THE MENTAL HEALTH OF ASYLUM SEEKERS: TRAUMA, POST-MIGRATION STRESS, TREATMENT AND CLINICAL OUTCOMES

Zachary Steel

St John of God Chair of Trauma and Mental Health, School of Psychiatry, University New South Wales, St John of God Health Care, Richmond Hospital

Waleed M. Sweileh
Fig. 1 Growth of medicine-related publications on refugees, asylum seekers, and internally displaced people (2000 – 2015)
Fig. 2 Geographical distributions of medicine – related publications on refugees
Table 3 List of active institutions/organizations that had published at least 20 articles on refugees, asylum seekers and internally displace people

<table>
<thead>
<tr>
<th>SCR</th>
<th>Affiliation</th>
<th>SCR</th>
<th>Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>Centers for Disease Control and Prevention</td>
<td>73 (2.9)</td>
<td>USA</td>
</tr>
<tr>
<td>2&lt;sup&gt;nd&lt;/sup&gt;</td>
<td>University of New South Wales UNSW Australia</td>
<td>66 (2.6)</td>
<td>Australia</td>
</tr>
<tr>
<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
<td>University of Melbourne</td>
<td>47 (1.9)</td>
<td>Australia</td>
</tr>
<tr>
<td>4&lt;sup&gt;th&lt;/sup&gt;</td>
<td>Monash University</td>
<td>42 (1.7)</td>
<td>Australia</td>
</tr>
<tr>
<td>4&lt;sup&gt;th&lt;/sup&gt;</td>
<td>London School of Hygiene &amp; Tropical Medicine</td>
<td>42 (1.7)</td>
<td>UK</td>
</tr>
<tr>
<td>6&lt;sup&gt;th&lt;/sup&gt;</td>
<td>University of Toronto</td>
<td>41 (1.6)</td>
<td>Canada</td>
</tr>
<tr>
<td>7&lt;sup&gt;th&lt;/sup&gt;</td>
<td>University of Minnesota Twin Cities</td>
<td>38 (1.5)</td>
<td>USA</td>
</tr>
<tr>
<td>7&lt;sup&gt;th&lt;/sup&gt;</td>
<td>Massachusetts General Hospital</td>
<td>38 (1.5)</td>
<td>USA</td>
</tr>
<tr>
<td>9&lt;sup&gt;th&lt;/sup&gt;</td>
<td>McGill University</td>
<td>37 (1.5)</td>
<td>Canada</td>
</tr>
<tr>
<td>10&lt;sup&gt;th&lt;/sup&gt;</td>
<td>United Nations High Commissioner for Refugees</td>
<td>36 (1.4)</td>
<td>UN</td>
</tr>
<tr>
<td>11&lt;sup&gt;th&lt;/sup&gt;</td>
<td>Johns Hopkins Bloomberg School of Public Health</td>
<td>32 (1.3)</td>
<td>USA</td>
</tr>
<tr>
<td>12&lt;sup&gt;th&lt;/sup&gt;</td>
<td>Boston University</td>
<td>29 (1.2)</td>
<td>USA</td>
</tr>
</tbody>
</table>

SCR Standard competition ranking. Equal countries were given the same ranking number, and then a gap is left in the ranking numbers. USA United States of America, UK United Kingdom, UN United Nations
Common mental disorders in asylum seekers and refugees: umbrella review of prevalence and intervention studies

Giulia Turrini*, Marianna Purgato, Francesca Ballette, Michela Nosè, Giovanni Ostuzzi and Corrado Barbui
Systematic reviews meeting inclusion criteria (n=27)

- Systematic reviews on the prevalence of common mental disorders in asylum seekers and refugees (n=13)
- Systematic reviews on the efficacy of mental health interventions in asylum seekers and refugees (n=14)
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Study name</th>
<th>Age</th>
<th>Proportion with mental health conditions (95% CI)</th>
<th>Point estimate and 95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANXIETY</td>
<td>Fazel et al., 2005</td>
<td>Adults</td>
<td>4% (3 to 6%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lindert et al., 2009</td>
<td>Mixed</td>
<td>40% (17 to 64%)</td>
<td></td>
</tr>
<tr>
<td>DEPRESSION</td>
<td>Fazel et al., 2005</td>
<td>Adults</td>
<td>5% (4 to 6%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bronstein and Montgomery, 2011</td>
<td>Children/adolescents</td>
<td>18% (7 to 28%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Steel et al., 2009</td>
<td>Adults</td>
<td>30.8% (26.3 to 35.6%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Slewa-Younan et al., 2015</td>
<td>Adults</td>
<td>43% (29 to 56%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lindert et al., 2009</td>
<td>Mixed</td>
<td>44% (27 to 62%)</td>
<td></td>
</tr>
<tr>
<td>PTSD</td>
<td>Fazel et al., 2005</td>
<td>Adults</td>
<td>9% (8 to 10%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Slewa-Younan et al., 2015</td>
<td>Adults</td>
<td>25% (14 to 35%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Steel et al., 2009</td>
<td>Adults</td>
<td>30.6% (26.3 to 35.2%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bronstein and Montgomery, 2011</td>
<td>Children/adolescents</td>
<td>36% (21 to 50%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lindert et al., 2009</td>
<td>Mixed</td>
<td>36% (23 to 49%)</td>
<td></td>
</tr>
</tbody>
</table>

