Recommendations for Canadian Mental Health Practitioners Working With War-Exposed Immigrants and Refugees

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ABSTRACT

With the inception of the mental health strategy for Canada, *Changing Directions, Changing Lives*, the ever increasing ethnic diversity in this country demands re-examination of our approaches to mental well-being and illness in the immigrant and refugee population arriving from war-torn countries. Contemporary clinical practice among mental health practitioners is not reflective of the emerging literature in this field, which points towards meaningful and culturally competent care. This article seeks to bridge the gap between existing knowledge and current practice, and provides recommendations for mental health practitioners who work with this population.

Keywords: mental health, war, clinical practice, immigrants and refugees, recommendations

RÉSUMÉ

À la suite de la publication de *Changer les orientations, changer des vies*, la stratégie en matière de santé mentale pour le Canada, et devant la diversité ethnique toujours croissante du pays, il est essentiel de réexaminer l'approche que nous utilisons en matière de bien-être et de santé mentale avec les immigrants et les réfugiés qui arrivent de pays ravagés par la guerre. Les pratiques cliniques en place aujourd'hui ne reflètent pas ce que l'on trouve dans la littérature qui porte sur ce domaine, et qui indique la nécessité d'offrir des soins adéquats qui tiennent compte des contextes culturels. Dans cet article, les auteurs, dans le but de combler le fossé qui existe entre le savoir actuel et les pratiques courantes, font des recommandations à l'intention des praticiens en santé mentale qui travaillent avec cette population.

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doi:10.7870/cjcmh-2017-010
Published by Canadian Periodical for Community Studies Inc.

Mots clés : santé mentale, guerre, pratique clinique, immigrants et réfugiés, recommandations

It is well documented that immigrants and refugees who are fleeing from arduous and life threatening circumstances experience myriad difficulties in their attempts to leave their homeland and resettle in the West. Employing a Delphi consensus process, the Canadian Collaboration for Immigrant and Refugee Health (CCIRH) identified mental health as one of the major priority areas among primary care practitioners in Canada, and four identified mental health conditions were rated in precedence: abuse and domestic violence, anxiety and adjustment disorder, depression and torture, and PTSD (Swinkels, Pottie, Tugwell, Rashid, & Narasiah, 2011).

Given Canada's cultural and ethnic diversity, mental health professionals are faced with exciting yet challenging opportunities to promote mental health and mitigate the potential for mental illness in this population by providing culturally competent services. Cultural competency is defined as a set of behaviours, attitudes, and policies that enable a system, agency, or individual to function effectively with culturally diverse consumers and communities; it requires recognition and an understanding of how economic conditions, race, culture, ethnicity, social context, and the environment define health and disability, and in turn, their influence on the provision of services (Jezewski & Sotnik, 2001).

The psychological effects of war trauma on immigrants and refugees have remained largely invisible to researchers and clinicians, primarily due to the challenges associated with ensuring that refugees and immigrants have access to well attuned and funded settlement services, and assessing mental health symptoms and resilience within culturally diverse populations. Refugee survivors of trauma and torture largely originate from non-western cultures (Johnson & Thompson, 2008); however, there are limited empirical studies undertaken by those from these cultures (Crumlish & O'Rourke, 2010), thus the research is limited by local understanding of psychological distress among traumatized immigrant and refugee populations. Lack of standardized measures and well-designed studies has further impeded research in this field (Campbell, 2007), and when distress is noted, the tendency is to misplace emphasis on post-traumatic stress disorder (PTSD; Almedom & Summerfield, 2004; Mollica, 2004; Pain, Kanagaratnam, & Payne, 2014). As a consequence of the now recognized differences in manifestations of distress and the lack of culturally valid assessment and treatment approaches to address these issues, refugees are considered to be the most clinically challenging group to engage in a psychotherapeutic context (Regel & Berliner, 2007). To date, there is no consensus on appropriate mental health care for war traumatized individuals (Kienzler, 2008), and the existing body of literature remains inconclusive regarding treatment efficacy and treatment of choice for refugees (Campbell, 2007).

