Refugee Mental Health

Psychiatric Interviewing of Refugee Patients

Video Workbook

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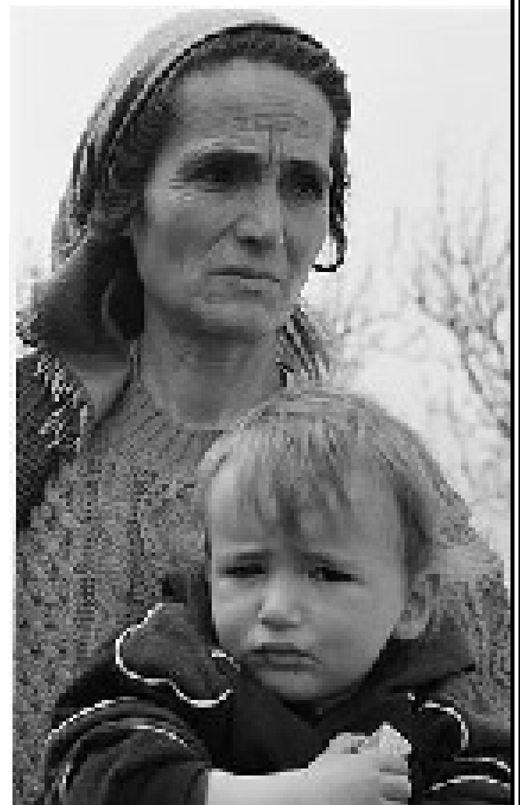

This is one in a series of training videotapes produced by the University of Minnesota's Refugee Assistance Program- Mental Health Technical Assistance Center, funded through a contract with the National Institutes of Mental Health in conjunction with the Office of Refugee Resettlement. The video workbooks have been updated by the MDH Refugee Health Program to promote continued use of these quality resources. Originals are available upon request.

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The music used in the videotape, Pucelete, a 13th century French motet, was performed by The New International Trio, a Minnesota musical group specializing in Medieval, Cambodian, Celtic, and American swing music played on traditional instruments. We wish to thank the group members, Dick Hensold, Bun Loeung, and Barb Weiss for their contribution.

Finally, we would like to express our appreciation to Rosa Garcia Peltoniemi, Ph.D., co-ordinator of the project, for her valuable assistance throughout the development of this videotape.

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Dr. Amos Deinard

Amos Deinard, MD, MPH, has been on the faculty of the Department of Pediatrics, University of Minnesota, since 1969. Beginning in 1979, as the Pediatric Consultant to the Minneapolis Health Department's Bureau of Maternal and Child Health program, he became involved not only in the direct care of refugee children who were immigrating from the refugee camps of Southeast Asia, but in health care program planning and development as well. In addition, he was the Principal Investigator of a resettlement project and a project funded by the National Institute of Mental Health to create a technical assistance center that would provide mental health assistance to those State mental health programs that were serving large numbers of refugees (NIMH-TAC/MH). All of the print and videotape documents that were developed under the terms of the NIMH-TAC/MH contract are included in this collection.

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Overview

Refugee Mental Health: Psychiatric Interviewing of Refugee Patients

This training package is one in a series of four videotapes, each with its own workbook, designed to provide training in refugee mental health. The other topics covered in the series include: primary prevention, psychological testing with refugees and the use of interpreters in mental health service delivery for refugees.

The primary audience for this program includes psychiatry, psychology, social work, and nursing professionals, or those currently in training for these professions. Other audiences include psychiatry and primary care medical residents or fellows and practicing allied mental health professionals wanting or needing continuing training, especially if they have limited cross-cultural exposure.

