

The Treatment of PTSD in Canadian Refugees and Immigrants from South Sudan

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AN INTEGRATED RESEARCH PROJECT

SUBMITTED TO THE SCHOOL OF ARTS AND SCIENCES

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF COUNSELLING

CITY UNIVERSITY OF SEATTLE

CALGARY, ALBERTA

APRIL, 2016

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### Abstract

The purpose of this integrative research paper was to explore and critique the state of knowledge derived from qualitative and quantitative research conducted in the area of Post-Traumatic Stress Disorder (PTSD) and refugees and immigrants from South Sudan. In the paper, I discuss the extent of knowledge about this population and associated PTSD. Crucial interventions that appeared in this literature review were evaluated and analyzed. Ethical practice and considerations when working with South Sudanese refugees and immigrants are discussed. The paper is concluded with some recommendations for individual and group practice, further research, and policy development.

*Keywords:* treatment, PTSD, refugee, immigrant, diaspora

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### Acknowledgements

I would like to thank my Advisor Dr. Andrew Estefan for guiding me through writing this paper. His dedication and tireless support made this work a reality. My thanks also go to Dr. Teeya Scholten and Dr. Heather MacKenzie for their help in reviewing and fine-tuning this paper. Thanks go to my Team Leader, Dr. Rita Ortiz for her unwavering support while pursuing my graduate studies and to my Program Supervisor, Anne-Marie Hagel, for the understanding she has had each time I would come to ask for leave. I thank Dr. Suzie Bisson, Mariel Guines, and Marion Christensen for the emotional support each day I would feel down. Dr. Robert Roughley, you are awesome and I will forever have a deep respect for you for being the best Program Director on the Calgary Campus.

Last but not least, I am very grateful for my wife Nyaman Puok Luke and my kids Sebit, Tasloach, Mat, and Nyadin for keeping my energy on track. Another thank you goes to Tut Tuach Kier, Riek Tut Bangoang, Khor Reat Top, Bol Tap Makuach, Simon Thuok Puok, Nyajuok Doluoth Kuoth, Nyabuay Puok Luke, Bayak Dak Guandong, and Gatluak Kayier Bichiok for supporting me emotionally on a daily basis. My father David Korow Wicleek and my mother Sarah Thalow Tuong, you have made this world a better place to be.

### The Treatment of PTSD in Canadian Refugees and Immigrants from South Sudan

Post-Traumatic Stress Disorder (PTSD) is a complex disorder, which results in the experience of a variety of symptoms of distress (Ameresekere & Henderson, 2012; Gojer & Ellis, 2014; Hollifield, Warner, Lian, Krakow, Jenkins, Kesler, Stevenson & Westermeyer, 2002; Sekhon, 2008). Many different populations are susceptible to PTSD, including emergency workers and first responders, those who have been subjects of trauma, and those who have been exposed to conflict and war. Among this latter category, refugees are one group for whom receiving a diagnosis of PTSD and appropriate treatment can be problematic. The issue of refugee mental health is becoming more prominent. The “violence, persecution and humanitarian crises are mobilizing new refugee movements” (Stewart, Simich, Shizha, Makumbe, & Makwarimba, 2012, p.516). This has resulted in a dramatic increase in the number of refugee claims, with 36,000 claims filed in 2008-2009 alone – a 30% increase from 2007-2008 (Tomasso, 2000). Canada “offers permanent resettlement to more than 20,000 refugees yearly” (Stewart, Simich, Makumbe, Makwarimba, & Shizha, 2011, p.186). Stewart et al. (2011) reported that in 2010, there were a total of 420,000 and 560,000 Sudanese and Somali refugees, respectively in Canada. The majority of refugees are directly or indirectly impacted by violence, which can cause them to develop PTSD sometime in their lives (Norredam, Jensen, & Ekstrom, 2011). PTSD is thought to affect “39 to 100 percent of the refugee population, compared to 1 percent for the general population” (Gojer & Ellis, 2014, p. 4). These authors also highlighted that “refugees experience extraordinary rates of mental illness including PTSD (84%), depression (61%), dementia/traumatic brain injury (0.5%) and cognitive limitations (9%)” (p.4). Other sources suggest that “adult refugees resettled in developed countries reported a 9% prevalence of Post-Traumatic Stress Disorder, and 5% also had major depression. Among

