches to the management of symptoms in people from refugee backgrounds are similar to the management of these conditions in the general population. There are several types of interventions with evidence for their efficacy. These are described in the following sections. In general, a combination of approaches, which includes the biological, psychological and psychosocial, is recommended as most effective.<sup>37,38</sup>

Cross-cultural responsiveness is integral to effective management.

It is important to:

- provide feedback to the person on your diagnosis or opinion of their condition
- explain what you understand to be the likely causes of the condition (psychological, social and physiological)
- outline treatment options so that the person is able to make a choice.

If the person presents with symptoms and behaviours such as suicidality or other high-risk behaviours, psychiatric management should be arranged in the usual way.

The *Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder* have been prepared by Phoenix Australia (formerly the Australian Centre for Posttraumatic Mental Health). The guidelines have been endorsed by the National Health and Medical Research Council (NHMRC). They include a section on refugees and asylum seekers. The guidelines are available at <http://phoenixaustralia.org/wp-content/uploads/2015/03/Phoenix-ASD-PTSD-Guidelines.pdf>.

## PHARMACOLOGICAL TREATMENT

Medication may be required to manage symptoms severe enough to interfere with the person's functioning. However, health professionals working extensively with torture and trauma survivors are of the view that optimum treatment involves non-pharmacological approaches either in addition to medication or as the primary treatment modality.

Accordingly, where a person presents with persistent symptoms believed to be related to trauma, consideration should be given to referring to a psychiatrist, psychologist or a counselling agency, such as the specialist service for survivors of torture and trauma in your state or territory. See 'State and territory referrals', Australian Refugee Health Practice Guide: <http://refugeehealthguide.org.au/referrals>.

There are several reviews of literature on the efficacy of drugs in trauma-related conditions for the general population.<sup>39</sup> The degree of improvement for different symptom groups varies across studies, as do reported side effects.

In the Cochrane Review of PTSD pharmacotherapy, a number of recommendations were made that apply to the general population.<sup>40</sup> The applicability of these recommendations to the refugee population is not reported.

An extensive review of pharmacotherapy conducted by the American Psychiatric Association included cross-cultural practice guidelines:

- Cultural values may affect the decision to take medication.
- Cultural values may affect adherence to medication regimes.
- There are differences in metabolism among ethnic groups, affecting therapeutic benefits and adverse effects of medication.
- There are a number of studies that specifically examine the efficacy of selective serotonin reuptake inhibitors (SSRIs), antidepressants and other psychotropic drugs in people from refugee backgrounds.<sup>41</sup>

## COMPLEMENTARY THERAPIES

Referral to a complementary therapist (e.g. massage therapist, naturopath) may also be useful, although the cost of these services needs to be considered. In some states and territories, torture and trauma service providers offer free services. Complementary approaches are acceptable to many people from refugee backgrounds, and can contribute to the management of many of the physical and psychological effects of torture or other traumatic events.

## PSYCHOLOGICAL INTERVENTIONS

Counselling and therapeutic methods that have been found to be effective in reducing symptoms with people from refugee backgrounds include cognitive behaviour therapy,<sup>42</sup> exposure therapy and the testimony method.<sup>43</sup>

Extensive reviews of the efficacy of psychological approaches to trauma-related conditions in the general population are available. As for pharmacotherapy, the degree of improvement varies, and some approaches, although found to be beneficial overall, can lead to a worsening of symptoms in some clients. In general, benefits have been shown for behaviour therapy and cognitive therapy. The number of studies conducted for other approaches is more limited, but benefits have also been shown for psychodynamic psychotherapy and group therapy.

Many strategies that promote recovery from torture and trauma-related problems are common to both counselling and other supportive approaches. They include:

- information provision and giving explanations for what you are doing
- setting realistic goals that enhance control and a sense of achievement
- gradual exposure to feared situations
- addressing settlement problems
- maximising predictability and safety
- linking with supportive groups and agencies
- strengthening personal resources
- a respectful and accepting attitude
- facilitating coping and problem-solving skills
- encouraging opportunities for sharing and the experience of pleasure.

What is distinctive about counselling is that the counsellor has the expertise to assess the specific causal determinants, both current and historical, of psychological problems in order to implement specific strategies to overcome maladaptive behaviour patterns, reduce symptoms and emotional distress, and build coping skills.