This article addresses the challenges of psychological assessment and treatment of populations who flee from war and political violence and resettle in the West. It summarizes current knowledge based on recent guidelines and best practices and lends emphasis to culture brokers and the importance of advancing the implementation of cultural formulation in the Diagnostic and Statistical Manual of Mental Disorders (DSM). A discussion ensues on the dissonance between existing knowledge and current clinical practice followed by conclusions and recommendations to enable mental health practitioners to be more informed, reflective and competent in working with this population. This article is not a systematic review. Rather, it

is a synthesis of knowledge to date to promote consensus among mental health practitioners in their clinical practice with this population. Community-based approaches and the provision of mental health services in conflict or post-conflict settings for displaced persons in refugee camps or countries is beyond the scope of this article. As exposure to war is not unique to people who come to Canada as refugees, the terms "immigrants" and "refugees" broadly encompass those who have been exposed to political violence and war prior to their arrival in Canada.

CHALLENGES IN THE ASSESSMENT AND TREATMENT OF IMMIGRANTS/REFUGEES

Limitations in literature and gaps in providing culturally proficient mental health care to refugees is well documented (Campbell, 2007; Crumlish & O'Rourke, 2010; Regel & Berliner, 2007; Kirmayer, Rousseau, & Measham, 2010) and also reflected in existing guidelines and manuals. The Field Manual of the Rehabilitation and Research Centre for Torture Victims (RCT) states, "Western researchers have developed psychometric tests, structured interviews, and rating scales but so far there has been insufficient attention paid to their applicability and acceptability in other cultural settings" (2007, p. 293). In its cautionary remarks in an introduction to the psychological consequences of torture, the Manual of Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, commonly known as the Istanbul protocol (1999) also speaks to the limitations of psychiatric classifications and the application of Western medical concepts to non-Western populations.

Hollifield and colleagues (2002) concluded that none of the research instruments to measure refugee trauma and health status met every evaluation criteria, namely the purpose of the instrument, construct definition of measures, design, methods and rationale of development of the instrument, and at least one measure of reliability and validity. The majority of articles on refugee mental health evaluation are either descriptive or include quantitative data from instruments with limited or untested validity and reliability, and a critical limitation cited was the lack of theoretical basis and sound measurement principles in applying assessment tools (Hollifield et al., 2002).

A 2007 review article reports there are few standardized mental health measures specifically designed for the refugee population (Campbell, 2007) and even these were found to present challenges in assessing refugees. Scores derived from a recent study utilizing the Harvard Trauma Questionnaire and the Beck Depression Inventory (McColl et al., 2010) failed to capture the events experienced by the refugee participants. In interpreting these findings, the authors emphasized the importance of personal meaning and appraisal of events in the development of trauma related disorders.

Two other reviews also found that a major drawback in the assessment of trauma is the lack of culturally valid assessment tools (Crumlish & O'Rourke, 2010; Hollifield et al., 2002). A recent evaluation of the training practices in the American Psychological Association's (APA) accredited clinical psychology programs revealed that, "coverage of ethical and multicultural issues was less than ideal" (Ready & Veague, 2014, p. 282), being only 60% to 70%. The authors recommended that psychological assessment courses include if, and how, measuring instruments may be used with a multicultural immigrant and refugee population.

An ongoing major controversy in the assessment and treatment of people exposed to war trauma is universal versus cultural applicability of a PTSD diagnosis and its framework in capturing mental distress within the refugee population (Kienzler, 2008). Critics argue that the PTSD framework was primarily derived from American Vietnam veterans and heedlessly extended to clinical practice with refugees (Almedom & Summerfield, 2004; Bracken, 2001; Summerfield, 1999). An antithetical argument suggests that criticism of PTSD and the assertion that it results in medicalization of the refugee experience has no valid grounds (Basoglu, 2006).

