Diagnosing posttraumatic stress disorder in refugees

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ABSTRACT
Global crises has amounted to the forced international displacement of 25.4 million refugees. Refugees from conflict-affected areas are especially vulnerable to posttraumatic stress disorder (PTSD) compared to the general population due to their past and present hardships and history of trauma. PTSD is characterized by a constellation of symptoms identified by the Diagnostic and Statistical Manual of Mental Disorders (DSM). DSM-5 departed from DSM-IV by reclassifying PTSD as a trauma- and stressor-related disorder and introducing a fourth symptom cluster—negative alterations in mood/cognition—to the previous three-symptom cluster model. In severely traumatized refugees, this new cluster exhibited relatively high sensitivity, specificity, positive predictive power, and negative predictive power—in concordance with the range of symptoms exhibited by this population—and allowed for the applicability of the DSM-5 criteria. However, the Western sample basis of the DSM-5 might make it inferior to alternative models as a diagnostic tool for PTSD in refugees and as a springboard for treatment. In addition (and possibly due) to PTSD, refugees are at high risk for mental health distress and suffer from poor health outcomes. Optimizing diagnostic criteria and overcoming barriers to diagnosis and access to care would benefit patients and facilitate treatment.

INTRODUCTION
The world is currently facing a humanitarian crisis, to a degree unprecedented since the Second World War. Troubled by persecution, war, and violence, refugees have felt the wide-reaching impact of this crisis and suffered forced displacement from their home countries as a result. According to the United Nations High Commissioner for Refugees, there are 25.4 million refugees worldwide and over 100,000 now living in Canada. Many of these refugees received by Canada in recent years came from Syria, Eritrea, Iraq, and Afghanistan. This paper will introduce psychosocial triggers and posttraumatic stress disorder (PTSD) in relation to refugees, cover the diagnosis of PTSD, and discuss further considerations that need to be taken into account during the provision of care. A potential future in which biomarkers are used to diagnose PTSD in refugees will also be touched on briefly.

PSYCHOSOCIAL STRESSORS AND PTSD
Refugees fall under the umbrella term newcomer, which covers additional groups including immigrants and asylum seekers. Even when compared to other newcomers, refugees present unique and complex challenges to clinicians, particularly for those unaccustomed to serving them. The distinct refugee journey—from premigration to resettlement and beyond—exposes individuals to multiple stressors and indelible trauma. Examples of stressors include violence, harmful living conditions, poverty, instability, separation and loss, isolation, and acculturation. While such exposures may not necessarily lead to PTSD, stressors and traumatic episodes are required for the condition to occur.

Greater exposure to premigration traumatic experiences and postmigration stress are consistent predictors for the development of PTSD in refugees. Accordingly, there is a higher prevalence rate of PTSD in refugees than in other groups—even across different stages, cultures, and contexts—and elevated rates of other psychological disorders. In samples of various different refugee populations, prevalence rates ranged from 4% to 86%, though a systematic review suggested that methodological inconsistencies were partially responsible for these heterogenous figures.

DIAGNOSING PTSD
In 2013, the fifth edition release of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) brought along with it a change in the diagnostic criteria for PTSD. DSM-5 reclassified PTSD from an anxiety disorder to a trauma- and stressor-related disorder, added and removed certain individual symptoms, and replaced the previous three-symptom cluster model (reexperiencing, avoidance, and hyperarousal) with a four-symptom cluster model (reexperiencing, avoidance, negative alterations in mood/cognition, and hyperarousal).

While previous studies found comparable rates of PTSD between DSM-IV and DSM-5 criteria in non-refugees, fewer participants of a Swiss-based study involving severely traumatized refugees met the DSM-5 diagnostic criteria for PTSD versus the DSM-IV criteria. This result was surprising because DSM-5’s inclusion of the “negative alterations in mood/cognition” cluster was expected by the study authors to be pertinent to refugees as the prolonged and repeated trauma relevant to individual refugee backgrounds can manifest as anger, guilt, and emotional dysregulation—and contribute to more probable cases of PTSD.

In reality, the “negative alterations in mood/cognition” cluster did indeed demonstrate high sensitivity, specificity, positive predictive power, and negative predictive power. The discrepancy in diagnostic rates between the DSM-IV and DSM-5 models were instead likely due to changes to symptom descriptions and the exclusion of the symptom of “a sense of a foreshortened future.” The authors of the study ultimately determined that the DSM-5 symptom structure remained a good fit for traumatized refugees.