The quality of the relationship in counselling is critical to recovery.<sup>44</sup> The advantage of a longer-term professional relationship is that fears concerning close relationships, dependency and isolation, which are effects of torture or other traumatic events, can be dealt with. Lack of trust, anger and disappointment may emerge in the relationship and can be talked about.

Counselling often has to be integrated with advocacy and referral to other agencies because of multiple presenting needs.

Group counselling can be a very helpful approach for addressing problems of social isolation and grief, and symptoms of anxiety, depression and PTSD.<sup>45</sup>

## DISCUSSING COUNSELLING

Counselling requires a significant level of engagement and investment by clients themselves. Some people from refugee backgrounds may not want a counselling referral, fearing that talking about past experiences may make them worse. Further, those who have only recently arrived in Australia may be preoccupied with the immediate challenges of resettlement. People from refugee backgrounds may be unfamiliar with counselling, and its purposes may need to be explained. Survivors may not understand or recognise that their behavioural responses are the consequence of their traumatic experiences and may see the need for psychological help as the preserve of those with an identifiable mental illness, or they may interpret their responses as signs of weakness.

Counselling that focuses on the individual may be unacceptable in some cultures where greater emphasis is placed on whole families or communities working through a problem together.<sup>46</sup>

Those from countries where there has been medical involvement in torture, or from small refugee background communities, may fear that their confidentiality may be breached in the process of seeking psychological support.

Health professionals can play an important role in preparing people from refugee backgrounds for counselling by explaining its purposes in simple terms and in ways that normalise and destigmatise seeking help for psychological issues.

Consider the following approach:

*'Many people who have experienced terrible things have worries, fears and experiences such as nightmares which do not go away by themselves. Counsellors can help with such experiences so that they do not interfere with daily life so much. Many people feel better when they discuss their worries and how to deal with them, although at first it seems that it will make things worse.'*

Reassure the person that strict confidentiality is observed by counselling agencies.

If a person indicates that they are not interested in a referral at that time, offer them information for self-referral at a later date. Show acceptance of their decision and indicate your willingness to discuss the matter further.

### **Practice tips: Discussing counselling with clients**

If a person presenting with persistent symptoms has not disclosed a trauma history to you, try the following approach:

- Begin by saying what you have noticed by way of a problem. For example, 'You have mentioned that you have been crying a lot.'
- Ask the person if there is anything you can do to make things easier.
- Using some of the mental health/psychological screening questions outlined on page 09, explore the possibility that the person's symptoms are related to past trauma.
- Affirm that it is not unusual for people to feel the way they do, particularly if they have experienced hardships and violence before coming to Australia.
- Explain that there are services that deal with problems that have resulted from trauma due to war, civil violence and political oppression. This will enable you to ascertain their interest in a referral.

### **Practice tips: Making a referral for counselling**

- Before offering a referral, make sure that you have time to undertake the necessary follow-up (e.g. phone calls, follow-up consultation). It is important to offer only what you are able to deliver.
- Agree to inform the person of the outcome of the referral (e.g. whether they have been placed on a waiting list, and how and when they will be contacted).
- If a person indicates they do want a referral, explain that you could refer them, if they agree, or explain how they can refer themselves.
- If referring to a counselling agency, explain that there may be a waiting time.

## **Making a referral to a service for survivors of torture and trauma**

Specialist services for survivors of torture and trauma have been established in each Australian state and territory. These services provide a range of counselling and advocacy services, including family case work and natural therapies. Services are non-denominational, politically neutral and non-aligned, and are free and confidential. A waiting period may apply.

Your client may benefit from a referral to the torture and trauma service in your state or territory if they:

- are believed to have a history of torture or other traumatic events prior to arrival in Australia
- are experiencing psychological and emotional distress believed to be related to torture or other traumatic events
- wish to seek assistance from a torture and trauma service and consent to a referral being arranged.

For referral to a torture and trauma service in your state or territory visit the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) website: [fasstt.org.au](http://fasstt.org.au).

A consultation service to other health and settlement providers working with survivors may also be available.

### **Which service should I refer to?**

This will depend on:

- the person's preferences, once aware of their choices
- the person's understanding of and motivation to engage in counselling
- your assessment of the extent to which settlement issues feature in the person's psychological state (specialist torture and trauma agencies generally adopt an approach that combines counselling with assistance in addressing issues such as accessing housing, employment and education)
- whether the person requires urgent attention
- your assessment of the extent to which the person's symptoms require specialist pharmacological management. For some people referral to both a psychiatrist and a counselling and support agency may be indicated.