refugees with major depression, 71% also had post-traumatic stress disorder” (Pottie, Feightner, Welch, Swinkels, Rashid, & Hassan, 2011, p. E53). Although there is a discrepancy in the estimated rates of PTSD in the refugee population, there is an agreement that it is an issue of grave concern.

The research by Sekhom (2008) on exploring effective treatment for PTSD revealed that “not all individuals that have experienced a traumatic event manifest PTSD symptoms; there may be other cognitive, physical sequelae such as muscle tension or headaches or psychosomatic problems, or psychological sequelae such as loss of trust and low self-worth” (p.5). Howard and Crandall (2007) reported that “the sufferer may not know he or she suffers from PTSD, and may think the suffering is ‘madness.’ The sufferer is afraid to tell anyone because of the social stigma associated with emotional distress” (p.5). In addition, it should be noted that “many individuals may also experience symptoms similar to PTSD but (may) not be diagnosed due to variations in its presentation in accordance with the varying traumatic stressors” (Sekhon, 2008, p.5). All of these factors strongly influence the perception of South Sudanese refugees and immigrants living in Canada and may determine whether or not and how successfully the PTSD or related symptoms are treated.

Given the increasing violence and manmade disasters across the globe, the influx of refugees and immigrants to Canada and the occurrence of PTSD and comorbid conditions within these populations, these concerns will likely grow rather than reduce. Because of the large number of refugees arriving in Canada every year (Stewart et al., 2011) and the high incidence of PTSD within this population (Gojer and Ellis, 2014; Norredam, Jensen, & Ekstrom, 2011), the treatment of PTSD is an area of great clinical importance worthy of further exploration.

My interest in this subject arose due to the fact that I am a refugee from South Sudan. I am also a Masters' student, studying to become a Counselling Psychologist. Therefore, I am interested in ways to promote mental health in general and specifically in refugee and immigrant populations. I left South Sudan when I was five years old and lived in a refugee camp in Ethiopia with my parents for 15 years. I then came to Canada as an adult. I am involved in my Diaspora community where I witness the prevalence of PTSD and the detrimental effects on the functioning of individuals, their families, community life and even integration into Canadian society.

The intended audience for this paper is mental health professionals who are working with South Sudanese refugees and immigrants and others who are interested in the effects of trauma on functioning and the effective treatment of PTSD. This integrative research paper explores and critiques the state of knowledge derived from qualitative and quantitative research conducted in the area of PTSD and refugees and immigrants. The results of the literature search are presented according to what we know about South Sudanese refugees and immigrants - the problem, interventions for PTSD and barriers to this population receiving treatment. This will be followed by a critique of the literature, issues related to clinical practice and ethical considerations. Finally, recommendations for practice will be offered in terms of individual and group interventions. Several research questions will be listed that have been identified from gaps in the literature and finally some suggestions will be made for policy development.

### **Literature Review**

In this section, I review the research literature to explore the state of knowledge about PTSD with Sudanese immigrants and refugees. This section will begin with a summary of the strategies used to identify the relevant scientific literature in the area of PTSD and South Sudanese

refugees and immigrants. This will be followed by a section on a definition of terms. Next, the material will be organized into several parts which include: a) the problem, b) interventions and c) barriers to treatment.