**Fig. 2** Prevalence rates (% with 95% CI) as reported by systematic reviews calculating overall summary measures. *A 99% confidence interval was used by Fazel et al. [8]*
Association of Torture and Other Potentially Traumatic Events With Mental Health Outcomes Among Populations Exposed to Mass Conflict and Displacement
A Systematic Review and Meta-analysis

Zachary Steel, PhD, M Clin Psych
Tien Chey, MA App Stat
Derrick Silove, MD, FRANZCP
Claire Marnane, BSc
Richard A. Bryant, PhD, M Psychol
Mark van Ommeren, PhD

Context Uncertainties continue about the roles that methodological factors and key risk factors, particularly torture and other potentially traumatic events (PTEs), play in the variation of reported prevalence rates of posttraumatic stress disorder (PTSD) and depression across epidemiologic surveys among postconflict populations worldwide.

Objective To undertake a systematic review and meta-regression of the prevalence rates of PTSD and depression in the refugee and postconflict mental health field.

Data Sources An initial pool of 5904 articles, identified through MEDLINE, PsycINFO and PILOTS, of surveys involving refugee-conflict-affected populations, or both, pub-
Table 1. Postconflict PTSD Random-Effects ORs and Prevalence

<table>
<thead>
<tr>
<th></th>
<th>Sample Size</th>
<th>No. of Surveys</th>
<th>Intersurvey Variance, %</th>
<th>Adjusted Prevalence Estimates, % (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PTE adversity ratio</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.0-0.19</td>
<td>51 492</td>
<td>107</td>
<td>10.8</td>
<td></td>
</tr>
<tr>
<td>0.20-0.29</td>
<td>17 749</td>
<td>17</td>
<td></td>
<td>11.1</td>
</tr>
<tr>
<td>0.30-0.39</td>
<td>82 856</td>
<td>20</td>
<td></td>
<td>25.7 (13.5-43.5)</td>
</tr>
<tr>
<td>≥0.40</td>
<td>12 595</td>
<td>29</td>
<td></td>
<td>28.6 (16.1-45.6)</td>
</tr>
<tr>
<td></td>
<td>12 863</td>
<td>41</td>
<td></td>
<td>35.5 (20.8-53.5)</td>
</tr>
<tr>
<td><strong>Torture, %</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤19</td>
<td>37 945</td>
<td>77</td>
<td>23.6</td>
<td></td>
</tr>
<tr>
<td>20-39</td>
<td>17 752</td>
<td>28</td>
<td></td>
<td>17.6</td>
</tr>
<tr>
<td>≥40</td>
<td>12 254</td>
<td>25</td>
<td></td>
<td>29.8 (20.1-41.8)</td>
</tr>
<tr>
<td></td>
<td>79 369</td>
<td>24</td>
<td></td>
<td>46.2 (33.0-60.0)</td>
</tr>
<tr>
<td><strong>Political Terror Scale</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤4.0</td>
<td>49 915</td>
<td>107</td>
<td>3.5</td>
<td></td>
</tr>
<tr>
<td>4.1-5.0</td>
<td>20 506</td>
<td>47</td>
<td></td>
<td>28.1</td>
</tr>
<tr>
<td></td>
<td>29 409</td>
<td>60</td>
<td></td>
<td>38.5 (28.6-49.4)</td>
</tr>
<tr>
<td><strong>Time since conflict, y</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-1</td>
<td>62 923</td>
<td>141</td>
<td>10.0</td>
<td></td>
</tr>
<tr>
<td>2-3</td>
<td>26 323</td>
<td>49</td>
<td></td>
<td>39.9</td>
</tr>
<tr>
<td>4-5</td>
<td>53 825</td>
<td>18</td>
<td></td>
<td>22.1 (13.0-35.1)</td>
</tr>
<tr>
<td>≥6</td>
<td>9 181</td>
<td>29</td>
<td></td>
<td>27.0 (17.8-38.7)</td>
</tr>
<tr>
<td></td>
<td>22 037</td>
<td>45</td>
<td></td>
<td>22.3 (15.1-31.6)</td>
</tr>
</tbody>
</table>
Descriptive, inferential, functional outcome data on 9,025 torture survivors over six years in the United States

