

7 Specific populations and trauma types: issues for consideration in the application of the guidelines

This section contains broad comment on issues to be considered when applying the guideline recommendations to particular populations who develop PTSD following trauma, and to particular types of trauma. It is beyond the scope of the section to include an exhaustive list of all traumatised populations and so it is limited to populations for whom specific contextual information may assist practitioners in the sensitive application of recommended treatments.

While there are significant differences between the trauma populations identified in this section, an experience common to many is exposure to sustained and/or repeated traumatic experiences, sometimes referred to as type II trauma (Terr, 1991). In many cases these sustained and/or repeated traumatic events are of human design, intended to leave the victim fearing, and feeling helpless to prevent, recurrence. Examples of type II trauma include childhood sexual or physical abuse, domestic violence, incarceration as a prisoner of war, torture and, arguably, prolonged combat. Repeated exposure to trauma on a community and familial level, such as may be the case in the Aboriginal and Torres Strait Islander community, is also consistent with this definition. It is also worth noting that, because of the sustained nature of some these traumatic experiences, people presenting for treatment may still be facing ongoing threat and be at risk of further exposure to trauma. Emergency and defense personnel, victims of domestic violence and victims of sexual assault perpetrated in the context of their current employment or intimate and family relationships, are some of the groups whose treatment may be affected by having to return to unsafe environments. In the context of such ongoing risk, the focus of interventions should be on ensuring safety, stabilisation and symptom management, rather than commencing the trauma-focussed components of treatment.

As outlined in the introduction, there is a body of literature suggesting that the symptom constellation that follows type II trauma is broader than PTSD, although not necessarily reflected merely in more extensive comorbidity with other psychological disorders (van der Kolk et al., 1996). This presentation, often referred to as complex PTSD or disorders of extreme stress, not otherwise specified (DESNOS), includes features such as impulsivity, problems with emotional regulation, identity disturbance, dissociative symptoms, self-destructive behaviour, abnormalities in sexual expression, and somatic symptoms (DSM-IV: APA, 1994). Issues of deliberate self harm and suicidality are more likely to be present in this group. All of these features need to be considered in both treatment planning (see recommendations in Chapter 2 — Factors influencing treatment outcome) and in delivering psychological interventions (see recommendations in Chapter 4).

This section differs from the clinical practice recommendations sections in that it is not based on systematic review of the empirical evidence. Rather, it is based on information provided by specialists in these areas. Within this section, emphasis has been placed on populations under-represented in the studies included in the systematic review. Consequently the first two sections, on Aboriginal and Torres Strait Islander peoples, and refugees and asylum seekers, are more comprehensive, with background information provided as a context for understanding the impact of specific traumatic experiences. This material should be used in conjunction with the information about particular types of traumatic events that follows.

The special populations covered in the section are:

- Aboriginal and Torres Strait Islander peoples
- refugees and asylum seekers.

The categories of traumatic event covered in the section are:

- military and emergency service
- motor vehicle accidents
- crime
- sexual assault
- natural disasters
- terrorism.

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

As stated in the introduction to this special populations section, the information provided is derived from expert opinion as to the application of the guidelines for this population. There were no studies in the systematic review that included participants reported to be Aboriginal or Torres Strait Islander peoples.

Specialised training in cultural competency and safety has been developed for practitioners working with Aboriginal and Torres Strait Islander peoples and wherever possible, Aboriginal and Torres Strait Islander peoples should be treated by practitioners with this training. However, in circumstances where this is not possible, culturally informed care for Aboriginal and Torres Strait Islander peoples should be available within non-specialised primary and mental health care settings. The information presented here is intended to assist practitioners in these settings, in their work with Aboriginal and Torres Strait Islander peoples.

Background issues

Since white settlement in Australia, Aboriginal and Torres Strait Islander peoples have suffered separation from land, family and cultural identity. This has resulted in multiple experiences of trauma, grief and loss that have affected people at the level of the individual, family, and community. In this process, some aspects of traditional kinship and community systems have been destroyed and, in some cases, formerly protective influences within those systems that buffered individuals and families from further trauma, have been lost. Thus, the legacy of historical trauma is still apparent in the increased risk and incidence of traumatic exposure amongst Aboriginal and Torres Strait Islander peoples today. In effect, family and community functioning can continue to be compromised in each subsequent generation by social and psychological problems (such as substance use), leading to a vicious cycle of deteriorating conditions, pervasive social disadvantage, and for individuals, increased risk of further victimisation and traumatic exposure, coupled with reduced psychological resilience. Notwithstanding these comments, it needs to be acknowledged that Aboriginal and Torres Strait Islander peoples have shown remarkable resilience in surviving such historical and ongoing adversity and continue to display cultural strengths today.

Impact of traumatic experience on the individual

Given this context, the notion of trauma and PTSD in Aboriginal and Torres Strait Islander peoples is inevitably complex. It is multigenerational and across all communities. Most Aboriginal and Torres Strait Islander peoples presenting with mental health problems in both urban and rural/remote locations, have multiple, severe traumatic exposure within their family, community and personally, that may include domestic violence, sexual abuse, murder, and suicide. In seeking to understand the impact of traumatic experiences on the individual, the practitioner should consider not just the nature or number of specific experiences, but the contextual factors that predispose and/or amplify the experience of and response to trauma. Traumatic experiences that are recurrent and difficult to talk about are likely to have had the most profound impact. Therefore, even when the focus is on a specific recent event (for instance a violent death), it is critical for the practitioner to explore the person's prior experience of traumatic events — particularly those that occurred in early life, such as physical and sexual abuse.

Due to the importance of extended kinship systems to Aboriginal and Torres Strait Islander peoples, a traumatic loss is likely to be felt broadly throughout the kinship group, rather than confined to the immediate nuclear family. That is, a person may have several mothers or be considered a mother to several nieces/nephews/grandchildren and if this is not recognised, the intensity of the loss may be underestimated. The impact on children of exposure to the event or the subsequent psychological illness in the parent should always be considered. In addition, given the frequency of traumatic events in Indigenous communities, a broader approach may be required than what can be offered to an individual.

Presentation

Aboriginal and Torres Strait Islander peoples are generally very tolerant and hence when they do present to services, it is likely to be very serious even if it may not appear so on the surface, or at first contact. It is not uncommon for the individual to be in crisis at first contact with presentations of acute distress, including interpersonal chaos, self harm and depression. Substance abuse/dependence is very often the presenting problem, with abused substances including alcohol, illicit drugs, and prescribed medications, such as analgesics. It is common to see high levels of dissociative symptoms and prominent auditory and visual phenomena that could be mistaken for psychosis. In many cases PTSD co-exists with prolonged grief/depression. While some people experience text-book PTSD symptoms, many more present with the range of additional symptoms associated with chronic and complex trauma (i.e. enduring patterns of social, psychological and behavioural difficulties, usually compounded by substance use). Further, culture-bound expressions of distress are often interpreted by non-indigenous people as anger. The complexity of these presentations can lead to a diagnosis of personality disorder, with PTSD being overlooked. Clinicians should be aware that many Aboriginal and Torres Strait Islander women and men in refuges and in prison suffer PTSD.

Assessment

Access, engagement, and trust in the therapeutic setting are complicated for Aboriginal and Torres Strait Islander peoples by a number of factors. These include the complexity of the trauma (particularly community level trauma), cultural factors and the historical legacy of mistrust of authorities. The potential for stigma and discrimination associated with mental health treatment to pose a barrier to engagement should be considered. Experiences of chronic loss mean that issues of abandonment and (the potential for) shaming may be heightened. As such, the recommendation noted in Chapter 2, regarding the need to allow more time and attention to the therapeutic relationship for people who have experienced prolonged and repeated trauma, would generally apply to this group.

Due to the complexity of the presenting problems for this population, PTSD is often overlooked. A culturally appropriate assessment is required for any diagnosis to be reliable. If no suitably trained practitioner is available, consultation with an Aboriginal and Torres Strait Islander mental health worker is highly recommended.

Issues of eldership, traditional law, and taboo need to be understood, at least to some extent, for reliable assessment. The following general practical advice is offered:

- Gain permission from the person (and others in attendance) for interview.
- With empathy, explain purpose of questions, the timeframe of the assessment, and potential outcomes.
- Identify relationships between the person and others present and be aware of their significance.
- Check with the person whether they prefer to be interviewed with/without significant others present.
- Observe cultural norms (eg eye contact, seating arrangements).
- Do not refer to a dead person by name.
- Do not refer to certain close relatives by name (a Torres Strait Islander male may not refer to his brother-in-law by name).
- Do not criticise an elder or other members of the extended family.
- Be aware of confiding certain personal information to a member of the opposite sex as men's and women's business are usually kept separate.
- Anxiety can be generated by interviewing someone in a confined space.
- Spiritual experiences are not necessarily hallucinations or delusions.
- Be aware of possible somatisation symptoms.
- Allow for reflection, periods of silence and any questions.
- Minimise the use of direct questions.
- Advise the person of confidentiality.