The scientific literature was explored in order to inform the professionals' understanding of the treatment of PTSD in South Sudanese refugees and immigrants using various treatment modalities. For peer-reviewed studies, the search engines PsychINfo, Google scholars, and Medline were used, covering the period from 1972 until 2015. Key words used during the literature search were "supporting refugees and immigrants with PTSD," "treating refugees and immigrants with PTSD," "responding more effectively to refugee and immigrants with PTSD," "effective intervention with refugees and immigrants with mental illness," and "supporting Sudanese/South Sudanese with PTSD/mental illness". These studies made use of both quantitative and qualitative methodology. In the studies using quantitative approaches, statistical analyses included mostly non-parametric methods, while the qualitative studies used techniques of ethnography, narrative, phenomenology, grounded theory, and case studies. Some grey sources were also used when evaluating the literature. These were from conference proceedings and workshops which presented information about refugees' and immigrants' mental health concerns and the need for support in the area of settlement and integration.

### **What is Known About South Sudanese Refugees and Immigrants**

Before proceeding further, the terms "refugee", "immigrant", "Diaspora" and "Post-Traumatic Stress Disorder (PTSD)" will be clarified. Who is a refugee? A refugee is someone who has been forced to flee his or her country because of persecution, war, or violence. A refugee has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group (Gojer et al., 2014). Who is an immigrant?

An immigrant is someone who has voluntarily moved from his or her country of origin (their homeland) to another country, for example, Canada, to become a citizen of that country (Gojer et al., 2014). There are several types of immigrants including those who are designated “economic class” versus “family class”. “Economic” immigrants come to the new country in order to improve their financial resources or to gain educational opportunities for their children, while “family class” refers to people who are sponsored by other members of their family and leave their country of origin in order to reunite and maintain the family unit in the new country. The term “Diaspora” refers to a body of people who have been scattered from their homeland for various reasons and are now living outside of their country of origin (hacker.2011). “PTSD” is defined as a “condition presenting with typical symptoms which follow the experiencing or witnessing of an event which threatens physical safety, or life” (Nicholl & Thompson, 2004, p.353). The Diagnostic and Statistical Manual for Mental Disorders (DSM-5) defines the criteria for Post-traumatic Stress Disorder (PTSD) as: Re-experiencing, avoidance, negative cognitions and mood, and arousal. The term “re-experiencing” means having spontaneous memories of the traumatic event, recurrent dreams related to it, flashbacks or other intense or prolonged psychological distress. “Avoidance” refers to wanting to avoid distressing memories, thoughts, feelings or external reminders of the event (American Psychological Association, DSM-5, 2013, p.271).

**The Problem.** While refugees and immigrants from South Sudan belong to the same Diaspora, they are two very different groups. Refugees have usually been displaced by war or some other grave threat to their survival; whereas immigrants are generally people who have chosen to leave their country of origin for a variety of reasons that have to do with hope for a better life for themselves and their families rather than because they are afraid of dying (Gojer &

Ellis, 2014). Refugees have come to their new country, not because they wanted to leave their country of origin, but because they feared for their lives (Behnia, 1997; Canadian Refugee Health Conference, 2011; City of Surrey, 2012; Donnelly, Hwang, Este, Ewashen, Adair, & Clinton, 2011; Stewart et al., 2011).

Immigrants, in contrast, tend to come for economic reasons - such as for education as students or for financial gain as skilled labourers who wish to earn money for their families. As a result, immigrants are often in much better shape emotionally than refugees prior to arrival in their new country (Newbold, 2009; Nolan, 2008). These authors draw our attention to the understanding that the health of the immigrant population begins to decline once they are exposed to the stressors of living in the new country. These stressors include poverty, culture shock, language barriers and misunderstandings that may result from the process of learning a new language, and may actually cause the development of PTSD from traumas experienced in Canada (Newbold, 2009).