Member Centers of the National Consortium of Torture Treatment Programs (NCTTP)

TORTURE Volume 25, Number 2, 2015
<table>
<thead>
<tr>
<th>Psychiatric diagnoses for torture survivors&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Total N = 1,360&lt;sup&gt;a,b&lt;/sup&gt;</th>
<th>Asylum Seekers N = 686&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Refugees N = 285&lt;sup&gt;b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N / %</td>
<td>N / %</td>
<td>N / %</td>
</tr>
<tr>
<td>Any Posttraumatic Stress Disorder (PTSD)&lt;sup&gt;c,*&lt;/sup&gt;</td>
<td>938 / 69</td>
<td>502 / 73</td>
<td>181 / 64</td>
</tr>
<tr>
<td>PTSD only</td>
<td>409 / 30.1</td>
<td>245 / 35.7</td>
<td>101 / 35.4</td>
</tr>
<tr>
<td>Any Major Depressive Disorder (MDD)&lt;sup&gt;c,*&lt;/sup&gt;</td>
<td>713 / 52.4</td>
<td>363 / 53</td>
<td>102 / 36</td>
</tr>
<tr>
<td>MDD only</td>
<td>185 / 13.6</td>
<td>103 / 15</td>
<td>28 / 9.8</td>
</tr>
<tr>
<td>Co-occurring conditions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDD + PTSD</td>
<td>437 / 32.1</td>
<td>215 / 31.3</td>
<td>63 / 22.1</td>
</tr>
<tr>
<td>MDD + other&lt;sup&gt;d&lt;/sup&gt;</td>
<td>47 / 3.5</td>
<td>19 / 2.8</td>
<td>7 / 2.5</td>
</tr>
<tr>
<td>PTSD + other&lt;sup&gt;d&lt;/sup&gt;</td>
<td>48 / 3.5</td>
<td>16 / 2.3</td>
<td>13 / 4.6</td>
</tr>
<tr>
<td>MDD + PTSD + other&lt;sup&gt;d&lt;/sup&gt;</td>
<td>44 / 3.2</td>
<td>26 / 3.8</td>
<td>4 / 1.4</td>
</tr>
<tr>
<td>Other diagnoses&lt;sup&gt;d&lt;/sup&gt;</td>
<td>190 / 14</td>
<td>62 / 9</td>
<td>69 / 24.2</td>
</tr>
</tbody>
</table>
We performed a systematic review of literature on violence and related health concerns among asylum seekers in high-income host countries. We extracted data from 23 peer-reviewed studies.

Prevalence of torture, variably defined, was above 30% across all studies. Tor-
Dermot A. Ryan, Fiona E. Kelly, and Brendan D. Kelly

Mental Health Among Persons Awaiting an Asylum Outcome in Western Countries
A Literature Review

ABSTRACT: Asylum seekers are among the most marginalized and powerless groups in Western societies. Unlike persons with refugee status, asylum seekers live with the constant fear of deportation. They are generally denied access to work, private accommodation, education, and regular social welfare benefits. These harsh postmigration living conditions place asylum seekers at risk for poor mental health. This article reviews the empirical literature on asylum seeker mental health from the last 20 years. It focuses on nondetained adults awaiting an asylum outcome in Western countries. Twenty-three studies reported data for 7,294 asylum seekers. Overall, reports of psychological distress levels and prevalence rates of mental disorder were very high. This risk for poor mental health can be reduced by appropriate changes to the asylum procedure and social policy.
Mortality and causes of death among asylum seekers in the Netherlands, 2002—2005