Source: Adapted from Tim Armstrong, Mental Health Project Officer for Northern Rivers Division of General Practitioners (<http://www.medicineau.net.au/clinical/abhealth/abhealt1345.html>)

As noted in Chapter 2 — Comprehensive assessment of PTSD, the assessment of PTSD should not be limited to a recent traumatic event, but should take into account previous traumatic experiences. Even if the person's PTSD or presentation for treatment has been triggered by a recent event, it is often the case that a recent loss or trauma brings up unresolved past events. The potential impact of the traumatic experiences of previous generations on members of the current generation, either directly (e.g., family environments characterised by psychosocial problems, violence, impaired parenting), or indirectly (e.g., vicarious traumatisation), should be considered.

Further, given the high physical health morbidity even in young people, careful screening or review of general health status may be important, especially if pharmacological treatment is likely to be prescribed, or if there is a lack of progress in treatment. Diseases such as diabetes, renal failure, chronic infection, anaemia etc can complicate recovery from traumatic events and vice versa.

Treatment

In the review of evidence-based treatment for PTSD, no trials have investigated treatment for Aboriginal and Torres Strait Islander peoples. In the application of these treatment guidelines to Aboriginal and Torres Strait Islander peoples the practitioner is advised to consider the recommendations in combination with common sense and knowledge of traditional practices. Where available, appropriate partnerships with indigenous mental health workers should be developed. In cases where this is not possible, consultation with indigenous mental health workers or other practitioners with appropriate cultural training is recommended.

Within Aboriginal and Torres Strait Islander cultures, traditional therapies include the use of healers, rituals, and ceremonies. In working with an Aboriginal person or Torres Strait Islander with PTSD, practitioners should apply the guidelines in a culturally sensitive way, with consideration given to what combination of traditional, pharmacological, and psychological approaches to treatment will be most effective for the individual. Narrative exposure therapy has been identified as a culturally sensitive approach for Aboriginal and Torres Strait Islander peoples. The value of using cultural social processes has been demonstrated in indigenous Cambodians who escaped to the United States post Vietnam and in American indigenous veterans.

In establishing treatment goals, practitioners should give consideration to a number of factors in addition to those outlined in Chapter 2 — Factors influencing treatment outcome. First, the magnitude of trauma in Aboriginal peoples and Torres Strait Islander families may be overwhelming to practitioners and lead them to feel powerless and be inclined to give up. Good supervision is essential and collaboration with an Aboriginal peoples or Torres Strait Islander mental health professional is preferred. Second, as noted in Chapter 2 above, with people who have suffered prolonged or repeated traumatic experiences, more preparatory work is required before trauma-focussed work begins. As such, unless the practitioner has the capacity to make a commitment to being available in the longer term, it is often more appropriate to address current life and behavioural problems, focussing on issues of structure and problem solving, rather than delving into a potentially long history of trauma. Third, specific cultural factors should also be considered. Issues of age, seniority, and gender impact on who should provide treatment and how the treatment should be given. If the practitioner is ignorant of, or disregards these traditions, the Aboriginal or Torres Strait Islander person may be less likely to engage effectively in treatment.

In regards to early interventions following traumatic events affecting whole communities, local and traditional Aboriginal peoples and Torres Strait Islander approaches should be identified and supported in preference to debriefing or other psychological interventions.

There are significant challenges in the application of these guidelines to Aboriginal and Torres Strait Islander peoples. In addition to the historical and current socio-political factors outlined, the pervasive and enduring social disadvantage and the prevalence and complexity of traumatic experience, geographical isolation and limited availability of appropriately trained mental health practitioners all combine to create considerable barriers to effective care for posttraumatic mental health conditions.

Recommended reading

Dudgeon, P., Garvey, D., Pickett, H., (eds) (2000). *Working with Indigenous Australians: A Handbook for Psychologists*. Curtin Indigenous Research Centre, Western Australia.

Human Rights and Equal Opportunity Commission (1997). *Bringing Them Home: A guide to the findings and recommendations of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families*. HREC, Canberra.

Milroy, H. (2005). Preface. In: *The Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People*, Zubrick S.R., Silburn S.R., Lawrence D.M., Mitrou F.G., Dalby R.B., Blair E.M., Griffin J., Milroy H., De Maio J.A., Cox A. & Li J. Perth, Curtin University of Technology and Telethon Institute for Child Health Research.

Swan, P. & Raphael, B. (1995). *Ways Forward: National Aboriginal and Torres Strait Islander Mental Health Policy. National Consultancy Report*. AGPS, Canberra.

REFUGEES AND ASYLUM SEEKERS

As stated in the introduction to this special populations section, the information provided is derived from expert opinion as to the application of the guidelines for this population. Three studies in the systematic review included participants that were refugees and asylum seekers. The limited evidence-base in the field for both direct clinical trauma work and more general psychosocial interventions thus needs to be acknowledged.

In treating refugees and asylum seekers with PTSD, the practitioner is faced with a number of complex factors over and above the individuals' traumatic experiences, including language, ethnocultural, socio-political and community issues, as well as the persons' current clinical and psychosocial situation. It is not uncommon for practitioners to feel overwhelmed by these cultural and clinical complexities. In some cases this can lead the practitioner to being immobilised for fear of making mistakes, and in other cases it can lead to practitioners ignoring the complexities completely and proceeding as though they did not exist. Either response is unlikely to result in effective treatment. The middle ground, in which the practitioner is mindful of ethnocultural issues, but does not attempt to deal with them as the end in itself, is ideal. The practitioner's genuine interest and respect are the most effective tools for building trust and the positive therapeutic relationship needed to help the individual recover from their traumatic experience.

Practitioners working with refugees and asylum seekers need to be culturally skilled including having awareness of biases, awareness of values, avoidance of stereotyping, the capacity to respond to potential conflicts between traditional values and values of the dominant culture and the ability to choose the appropriate approach. Practitioners should also recognise that cultural factors interact with what are commonly termed social factors — class, education, social status, rural or urban background.

In working with refugees and asylum seekers, interpreters are often involved. Practitioners should be mindful of the following issues when working with interpreters. First, in regard to perceptions of confidentiality, in small migrant communities, interpreters are frequently educated members of the community, often community leaders. People may feel that their confidentiality is compromised when they have to disclose their experiences, through known members of their own community. Secondly, when interpreters are used for specific interventions such as imaginal exposure, it is important that the interpreter understands the procedure as well as the underlying rationale and potential client responses, so that the intervention is not unintentionally compromised. Finally, practitioners should be aware of the potential negative emotional impact on interpreters of re-telling the client's traumatic experiences. In addition to the general point made in Chapter 2 regarding the potential for all practitioners in the field of posttraumatic mental health to be adversely affected by the work, the possibility that the interpreter has suffered similar traumatic experiences of their own, needs to be considered.

The following section outlines a range of general issues with which practitioners working with refugees and asylum seekers in Australia should be familiar. Further information about the specific background and experience of each person is of course still required.

Background issues

There is an inevitable political context in which the traumatic experiences and subsequent treatment of refugees and asylum seekers occur. Within Australia, as well as internationally, government policy, community attitudes, and media coverage of refugee and asylum seeker issues impact the mental health and well-being of this group. The impact can be direct, creating a welcoming or hostile environment, or indirect, potentially influencing public attitudes. For asylum seekers, these factors have a direct bearing on government policies relating to detention, visa options, and fundamental rights and entitlements such as access to medical care.

The traumatic experiences of refugees need to be understood in the context of socio-political factors in the country of origin. It is helpful for the practitioner to have an understanding of these factors at both the macro level — the nature and history of the conflict and its impact on the individual, their family, and community over time — as well as at the level of the individual's experience.

There are three defining characteristics of the refugee and asylum seeker experience, common to most:

- trauma (experienced or witnessed situations where their lives have been threatened or people have been killed)
- loss (of family friends and relatives, possessions, livelihood, country, status, etc)
- deprivation (of food, water, shelter, education and medical attention).

The frequency and nature of traumatic exposure inevitably varies, but the following experiences, designed to maximize psychic injury, are common:

- Extreme forms of violence that have been repeated and/or prolonged.
- Destruction of identity and the breakdown of families and communities, which may occur deliberately through the systematic disruption of core attachments to families, friends, and religious and cultural systems.
- Conditions of inescapability and unpredictability, that maximize the experience of helplessness.
- Loss under violent circumstances with consequences such as prolonged grief.
- Witnessing of atrocities such as mass killings, children targeted for violence and death, the violation of sacred values, betrayal, and the weakness of restorative justice.
- Deliberate erosion of personal integrity — physical boundaries invaded, the right to privacy violated, basic functions of eating, sleeping closely controlled, confronted with impossible choices, such as choosing who should die or who should be left behind.

The practitioner should also be aware that once in Australia there are several stressors that can continue to impact upon the mental health of refugees, including:

- concern about the safety of relatives and friends remaining in the country of origin when conflict is ongoing
- loss or separation from family and friends
- difficulties in tasks of settlement such as learning a new language, gaining employment, and inter-generational tensions
- discrimination in the host community
- minority status in the dominant Australian culture
- in the case of asylum seekers, environmental and policy factors such as mandatory detention and temporary protection (see additional issues specific to this group below).