**TABLE 1 Differences in Characteristics of Refugee and Immigrant Populations**

	<b>Refugees</b>	<b>Immigrants</b>
<b>DIFFERENCES</b>		
<b>Reason for leaving country of origin</b>	Fear of death	Hope for a better life
	Escape from violence	Opportunity for education and/or economic betterment
<b>Level of functioning prior to arrival in Canada</b>	Low	High
<b>Source of stress prior arrival in Canada</b>	Safety	Financial
	Emotional	Educational

	Social	
	Financial	
<b>Presence of Co-morbid conditions</b>	Highly likely PTSD, depression, substance abuse	Unlikely prior to arrival in Canada
<b>Parental influence</b>	Compromised, resulting in developmental delays in children	In tact
<b>Economic resources</b>	Compromised	May be available

In the case of refugees from South Sudan, there may be even greater differences between this population and that of immigrants and refugees from other countries, in that the cause of the danger at home was from civil war. This means that with the current reality of ongoing civil war, South Sudanese refugees and immigrants continue to experience reasons for being upset and therefore become re-traumatized when they hear that a loved one has been murdered by the relative(s) of one of the people with whom they may be involved with in their community association in Canada (Nolan, 2008). These experiences result in feelings of anger, betrayal and mistrust. Nolan further argued that the PTSD is then made worse and the developing community (South Sudanese) life is compromised.

PTSD is real and results in symptoms which compromise the functioning of an individual at home, in relationships with partners and children, at work, as a parent and as member of the Diaspora Community and Canadian Society (Cohen, 2008). The ripple effect of marital violence on children’s mental health has been known for years and is now seen in the failure of the South

Sudanese children to achieve academically and their tendency to become involved in gang behaviour which results in criminal charges and entry into the criminal justice system (Cohen, 2008; Sekhon, 2008). In addition, untreated PTSD can result in other problems (comorbidities) in an effort to cope with distress. The incidence of comorbid depression is estimated at a higher level in those who have PTSD (Sekhon, 2008). It should be noted that these studies refer to both refugees and immigrants. It would be interesting to know the actual incidence of PTSD and comorbid disorders in each type of population.

Of course, there are many similarities in the stresses to which both refugees and immigrants from South Sudanese are subjected upon their arrival in Canada. The arrival of a refugee in Canada does not signal the end of troubles for refugees and, for many, beginning life in a new country presents new challenges and difficulties associated with resettling, integrating, and navigating their new home. Integrating into mainstream society is a large challenge for immigrants and for those whose role it is to help them. This list is not exhaustive, but provides an idea of the kinds of stressors that any new arrival would experience:

- Adaptation to the receiving culture and the need to learn a new language, systems of transportation and monetary management;
- Changes in cultural norms. For instance, it is illegal to leave your children alone in Canada whereas it is a common practice in a group-oriented culture in which children were cared for by the community back home. Failure to ensure constant child care has often resulted in involvement in the criminal justice system when Canadian rules are not followed (Gojer et al., 2014);
- Shift from a focus on group life to more of an individual orientation which can result in social isolation;

- Absence of extended family which offered emotional and physical support in the raising of children in the country of origin;
- Financial challenges in general and for government-sponsored refugees, in particular, the economic stress of being expected to live on the monthly stipend of about \$580 for a single person. Living on this amount cannot possibly cover the costs of living accommodation, food, health care and other expenses...and often results in being required to learn to live “in poverty”. This monthly stipend is given for one year, after which new Canadians are expected to have learned English enough to be able to earn an income of their own. This may not be a realistic expectation. The low amount of income is a factor that results in living in poverty and may precipitate experiences that cause PTSD or re-traumatize those who already suffer from it;
- Pressure to learn English and obtain get employment may also be a factor that results in compromised functioning and may increase one’s susceptibility to the situations such as dealing with drugs that expose one to dangerous situations that may become life-threatening and result in PTSD; and
- Lastly, in the case of any person of African descent who has come to Canada for any reason, there is the added stress of prejudice due to the colour of their skin with the resultant potential for altercations and entry into the criminal justice system (Gojer et al., 2014; Nolan, 2008).