I E A van Oostrum,¹ S Goosen,¹,² D G Uitenbroek,³,⁴ H Koppenaal,⁵ K Stronks²
<table>
<thead>
<tr>
<th>Primary cause-of-death categories</th>
<th>No of deaths</th>
<th>Crude death rate/100000 person years</th>
<th>Crude death rate/100000 person years</th>
<th>SMR*</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infectious and parasitic diseases</td>
<td>18</td>
<td>13.40</td>
<td>10.52</td>
<td>5.44</td>
<td>3.22 to 8.59</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>2</td>
<td>1.49</td>
<td>0.53</td>
<td>13.02</td>
<td>1.61 to 48.16</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>3</td>
<td>2.23</td>
<td>0.46</td>
<td>16.52</td>
<td>3.44 to 48.70</td>
</tr>
<tr>
<td>AIDS</td>
<td>10</td>
<td>7.44</td>
<td>0.86</td>
<td>14.04</td>
<td>6.75 to 25.90</td>
</tr>
<tr>
<td>External causes of injury/poisoning</td>
<td>70</td>
<td>52.11</td>
<td>37.94</td>
<td>1.95</td>
<td>0.52 to 2.46</td>
</tr>
<tr>
<td>Accidents and injuries†</td>
<td>40</td>
<td>29.78</td>
<td>21.70</td>
<td>2.12</td>
<td>1.52 to 2.89</td>
</tr>
<tr>
<td>Accidents: drowning</td>
<td>12</td>
<td>8.93</td>
<td>12.98</td>
<td>12.88</td>
<td>6.66 to 22.54</td>
</tr>
<tr>
<td>Suicide</td>
<td>22</td>
<td>16.38</td>
<td>1.61</td>
<td>1.63</td>
<td>1.02 to 2.46</td>
</tr>
<tr>
<td>Homicide</td>
<td>5</td>
<td>3.72</td>
<td>0.67</td>
<td>2.13</td>
<td>0.94 to 5.55</td>
</tr>
<tr>
<td>Other external causes of death</td>
<td>3</td>
<td>2.23</td>
<td>0.98</td>
<td>2.97</td>
<td>0.37 to 10.95</td>
</tr>
</tbody>
</table>
War exposure, daily stressors, and mental health in conflict and post-conflict settings: Bridging the divide between trauma-focused and psychosocial frameworks

Kenneth E. Miller, Andrew Rasmussen

Abstract

This paper seeks to bridge the divisive split between advocates of trauma-focused and psychosocial approaches to understanding and addressing mental health needs in conflict and post-conflict settings by emphasizing the role that daily stressors play in mediating direct war exposure and mental health outcomes. The authors argue that trauma-focused advocates tend to overemphasize the impact of direct war exposure on mental health, and fail to consider the contribution of stressful social and material conditions (daily stressors). Drawing on the findings of recent studies that have examined the relationship of both war exposure and daily stressors to mental health status, a model is proposed in which daily stressors partially mediate the relationship of war exposure to mental health. Based on that model, and on the growing body of research that supports it, an integrative, sequenced approach to intervention is proposed in which daily stressors are first addressed, and specialized interventions are then provided for individuals whose distress does not abate with the repair of the social ecology.
Fig. 1. Direct effects model of the relationship between war exposure and mental health.
Fig. 3. Daily stressors as partially mediating the relationship of armed conflict to mental health and psychosocial status. Adapted from Fernando et al., in press.
The mental health of civilians displaced by armed conflict: an ecological model of refugee distress

K. E. Miller\(^1\)* and A. Rasmussen\(^2\)

\(^1\) War Child Holland, Helmholtzstraat 61, 1098 LE Amsterdam, The Netherlands

\(^2\) Department of Psychology, Fordham University, New York, USA

Early research on the mental health of civilians displaced by armed conflict focused primarily on the direct effects of exposure to war-related violence and loss. Largely overlooked in this war exposure model were the powerful effects of ongoing stressors related to the experience of displacement itself. An ecological model of refugee distress is proposed, drawing on research demonstrating that mental health among refugees and asylum seekers stems not only from prior war exposure, but also from a host of ongoing stressors in their social ecology, or displacement-related stressors. Implications of this model for addressing the mental health and psychosocial needs of refugees and other displaced populations are considered.
Fig. 1. Armed conflict, displacement and mental health.
## Post Migration Difficulties Questionnaire

<table>
<thead>
<tr>
<th>1. Residency determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Interviews by Immigration</td>
</tr>
<tr>
<td>• Conflict with Immigration officials</td>
</tr>
<tr>
<td>• Difficulties in obtaining a work permit</td>
</tr>
<tr>
<td>• Fears about being sent home</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Health, welfare and asylum problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Limited access to medical, dental or psychological care</td>
</tr>
<tr>
<td>• Limited welfare support</td>
</tr>
<tr>
<td>• Delays in processing applications</td>
</tr>
<tr>
<td>• Fears of being sent home</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Threat to family and friends</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Separation from family</td>
</tr>
<tr>
<td>• Worries about family still at home</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Adaptation difficulties</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Communication difficulties</td>
</tr>
<tr>
<td>• Discrimination</td>
</tr>
<tr>
<td>• Unemployment</td>
</tr>
<tr>
<td>• Poverty</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Loss of culture &amp; support</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Loneliness and boredom</td>
</tr>
<tr>
<td>• Isolation</td>
</tr>
<tr>
<td>• Poor access to traditional foods</td>
</tr>
</tbody>
</table>
Predictors of depression, anxiety and PTSD