Presentation

As noted above, refugees and asylum seekers have typically been exposed to prolonged and repeated traumatic experiences. In those with PTSD, common comorbid problems include:

- anxiety, depression, substance abuse, compulsive gambling and brief reactive psychoses
- interpersonal difficulties associated with mistrust, fear, anger and withdrawal
- high-risk and maladaptive behaviours
- grief responses such as numbing, anger, hopelessness and meaninglessness
- family conflict, family breakdown and domestic violence
- physical illness.

In seeking to understand refugees and asylum seekers with PTSD, the potential existential impact of this particular type of traumatic experience needs to be recognised. For example:

- Violence and uncertainty experienced during trauma may lead to anxiety, fear and helplessness.
- Forced impossible choices, and experiences of humiliation experienced, may lead to feelings of guilt and shame.
- Disruption of relationships, separation, and isolation may lead to grief, depression, and altered interpersonal relatedness (e.g., fear of relationships, dependency or extreme self-sufficiency).
- Shattered values of human existence resulting from trauma may lead to a loss of faith in humanity, distrust, sensitivity to injustice, and idealisation and devaluing of others.
- Anger and potentially aggressive behaviour can result from low frustration tolerance, protest about loss, reaction to injustice and betrayal, and as a defense against shame and guilt.

It is also important to recognise that individual strengths can emerge in the face of trauma.

Assessment

A framework for assessment that covers the multiple potential contributing factors to a refugee or asylum seeker's PTSD and related problems, is critical. Table 7.1 summarises the information that should be collected for a comprehensive assessment.

Table 7.1 **Factors in the assessment of refugees and asylum seekers with PTSD**

Assessment domain	Implications
Country of origin and date of arrival	This information alone alerts the assessor to: <ul style="list-style-type: none"> • region-specific physical health problems • nature and duration of violence and hardship • access to health care.
Visa status	Visa status is critical to understanding rights and entitlements and thereby the stresses of the client's everyday environment.
Language	Check preferred language and country of origin of interpreter as some prefer that the interpreter does not come from their country
Cultural background	<ul style="list-style-type: none"> • Cultural notions of causal attributions, stigma, help-seeking behaviour, and concepts of healing are important to assess, as well as familiarity with systems in Australia. • A cultural, ethnic or religious group is very diverse; generalizations need to be cautious. • Some may wish to involve other family members in health care decision making.
Extent of exposure to violence and other traumatic events	A 'thumbnail' sketch is sufficient for the assessment process and provides an indication of likely physical and psychological health sequelae.
Family functioning	Children and adolescents have usually been directly affected through the experience and/or witnessing of violence, disrupted schooling and ongoing loss or separation from important caregivers. Ascertaining whether children and other family members require support involves proactive and sensitive exploration.
Economic circumstances including housing, employment	Potential sources of stress or strength
Legal-immigration situation re refugee determination or family sponsorship	Sponsorship issues and refugee determination processes are major sources of stress and mental health problems.
Physical health screening including dental care	Considerations include: <ul style="list-style-type: none"> • physical injuries or pain which are the result of torture/physical trauma • somatisation of a psychological problem.

As noted in recommendations for assessment in Chapter 2 above, a comprehensive assessment should go beyond the DSM-IV diagnosis of PTSD to include broader psychosocial factors. In refugees and asylum seekers, particular attention should be paid to: indicators of family breakdown, behavioural problems, quality of daily functioning, socially disruptive, aggressive or withdrawn behaviour, and physical symptoms. In undertaking the assessment and planning treatment, the recommendations outlined in Chapter 2 — Factors influencing outcome, for people with PTSD arising from prolonged and repeated trauma apply. The following additional considerations are recommended for refugees and asylum seekers with PTSD:

- Trust and rapport are very important. First appointments often need to be longer and/or several appointments may be needed for a comprehensive assessment.
- Refugees need to be seen in a safe place which does not trigger traumatic memories of overly-officious, authoritarian behaviour.
- Medical settings may act as reminders of torture.
- The gender of the therapist can be especially important for survivors of sexual assault.
- A person's hostility may be a reaction to fear and uncertainty.
- Information should be provided and the person encouraged to ask questions to promote a sense of control.
- Explanations of the meaning of confidentiality are helpful.
- Intrusive investigative procedures may be frightening.
- Factors affecting 'non-compliance' are important to anticipate, such as cultural beliefs about damaging effects of investigations such as taking blood, attitudes to medication and misunderstanding of side-effects, and suddenly stopping medication.

Treatment

A small number of studies suggest that culturally-adapted CBT (including exposure) may be effective for refugees with trauma-related disorders. There is a need, however, to define more clearly who needs specific psychological (specifically CBT) interventions and/or pharmacological interventions over and above the general psychosocial assistance and counselling that is given in contemporary programs provided by torture and trauma services.

Consistent with the treatment guidelines for individuals with complex PTSD outlined in Chapter 2, it is essential that a therapeutic relationship and conditions of trust and safety are established in working with refugees and asylum seekers. In addition, the clinician should consider the following issues:

- The need for a holistic framework for treatment, which parallels the holistic framework for assessment.
- The value of different levels of intervention — individual, family, community, and important settings such as schools.
- Due regard for coping strategies that develop in response to situations of chronic violence and extensive losses — such as denial, withdrawal, and anger — and their protective value for the person.
- The critical role of guilt and shame in maintaining health problems.

In working with a refugee or asylum seeker, treatment goals need to extend beyond PTSD. Of uppermost importance for refugees and their families, is usually the rebuilding of their lives through a successful settlement process. The practitioner should facilitate opportunities for retraining, employment, recovery of status, and establishing connections. Attention also needs to be paid to physical health as the alleviation of physical health problems can be a pathway to mental health well-being.

Finally, it needs to be recognised that mental health problems in refugees are the result of systematic violation of their human rights. Restoration of faith in human beings, the right to health, the right to protection from human rights violations, and restoration of justice are part of the process of healing for refugee survivors of torture and trauma. Services which address the mental health needs of survivors must respect and reinforce the concept of human rights as expressed in various international charters and agreements (Aristotle, 1990).

Additional issues specific to asylum seekers subject to mandatory detention and temporary protection

Australia's policies of mandatory detention and temporary refugee protection have been implicated as predictors of PTSD in refugees in Australia. Steel and colleagues (2004, 2006) report an extremely high incidence of PTSD in temporary visa holders and asylum seekers in detention.

The particular difficulties of working with this group of asylum seekers should be noted. Asylum seekers subject to mandatory detention or temporary protection often have difficulty engaging in therapy to address their trauma, as their traumatic experiences are, in many cases, ongoing. Most have a history of premigration trauma, followed by a dangerous and traumatic flight to safety and finally detention in penal-like institutions. The limitations of the temporary visas (reduced access to settlement services and welfare benefits) cause severe distress to many. Some visa conditions do not allow the visa holder to work, to access welfare support or to access a Medicare card, conditions which provoke extreme levels of anxiety.

During their time as temporary visa holders, asylum seekers face further distressing events — interviews to apply for permanent protection, the frequent rejections of their application, the appeals to the Refugee Review tribunal and other courts of appeal. Many report that their intense intrusive and disturbing thoughts and nightmares are about being arrested by detention guards and returned to detention or being deported — they experience 'flash-forwards'. McNerney and Kaye (2006) argue that standard diagnostic categories and individual therapy in these conditions may be inadequate to address these complexities that have such a devastating impact on asylum seekers' lives.

There are significant challenges in the application of these guidelines to refugees and asylum seekers. In addition to the complexity and severity of their traumatic experience, with its potential impact on fundamental beliefs about self and others, in many cases refugees and asylum seekers face ongoing stressors of re-settlement and in some cases, ongoing trauma of detention. Asylum seekers in detention are generally in geographically remote areas with limited or no access to appropriately trained mental health practitioners. Thus, there are considerable barriers to effective care for their posttraumatic mental health needs.

Recommended reading

- Andary, L., Stolk, Y., Klimidis, S. (2003). *Assessing Mental Health Across Cultures*. Australian Academic Press, Bowen Hills.
- Aristotle, P. (1990). A wholistic approach. In: *Hope After Horror: Helping Survivors of Torture and Trauma*, Hosking, P. (ed), Uniya, Sydney, 157–176.
- McInerney, D. and Kaye, J. (2006). Asylum Seekers, therapy and ethics. *Critical Psychology*; 16: 166–179.
- Steel, Z., Momartin, S., Bateman, C., Hafshejani, A., Silove, D., Everson, N., Roy, K., Dudley, M., Newman, L., Blick, B. and Mares, S. (2004). Psychiatric status of asylum seeker families held for a protracted period in a remote detention centre in Australia. *Australian and New Zealand Journal of Public Health* 28(6): 23–32.
- Steel, Z., Silove, D., Brooks, R., Momartin, S., Alzuhairi, B. and Susljik, I. (2006). Impact of immigration detention and temporary protection on the mental health of refugees. *British Journal of Psychiatry* 188: 58–64.
- VFST (Victorian Foundation for Survivors of Torture) (2002). *Promoting Refugee Health: a handbook for doctors and other health care providers caring for people from refugee backgrounds*. Brunswick, VFST.
- VFST (Victorian Foundation for Survivors of Torture) (1998) *Rebuilding Shattered Lives*. Brunswick, VFST.