If you are unsure about the most appropriate referral, consider consulting a counsellor at the service for survivors of torture and trauma in your state or territory. See Forum of Australian Services for Survivors of Torture and Trauma: [fasstt.org.au](http://fasstt.org.au).

## **CHRONIC PAIN AND PSYCHOSOMATIC DISORDERS**

Psychosomatic disorders and chronic pain in people from refugee backgrounds, including people seeking asylum, are very common presentations in primary care. Psychosomatic presentations may not simply encompass pain but also other unusual symptoms. Often long periods (even years) may elapse between the trauma and when the person is seen by the healthcare practitioner. Physical injuries due to torture or other traumatic events are frequently interrelated with physical deprivation, language and cultural barriers to accessing health services, as well as resettlement difficulties – the interaction of which creates complex management issues.

With any person with longstanding pain, establish whether this may be due to previous inadequate assessment and treatment. Appropriate management may then yield good results despite the time delay. However, in many cases a more holistic approach is required.

*"I feel sick and they said there's nothing that they've found in my body."*

*"There is a reason why my head hurts, there's a reason why my back hurts but if they don't detect anything there has to be a solution."*

### **Assisting a person who appears to have somatised their psychological distress**

Consider the following approaches:

- Take complaints seriously and conduct appropriate investigations. Often people from refugee backgrounds fear that their experiences have caused irreparable harm. Thorough investigation can often serve as reassurance when nothing is physically wrong.
- Help the person to make connections between body and mind. The example of the body's physiological response to extreme danger can be useful to explain this.
- Avoid dismissing somatic complaints or giving reassurances that they will 'go away with time'. The person may interpret this as trivialising their concerns.
- If somatic symptoms persist, consider a referral for counselling and support. This may involve establishing the person's history of torture or other traumatic events if they have not already disclosed this to you.

## THE IMPACT OF THE REFUGEE EXPERIENCE ON FAMILIES

Previous exposure to traumatic experiences, accompanied by the stresses associated with resettlement, can contribute to high levels of family tension and breakdown.

The refugee experience can impact on families in the following ways:

- Roles within the family are often dramatically altered.
- Traumatized parents can have their capacity for emotionally supporting and protecting their children reduced.
- Parents may fear 'losing' their children to the new culture.
- Extreme disturbances in parents can become new trauma for family members.
- Financial difficulties and generational conflict can produce extra burdens on family members.
- Guilt associated with leaving family behind can disrupt emotional recovery for all family members.
- Considerable pressure can fall on children to be successful with little accommodation of their settlement stresses.

## THE IMPACT OF TRAUMA ON CHILDREN AND YOUNG PEOPLE

Children and young people from refugee backgrounds will have experienced a wide range of stressors and traumatic events prior to their arrival in Australia. They may include:

- coming under combat fire and bombing
- destruction of homes and schools
- perilous journeys
- separation from care givers
- sudden disappearances of family members or friends
- loss of family members in violent circumstances
- threat of harm to family members and friends
- refugee camps
- witnessing violence and death
- forced conscription
- physical injury
- arrest, detention or torture
- sexual assault.

Stressors can continue once children and young people arrive in Australia. As well as changes in their families and family relationships, on arrival in a new country they are required to learn a new language, adapt to a new set of cultural norms, and orient themselves to a new and unfamiliar school system.

Unaccompanied young people face additional stresses, and can be at risk of destitution if unsupported in Australia.

There is a considerable body of evidence to show that children often experience a psychological reaction to trauma not dissimilar to that found in adults.<sup>47-49</sup>

There may also be important and far-reaching impacts on social, cognitive and neurobiological development affecting the early formation of the capacity for attachment, sense of self, affect modulation, learning capacities and development of the child's social relationships.

This may manifest itself in children in a number of ways, including:<sup>50</sup>

- withdrawal, lack of interest and lethargy
- aggression, anger and poor temper control
- tension and irritability
- poor concentration
- repetitive thoughts about traumatic events
- poor appetite, overeating, breathing difficulties, pains and dizziness
- regressions (e.g. return to bedwetting)
- nightmares and disturbed sleep
- crying
- nervousness, fearfulness and proneness to startle
- poor relationships with other children and adults
- lack of trust in adults
- clinging, school refusal
- hyperactivity and hyper-alertness.