- Anxiety & Depression
  - Poverty
  - Loneliness and boredom
  - Conflict with immigration officials

- PTSD
  - Number of trauma experiences in home country
  - Interviews with immigration officials
  - Racism
  - Unemployment
  - Delays in processing refugee applications
  - Not having a work permit
Pathways from War Trauma to Posttraumatic Stress Symptoms

Trauma Events (20.3% of PTS)
- Detention and abuse
- Flight from conflict
  - Traumatic Loss

Posttraumatic stress symptoms

Post migration living difficulties (14.4% of PTS)
- Health, welfare and asylum
- Adaptation difficulties
- Loss of culture and support
Sydney ReAssure Study: A time by location sample of 415 Farsi- and Dari-Speaking asylum seekers and refugees in Sydney Australia who been resident in Australia for five years or less (2017).

Zachary Steel, Reza Rostami, Jila Solaimani, Ruth Wells, Haleh Abedy, Changiz Iranpour, Sami Mangol, David Berle, Derrick Silove, Dusan Hadzi-Pavlovic
Prevalence of Depression & PTSD: Permanant Residents (n=166) and Insecure Protection (n=202)

- Probable Depression
  - Permanent Residents: 20%
  - Bridging Visa / Asylum: 47%

- Probable PTSD
  - Permanent Residents: 10%
  - Bridging Visa / Asylum: 29%

- Severe Depression
  - Permanent Residents: 10.6%
  - Bridging Visa / Asylum: 25%

- Severe PTSD
  - Permanent Residents: 3.0%
  - Bridging Visa / Asylum: 8.7%
Prevalence of Depression & PTSD:
Asylum seekers endorsing torture (n=51) and non-torture (n=149)

- Depression:
  - AS not reporting torture: 41%
  - AS reporting torture: 63%
  - ≈Severe Depression 22.1%
  - ≈Severe Depression 33.4%

- PTSD:
  - AS not reporting torture: 25%
  - AS reporting torture: 41%
  - ≈Severe PTSD 7.5%
  - ≈Severe PTSD 12.3%
Post-conflict struggles as networks of problems: A network analysis of trauma, daily stressors and psychological distress among Sri Lankan war survivors

Nuwun Jayawickreme a, *, Candace Mootoo b, Christine Fountain c, Andrew Rasmussen b, Eranda Jayawickreme d, Rebecca F. Bertuccio a, 1
Table 5
Descriptive statistics for GLASSO centrality measures by node type.

<table>
<thead>
<tr>
<th></th>
<th>Betweenness M (SD)</th>
<th>Closeness M (SD)</th>
<th>Strength M (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic Problem</td>
<td>0.152 (0.052)</td>
<td>0.819 (0.014)</td>
<td>0.760 (0.105)</td>
</tr>
<tr>
<td>Family Problem</td>
<td>0.137 (0.118)</td>
<td>0.779 (0.045)</td>
<td>0.660 (0.158)</td>
</tr>
<tr>
<td>Lack of Basic Need</td>
<td>0.157 (0.096)</td>
<td>0.801 (0.057)</td>
<td>0.713 (0.136)</td>
</tr>
<tr>
<td>Physical Problem</td>
<td>0.173 (0.114)</td>
<td>0.830 (0.054)</td>
<td>0.660 (0.122)</td>
</tr>
<tr>
<td>Symptom (Anxiety)</td>
<td>0.163 (0.168)</td>
<td>0.708 (0.063)</td>
<td>0.671 (0.090)</td>
</tr>
<tr>
<td>Symptom (Depression)</td>
<td>0.135 (0.152)</td>
<td>0.670 (0.066)</td>
<td>0.659 (0.094)</td>
</tr>
<tr>
<td>Social Problem</td>
<td>0.217 (0.265)</td>
<td>0.852 (0.059)</td>
<td>0.750 (0.103)</td>
</tr>
<tr>
<td>Trauma</td>
<td>0.109 (0.068)</td>
<td>0.783 (0.052)</td>
<td>0.692 (0.091)</td>
</tr>
</tbody>
</table>

Note: Centrality values are scaled relative to the largest value.
Research on treatments and interventions for refugees and asylum seekers
RESEARCH ARTICLE

Psychosocial interventions for post-traumatic stress disorder in refugees and asylum seekers resettled in high-income countries: Systematic review and meta-analysis

Michela Nosé¹, Francesca Ballette¹, Irene Bighelli¹, Giulia Turrini¹, Marianna Purgato¹, Wietse Tol², Stefan Priebe³, Corrado Barbui¹*
### Table