MILITARY AND EMERGENCY SERVICE PERSONNEL

As stated in the introduction to this special populations section, the information provided is derived from expert opinion as to the application of the guidelines for this population. Twenty seven studies in the systematic review included participants that were military (25) or emergency service (2) personnel. This section addresses a number of the issues common to military and emergency service personnel. Additional issues specific to military veterans are outlined at the end of the section.

The nature of the exposures experienced in military and emergency service personnel is somewhat different to that in other trauma exposed populations. Their operational role entails an expectation of trauma exposure. While systems are in place within organisations to minimise the risks of injury, and personnel are specifically trained to deal with threat and danger, these strategies clearly have their limitations.

Increasingly, as the armed services are involved in humanitarian and peacekeeping duties, military personnel can be exposed to situations of considerable human suffering without any immediate threat to themselves. In this regard, over the last decade, the exposures of military personnel have an increasing commonality with that of emergency service workers. As such, the issues common to both groups will be outlined first, followed by specific issues for consideration in the military veteran population.

Organisational factors

The particular challenge with these groups of people is to implement treatment as early as possible. Using the principles of secondary prevention, this minimises the development of a series of secondary patterns of adaptation that in themselves can present a significant disadvantage. The systems of care that ensure early identification, such as screening and addressing stigmatisation in the workplace, are of particular importance. Recognition of the value to an organisation of maintaining the skill base of highly trained officers is an important priority in encouraging a general attitudinal change within these organisations. Significant experience in dealing with these particular groups is also an important matter for clinicians because understanding the specific culture of these organisations can be central to the development of a positive therapeutic relationship with the ASD or PTSD sufferer.

Screening

Systematic screening potentially has an important role in identifying ASD or PTSD in groups of military and emergency services personnel who are either engaged in repeated high risk exposures or have had a recent deployment or major event which carries a significant risk of PTSD. However, it should be recognised that the emergence of symptoms might be delayed, pointing to the value of an annual health assessment above and beyond an initial screening process. The administration of screening questionnaires should only be seen as a guide to a more systematic diagnostic assessment by a trained clinician.

A range of psychometric instruments have been trialled in police, military and fire services for monitoring the emergence of symptoms. Given the issues about under reporting, there is some evidence that lower thresholds should be used in determining referral for a clinical assessment. Any screening process should also regularly interview a fixed proportion of people who are symptomatic to remove the stigma of referral for follow-up. Measures of an exposure and symptom questionnaire need to be flexibly applied in regards to the nature of the exposure. The PCL (described in recommendations in Chapter 2 — Self-report measures) has a military version which addresses this challenge because it does not simply focus on exposure to a sole traumatic event. This approach should be considered with other standard measures.

Symptom presentation

The presentation of symptoms for this group tends to be somewhat different to other traumatic stress victims. The association between the trauma exposures and the workplace means PTSD often has an indirect presentation in these cases. For example, the individual's difficulties may become manifest as increasing conflict with senior personnel over a variety of operational and disciplinary issues. Furthermore, the individual may have had a prolonged period of symptomatic distress which they have attempted to minimise and deny. The general sense of camaraderie and collegial support in these organisations often assists the individual in maintaining a façade of functioning. A failed promotion or a disciplinary charge often becomes the focal point around which an individual's distress is manifest, and may themselves be a consequence of the individual's increasingly disorganised behaviour. The indirect manifestation of the individual's distress can delay the appropriate assessment and diagnosis.

The clinical manifestation of an individual's distress in these situations can occur in a variety of ways:

- Comorbid alcohol abuse is not an uncommon presentation where the individual attempts to self-medicate. The associated interpersonal and work-related difficulties may lead to individuals, other than the person suffering from PTSD, being aware of the difficulties prior to the sufferer.
- Interpersonal conflict with family and, in particular, violent outbursts, is another indirect manifestation that may first be brought to the attention of welfare services from a secondary victim, such as the spouse.
- The individual may initially present with a prolonged period of numbing and increasing interpersonal insensitivity. This can be manifest as inappropriate management of junior personnel or conflict with superiors.
- An intense pattern of distress may emerge in response to a recent traumatic event. The recent event may have some particular similarity to prior exposure which played an important role in the initial disruption of the individual's reactivity to stress. Hence, the longitudinal pattern of symptoms needs to be assessed, as well as the acute disorganisation in response to recent exposures.
- Individuals who leave an organisation may first present some time after their discharge. The loss of identity and support through the structure of the organisation, which has provided the *raison d'être* for the individual's functioning, can lead to the progressive emergence of PTSD symptoms, including increasing and distressing recollections and nightmares.

Assessment

Individuals with a work-related disability are often placed in a difficult conflict about seeking assistance because this can lead to significant discrimination and disadvantage in the workplace. This is a recognised difficulty when presenting to occupational health services. This requires a high index of suspicion from the assessing practitioner. It is important that supervisors who are familiar with the individual's normal disposition and capability have some awareness of the indirect manifestation of the effects of PTSD in the workplace, so that appropriate referrals can occur. The health professional needs to have access to personnel records to assist in a clinical assessment.

The clinical presentation of emergency service and military personnel infrequently occurs following the initial exposure to a single traumatic incident. The more typical scenario is where the individual breaks down after repeated experiences of a variety of traumatic incidents, which entail varying degrees of a sense of personal threat, often combined with the witnessing of harm or death to others. The extent to which a specific incident is personalised through some identification with the event or the victim, plays an important role in modifying the resilience and vulnerability of the individual. Major terrorist incidents, disasters with multiple losses of life, and exposure to gruesome or horrific accident scenes carry a particular risk for such individuals.

The available evidence suggests that prolonged exposure or repeated intense exposures over a period of time leads to an accumulated risk. As a consequence, the recommendation regarding assessment for people exposed to prolonged or repeated trauma in Section Chapter 2 — Comprehensive assessment of PTSD, applies; the history obtained from military and emergency service personnel should focus on the lifetime exposure, as well as the immediate antecedent event that may have prompted the presentation for treatment.

Treatment

In general, the standard evidence-based treatments apply to military and emergency service personnel. Specific consideration of the following points may be helpful:

- Treatment planning needs to take into consideration the multiplicity of traumatic exposures that military and emergency service personnel have had to deal with and the consequent multiple triggers or trauma reminders.
- Addressing the issues of emotional numbing can be of particular relevance to those individuals who have had a prolonged period of service where this method of adaptation may have become ingrained.

- The existence of comorbid substance abuse is a frequent therapeutic challenge. Evidence suggests this should be dealt with alongside the initial control of an individual's symptomatic distress. This approach takes account of the fact that frequent alcohol usage has been a form of self medication which the individual has used to address their difficulties.

A particular challenge when working with currently serving emergency service or military personnel is the management of exposure to further stressors in the workplace during the immediate aftermath of treatment. In general, it is important to remove the external threat and triggers to the individual's distress. A model of sensitisation and kindling is a valuable theoretical construct to inform any cognitive behavioural management.

The challenge of determining recommendations for future duties should be based on an individual's residual pattern of arousability and general adaptation. If a significant degree of triggered distress remains, it is probable that further exposures will exacerbate the individual's symptoms. In these instances, it is best to minimise the probability of such exposures and recommend alternative duties.

Additional issues specific to military and ex-military personnel

There is some evidence to suggest that military recruits have increased rates of childhood physical abuse, sexual abuse and neglect, as well as high rates of family dysfunction compared with community averages. The practitioner needs to be aware of any such pre-military history, as it is likely to influence the establishment of a therapeutic relationship as well as treatment planning.

On joining the service, military personnel are then confronted with a range of experiences that may contribute to mental health problems. Perhaps of most importance, is the unique requirement for military personnel to be prepared to kill other human beings in the course of their duties. This capacity is fostered through their training to respond to a threat with aggression and to respond to orders with 'instinctive obedience'. For most, the preparedness to kill another person challenges their personal values and the act of doing so can have long-term effects on their fundamental beliefs.

During deployment, it is not uncommon for military personnel to experience multiple traumatic events. Military deployment almost invariably involves exposure to real or threatened death and serious physical injury that can lead to PTSD. Furthermore, the nature of traumatic events experienced on deployment can challenge fundamental beliefs about the self, the world, and humanity. For example, traumatic events may involve the death of civilians and destruction of communities on a scale that is often unimaginable and for which the veteran has had little preparation. Military personnel themselves may have committed acts of violence that, with the benefit of hindsight or emotional distance from the event, may be deemed to be atrocities — such experiences may shatter previously held beliefs about the self.

It was initially thought that peacekeepers suffered low rates of exposure to traumatic stressors, however a number of studies have indicated that peacekeeping missions may present a range of unique stressors that can have a significant psychological impact on deployed personnel. Peacekeepers are often exposed to war zone stress as well as experiencing frustrations associated with peacekeeping duties, such as restrictive rules of engagement (Litz et al., 1997). Experiences that were rated to be moderately to extremely negative, in a recent study of peacekeepers deployed to Kosovo, included: knowing that many of the war criminals were not arrested (73%), seeing children who were the victims of war (67%), seeing civilians in despair (58%), seeing the physical devastation (52%), and knowing that there was a lack of supplies for civilians (52%).