As with adults, some children and young people will experience few or no adverse effects in response to stressors and traumatic events. Some of the factors that have been found to be protective in minimising psychological distress are social support, peer support and parental wellbeing.<sup>51,52</sup>



Families play an important role in helping their children meet the developmental tasks of childhood and adolescence and in protecting them from the effects of adverse life events. However, the refugee experience can affect the capacity of families to carry out this role, particularly when parents or care givers experience mental health difficulties as a result of their experiences of torture or other traumatic events. The feeling of guilt associated with being unable to protect children may serve as a barrier to acknowledging adverse effects.

### **Assisting a parent whose child is experiencing a trauma reaction**

Healthcare providers working with child survivors of trauma advise parents to:

- support stability and continuity of primary attachments with significant people
- encourage children to express their emotions with reassurance when they are upset
- ask children questions to find out what they are thinking and imagining
- reassure children about the future
- ask children questions about their daily lives that are important to them
- encourage children to be children, to play, explore and laugh
- maintain routine and predictability, as this helps children to believe that life is secure and predictable
- minimise change and, when it is necessary, take time to prepare children for change
- give children positive encouragement about how they are going
- avoid making time together as the way to correct any bad habits
- avoid over-reacting to difficult behaviour, as this may be children's way of letting their tension out
- give children time to adjust to a new situation
- make time for just being together.

### **Interventions for children and young people from refugee backgrounds**

Interventions can occur in a range of settings. The medical setting can be advantageous because it is less associated with the stigma of acknowledging emotional difficulties than a specialist mental health service. Schools can be an optimal

setting because stigma is reduced, involvement of parents can be facilitated and the school itself provides a range of opportunities for intervention.

Reviews on the effectiveness of interventions for children and young people from refugee backgrounds highlight the importance of employing a diversity of modalities: individual, family and group therapy, preventive interventions and school-based interventions.

This is an ongoing body of work conducted by Foundation House. Updates will be made available at <http://www.foundationhouse.org.au/our-service-model>.

### **Recognising PTSD and other reactions to traumatic events in children**

In the primary care setting, it is important to recognise children who may have post-traumatic stress disorder<sup>53</sup> (PTSD) or other trauma-based emotional and behavioural difficulties.

- Consideration should be given to asking the child and/or parents about sleep disturbance or significant changes in sleeping patterns.
- Questioning the children as well as parents or guardians will improve the recognition of trauma-based effects.
- Along with the screening questions for adults on page 09, you may also like to ask if there have been any sudden changes in the child's behaviour, aggression and/or withdrawal.

A comprehensive set of resources for clinicians working with children and young people from refugee backgrounds can be found at the National Child Traumatic Stress Network (NCTSN): <https://www.nctsn.org>.

- Refugee trauma: <https://www.nctsn.org/what-is-child-trauma/trauma-types/refugee-trauma>
- Screening and assessment: <https://www.nctsn.org/what-is-child-trauma/trauma-types/refugee-trauma/screening-and-assessment>
- Interventions: <https://www.nctsn.org/what-is-child-trauma/trauma-types/refugee-trauma/interventions>

## FAMILY VIOLENCE AND WOMEN

Immigrant women subject to family violence are a vulnerable group who may have difficulties seeking assistance. This is particularly the case for women from refugee backgrounds, as:

- they may lack family and community support
- if they are experiencing a trauma reaction they may fear being alone – for some, an unsatisfactory union may be perceived to be better than having no adult relationship
- their tolerance of their partner's violent behaviour may be heightened by the knowledge of the trauma to which he has been subject
- they may be unaware of Australian laws prohibiting family violence
- inability to speak English and a lack of knowledge of alternative housing, income and support services can make it difficult for a woman from a refugee background to leave a violent relationship
- they may encounter difficulties in accessing legal and support services owing to language and cultural differences
- they may have fears that their confidentiality may be breached by support services
- many women from refugee backgrounds come from traditional societies in which there are strong cultural prohibitions against separation and divorce, and the pressure on women to 'keep the family together' may also be particularly strong given the degree of trauma and dislocation to which families have been subject
- women in families from refugee backgrounds may be wary about involving the police and legal personnel in family matters given their experiences of legal and law enforcement systems in their countries of origin.<sup>54</sup>

Working with families from refugee backgrounds in which domestic violence is occurring may be challenging, particularly if the perpetrator has himself been subject to torture or other traumatic events.