This program examines challenges that face mental health professionals when assessing psychopathology across cultures and discusses how interviewing refugee patients differ from interviewing non-refugee patients. It describes the psychiatric interview and offers suggestions for modifying it to fit the needs of refugee patients. Included is a simulated interview which illustrates mistakes commonly made by clinicians who interview refugee patients with the assistance of an interpreter. The program discusses differences in frequent psychiatric disorders and presentation of mental disturbances in refugees. It highlights the differing cultural expectations which refugees and clinicians bring to the interview. Interview content, approaches to interviewing, and common problems encountered when assessing refugees are reviewed in detail. The narrator, along with selected experts, comments on a number of special issues facing the clinician, such as evaluating the needs of torture victims, addressing counter transference, using rating scales, and working with interpreters. Guidelines for working with trained and untrained interpreters are suggested.

The handouts and supporting materials summarize important points for the viewers and provide a further opportunity for review and discussion. Instructors can choose among them to meet the needs of their participants. Suggestions for conducting video discussion groups are included. Literature references are provided.

Suggested Guidelines for Video Discussion Groups

This videotape provides an overview of psychiatric interviewing of refugee patients and reviews interview content, approached, and common problems in assessing psychopathology in this population. The videotape is structures so that it can be shown in its entirety or in sections. Because the videotape presents a great deal of information within a relatively short period of time, showing the videotape in sections may be more constructive for training. This format also provides opportunities to discuss the material immediately after it is presented. The depth of the discussion that can follow the videotape, wither in sections or in its entirety, will be shaped by the needs of the trainees and by the limitations of the training sessions.

Listed below are the major sections of the videotapes with suggestions for further discussion. The length of each section in included in parentheses.

1) Introductions and simulated interview

10 minutes

After viewing the simulated interview, the instructor can lead a discussion on mistakes observed in the vignette. Put discussion of the vignette in the videotape can be shown either before, to stimulated interaction among training participants, or afterwards, as a general summary of this section.

Given the scope and the time limitations of this videotape, showing a "correct" interview was not feasible. The specific approach used in an interview will vary depending upon the characteristics of the patient and the background of the interviewer. Instead, role playing is suggested as a way of learning appropriate ways of interviewing. When role playing, the "patient" can be from any culture and have different chief complaints. Therefore, the patient profile can be tailored to resemble patients seen by trainees in their clinical practice. Role playing can be done wither after viewing this sections or after the participants have become familiar with other issues presented in this videotape.

2) Expectations of refugees and clinicians; concepts of disease etiology

7 minutes

The participants can become familiar with cultural characteristics and issues by sharing experiences they have had with refugee patients. The instructor can expand upon issues that are problematic or sensitive. For example, the following issues may deserve further discussion:

Trainees often hold stereotyped views of refuges. Because these stereotypes can influence the clinician's expectations of the patient, it is importance to examine them. Participants can select an ethnic refugee group that is common in their community and discuss their knowledge of that group and their expectations for patients from this group.

Confidentiality is an important issue in clinical practice. Although many refugee patients may not be familiar with formal aspects of confidentiality in the mental health setting, this concept is not totally unfamiliar to them. Many refugee groups may tell or receive information in confidence, but only with selected people such as family members, as is true with the Hmong. Because this background, many refugees do not chare sensitive or personal topics with outsiders, including mental health professionals.

People from different cultures have different concepts of disease etiology. Many refugees believe in spiritual causes of illnesses, which may include influences from gods, ghosts, and witches. Examining these firmly-rooted belief systems is important for understanding the refugee patient.

Translating certain psychiatric terms is problematic. In many cultures, there may not be a direct translation for words such as anxiety and depression. However, this does not mean that such concepts do not exist in these cultures. Clinicians should not be alarmed if the refugee patient fails to express subjective distress in the same manner as non-refugee patients.

3) History taking and mental status exam

12 minutes

There is much information that needs to be gathered during an interview. A thorough history and assessment of current functioning are particularly important for refugee patients. The videotape examines these areas systematically and offers ways to modify the interview for use with the refugee patient.

The audience needs to become familiar with areas assesses and to focus on specific ways the interview can be adapted for use with refugees. Participants can offer suggestions on how interview can be modified to meet their specific needs and discuss the strengths and weaknesses of such modifications.