An understanding of the psychological underpinnings of the veteran's initial presentation and a preparedness to give sufficient time to the veteran to establish a trusting relationship will be immeasurably helpful. Given the war-related nature of traumatic events experienced by many veterans, they may anticipate negative evaluation on the part of the health practitioner. To work effectively with military personnel, the practitioner must demonstrate a willingness to listen and the capacity to tolerate the details of traumatic experiences whilst maintaining a positive regard for the individual throughout.

Most clinical treatment trials with veteran populations, both pharmacological and psychological, have shown treatment to be less effective than for non-veterans with PTSD. This may be due to characteristics of the veterans themselves (their gender, nature and duration of traumatic experiences, chronicity of PTSD, high rate of comorbidity), the less rigorous treatment interventions generally used with this population, or potentially complicating factors relating to veterans' compensation, pensions, and other entitlements. Although the practitioner may anticipate more modest outcomes, the general recommendations regarding treatment for PTSD still apply.

MOTOR VEHICLE ACCIDENT AND OTHER INJURY SURVIVORS

As stated in the introduction to this special populations section, the information provided is derived from expert opinion as to the application of the guidelines for this population. Thirty-two studies in the systematic review included participants that were injury survivors from motor vehicle accidents or other causes. With study participants recruited from hospital admissions, most of what we know about motor vehicle accident (MVA) and other injury survivors is based on people who have been severely injured and hospitalised, or at least admitted to a hospital emergency department. MVA survivors with less severe injuries, for example soft tissue injury, may of course also develop PTSD, and many of the issues discussed in this section are relevant to that group. This section addresses issues of PTSD in the context of physical injury and so does not include MVA survivors with PTSD who have sustained no physical injuries. The guideline recommendations can be applied to this group without need for special consideration.

Approximately 2 per cent of all Australians every year are injured severely enough to require a hospital admission. The frequency with which severe injury occurs makes it one of the greatest causes of PTSD in Australia. MVAs are a major cause of severe injury and therefore contribute significantly to the PTSD rate in Australia. Consistent with common responses to traumatic experience noted in Chapter 2, many injury survivors will display PTSD symptoms (nightmares, intrusive memories) in the initial weeks after being injured, but for most these symptoms will resolve within three months. Approximately 10–15 per cent of injury survivors will go on to develop chronic PTSD.

The severity of the injury in terms of its relationship to mortality does not predict the development of PTSD. That is, those with a life threatening injury are no more likely to develop PTSD than those who suffer a serious injury that is not life threatening. The rate of PTSD in those with soft tissue injury has not been established, but if the rate of PTSD is unrelated to injury severity, it may also be in the 10–15 per cent range. The relationship between injury severity and PTSD is, however, different with traumatic brain injury (TBI). Those with severe TBI are less likely to develop PTSD, while those who suffer a mild TBI are just as likely to develop PTSD as those with no brain injury. This is probably associated with the high level of amnesia experienced by those with a severe TBI — those with no memory of the event are less likely to develop PTSD.

Common presenting problems in injury survivors include distressing memories and nightmares about the accident, insomnia, irritability, elevated startle response, and concentration problems. Individuals often avoid situations that are consistent with the event in which they were injured. For example, those injured in a MVA often experience fear of driving and avoidance of traffic. Individuals surviving assault are often avoidant of social situations, especially where there may be crowds or intoxicated people. In some cases individuals become avoidant of hospitals and fail to attend appointments, or do not have follow-up surgery. This may significantly impact their physical recovery. Practitioners should be aware that many injury survivors suffer mild TBI, and have no memory of some parts of the event in which they were injured. Interestingly, although these people may not be able to remember critical aspects of the event, they can still be fearful and avoidant of situations which trigger memories of the event. Depression is very commonly comorbid with PTSD in injury survivors. This is especially the case with those who experience orthopaedic injuries which require long term rehabilitation. The loss of important roles, financial difficulties and uncertainty about the future often contributes to depression. Many injury survivors also suffer chronic pain and this pain can serve to trigger memories of the accident. This can result in individuals avoiding situations which may cause pain to escalate, such as exercise or physiotherapy.

Assessment

There are three main issues pertaining to injury survivors with PTSD that need to be considered during assessment.

First, be aware of the timing of the assessment. There is strong evidence that many PTSD-type reactions that occur in the initial two months will subside in the following period. Intense reactions in this period are less likely to subside without intervention and may need immediate attention. Less severe reactions, however, which are common in this period, are more likely to be transient and resolve without treatment.

Second, injury survivors are characterised by comorbid presentations that have implications for treatment planning. As discussed, depression, mild TBI, and chronic pain are the major problems that co-exist with PTSD after severe injury. It is important to ask specifically about each of these problems to determine the primary presenting problem. Often patients will focus on pain because of its highly intrusive and aversive nature. The practitioner needs to focus interview questions specifically on PTSD or depression in order to avoid missing important information. In the case of mild TBI, it should be noted that people can meet the re-experiencing criteria for PTSD if they are distressed by reminders of the injury causing event (e.g., returning to driving) even if they cannot recall some critical aspects of the accident.

Third, many injury survivors are involved in litigation for criminal or civil purposes. This issue can complicate treatment planning because it can confound the motivational stance of the patient, especially if legal advice is suggesting a particular view about PTSD and its treatment. Assessment should explicitly enquire about litigation status.

Treatment

Injury survivors are often entitled to treatment for mental health conditions arising from their accident through individual state-based authorities. This is especially the case for MVAs and work place accidents. Practitioners should be familiar with entitlements and procedures in the state in which they work.

Treating injury survivors should follow standard guidelines, with particular attention to several possible modifications that are dependent on comorbid presentations.

Chronic pain is a major obstacle to treating PTSD because it can actively interfere with attention on therapy tasks. Also, pain can act as a reminder of the trauma and complicate treatment for pain and PTSD. Depending on the severity of the pain, it may be preferable to achieve adequate pain management prior to the commencement of PTSD treatment.

Depression that is comorbid with PTSD typically leads to a more severe clinical presentation. As outlined in the guideline recommendations, suicidal ideation requires careful assessment and management prior to commencement of exposure therapy.

Patients with brain injury who are amnesic of the accident (or part of it) may benefit more from in vivo exposure to situations that elicit anxiety than imaginal exposure. This approach can be beneficial because imaginal exposure can be limited when there are few memories of the trauma, and when attentional deficits interfere with focus on trauma memories for prolonged periods.

Although exposure therapy is the treatment of choice for people who develop PTSD following injury, practitioners should be aware that any therapy that actively addresses trauma memories has the potential to alter memory and, therefore, may be subjected to scrutiny in court. Some courts are particularly concerned about the use of hypnosis and EMDR as techniques that have the potential to modify trauma-related memories. Thus the use of these treatments may lead to a client's evidence being inadmissible in court. It is advisable to avoid these treatments in cases that are subject to litigation. If such approaches are adopted, the practitioner would be advised to videotape all sessions.

VICTIMS OF CRIME

As stated in the introduction to this special populations section, the information provided is derived from expert opinion as to the application of the guidelines for this population. Twenty seven studies in the systematic review included participants that were victims of crime.

Background

There is debate in the literature about what constitutes a victim of crime, but the following United Nations (1985) definition is widely accepted:

...persons who, individually or collectively, have suffered harm, including physical or mental injury, emotional suffering, economic loss or substantial impairment of their fundamental rights, through acts or omissions that are in violation of criminal laws operative within Member States, including those laws proscribing criminal abuse of power.

Around 30 per cent of the Australian population report being a victim of crime (including robbery, burglary, attempted burglary, car theft, car vandalism, bicycle theft, sexual assault, theft from car, theft of personal property, assault and threats) in a given year. However, PTSD is not a potential outcome for all victims of crime. The diagnosis is applicable only in cases where the crime constituted a potentially traumatic event as defined by DSM-IV. In general terms these are crimes of an interpersonal and violent nature. A much lower, though still significant figure of 4 per cent of the Australian population, report being a victim of personal crimes, such as robbery, sexual assault and assault with force, that are more likely to be associated with subsequent PTSD. When looking at recorded (by the police) crimes, males are more likely than females to be victims of all personal crimes, except sexual assault and abduction. For example, in 2003, just under 1 per cent of males reported to police that they were a victim of assault and 0.15 per cent of females reported being a victim of sexual assault or kidnapping (ABS, 2005). However, because there is a suspected low incidence of reporting, the true figure of victimisation, particularly for sexual crimes, is unknown.

The prevalence of PTSD in victims of crime is dependent upon the type of crime, the method of measurement and the definitions used. The lifetime PTSD prevalence rate for victims of crime is estimated to be about 25–28 per cent, with higher rates following interpersonal crimes such as rape (e.g., 45–60% following rape in women). In an Australian representative sample, it was found that 5.4 per cent of women reported experiencing a rape and 10.2 per cent reported molestation. Of those who reported that the most traumatic event they had experienced was rape, 9.2 per cent met criteria for PTSD in the past 12 months. Males who are raped appear to report a higher prevalence rate of PTSD.