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Experimental</th>
<th>Control</th>
<th>Std. Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>SD</td>
<td>Total</td>
<td>Mean</td>
</tr>
<tr>
<td>Hinton 2005</td>
<td>1.72</td>
<td>0.43</td>
<td>20</td>
</tr>
<tr>
<td>Adenauer 2011</td>
<td>14.9</td>
<td>5.5</td>
<td>11</td>
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<tr>
<td>Hinton 2004</td>
<td>2.1</td>
<td>0.5</td>
<td>6</td>
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<tr>
<td>Drozdek 2010</td>
<td>2.6434</td>
<td>0.5594</td>
<td>64</td>
</tr>
<tr>
<td>Renner 2011</td>
<td>0.89</td>
<td>0.46</td>
<td>12</td>
</tr>
<tr>
<td>Morath 2014</td>
<td>17</td>
<td>9.81</td>
<td>17</td>
</tr>
<tr>
<td>Hijazi 2014</td>
<td>27.46</td>
<td>13.54</td>
<td>41</td>
</tr>
<tr>
<td>Buhmann 2016</td>
<td>23.9</td>
<td>5.9</td>
<td>52</td>
</tr>
</tbody>
</table>

**Total (95% CI)**
- 223
- 155
- 100.0%
- -1.10 [-1.67, -0.54]

**Heterogeneity:** Tau² = 0.50; Chi² = 37.37, df = 7 (P < 0.00001); I² = 81%

**Test for overall effect:** Z = 3.82 (P = 0.0001)

### Figure 2
- Efficacy of psychosocial interventions for PTSD in refugees and asylum seekers displaced in high-income countries.
  - Random sequence generation; (B) Allocation concealment; (C) Blinding of participants and personnel; (D) Blinding of outcome assessment; (E) Incomplete outcome data; (F) Selective reporting; (G) Other bias.
Cognitive-behavioral treatment of tortured asylum seekers: a case study

Metin Başoğlu a, *, Solvig Ekblad b, Sofie Bäänhielm c, Maria Livanou a

a Section of Trauma Studies, Institute of Psychiatry, Division of Psychological Medicine, University of London, 38 Carver Road, London SE24 9LT, UK
b Unit for Immigrant Environment and Health, The National Swedish Institute of Psychosocial Factors and Health, Stockholm, Sweden
c Transcultural Center, Stockholm County Council, Stockholm, Sweden

Received 5 February 2002; received in revised form 17 May 2002; accepted 24 June 2002

Abstract

The present study examined results of cognitive-behavioral treatment (CBT) in a 22-year-old, male, tortured asylum-seeker living in Sweden. The patient received 16 sessions of CBT involving mainly self-exposure to trauma-related cues. Clinical measures (assessor- and self-rated) were completed at pre-treatment, weeks 6, 8, 12, and 16, post-treatment and at follow-up (1-, 3-, and 6-month). Treatment led to significant improvement across all measures of post-traumatic stress disorder, anxiety, and depression. The improvement was maintained at 6-month follow-up. The results suggest that CBT could be useful in treating tortured asylum-seekers and refugees despite the additional stressors experienced by asylum-seekers and refugees.
Fig. 1. Improvement in PTSD symptoms (CAPS). CAPS: Clinician Administered PTSD Scale (sum of frequency and intensity scores, range 0–136); B1: Baseline 1, B2: Baseline 2; w6, w8, w12, w16, w20: weeks 6, 8, 12, 16, and 20; w20: Post-treatment; 1-, 3-, and 6-mFU: 1-, 3-, and 6-month follow-up.
Fig. 1. Improvement in PTSD symptoms (CAPS). CAPS: Clinician Administered PTSD Scale (sum of frequency and intensity scores, range 0–136); B1: Baseline 1, B2: Baseline 2; w6, w8, w12, w16, w20: weeks 6, 8, 12, 16, and 20; w20: Post-treatment; 1-, 3-, and 6-mFU: 1-, 3-, and 6-month follow-up.
Figure 1. Change in average mental health scores after asylum decision.
The impact of the refugee decision on the trajectory of PTSD, anxiety, and depressive symptoms among asylum seekers: A longitudinal study

Derrick Silove, MBChB (Hons I), MD, FRANZCP; Zachary Steel, MPsyCh(Clinical), BA(Hons);
Ina Susljk, BA, PDip(Psychol); Naomi Frommer, BA(Hons), LLB; Celia Loneragan, BA(Hons);
Tien Chey, MAppstat; Robert Brooks, PhD; Dominique le Touze, BA(Hons), MSc;
Mariano Ceollo, BA, MPsyCh; Mitchell Smith, MBBS; Elizabeth Harris, MPH, DIp Social Work, Dip ED;
Richard Bryant, PhD
Can Asylum-Seekers with Posttraumatic Stress Disorder Be Successfully Treated? A Randomized Controlled Pilot Study