4) Special Issues

12 minutes

This section presents topics with which refugee mental health providers should become familiar. The participants can share their own experiences and feelings associated with specific populations or issues (i.e. torture victims or counter transference).

An issue of interest to most clinicians in refugee mental health is working with interpreters. The benefits and limitations of working with interpreters can be discussed. The audience can also discuss the utility of the guidelines presented in the videotape. A related issue is that of translation distortions which can occur when interpreting through interpreters. Another program in this series entitled “Refugee Mental Health: Interpreting in Refugee Mental Health Settings” addresses this topic in more detail.

Abstracts of Reports on Interpreting in Mental Health Settings

Refugee Assistance Program – Mental Health: Technical Assistance Center, University of Minnesota

1) **Benhamida, L (1988). Interpreter training: A review and discussion of existing interpreter training programs. (Contact No. 278-85-0024 CH). Washington, DC: National Institute of Mental Health.**

This report is directed to mental health professionals and interpreter trainers who wish to increase their knowledge of existing interpreter training programs. The appendices contain valuable information for those seeking local and regional contacts with others with expertise in interpreter training. In addition curriculum outlines of several outstanding programs are included.

2) **Benhamida, L. (1988). Language planning in mental health for refugees and others: Obtaining quality translations (Contact No. 278-85-0024 CH). Washington, DC: National Institute of Mental Health.**

This report is directed to mental health professionals who may need to have written material, such as informed consent forms, translated. The purpose is to introduce them to the best way to ensure a quality translation as a fair price and on a timely basis. Those who follow the guidelines presented should be able to avoid the frustrations and expense, in time and money, of having an inadequate translation by an amateur redone. In addition they will not be vulnerable to liability suits for having provided patients and clients with inaccurate and misleading translations.

3) **Benhamida, L. (1988) Interpreting in mental health settings for refugees and others: A guide for the professional interpreter. (Contact No. 278-85-0024 CH). Washington, DC: National Institute of Mental Health.**

This paper is directed to interpreter trainers and professional interpreters who may wish to consider accepting assignments or positions in mental health settings. Interpreter trainers may wish to use this paper in their courses. Mental health service providers who wish to engage professional interpreters on a free-lance or salaried basis can use this paper to help prepare them for these assignments. Hospitals with mental health services may find their interpreters who are familiar with primary health care interpreting can use this paper as an introduction to special aspects of mental health interpreting. It provides an introduction to interpreting in mental health settings. Several principles of interpreting for those with disturbed though and language are presented. Special considerations involved when interpreting for refugees and victims or trauma or torture are noted. Suggestions for productive pre- and post- interview meetings are outlined.

4) **Benhamida, L., Downing, B., & Zhu, Y. (1988). Professional standards and training for interpreters in mental health for refugees and others. (Contact No. 278-85-0024 CH). Washington, DC: National Institute of Mental Health.**

Prepared for mental health professionals and those administering or managing mental health care in any kind of setting, public or private, where refugees and others whose English is limited may be served. No knowledge or interpreting is presumed. A rationale for the professionalization of interpreters in mental health settings, models for training interpreters who would then be able to work in mental health, and certification issues are presented.

For further information or questions about how to obtain any of these reports, please contact Bruce Downing, Ph.D., Department of Linguistics, 142 Klaeber Court, University of Minnesota, Minneapolis, Minnesota 55455. (612) 624-4055.