Anecdotal reports suggest that PTSD in victims of crime is frequently erroneously diagnosed. It has been noted that the diagnosis is sometimes given based upon the type of incident leading to therapy, rather than the actual presentation, and the symptoms cited to support the diagnosis were frequently not PTSD criteria. With this in mind, it has been found that victims of crime are more likely to suffer from depression rather than PTSD, with up to 13 per cent of rape victims attempting suicide.

Assessment

In addition to the recommendations regarding assessment in Chapter 2 — Comprehensive assessment of PTSD, issues of particular relevance to victims of crime during assessment include the following:

- The practitioner should clarify with the person whether the interview is a forensic assessment or a therapeutic assessment.
- A full assessment of the person's functioning and impairment before the crime in question and an assessment of current functioning needs to be conducted.
- An assessment of the full breadth of areas affected by the crime—including reactions to both personal victimisation and property damage, subsequent family, vocational and social relationships, as well as the affective and psychological reaction of the victim.
- General interview-based questions should be used to initiate the assessment procedure rather than specific questions or structured questionnaires, which may prime the person to answer in certain ways.
- Unless conducting a forensic assessment, conclusions should be fed back to the person and explained appropriately so as to minimise later confusion should these results be called into court.
- It is essential that complete and full notes be taken during the assessment interviews and subsequent treatment sessions. Failure to do so may later prejudice the victims' rights should any court case ensue.

Treatment

An awareness of the legal system is important when treating victims of crime with PTSD. In Australia, the rights and laws pertaining to victims of crime are predominantly state based rather than national and hence vary between states. However, all the states have some mechanism whereby victims of crime can claim either compensation and/or access to mental health treatment for conditions related to their victimisation. Mental health practitioners need to have knowledge of these laws and services specific to where they practice.

In addition to the recommendations regarding treatment outlined in Chapter 4, issues of particular relevance to victims of crime include the following:

- Due to the nature of criminal compensation some people may perceive a vested interest in maintaining symptomatology until all proceedings have completed. It is advised that the therapist address this issue with the person before initiating treatment.
- Prolonged imaginal exposure to the event, when managed by a well trained therapist, has demonstrated efficacy with victims of crime and should be administered, sensitively, as a matter of course.
- It can be difficult for new therapists to avoid being compromised in their role as an agent of change to become, instead, an advocate. Therapeutic outcomes are best served through objective analysis of the presenting problems and the impartial application of evidence-based practice.
- Treatment sessions should be recorded, where possible, so that any accusations of tainted evidence arising during later litigation can be evaluated. Of course the rationale for recording sessions should be carefully explained to the person and their consent obtained before recording begins.

Beyond these general considerations, an individual's needs will vary depending on the nature of the crime. For example, there is domain specific knowledge related to rape victims that may be less relevant to victims of assault; practitioners should acquaint themselves with these areas before providing treatment. Secondary consultation with a counsellor from a specialist sexual assault centre in your state would be recommended. The practitioner may also consider referring the person to a specialist sexual assault centre for advocacy or assistance with court proceedings if the practitioner is not going to offer this service themselves.

SEXUAL ASSAULT

As stated in the introduction to this special populations section, the information provided is derived from expert opinion as to the application of the guidelines for this population. Twenty four studies in the systematic review included participants that were survivors of sexual assault.

This section applies to adults with PTSD arising from sexual assault, whether that assault occurred during childhood or adulthood. As such, the nature of the traumatic event is highly variable (from repeated childhood sexual abuse to a discrete adult rape) and the posttraumatic mental health sequelae are consequently also highly variable. The guidelines are applicable to survivors of sexual assault with PTSD, with or without comorbid disorders. Of course not all survivors of sexual assault will have PTSD and therefore PTSD treatment guidelines will not be applicable to all.

Background

The mental health practitioner treating survivors of sexual assault should be aware of a number of important background issues. Sexual assault is a unique crime in that it is most often carried out in private, is shrouded in secrecy and involves a victim who often blames himself or herself. In children the majority of sexual abuse is perpetrated by a family member or person known to the child. (The media push for awareness via the concept of ‘stranger-danger’ only addressed a minority of perpetrators and victims). As a consequence, many adult survivors of child sexual abuse may still have contact with their abuser.

Sexual assault was rarely discussed in Australia until the 1970s and childhood sexual assault was almost never disclosed. Unfortunately, when childhood sexual abuse was disclosed, the victim risked being accused of fantasising, lying, seeking attention or seeking revenge. In the past 30 years survivors of sexual assault have increasingly reported the assault, but there is still considerable societal, familial and individual pressure to remain silent. People alleging sexual assault are the least likely of all crime victims to report the offence to the police. Further, of those reported, only a small proportion are prosecuted — one in six rapes and less than one in seven reports of incest/sexual penetration of a child. These conviction rates are substantially lower than rates for other offences, and unfortunately there is no trend towards successful convictions over time. Convictions for rape have actually fallen since the late 1980s.

Negative stereotypes of sexual assault survivors as unworthy or undeserving continue to prevail in both the legal system and broader society. These stereotypes inevitably impact on the individual, creating additional distress beyond the traumatic experience itself.

Given the ‘hidden’ nature of sexual assault and low reporting and conviction rates, it is perhaps not surprising that there is little reliable information on the prevalence of sexual assault or childhood sexual assault in the Australian population. Existing data is based on the Australian Institute of Criminology’s studies on sexual assault and the criminal justice system, and the Australian Bureau of Statistics Women’s Safety Survey. To-date there has been no large-scale national population survey that includes childhood violence against boys. As a result, current knowledge about childhood sexual assault on boys is dependent on reports made to statutory child protection agencies. It is estimated that the prevalence of sexual assault before the age of 18 years in the Australian community ranges between 15 and 30 per cent for females, and between 3 and 15 per cent for males. As adults, those at greater risk of sexual assault are female, young and single, have a prior history of sexual assault, and have existing relationships with offenders.

It is important to acknowledge the intergenerational transmission of abuse. Women abused as children may repeatedly form relationships with abusive, violent partners who may, in turn, sexually and/or physically abuse her children. Additionally, if, for example, female caregivers are depressed, children may be receiving little protection and/or no positive parenting guidance or strategies.

Adult versus childhood sexual assault

For adults with PTSD following sexual assault, the trauma may range from a discrete adult trauma of rape to repeated sexual abuse during childhood, or a combination of both. The nature of childhood sexual abuse itself is highly variable. Sexual abuse involving penetration (digital or otherwise), as opposed to touching or fondling, has been found to be the most harmful abuse experienced. This is also true of sexual abuse involving degradation and violence. Not surprisingly, typical presenting problems differ according to the type and number of sexual assaults experienced. The practitioner should be aware of these typical presentations (outlined below) and ensure a comprehensive assessment of sexual assault, especially if a prior history of assault or sexual abuse is suspected. In some cases, the individual who has been sexually abused as a child will present for treatment of PTSD for the first time as an adult.

A. COMMON PRESENTING PROBLEMS IN SURVIVORS OF ADULT SEXUAL ASSAULT

- recurrent daytime memories/flashbacks and distressing dreams
- intrusive physical symptoms such as palpitations, sweating, breathing difficulties
- hypervigilance (e.g. fear of going out)
- sleep problems
- eating difficulties
- mistrust of males/females affecting the formation of relationships
- loss of interest in usual activities.

B. COMMON PRESENTING PROBLEMS IN ADULT SURVIVORS OF CHILDHOOD SEXUAL ASSAULT

- PTSD with prominent avoidance/numbing symptoms
- depression/anxiety
- personality disorders (e.g. borderline personality disorder)
- attachment disorders
- self harming
- recurrent thoughts of death, suicidal behaviour
- drug and/or alcohol abuse
- substance abuse
- eating disorders
- relationship problems
- sexual difficulties
- promiscuity or acting out sexually
- parenting problems
- regular dissociative episodes.

Assessment

As noted above, many survivors of sexual assault have experienced prior assault in adulthood or as children. It can be difficult in some cases to assess whether the most recent assault is the cause of PTSD or whether it is the result of previous or repeat assault(s). Consistent with the assessment recommendation in Chapter 2 above, a comprehensive assessment should include a detailed lifetime history of sexual assault and psychological sequelae of any previous trauma. In addition, with survivors of childhood sexual assault it is important to gain an understanding of their family background. It is unclear whether there is a direct causal link between childhood sexual assault and adverse psychological and social outcomes. It has been suggested that the fundamental damage is to the child's developing capacities for trust, intimacy, agency and sexuality, and that many of the mental health problems of adult life associated with histories of abuse are second-order effects.

Given the societal context of sexual assault, it is essential that the practitioner accepts the person's account of their traumatic experience without seeking to investigate the authenticity of their claims. Victims/survivors have often had negative responses to their disclosures from friends, family or the criminal justice system and may anticipate disbelief and denial from the clinician.

The gender of the practitioner needs to be given due consideration in working with survivors of sexual assault. It cannot be assumed that a female or male will prefer to work with a practitioner of either the same or the opposite gender. This matter needs to be discussed and if possible, the person given the choice of therapist gender.