A review of the meta-analysis leading to the PTSD guidelines for the National Institute of Clinical Excellence (NICE) concluded that the first-line of psychological treatment for all patients suffering from chronic PTSD should be trauma-focused and exposure-based (Bisson et al., 2007). The review included 38 randomized controlled trial studies, but only two involved a refugee population; the first study provided support for exposure and cognitive-behaviour therapy (Paunovic & Ost, 2001), while the second lent evidence for comparative effectiveness of narrative exposure therapy for treating PTSD in an African refugee settlement in Uganda (Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004). Nonetheless, there is still insufficient evidence to support the treatment of choice being exposure-focused (Pain et al., 2014; Wampold et al., 2010). A recent systematic review of studies by Crumlish & O'Rourke (2010) also failed to conclusively support a treatment modality for PTSD among refugees due to limitations in study design and characteristics.

PTSD is less common than depression or generalized anxiety arising from a traumatic event (Mollica, 2004); nonetheless, the few existing randomized controlled trials based on refugee trauma treatment are limited to PTSD. Notably, Bernardes and co-authors suggest that the recommended guidelines by NICE, which emphasize PTSD as a diagnosis and cognitive behavioural therapy (CBT) as treatment, need to be re-considered when it comes to refugees (Bernardes et al., 2010). They note that despite the many asylum seekers in their study who satisfied the criteria for PTSD, other more subjectively valid concerns were expressed, such as post-migration difficulties and worries about those left back home. The authors suggest that psychological interventions that target other aspects of mental health, such as adjustment to a new culture, may be more significant for refugees.

Despite growing research in the field, there is no evidence-based method of assessing and treating people migrating from war torn countries (Aroche & Coello, 2004; Crumlish & O'Rourke, 2010; Johnson & Thompson, 2008) reported no preferred evidence-based treatment for refugees given their diversity of backgrounds and clinical expressions. The dearth of treatment evaluation studies reflects the major challenges of understanding, measuring, and treating emotional distress in refugees. The few studies that were conducted reported no notable impact. Carlsson, Mortensen, and Kastrup (2005) found no significant effects on mental health symptoms and quality of life following eight months of a multi-disciplinary treatment of torture victims. Rather, the study found social factors to be significant contributors to the subjects' symptomatology versus the impact of torture per se. Drawing on another study with similar treatment outcomes (Miller et al., 2002), Carlsson, Mortensen, & Kastrup (2006) argue for a broader scope in treatment interventions that are more closely linked to the context in which refugees live.

Restricted exposure and accessibility to the refugee population by mental health professionals in developed countries, combined with lack of resources and culturally applicable tools and methods to assess and treat an ethnically diverse population, has led to relatively limited literature, controversy, and lack of

consensus among experts in the field (Kienzler, 2008). Also noted is that a Western deficit model tends to negate the resilience in this population by pathologising their trauma stories and leads to their alienation from the larger society (Hutchinson & Dorsett, 2012).

Best Practices and Guidelines: The Current Status of Our Knowledge in the Field

The ongoing efforts by many scholars and researchers (Beiser, 1999; Kleinman, 1977; Mollica 2004; Summerfield, 1999) to address key issues in the field of immigrant and refugee trauma have contributed to the progress realized today. Recent literature on best practices and guidelines reflect these efforts and paves the way for betterment in working with people who have been exposed to political violence and war in their home countries.

In a review of refugee mental health interventions following resettlement, Murray, Davidson, and Schweitzer (2010) summarize their recommendations on best practices and endorse the shift in research from an emphasis on trauma/PTSD to resettlement. In their review, they noted the frequency of cognitive behavioural therapy interventions and the trend towards adapting recommended Western interventions to reduce PTSD symptoms in the refugee population as well as the minimal information provided regarding the role of culture. They conclude that sample populations involving culturally homogeneous groups would enhance research efficacy and call for increased practice-based interventions and clinical research in the field.