Recommended Handouts

Common Mental Disorders

*Typical Symptoms**

Depression

- Depressed or irritable mood
- Disturbed sleep
- Fatigue and loss of energy
- Loss of interest in daily activities
- Difficulties with memory and concentration
- Frequent thoughts of death or suicide attempts
- Significant weight or appetite changes
- Feelings of worthlessness or excessive or inappropriate guilt

Post-traumatic Stress Disorder (PTSD)

- Recurrent recollections and nightmares about traumatic event(s)
- Avoidance of thoughts, feelings, and activities associated with the trauma
- Dissociative episodes
- Markedly diminished interest in significant activities
- Inability to recall important aspect(s) of the trauma
- Feelings of detachment or estrangement from others
- Restricted range of affect
- Sleep difficulties
- Irritability or anger outbursts
- Difficulty concentrating
- Hyper vigilance
- Exaggerated startle response

Brief Reactive Psychosis

- Florid presentation which may include incoherence or loosening of associations
- Grossly disorganized or catatonic behavior
- Confusion or delusions of persecution
- Delusions and hallucinations
- Short-lived episode, lasting less than one month
- Eventual return to previous level of functioning

Paranoid Symptoms and Disorders

- Non-bizarre delusion(s) involving situations in real life such as being followed, poisoned, loved at a distance, and having a disease
- Auditory or visual hallucinations are not prominent, even if present
- Behavior is not odd or bizarre, apart from the delusion(s) or its ramifications

Above symptoms are primarily for Delusional Disorder, in which symptoms need to last at least one month; similar symptoms can also be found in transitory paranoid states.

* For complete diagnostic criteria and symptom description, consult DSM-III-R

Common Mental Disorders

Points to Remember

Depression

- Any symptoms of depression can interfere greatly with the tasks that refugees face, such as learning a new language, seeking or keeping a job, and adapting to a new culture.
- A depressed refugee may complain about physical problems initially, rather than express emotional or psychological concerns.
- Frequent reporting of physical symptoms may indicate the presence of a mental disorder, in general, and depression in particular.
- Misdiagnosis of physical symptoms can contribute to costly and unnecessary medical procedures. These can delay the needed psychiatric and psychological interventions and the patient may deteriorate further.

Post-traumatic Stress Disorder (PTSD)

- Both PTSD and the isolated symptoms of this disorder are very prevalent in refugee populations.
- Refugee children and adults may also exhibit PTSD symptoms and meet criteria for the full disorder as well.

Brief Reactive Psychosis

- Brief reactive psychosis is always preceded by a recognizable stressful event and is more common than schizophrenia among refugees.
- There is a potential for over diagnosing psychotic conditions in refugees due to language and cultural barriers between clinician and patient. Culturally appropriate experiences and behaviors may be misidentified as psychotic symptoms.

Paranoid Symptoms and Disorders

- Symptoms frequently found in refugee populations include distrust, suspiciousness, anger, persecutory beliefs, and paranoid delusions.
- Symptoms may range from transient paranoid states to full blown psychotic states and may necessitate careful assessment and intervention.
- Refugees may be at risk for paranoid symptoms and disorders long after their initial resettlement. This may be particularly true of refugees who remain isolated because of their limited ability to communicate with the mainstream group or their lack of support systems in their own groups.

Information Gathered During Psychiatric Interview with Refugees

The Initial Phase

The interviewer should begin by discussing the following points:

- Referral Source
- Reasons for Seeking Help
- Confidentiality

History

During the history gathering part of the interview, the following areas should be covered:

- Presenting Illness
- Psychiatric History
- Medical History
- Family History
- Psychosocial Background
- *Be sure to inquire about the refugee experience*
    - Pre-flight conditions
    - Flight
    - Internment in refugee camps
    - Conditions of final resettlement

Mental Status Exam

The mental status exam provides an accurate description of the patient's functioning. Areas of functioning assessed for refugee patients do not differ from those of non-refugee patients, although the interviewer needs to take into account cultural differences. Much of the information needed for completing the mental status exam has already been gathered throughout the history taking part of the interview.

- Physical Aspect and Behavior
- Abnormal Thought Processes
- Cognitive Assessment:
    - Abstract Reasoning
    - Orientation
    - Fund of Information
    - Calculations
    - Memory
- Suicidal and Homicidal Intent

Psychiatric Interview

Refugee Children and Adolescents

In addition to the areas commonly covered in a psychiatric interview, areas specific to children and adolescents include the following.