Treatment

Recommended treatments for PTSD outlined in Chapter 4 above, apply to survivors of sexual assault. The recommendation to allow more time for establishing a therapeutic relationship, and teaching emotional regulation skills in those with prolonged and/or repeated traumatic experiences, is generally relevant to survivors of childhood sexual assault. In addition, the following specific considerations apply to sexual assault survivors with PTSD.

Given the broader legal context, practitioners working with survivors of sexual assault should have knowledge of relevant reporting, compensation and restorative justice approaches, in order to provide the person with appropriate support and advice.

If the person has ongoing involvement with the criminal justice system there is a high risk of additional distress from a variety of sources, including contact with the alleged offender, cross examination and the general experience of the court system. This will inevitably impact on treatment and should be taken into consideration in treatment planning. In general terms, it would not be reasonable to postpone treatment until the end of (often lengthy) legal proceedings, but the practitioner and PTSD sufferer should give careful consideration to the appropriate timing of trauma-focussed work in this context. In circumstances when the decision is made to defer treatment, the practitioner should consider referring the person to a specialist sexual assault centre for support during legal proceedings.

NATURAL DISASTERS

As stated in the introduction to this special populations section, the information provided is derived from expert opinion as to the application of the guidelines for this population. Four studies in the systematic review included participants that were survivors of natural disaster.

Please note that this section does not provide guidelines for disaster response more broadly. The National Mental Health Disaster Response Committee has been established to inform planning, preparation, rescue and response as well as the recovery period, in terms of mental health.

Disasters, by their nature, are large-scale events that impact upon significant groups within the community. There are a variety of natural and other types of disasters. Some, such as earthquakes and bushfires affect a local community and impact on a relatively well defined geographical region. Others, such as aeroplane crashes, involve individuals from many geographic regions as well as a local community where the actual accident occurred. Furthermore, these events may be brief and dramatic, such as a bushfire, or may have evolved over a much longer timeframe, such as a flood or drought. The nature of exposure to trauma in disasters varies considerably according to the type of disaster and the proximity of the individual to the causal agent. Equally, the various roles that people can play in disasters means there will be a significant difference in the impact upon the primary victims, compared with the impact on secondary victims, (i.e., emergency service personnel who are required to become engaged in the search and rescue). This section includes issues for consideration by both service planners and service providers.

Issues for service planners

For natural disasters, there is some support for using generic, community-based low-level services as preferred sources of support. These underpin the identification of needs and uptake of more specialist mental health interventions. The size of the population affected by a natural disaster is critical in determining the structure of the treatment services required to deal with the aftermath. Optimally, any treatment services should be linked to the existing health services in which disaster victims have confidence prior to the event. A frequent mistake is that planners presume there will be an early need for services, when in fact there tends to be low rates of uptake of services in the immediate aftermath of the disaster, with a progressive increase in need over a period of approximately two years after the event. In the aftermath of the disaster, particularly in light of the evidence about debriefing, those responsible for disaster management should attempt to limit the many volunteers who have emerged to provide 'post disaster counselling' in the aftermath of such an event. These individuals and their desire to assist can at times become a major issue in terms of the logistics and management of the large number of people converging on the disaster zone. It is important that the evidence about debriefing and acute treatments are provided to those involved in policymaking to ensure that the structure and nature of the services provide evidence-based interventions.

In the acute aftermath, psychological first aid is optimally provided in conjunction with the acute welfare needs of the population. Also, a decision should be made in the early recovery phase as to whether a systematic outreach, with an emphasis on screening, is to be instigated. If such a program is to be implemented, the high-risk groups should be identified and targeted. At-risk groups will be those who have lost family or suffered major property destruction or sustained injury.

Disasters are an opportunity to address many longstanding deficiencies in the provision of mental health care in the affected populations. Therefore, these events are of considerable importance in ensuring that high quality evidence-based care programs are put in place. They provide an opportunity for upgrading and improving the quality of clinical care for the broader population. Individuals who have been previously traumatised may first present for treatment in the aftermath of a disaster. Therefore, the skill base of the clinicians intervening with a disaster affected population should be capable of dealing with the broad range of traumatic events.

In disasters involving the loss of a large number of lives, specific consideration needs to be given to the issue of traumatic bereavement. In such instances, the sole treatment of PTSD will not address the full extent of the person's predicament. The interaction between an individual's traumatic memories and the grief process needs to be addressed. Also, in large mass casualty situations, providing basic skills and training to the surgeons, doctors and nurses involved in care can be a method of disseminating information and basic principles to a large number of people.

Media coverage of disasters provides an opportunity to use this coverage to provide information to a large number of people. Equally, it is important to have a series of information resources that can be made available to various organisations that have ongoing contact with those affected by the disaster. Such information sheets can assist in facilitating the linking of those in need with appropriate treatment services.

Issues for service providers

The immediate aftermath of a disaster involves a dramatic period where there is an attempt to mitigate the immediate physical threats and take steps to ensure the physical safety and wellbeing of the affected population. This involves the provision of emergency food and shelter and securing people's possessions if their homes have been destroyed. There is also the need to document and take stock of the losses incurred. In the immediate aftermath of these events, there is a small group of people who become acutely distressed and may develop an acute distress disorder. However, the majority of people rise to the practical demands of the situation and their psychological distress is not an immediate issue.

There is often a long window of presentation to health services following such events. There is an expectation within communities that people who have sustained significant losses will experience a degree of enduring distress. However, once there is a relative degree of normality returning within a community, the experience of distress for some individuals will remain and may even intensify. It is at such times that presentations for care often increase in frequency. In other words, once the external demands begin to decrease and the obvious causes of distress lessen, individuals begin to acknowledge the possibility that their distress is out of keeping with the reality of their circumstances and may seek care.

Psychological distress in the aftermath of disasters can emerge in the form of family dysfunction, substance abuse, and conflict within the affected community. Disasters not only trigger PTSD but a range of other possible presentations, such as adjustment disorders, somatic distress, major depressive disorder, and substance abuse.

One of the more characteristic presentations of PTSD in this setting is the considerable anxiety that the individuals will demonstrate if the threat of a similar event begins to emerge. Their triggered pattern of distress is a matter that is readily observed.

Assessment

Unless the entire infrastructure of a community is destroyed, most disaster victims prefer to utilise the care networks that they are familiar with, focusing primarily on the local general practitioners. Given the delay in help-seeking, an opportunity exists for training general practitioners in the diagnosis and assessment of PTSD and other psychiatric conditions which are likely to emerge.

Given the predictability of disorder, if the affected population can be well circumscribed, an outreach program involving screening should be considered for high-risk individuals. Such an approach should only be contemplated if the appropriate clinical services are in place to provide care to those who are identified. Standard diagnostic tools such as the PCL and the CAPS, described in Chapter 2, are appropriate for use in this setting.

The assessments conducted in these populations should consider the fact that there will be a background pool of psychiatric morbidity within the affected community. The challenge is to define those individuals who have had an exacerbation or modification of existing symptom patterns, as opposed to the emergence of a new condition. This is relevant to the provision of treatment.

Treatment

As noted above, various forms of psychological distress are seen in survivors of natural disasters and there is likely to be a wide range of clinical needs. For those who develop ASD and/or PTSD, the recommended treatments generally apply. There are however, a number of specific challenges:

- Large numbers of people will potentially require access to treatment over a prolonged period of time. It is important that evidence-based treatments for PTSD are available to these affected communities. This is a particular challenge in rural and remote communities where there is often a paucity of appropriately trained practitioners.
- Multiple members of the same family may be suffering simultaneously, possibly impacting upon the pattern of symptomatic distress; for example, if both a husband and wife are suffering. Treatment may need to address these relationship dimensions because they can serve to influence the patterns of withdrawal and avoidance.
- In cases where the individual with PTSD has suffered economic and social disadvantage as a result of the disaster, the circumstances in which they find themselves can serve as a constant reminder of their traumatic experience and thus complicate the treatment.

Recommended reading

Davidson, J.R.T (2006) After the tsunami: mental health challenges to the community for today and tomorrow. *Journal of Clinical Psychiatry* 67 (Suppl 2), 3–79.

Drabek, T. E., (1986). *Human System Responses to Disaster: An Inventory of Sociological Findings*, Springer-Verlag, New York.

Kaniasty, K. & Norris, F. (1999). The experience of disaster: individuals and communities sharing trauma. In: Gist R. & Lubin B. (eds) *Response to Disaster: Psychosocial, Community, and Ecological Approaches*. Brunner/Mazel, Ann Arbor.

TERRORISM

As stated in the introduction to this special populations section, the information provided is derived from expert opinion as to the application of the guidelines for this population. No studies in the systematic review included participants that were reported to be survivors of acts of terrorism.

Please note that this section does not provide guidelines for disaster response more broadly. The National Mental Health Disaster Response Committee has been established to inform planning, preparation, rescue and response as well as the recovery period, in terms of mental health.