Frank Neuner\(^1\), Silke Kurreck\(^2\), Martina Ruf\(^2\), Michael Odenwald\(^2\), Thomas Elbert\(^2\) and Maggie Schauer\(^2\)

\(^1\)Department of Psychology, Bielefeld University, Bielefeld, Germany; \(^2\)Department of Psychology, University of Konstanz, Konstanz, Germany
Table 2. Means and standard deviations within-treatment effect sizes (Cohen’s d) of the outcome variables by group

<table>
<thead>
<tr>
<th>Treatment group</th>
<th>Pre</th>
<th>Post</th>
<th>ES pre to post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample size</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NET</td>
<td>16</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>TAU</td>
<td>16</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Posttraumatic Stress Diagnostic Scale ($M$, $SD$)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NET</td>
<td>38.9 (6.4)</td>
<td>26.0 (9.2)</td>
<td>1.6</td>
</tr>
<tr>
<td>TAU</td>
<td>36.9 (8.0)</td>
<td>34.1 (6.1)</td>
<td>0.4</td>
</tr>
<tr>
<td>Hopkins Symptom Checklist–25 Depression scale ($M$, $SD$)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NET</td>
<td>3.0 (0.4)</td>
<td>2.6 (0.6)</td>
<td>0.8</td>
</tr>
<tr>
<td>TAU</td>
<td>3.0 (0.5)</td>
<td>2.9 (0.5)</td>
<td>0.2</td>
</tr>
<tr>
<td>Composite International Diagnostic Interview–C Pain score ($M$, $SD$)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NET</td>
<td>5.6 (2.5)</td>
<td>4.9 (1.9)</td>
<td>0.3</td>
</tr>
<tr>
<td>TAU</td>
<td>3.9 (2.7)</td>
<td>5.4 (1.7)</td>
<td>−0.7</td>
</tr>
</tbody>
</table>

Note. NET = narrative exposure therapy; TAU = treatment as usual; ES = effect size.
Shorter communication

Treating PTSD in refugees and asylum seekers within the general health care system. A randomized controlled multicenter study

Håkon Stenmark a,b,*, Claudia Catani c, Frank Neuner c, Thomas Elbert e, Are Holen a,d

aDept. of Neuroscience, Norwegian University of Science and Technology, 7489 Trondheim, Norway
bCentre on Violence, Traumatic Stress and Suicide Prevention, Mid-Norway, St. Olav University Hospital, Schwacks Gt. 1, 7030 Trondheim, Norway
cDept. of Psychology, University of Bielefeld, 33501 Bielefeld, Germany
dSt. Olav University Hospital, 7030 Trondheim, Norway
eDept. of Psychology, University of Konstanz, 78457 Konstanz, Germany

Eighty one of the 104 screened respondents (refugees N = 50; asylum seekers N = 31) met the inclusion criteria.
Changes in CAPS score over time
Standard errors are shown

Changes in CAPS mean score over time:
- Pre
- Post
- Follow-Up

* NET
* TaU
<table>
<thead>
<tr>
<th></th>
<th>NET(^c) ((n = 33))</th>
<th>Refugees ((n = 21))</th>
<th>Asylum seekers ((n = 12))</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAPS(^a) total score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within-group effect size(^e) (1 month after treatment)</td>
<td>1.37 [0.70, 2.04]</td>
<td>0.90 [0.06, 1.74]</td>
<td></td>
</tr>
<tr>
<td>Within-group effect size (6 months after treatment)</td>
<td>1.53 [0.85, 2.22]</td>
<td>0.93 [0.09, 1.77]</td>
<td></td>
</tr>
<tr>
<td>HAM-D(^b) score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within-group effect size (1 month after treatment)</td>
<td>0.89 [0.26, 1.52]</td>
<td>0.72 [−0.11, 1.54]</td>
<td></td>
</tr>
<tr>
<td>Within-group effect size (6 months after treatment)</td>
<td>1.07 [0.42, 1.71]</td>
<td>0.31 [−0.49, 1.12]</td>
<td></td>
</tr>
</tbody>
</table>
Is legal status impacting outcomes of group therapy for posttraumatic stress disorder with male asylum seekers and refugees from Iran and Afghanistan?