### Refugee families and family violence

If there are signs that violence is occurring, ask the woman if this is the case (when her husband or partner is not present). Use a professional interpreter if possible.

Provide information on support options and legal rights, including the fact that violence between intimate partners is illegal.

Take steps to ensure the woman's safety. If she wishes to leave, support her and give her the telephone numbers of services able to assist her to do so.

If she chooses to remain in the home, respect her decision. Support her by giving her telephone numbers she can contact in the event of a crisis.

The temptation may be to rationalise the perpetrator's behaviour in light of his own experience of torture. However, this does not justify his behaviour nor minimise the danger to his partner and children.

Consider consulting with a family violence outreach worker on how you might best assist your client.

Consider consultation with local family support services.

For information on services for women affected by family violence see 'State and territory referrals', Australian Refugee Health Practice Guide: <http://refugeehealthguide.org.au/referrals> or contact your state or territory health authority.

## SEXUAL ASSAULT

Rape and other forms of sexual torture are commonly perpetrated by persecutory regimes against women and men. Women who have been subject to rape face particular concerns as they may suffer rejection by partners, other family members and even their communities. The same guidelines apply in dealing with a disclosure of rape as those described for other forms of torture. Also consider consultation with, or referral to, a Centre Against Sexual Assault, Centre Against Sexual Violence or Sexual Assault Resource Centre, or contact your state or territory health authority for details. A counsellor/advocate can be reached at these centres usually on a 24-hour basis.

Where sexual assault is a concern, general practitioners (GPs) should ask the person if they would prefer a referral to a doctor of a particular gender.

The availability of testing for sexually transmitted infections (STIs) may be raised with the person when and if appropriate. When deciding whether to encourage women from refugee backgrounds to undertake STI screening, take into account the invasive nature of some of these tests and the anxiety that may be associated with them. Also be aware that tests for some STIs may have been undertaken as part of pre-arrival or on-arrival screening for some people. See 'Refugee health assessment', Australian Refugee Health Practice Guide: <http://refugeehealthguide.org.au/refugee-health-assessment>.

Whatever your management plan, it is important to be watchful for clinical symptoms and signs. Chlamydia, often asymptomatic, can be detected by a urine test, which has the advantage of being non-invasive.

Sensitivity is similarly required in offering pap tests and other gynaecological procedures to women from refugee backgrounds.

Further information on women's health and sexually transmissible infections is available in the *Recommendations for comprehensive post-arrival health assessment for people from refugee-like backgrounds*<sup>55</sup>, accessible on the Australian Refugee Health Practice Guide website: <http://refugeehealthguide.org.au/womens-health>. <http://refugeehealthguide.org.au/sexually-transmissible-infections-stis>.

## STAYING EFFECTIVE

Providing care to a highly traumatised person can evoke emotional feelings in the health practitioner, which may influence the provision of appropriate care as well as lead to personal stress.

Health practitioners and others working with people from refugee backgrounds have found that they are better able to deal with this stress if they have the opportunity to talk about their work with others.

Ways of achieving this include:

- accessing formal professional debriefing (contact details can be obtained through your professional association, union or Primary Health Network)
- arranging formal times for case discussion or review
- arranging regular meetings with colleagues whose client profile is similar to your own
- developing a reciprocal arrangement with a colleague whereby you are available to each other for case discussion or 'debriefing' when required
- undertaking further training in refugee health and wellbeing.

**Practice tip:** Patients may disclose experiences of torture or other traumatic events during discussion that may seem safe and routine to health practitioners, for example while asking questions about family composition. As a result of listening to the traumatic stories of their patients, health practitioners may experience vicarious trauma. See the RACGP White Book – 'The importance of self-care for practical advice about managing vicarious trauma': <https://www.racgp.org.au/your-practice/guidelines/whitebook/chapter-14-the-doctor-and-the-importance-of-self-care>.

## Professional development and capacity building

Given the changing nature of Australia's humanitarian response and emerging research in this area, regular skill development is recommended for health professionals who work with survivors of torture or other traumatic events.

Information regarding professional development in your state or territory is available from your local torture and trauma service. For contact information visit: the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT): [www.fasstt.org.au](http://www.fasstt.org.au).

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