There have been several attempts to develop precise working definitions of terrorism. The United Nations has proposed a short legal definition: '[an act of terrorism is] the peacetime equivalent of a war crime'. More precise definitions of terrorism tend to be relative, because judgments about acts of political violence are often subjective. For example, the United States Department of Defense defines terrorism as:

...the calculated use of unlawful violence or threat of unlawful violence to inculcate fear; intended to coerce or to intimidate governments or societies in the pursuit of goals that are generally political, religious, or ideological.

Although more comprehensive, this definition is problematic because it relies on vague terms which are left open to interpretation (such as 'unlawful violence', 'intended to coerce or intimidate', 'the pursuit of goals...').

Terrorist acts usually involve high levels of destruction to property and, more importantly, to people. There is likely to be widespread threat to life and actual loss of life. There may well be exposure to grotesque sights for those involved, including the death and suffering of others; this may include close family members and friends. Difficulty (or inability) in helping others in the aftermath of the attack may precipitate feelings of helplessness and guilt.

The fear generated by terrorist attacks is unsurprising; they are characterised by many features typical of high severity traumatic events. Terrorist acts are generally unpredictable in terms of place, timing, and potential victims; as such, they are completely uncontrollable (at least for the general population), increasing the risk of perpetual hypervigilance. Bioterrorism carries added threat since it is so poorly understood and is, effectively, 'invisible'. It is hard to be definite about whether an individual or group has been 'contaminated' and, even if individuals have clearly been exposed to pathogens, the likely health effects are rarely clear.

It is important to remember that the main goal of terrorism is exactly that — to generate feelings of terror in the community. Acts of terrorism are extremely rare (particularly in Australia) and the effects of fear and hypervigilance are often well in excess of the actual damage posed by, or caused by, the terrorist act.

In short, terrorist acts are generally high magnitude traumatic events, of very rare occurrence, capable of generating widespread fear and hypervigilance.

Importantly for these guidelines, there has recently been an increase in the (perceived) threat of imminent terrorist activity. For mental health professionals, this raises questions as to the best way to prepare for such attacks and the best way to manage the mental health consequences.

Preparing for the threat of terrorism

Reactions to terrorism can be made worse by sensational media reports and by poor communication by public officials. Thus, a key role for mental health professionals is often that of working with the media and public officials to ensure that appropriate messages are disseminated. Communications to the general population should be informed by the following recommendations (adapted from Foa et al., 2005):

- Provide realistic information on the likelihood of a terrorist attack and possible impact.
- Communicate that the individual risk is quite low.
- Explain that negative health behaviours which may increase during times of stress (e.g., smoking, unhealthy eating, substance use) constitute a greater health hazard than the hazards likely to stem from terrorism.
- Emphasise that the only action required on the individual level is increased vigilance of suspicious actions, which should be reported to authorities.
- Clearly communicate the meaning of different levels of warning systems.
- When issuing a warning, specify the type of threat, the type of place threatened, and indicate specific actions to be taken.
- Make the public aware of steps being taken to prevent terrorism without inundating people with unnecessary information.
- Provide the public with follow-up information after periods of heightened alert.

Communications by the media and public officials should also include simple information about resilience and about expectations of recovery. Many simple fact sheets on resilience in the face of terrorism are available on the internet (see, for example, <http://www.acpmh.unimelb.edu.au>, <http://www.ncptsd.org> <http://www.usuhs.mil/csts>, <http://www.apa.org/topics/topictrauma.html>).

Responding to an attack

A. IMMEDIATE

An attack of small to moderate impact is likely to generate moderate to major psychological and behavioural reactions in the short term, and the greater the harmful impact of the attack, the greater the likely reaction. Proximity to the attack and number of attacks will influence the severity of individual reactions. There is no reason to assume that the nature of clinical reactions, when they occur, would be significantly different to those seen following other types of traumatic events.

Immediate reactions are likely to include heightened anxiety, panic attacks, sleep and substance use problems, absenteeism from work, and retaliatory reactions against minorities identified with the terrorists. Reactions are likely to subside over the medium term (days to weeks), although repeated attacks and/or widespread loss of life and/or significant damage to infrastructures may result in increased psychological and behavioural reactions.

It is important to remember that most people will recover without any mental health assistance; thus, interventions at this stage should be based around providing information and activating community support:

- support the work of the emergency services
- activate and facilitate community support networks
- provide accurate information about the event and its consequences
- facilitate accurate and balanced communication by the media, schools, workplaces, etc
- establish information and drop-in centres to provide information, support, contacts, etc.

Although debate exists in this area, it seems reasonable to implement some kind of low key screening to facilitate identification of those individuals who are not showing the normal recovery trajectory and who are developing identifiable mental health problems. This might be done as part of a public health approach ('... if you are experiencing several of these symptoms, we suggest you visit your local GP') or in a more restricted manner (such as through advertising telephone numbers for trained personnel to conduct screening). The key point is that secondary prevention — early intervention for individuals with mental health problems following trauma — is demonstrably effective IF they can be identified. This approach requires that educational material is made available to general practitioners to ensure that appropriate assessment, education and advice is forthcoming.

B. LONGER TERM

Significant longer term mental health reactions are likely to be limited to a relatively small proportion of the population. These reactions may include traumatic stress symptoms, other anxiety disorders, depression and substance use, all of which may be associated with impaired functioning and increased distress. The ongoing fear of another attack is likely to pervade all reactions to a greater or lesser extent.

With regard to interventions, there is little empirical knowledge about optimum interventions following terrorism and no available empirical knowledge about interventions following bio-terrorism. However, there is no reason to assume that interventions for those developing PTSD and related conditions following terrorism should be any different to those recommended for other trauma survivors. Thus, decisions regarding interventions with populations who have undergone a terrorist attack should be driven by the recommendations in the remainder of these guidelines.

Notes:

1. Parts of the first paragraph were adapted from <http://en.wikipedia.org/wiki/Terrorism>
2. The remainder of this section relied heavily on information taken from Ursano (2003).

Recommended Reading:

Ursano, R. (ed) (2003). *Terrorism and disaster: Individual and Community Mental Health Interventions*. Cambridge University, New York.

ADDENDUM TO THE SPECIAL POPULATIONS SECTION: NICE GUIDELINE RECOMMENDATIONS FOR THE RECOGNITION AND MANAGEMENT OF PTSD IN CHILDREN AND YOUNG PEOPLE

As noted in Chapter 1, the current guidelines did not include a systematic review of the literature on children. As a guide to assist practitioners, however, we include the following recommendations made by the United Kingdom National Institute for Clinical Excellence (NICE) in their Clinical Practice Guidelines for PTSD. The full NICE Guidelines are available from their website (<http://www.nice.org.uk>).

Recognition in primary care

For children, particularly younger children, consideration should be given to asking the child and/or the parents about sleep disturbance or significant changes in sleeping patterns. **C**

Specific recognition issues for children

Children, particularly those aged under 8 years, may not complain directly of PTSD symptoms, such as re-experiencing or avoidance. Instead children may complain of sleeping problems. It is therefore vital that all opportunities for identifying PTSD in children should be taken. Questioning the children as well as parents or guardians will also improve the recognition of PTSD. PTSD is common (up to 30%) in children following attendance at emergency departments for a traumatic injury. Emergency department staff should inform parents or guardians of the risk of their child developing PTSD following emergency attendance for a traumatic injury and advise them on what action to take if symptoms develop.

- When assessing a child or young person for PTSD, health care professionals should ensure that they separately and directly question the child or young person about the presence of PTSD symptoms. They should not rely solely on information from the parent or guardian in any assessment. **GPP**
- When a child who has been involved in a traumatic event is treated in an emergency department, emergency staff should inform the parents or guardians of the possibility of the development of PTSD, briefly describe the possible symptoms (sleep disturbance, nightmares, difficulty concentrating and irritability) and suggest that they contact their GP if the symptoms persist beyond one month. **GPP**

Early intervention

The treatments for children with PTSD are less developed, but emerging evidence provides an indication for effective interventions.

- Trauma-focussed CBT should be offered to older children with severe posttraumatic symptoms or with severe PTSD in the first month after the traumatic event. **B**

PTSD where symptoms have been present for more than three months after a trauma

- Children and young people with PTSD, including those who have been sexually abused, should be offered a course of trauma-focussed cognitive behavioural therapy adapted appropriately to suit their age, circumstances and level of development. **B**
- The duration of trauma-focussed psychological treatment for children and young people with chronic PTSD should normally be 8–12 sessions when the PTSD results from a single event. When the trauma is discussed in the treatment session, longer sessions than usual are usually necessary (eg., 90 minutes). Treatment should be regular and continuous (usually at least once a week) and should be delivered by the same person. **C**
- Drug treatments should not be routinely prescribed for children and young people with PTSD. **C**
- Where appropriate, families should be involved in the treatment of PTSD in children and young people. However, treatment programs for PTSD in children and young people that consist of parental involvement alone are unlikely to be of any benefit for PTSD symptoms. **C**
- When considering treatments for PTSD, parents and, where appropriate, children and young people should be informed that, apart from trauma-focussed psychological interventions, there is at present no good evidence for the efficacy of widely-used forms of treatment of PTSD such as play therapy, art therapy or family therapy. **C**