Boris Droždek¹†, Astrid M Kamperman²†, Wietse A To³†, Jeroen W Knipscheer⁴† and Rolf J Kleber⁴†
<table>
<thead>
<tr>
<th></th>
<th>Refugee status obtained (N = 16)</th>
<th>Asylum seeker status unchanged (N = 38)</th>
<th>Refugee status unchanged (N = 12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>mean (sd)</td>
<td>−0.85 (0.74)**</td>
<td>−0.53 (0.49)**</td>
<td>−0.37 (0.65)</td>
</tr>
<tr>
<td>Cohen’s d</td>
<td>1.64</td>
<td>1.13</td>
<td>0.68</td>
</tr>
<tr>
<td>R</td>
<td>0.63</td>
<td>0.49</td>
<td>0.32</td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>mean (sd)</td>
<td>−0.99 (0.62)**</td>
<td>−0.47 (0.48)**</td>
<td>−0.62 (0.53)*</td>
</tr>
<tr>
<td>Cohen’s d</td>
<td>2.33</td>
<td>0.94</td>
<td>1.12</td>
</tr>
<tr>
<td>R</td>
<td>0.76</td>
<td>0.42</td>
<td>0.49</td>
</tr>
<tr>
<td>PTSD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>mean (sd)</td>
<td>−0.84 (0.49)**</td>
<td>−0.52 (0.43)**</td>
<td>−0.46 (0.61)*</td>
</tr>
<tr>
<td>Cohen’s d</td>
<td>2.32</td>
<td>1.14</td>
<td>0.71</td>
</tr>
<tr>
<td>R</td>
<td>0.76</td>
<td>0.50</td>
<td>0.33</td>
</tr>
<tr>
<td></td>
<td>Anxiety B (95% CI)</td>
<td>Depression B (95% CI)</td>
<td>PTSD B (95% CI)</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------------</td>
<td>-----------------------</td>
<td>----------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3-in-3</td>
<td>.231 (−.102−.563)</td>
<td>.347 (0.51−.642)*</td>
<td>.237 (−.073−.547)</td>
</tr>
<tr>
<td>3-in-2</td>
<td>.245 (−.68−.558)</td>
<td>.329 (0.53−.606)*</td>
<td>.161 (−.125−.446)</td>
</tr>
<tr>
<td>2-in-2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refugee status obtained</td>
<td>.541 (1.74−.908)**</td>
<td>.335 (0.08−.661)*</td>
<td>.400 (0.05−.740)*</td>
</tr>
<tr>
<td>Asylum seeker status unchanged</td>
<td>.189 (−.170−.547)</td>
<td>−.194 (−.514−.127)</td>
<td>.061 (−.270−.393)</td>
</tr>
<tr>
<td>Refugee status unchanged</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Resilience-Oriented Treatment of Traumatised Asylum Seekers and Refugees

Cornelis J. Laban

© Springer International Publishing Switzerland 2015
M. Schouler-Ocak (ed.), Trauma and Migration: Cultural Factors in the Diagnosis and Treatment of Traumatised Immigrants, DOI 10.1007/978-3-319-17335-1_13
Refugee Decision-makers, credibility assessment and mental health


• Sharon Cowan, Helen Baillot and Vanessa Munro, “Hearing the Right Gaps: Enabling and Responding to Disclosures of Sexual Violence within the UK Asylum Process” (2012) 21 Social and Legal Studies 269


Increasing Mental Health Awareness in Refugee Status Determination

By UNHCR Regional Representation in Canberra  |  20 November 2017

Nour, a single mother of two, fled from Syria in 2012 along with her parents and young children. She tells Emily, a Protection Officer with UNHCR in Lebanon, how the war had made her feel so helpless. © UNHCR / Sarah Holbæk.
GUIDANCE NOTE ON THE PSYCHOLOGICALLY VULNERABLE APPLICANT IN THE PROTECTION VISA ASSESSMENT PROCESS
The basic principles in relation to psychological evidence and the assessment of protection claims

[3] The psychological abilities required to undertake the protection visa assessment process may be impaired by: mental illness; psychological trauma.... When an applicant’s psychological abilities are reduced, the fairness and accuracy of protection visa assessment may be compromised unless each stage of the process is informed by the applicant’s mental state and cognitive abilities.

[29] Psychological and medical evidence can assist the fair and accurate assessment of the claims of the psychologically vulnerable applicant.
Managing and Understanding Psychological Issues Among Refugee Applicants

Guidelines for Best Practice

Resources Manual

Legal

Jill Hunter Professor, Faculty of Law, UNSW
Linda Pearson Visiting Fellow, Faculty of Law, UNSW
Mehera San Roque Senior Lecturer, Faculty of Law, UNSW
Ronnit Redman Lecturer, Faculty of Law, UNSW (2002 – 2007)

Mental Health

Zachary Steel Associate Professor, PRTU, School of Psychiatry, UNSW
Naomi Frommer Research Officer, PRTU, School of Psychiatry, UNSW
Derrick Silove Professor & Director, PRTU, School of Psychiatry, UNSW