In support of a sequenced, integrated model for interventions in conflict and post-conflict settings, Miller and Rasmussen (2010) state,"…a narrow focus on treating PTSD may reflect the interest of mental health professionals more than it does the actual priorities of community members regarding their own mental health" (p. 14). Their guidelines first call for a contextually grounded assessment to identify and address locally salient daily stressors; when specialized mental health interventions are indicated, they should go beyond the PTSD framework; and lastly, it must be recognized that symptoms of trauma are not all necessarily related to conflict exposure, but also to other sources of trauma, even in situations of armed conflict. They further cite lack of evidence to support the current trend which connects war trauma to conceptualization of PTSD.

McFarlane and Kaplan (2012) conducted a 30 year review on evidence-based psychological interventions for adult survivors of torture and trauma. They report that studies are biased towards the inclusion of individuals with PTSD symptoms, particularly in Western settings, resulting in an over-reliance on PTSD diagnosis and post-traumatic symptom scores as outcome measures. They also called for a replication of the few randomized controlled trials conducted in this area. The authors voiced concern that cross-cultural diversity is often ignored and insufficient importance given to factors such as external stressors and daily adaptive functioning, thus impacting the clinical utility of study findings in the lives of individuals. Overall, the limitations made it impossible for the authors to draw conclusions about the effectiveness of psychological treatments within this population.

Controversy has surrounded which factors, pre-migration, migration, or post-migration, most influence the mental health status of immigrants and refugees (Miller & Rasmussen, 2010; Neuner, 2010); however, the need, first and foremost, to intervene and support the post-migration resettlement of this population is now being recognized (Summerfield, 1999; Miller & Rasmussen, 2010, Rousseu et al., 2011; Pain et al., 2014). Though critical in diagnosing and treating any individual or group, contextualization of mental health

distress is of paramount importance within the immigrant and refugee population. Successful resettlement in the new country seems to play an important role in mitigating distress (e.g., Kanagaratnam, Rummens, & Toner, 2017). Evidence suggests that factors in the post-displaced environment are a stronger predictor of the well-being and adjustment of people fleeing violence than past trauma (Beiser, 1999, 2006; Kirmayer & Minas, 2000). Factors related to their current circumstances are also potentially more responsive to change.

Following a CCIRH systematic review of common mental health problems in immigrants and refugees in primary care, Kirmayer and colleagues underscore the importance of including pre-migration, migration, and post-migration experiences in assessing the risk for mental health problems and further recommend the use of trained interpreters and culture brokers to overcome linguistic and cultural barriers (Kirmayer et al., 2011). The authors also emphasize the need for/importance of follow-up on culturally appropriate indicators such as social, vocational, and family functioning of these individuals and communities, which could aid in health promotion and disease prevention.

In a review for CCIRH, Rousseau et al. (2011) addressed PTSD in primary care and sought evidence for its applicability to newly arrived immigrants and refugees. Their findings noted the problems with diagnostic accuracy of screening instruments and lack of clear evidence that supports effective screening and treatment of PTSD in this population. The authors recommend a phased approach of interventions that initially focus on practical family and social supports; once safety has been objectively established, subsequent treatment should address patient priorities, including treatment of PTSD symptoms and support for social integration. Other authors (Kanagaratnam, Rummens, & Toner, 2017; Kanagaratnam et al., 2012; Kanagaratnam, Raundalen & Asbjornsen, 2005) have noted the significance of patient priorities based on ethnic groups' definition and perception of mental well-being, distress, and meaning. The review by Rousseau et al. (2011) calls for additional research prior to determining the effectiveness of psychological interventions and culturally acceptable modalities of treatment.

Growing attention in this field underscores the importance of integrating cultural formulation into the diagnostic assessment of culturally diverse populations, and utilizing interpreters and culture brokers to aid in the assessment and treatment of mental health issues.