- Age at the time of departure from the home country
- Family relationships
  - People the child lives with
  - Presence or absence of family members in the resettlement country
  - If separated from parents or relatives, the possibility of future reunification
- General health issues
- Educational background
  - Level of formal education received in the home country
  - Education received in internment camps
- Experiences of trauma or torture
- Post-migratory factors
  - Expectations in the new educational or family setting

Working with Trained and Untrained Interpreters*

The following are offered as general guidelines when working with interpreters:

- Working with interpreters generally takes a longer time. Set aside a longer period of time or expect to get less accomplished during a session.
- As a general rule, avoid using family members or friends of the patient as interpreters because they lack objectivity and may interfere with the assessment process.
- Be aware of the additional interpersonal dynamics involved in the session when the interpreter is present. For example, traumatized refugee women often feel uncomfortable with a male interpreter.
- Discuss confidentiality with the interpreter. The confidentiality requirements that guide the clinician should also apply to the interpreter. This should also be explained to the patient at the start of the session.

Working with trained interpreters

- Develop a working relationship with the interpreter.
- Meet with the interpreter before the evaluation to discuss the goals and purpose of the interview, determine mode of interpretation, and obtain culturally relevant details from the interpreter (for example, appropriate proverbs to use in the mental status exam).
- Direct questions to the patient, not to the interpreter.
- Keep your questions simple. Avoid the use of idioms, slang, or double negatives.
- Encourage the interpreter to interpret everything the patient says. The interpreter should not screen what patients says, no matter how irrelevant it appears.
- Ask for clarification or elaboration from the interpreter if the response is unclear, or it you are not sure what the response means.
- If the interpreter does no appear to understand the question or specific phrase, explain it in understandable terms.
- Hold post-session discussions with the interpreter. This session can be used to give feedback about the overall interview process and the working relationship. The interpreter can also elaborate any impressions about the patient or the interview during this time.

* For more information on interpreting, please refer to another program in this series entitled "Refugee Mental Health: Interpreting in Refugee Mental Health Settings".

Working with Untrained Interpreters

- During the pre-session meeting, assess the communication skills of the interpreter with the needs of your patient in mind. If the interpreter seems incapable of the task, the evaluation may need to be rescheduled with a more appropriate interpreter, unless the patient is in acute distress.
- Spend more time in pre-session meetings with untrained interpreters. Be sure to discuss confidentiality, and emphasize the need for accurate interpretation. Discuss possible uncomfortable situations that may arise during the interview.
- Use a post-session meeting to debrief the interpreter carefully, particularly if the interview was emotionally charged.

Remember – *the guidelines for trained interpreters also apply to those who are not trained.*

Psychiatric Rating Scales

There are currently a number of psychiatric self-rating scales that have been translated for use with refugee patients. A listing of such scales can be found in the Cross-cultural psychological assessment: Issues and procedures for psychological appraisal of refugee patients (Butcher, 1986). The following is a selected reference list of rating scales which have been used with refugee patients.

Cornell Medical Index

Broadman, K. Erdmann, A.J., Lorge, et al. (1949). The Cornell Medical Index: Adjunct to medical interview. JAMA, 140, 530-534.

Lin, K.M., Tazuma, L., & Masuda, M. (1979). Adaptational problems of the Vietnamese refugees. Archives of General Psychiatry, 36, 955-961.

Hamilton Anxiety Scale

Hamilton, M. (1959). The assessment of anxiety states by rating. British Journal of Medical Psychology, 32, 50-55.

Hamilton Depression Scale

Hamilton, M. (1960). A rating scale for depression. Journal of Neurology, Neurosurgery and Psychiatry, 23, 56-62.

Hopkins Symptom Checklist-25 Indochinese Version (HSCL-25).

Mollica, R.F., Wyshak, G., de Marneffe, D., Tu, B., Yang, T., Khuon, F., Coelho, R., & Lavelle, J. (1985). Hopkins Symptom Checklist-25 manual. Cambodian, Laotian, and Vietnamese versions. Washington D.C.: U.S. Office of Refugee Resettlement.