Interestingly, an Australian-based study revealed that while the DSM-5 criteria was adequate for this population, it was the poorest fit compared to four alternative models. Instead, the...
authors identified the competing six-symptom cluster Anhedonia model (reexperiencing, avoidance, negative affect, anhedonia, dysphoric arousal, and anxious arousal) as the superior model for diagnosing PTSD in refugees. This result was consistent with an earlier study looking at Burmese refugees in Thailand that found an approximation of the DSM-5 criteria as adequate but inferior to competing models. The implication of these two studies is that the Western sample based DSM-5 criteria may not optimally reflect the symptom clusters expressed in refugees suffering from PTSD that come from non-Western countries. Another implication is that refugees may be better served during treatment of PTSD symptoms when using these alternative models.

FURTHER CONSIDERATIONS

PTSD does not exist in isolation in refugees. It often coincides with mood disorders, anxiety disorders, and depression and may contribute to increased mental health distress in refugee post-partum women and refugee youth. Post-partum refugee women in Canada are more likely to experience depression, have a psychiatric emergency department visit, and have a psychiatric hospitalization than their immigrant and non-refugee counterparts. Refugee youth, meanwhile, rely more on the emergency department as a first mental health contact than immigrant and non-refugee youth. Although the exact role of trauma in health status is unclear, other health issues documented in refugees are increased morbidity, decreased life expectancy, and elevated acute and chronic health disparities.

Poor health outcomes, comorbidities, and greater reliance on the emergency department highlight the importance of properly diagnosing PTSD in this population and the need to address barriers in care. However, competing classification systems and models for PTSD define trauma and conceptualize symptoms differently, as discussed in greater detail earlier, which can lead to underdiagnosis and has consequences on treatment. Diagnostic discordance in up to 30% of patients occurs between DSM-IV and DSM-5 PTSD criteria, illustrating the magnitude of effect changes in diagnostic formulation can have. The misclassification rate is similar in young children. In such misdiagnosed children, trauma-related symptoms can go untreated and be perceived as manifestations of other diagnoses. Complaints about the inadequacy of the DSM-IV PTSD criteria for this age group led to the introduction of PTSD criteria specific for preschool-aged children in DSM-5. Considering 50% of refugees are children, this may affect how PTSD in young refugees is studied and diagnosed in the future.

Additionally, having a proper characterization of symptoms is important for treatment itself as current trauma-focused interventions are symptom-oriented. Such interventions include Cognitive Behavioral Therapy, Narrative Exposure Therapy, and Eye Movement Desensitization and Reprocessing. These interventions attempt to address the symptoms associated with PTSD by processing traumatic memories and altering maladaptive cognitive behaviors into functional and adaptive ones. While some of these interventions already demonstrate significant promise, a more definitive understanding of PTSD symptoms in refugees would provide clearer targets for clinical intervention.

Symptom disclosure difficulties, possible issues in cross-cultural diagnostic validity, normalization of distress, and overt focus on co-occurring somatic complaints can add to the challenges involved in diagnosing PTSD. Barriers that prevent refugee PTSD patients from accessing care in the first place and contribute to the other poor health outcomes mentioned above include language gaps, discrimination, cultural influence, difficulty navigating the healthcare system, and isolation and lack of social support.

FUTURE POSSIBILITIES

One day, a wide array of biomarkers based on biological disruptions associated with PTSD may supplant DSM criteria as the gold standard for PTSD diagnosis and help overcome some of the diagnostic barriers discussed. Having an objective confirmation of PTSD, rather than relying purely on subjective reports from patients, may also help clinicians distinguish PTSD from comorbidities that share overlapping symptoms, identify novel subtypes of PTSD unique to refugees, and inform therapeutic targets. While knowledge of several PTSD-related autonomic and neuroanatomic abnormalities exists, much work is needed to attain a constellation of biomarkers with the sensitivity, specificity, and practicality necessary to clinically diagnose as heterogenous a disorder as PTSD. As the search for biomarkers of PTSD continues, any new insight gathered into how the disorder manifests clinically in refugees would benefit those looking to optimize DSM criteria for this population. A stronger DSM would then better serve patients who lack access to testing for these biomarkers.

CONCLUSION

Refugees total over 25 million worldwide and are at high risk for PTSD due to previous traumatic events and stressors associated with the protracted journey to resettlement. The DSM-5 criteria represents an adequate clinical lodestar for diagnosing PTSD yet may be inferior to other models due to sample bias. Criteria discrepancies and other factors further complicate diagnosis. Optimizing diagnostic criteria and overcoming diagnostic and healthcare access barriers may promote the mental and general wellbeing of refugee patients.

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