The Cultural Formulation

The DSM cultural formulation (Lewis-Fernandez & Diaz, 2002) is a necessary first step to understand and incorporate important cultural meaning systems into the treatment of persons from non-Western cultures. A major drawback, however, is that the cultural formulation continues to maintain the universality and validity of the DSM-derived diagnoses. This position is difficult to challenge due to the a-theoretical stance of the DSM which concurrently adapts a bio-medical model (Thakker & Ward, 1998). Mezzich, Caracci, Fabrega Jr., and Kirmayer (2009) point out that the lack of clear guidelines around cultural formulation as originally presented in the DSM IV has so far restricted the use of this approach in assessing refugee populations. The authors' recommended guidelines in the application of cultural formulation appear to be an excellent process to bridge the bio-psycho-social approach with the conceptual framework of clinical psychiatry.

When arriving at a diagnostic conclusion by applying the cultural formulation guidelines, the "universality" blunder of searching for similarities and disregarding significant differences should be avoided, as such

differences may in fact be the key targets in treatment. In response to the development of the DSM V, the British Psychological Society (2011) recommended revision of the DSM classification system to a bottom-up approach, which begins with symptoms or complaints rather than predetermined diagnostic categories. The DSM V states that, "…all forms of distress are locally shaped, including the DSM disorders" (2013, p. 758) and is opined to be a "vast improvement" in its treatment of culture, relative to the DSM IV-TR.

Cultural formulation is a potentially useful tool, but again, it is important that a diversity of voices be represented and not restricted to the North American perspective. Though slow to emerge, it is promising that research is evolving in this area (Dinh, Groleau, Kirmayer, Rodriguez, & Bibeau, 2012) and the challenges in its application, including a need for theory, is being recognized (Aggarwal, 2014). Undoubtedly, more research is needed to evaluate the effectiveness of applying cultural formulation as a tool to improve diagnosis and treatment, the findings of which would inform further development and modification in the utilization of this tool. A push towards the systematic use of cultural formulation among mental health professionals would facilitate such research.

Use of Interpreters and Culture Brokers

An "interpreter" is a person who verbally transfers one language to another. Qualified professional interpreters are essential to facilitate equitable access to care for clients who lack fluency in one of Canada's official languages. The core competencies necessary for an interpreter in mental health settings have been discussed in the literature (Victorian Transcultural Psychiatry Unit, 2006) and the pros and cons of utilizing interpreters in clinical settings have been well documented (Kirmayer et al., 2011; Miller, Martell, Pazdirek, Caruth, & Lopez, 2005; Eytan et al., 2002).

To date, the training of clinicians in the use of interpreters has not been adequately met (Brisset et al., 2014). A key observation based on our clinical and community experience is the interpreter's bias towards a Western bio-medical model of mental health, which is attributed to either a tendency to downplay their own view of indigenous understandings and practices as primitive or backward, or unease with being perceived as such; this in turn impacts their ability to accurately interpret issues from clients' perspectives and is further compounded by their interpreter training or education which reflects mainstream knowledge on mental health. Though interpreters may not have an adequate understanding of what they have learned, it may be difficult for them to "let go" of this knowledge, which they may also perceive as a symbol of power and authority.

Culture brokering is defined as the act of bridging, linking, or mediating between groups or persons of differing cultural backgrounds for the purpose of reducing conflict or producing change (Jezewski, 1990); the culture broker acts as a go-between, one who advocates or intervenes on behalf of another individual or group. A culture broker puts forward the cultural behaviours and concepts of immigrants' ethnic backgrounds to further the understanding of the examiner or therapist (Kai, 2003; Kirmayer et al., 2011), and is a relatively new concept that requires further exploration for the development of best practices for training. In working with refugee youth, a qualitative case study by Brar-Josan and Yohani (2014) proposes a framework that consists of four levels, namely professional education, case conceptualization, professional empowerment, and integration of indigenous methodologies, to create an effective working relationship between the therapist and the culture broker.

DISSONANCE BETWEEN KNOWLEDGE AND CLINICAL PRACTICE

It is the view of the authors of this article that despite the growing research and recommended guidelines for best practices in the field of war trauma among resettled refugees and immigrants in the West, they are not well reflected in current clinical practice. Referring sources and stakeholders seem to operate on the false premise that recommended evidence-based practices for mainstream communities are just as effective in immigrant and refugee populations. Moreover, the bias towards a PTSD diagnosis promotes the expectation that clinicians apply trauma-focused treatment with an exposure component (Pain et al., 2014).