Symptom Check List-90 (SCL-90)

Derogatis, L.R., Lipman, R.S., & Covi, L. (1973). SCL-90: An outpatient psychiatric rating scale-Preliminary report. Psychopharmacology Bulletin, 9, 13-18.

Piasecki, J., Heegaard, W., Holtan, N., & Jaranson, J. (1985). Interviewer manual for rating the Hopkins Symptom Checklist-90 (SCL-90). St. Paul Ramsey Foundation, Grant Number 8387.

Westermeyer, J. (1986). Two self-rating scales for depression in Hmong refugees: Assessment in clinical and nonclinical samples. Journal of Psychiatric Research, 20, 103-113.

Vietnamese Depression Scale.

Kinzie, J.D., Manson, S.M., Vinh, D.T., Nguyen, T.T.L., Bui, A., & Than, N.P. (1982). Development and validation of a Vietnamese-language depression rating scale. American Journal of Psychiatry, 139, 1276-1281.

Zung Depression Scale.

Zung, W.W.K. (1965). A self-rating depression scale. Archives of General Psychiatry, 12, 63-70.

Westermeyer, J. (1986). Two self-rating scales for depression in Hmong refugees: Assessment in clinical and nonclinical samples. Journal of Psychiatric Research, 20, 103-113.

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Comas-Diaz, L., & Griffith, E. E. (Eds.). (1987). Clinical guidelines in cross-cultural mental health. New York: John Wiley & Sons.

Egli, E. (1987). The role of bilingual workers without professional mental health training in mental health services for refugees. (Contract No. 278-85-0024 CH). Rockville, MD: National Institute of Mental Health.

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Foster, G.M., & Anderson, B. G. (1978). Medical Anthropology. New York: John Wiley & Sons.

Jacobson, F.M. (1987). Ethnolocultural assessment. In L. Comas-Diaz & E.E.H. Griffith (Eds.), Clinical guidelines in cross-cultural mental health. New York: John Wiley & Sons.

Garcia-Peltoniemi, R. (1987). Psychopathology in refugees. (Contract No. 278-85-0024 CH). Rockville, MD: National Institute of Mental Health.

Holtan, N. (1986). When refugees are victims of torture. Washington, DC: The US Committee for Refugees – World Refugee Survey.

Horowitz, M.J. (1986). Stress- response syndromes: A review of post traumatic and adjustment disorders. Hospital and Community Psychiatry, 37, 242-249.

Hughes, C. (1985). Culture-bound or construct-bound? The syndromes and DSM-III. In R.C. Simons & C.C. Hughes (Eds.), The culture- bound syndromes. Dordrecht, The Netherlands: D. Reidel, pp. 1-24.

Kinzie, J. D. (1986). Evaluation and psychotherapy of Indochinese refugee patients. American Psychotherapy, 35, 251-261.

Kinzie, J. D., & Manson, S.M. (1987). The use of self-rating scales in cross-cultural psychiatry. Hospital and Community Psychiatry, 38, 190-195.

Kleiman, A., & Good, B. (Eds.). (1985). Culture and depression. Berkeley and Los Angeles, CA: University of California Press.

Krener, P.G., & Sabin, D. (1985). Indochinese immigrant children: Problems in psychiatric diagnosis. Journal of the American Academy of Child Psychiatry, 24, 453-458.

Leonidas, J. (1982). Depression a la Haitian, a linguistic interpretation. New York State Journal of Medicine, 2(5), 754-755.
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Williams, C.L. (1986). Mental health assessment of refugees. In C.L. Williams & J. Westermeyer (Eds.), Refugee mental health in resettlement countries. Washington, D.C.: Hemisphere Publishing Corporation.

*** Updated resources are currently being collected by the Refugee Health Program at the Minnesota Department of Health and will be added to the workbook when available.**