Resilience, most particularly in the refugee population, is underestimated (Simich & Andermann, 2014). As noted by Rousseau et al. (2011), around 80% of individuals who experience traumatic events will heal spontaneously after reaching safety. However, as noted by the current authors in their clinical practice, there is an over-emphasis on diagnosing immigrants and refugees with PTSD perhaps, in part, because in response to the refugee's account of war and terror the clinician cannot imagine the individual not having PTSD, resulting in the tendency for individuals to become more symptomatic in an unconscious attempt to align themselves with what the dominant culture regards as important. Furthermore, as noted in refugee hearings, a diagnosis of PTSD is often cited as implied evidence of torture in the country of origin, thereby attributing their distress solely to post-traumatic stress and discounting other psychological symptomatology (Pain et al., 2014).

A pitfall observed in the current clinical practice of the authors of this article is the emphasis on PTSD and the resulting confusion around the etiology and temporality of psychological distress that occurs following trauma. For example, if an individual functions adequately in his country of resettlement, despite previous exposure to war trauma or torture in his home country, and subsequently experiences a workplace accident or violence, it is argued that the individual is suffering not from the trauma of this non-war related incident, but from events that occurred in his home country. We see, in our professional practice, how incorrectly assigning distress to pre-migration factors hinders appropriate treatment.

Another observation is that immigrants and refugees who experience non-war related traumatic events in their country of resettlement may present with symptomatology similar to the DSM criteria for PTSD; on the other hand, individuals exposed to pre-migration war trauma express guilt, anger, and collective loss—symptoms that vary vastly from the core diagnostic criteria for PTSD, which primarily emphasizes the anxiety aspect of a traumatic event or events (Kanagaratnam, Rummens, & Toner, 2017; Somasundaram, 2014). As the western conceptualization of trauma does not capture this difference in the phenomenology of war trauma in collective societies, the associated symptoms tend to be disregarded when assessing only for PTSD and thus are deprived of the clinical attention they deserve in a treatment context.

There is no evidence-based research that links exposure to events of war and political violence to a diagnosis of PTSD. In view of this, the concept of trauma and the notion that PTSD symptomatology is the primary clinical issue for war-exposed immigrants and refugees settling in the West, notwithstanding its presence as confirmed by questionnaires to assess PTSD, is hypothetical and should be considered as such.

In terms of assessment and treatment, a limited number of standard sessions does not always allow clinicians additional time to utilize the DSM cultural formulation or a culture broker to better understand

the clinical significance of the person's symptoms to determine the most appropriate and effective mode of therapy. An acknowledgement of the utility of culturally competent tools is required.

It is the authors' observation that mistrust of interpreters' professionalism and quality of work is also an issue among health providers as exemplified by the lack of appreciation for nuances in language which may, for instance, result in delays in interpreting a statement. Also noted in clinical settings is the embarrassment of some interpreters on behalf of clients who belong to their community by the appearance of wanting to disassociate themselves from these clients' belief or practice. As stated, enhanced training in the utilization of interpreters and culture brokers is necessary for effective and ethical clinical practice (Pain et al., 2014).

FUTURE DIRECTIONS

To gain a better understanding of the mental health issues of refugees, we need to extend the focus beyond individual pathology, taking into account the social determinants of health and develop appropriate treatment models for their care. The impact of clinical distress on daily functioning should be the target of future research and clinical practice. Repetitive use of measures short of clinical meaning (Zur, 1996; Watters, 2001; Kirmayer, 1996) leads to "category fallacy" (Kleinman, 1977); a recent study in Afghanistan found PTSD to be a valid diagnosis but having limited clinical utility (Miller et al., 2009). Others also emphasize the importance of addressing patient priorities when it comes to treatment (Rousseu et al., 2011; Miller & Rasmussen, 2010).

Further research is needed to confirm the conceptualization of war trauma among people living in conflict and post-conflict zones, as well as resettled populations in the West. Within the context of displacement, there may be a different conceptualization of trauma and coping between communities displaced within their home countries and those forced to flee their land and settle in the West. Thus, until research evidences any similarities, caution should be exercised in citing and cross referencing research as if it applies to both those living in conflict zones, or internally displaced and resettled immigrants and refugees in the West.

The living environment and prominence of traumatic events has significant implications for health promotion, prevention, and treatment of mental health issues. Research efforts by academics and clinicians belonging to war-affected cultural groups should be encouraged and welcomed in order to lend equity to voices in the field as well as greater insight and validity.

The APA's Presidential Task Force on Evidence Based Practice (Levant, 2005) underlines the need for research evidence that is not only limited to randomized controlled trials but integrated with multiple investigative research such as qualitative and case studies, and effectiveness and efficacy studies which are equally important contributors to evidence-based practices. Given the current status, there is a clear need for more research and insight; diverse sources of research study findings, which informs and develops our understanding and knowledge, should be valued and welcomed, not only to promote mental health, but also to prevent and treat mental illness among war-exposed immigrants and refugees.

Referring to studies that fail to describe the connection between diagnostic labels and their relevance to clinically significant impairments, Hollifield et al. (2002) highlight the need for a better theoretical framework to disentangle the assessment challenges in the field of refugee trauma. In harmony with other mental health fields, it is critical that an underlying theoretical basis inform assessment and treatment methods in

working with refugees, and that the long term goals of academic and clinical research ultimately lead to a theoretical framework with improved assessment tools and more efficient treatment.

RECOMMENDATIONS FOR CLINICAL PRACTICE

There is an urgent need to improve mental health interventions by refining our treatment models and practices so that they are based on the best possible evidence. Unanimity in directions that are informed by limitations and challenges should lay the foundation for further development of evidence-based methods and techniques in the area of immigrant and refugee trauma. Consensus on clinical practice with immigrants and refugees is an urgent and crucial step to facilitate the provision of enhanced health care.

As noted, there are ongoing efforts by experts in the field to improve research and clinical practice in working with immigrants and refugees fleeing war and violence and resettling in the West. Based on a synthesis of current knowledge, reviews, and suggested models of interventions and best practices, the following recommendations are offered for mental health practitioners in their clinical practice with this population in Canada:

1. The significance of social determinants of health, which translate into post-migration factors as well as their influence on immigrant/refugee mental health, including illness and resilience, needs to be acknowledged and incorporated into assessment and treatment interventions.
2. The lack of evidence to date for an exposure-focus in trauma treatment should be explicitly acknowledged, unless identified as important for the individual, as this will help prevent iatrogenic effects that result from unnecessary emphasis on clinically insignificant symptoms and lack of clinical sensitivity in treatment.
3. The DSM cultural formulation and its guidelines in the assessment and diagnoses of immigrants and refugees should be incorporated as standard practice. Conclusions derived from the proper application of the DSM cultural formulation as detailed by Mezzich et al. (2009) should inform treatment goals, guide treatment, and direct the development of theory.
4. Training in cultural formulation should be mandated for professionals and students and integrated into the formulation of all patient assessments in psychiatry/psychology.
5. Stakeholders should be informed and educated on the status (or lack) of evidence-based practices in the field. This would afford clinicians the opportunity to incorporate the cultural formulation interview into the assessment process, work with interpreters or culture brokers as appropriate, and allow for increased assessment and clinical hours.
6. Training for clinicians in the appropriate use of interpreters and culture brokers should be mandatory. There should also be a dialogue between mental health practitioners and professional interpreters with room for mutual education and improved understanding to enhance efficacy with the immigrant and refugee population.
7. Clinicians should keep abreast of current knowledge in the field and gain an understanding of the limitations and an awareness of lack of evidence-based practice guidelines in working with immigrant

and refugee trauma. Clinicians should also be receptive to advancements in best practices that may evolve with further research involving this population.

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