Research by White (2009) on 11 refugee and immigrant women in Saskatchewan employed ethnographic methodology. Data were collected using focus groups and interviewing members. The research indicated that many refugees and immigrants suffer from PTSD, which detrimentally effects on their own functioning and that of their children, and that there is a need

for treatment, but an absence of effective forms of intervention. White argued that lack of sensitivity to the clients' language and culture makes clients feel disrespected. Confrontations with the dominant culture which are likely to result from an unfamiliarity with or a misunderstanding of expectations rather than a blatant disregard for Canadian societal rules often results in further trauma. In the South Sudanese refugee population, this may exacerbate the PTSD and in the immigrant population who have generally had much less stress before coming to Canada, this may cause the people to experience PTSD for the first time (White, 2009).

The studies described below offer some examples of the difficulties new Canadians can encounter. In a descriptive exploratory qualitative study, which involved 10 Sudanese and Chinese refugee women, Donnelly et al. (2011) showed that refugees and immigrants manifested symptoms associated with PTSD caused by culture shock, losses of loved ones, the experience of guilt, stress of the language barrier, underemployment, lack of awareness of the environment, lack of education and change in careers. Recent research by Gojer et al. (2014) in Ontario supported Donnelly et al.'s research and the view that South Sudanese refugees and immigrants have a well-founded fear which stemmed from compound challenges in the above-mentioned areas and contributed to ongoing distress in their daily life.

Exploratory qualitative research and qualitative participatory research was conducted by Stewart et al. (2011) on 68 Somali and Sudanese refugee women (39 of them Somali and 29 of them Sudanese), both in Calgary and Edmonton. Their study revealed that symptoms of PTSD were associated with losses of happy childhoods, disappointment and difficulties in marital or familial relationships, difficulties finding a rewarding and satisfying career, and losses of loved ones through wars and that these were major contributors to them experiencing stress-related PTSD. They also argued that factors such as health promotion initiatives offered in a new

language (English) that was difficult to comprehend, hindering of decision-making skills in the new language for those who urgently needed help, and limited knowledge in how the health care system works increased the likelihood of developing symptoms of PTSD. Both Donnelly et al. (2011) and Stewart et al. (2011) concluded that the feeling of loneliness, new cultural values, norms and expectations and leaving family behind were factors that increased the likelihood of developing PTSD.

It was also found that “children of immigrants and refugees are often made to feel that they do not belong in Canada because of the constant questions regarding their country of origin” (Stewart et al., 2011, p.12). “Cultural diminishment”, because of one’s background, consists of belittling, bullying, rejecting, and segregation of the refugees’ and immigrants’ children. Most refugee and immigrant parents associated the diminishing of their culture of origin with their children’s substance abuse, and dropping out of school (Stewart et al., 2011, p. 10).

Research by Magro (2009) revealed that “refugees are relieved to find a safe haven in Canada; however, they may also face a new set of barriers once they arrive: living in unsafe neighborhoods, unemployment, the absence of social networks, isolation, discrimination, and trauma” (p.2). Magro (2009) has observed a movement of these people to “reunite with family members, or (seek) educational and employment opportunities in other Canadian provinces” (p. 3). Therefore, the South Sudanese refugees’ and immigrants’ experiences of the challenges brought on by a new way of life such as changes in culture, language and norms and expectations pose a significant risk to them finding their place in the society, and also in them developing symptoms associated with PTSD. Magro has continued to argue that “barriers such as financial hardship, stress, and the difficulties of balancing home, work, and educational responsibilities as interfering with the ability to realize their educational, social, and career aspirations in Canada”

(p. 9). More importantly, it was found that such barriers influenced the motivation of refugees to not participate in research because they will tend to experience “disruptions and stresses that they have already experienced in fleeing from their home country” (p. 8).

The North American Refugee Health Conference sponsored by the University of Toronto, Faculty of Medicine in 2016 focused on a variety of refugees’ mental health issues to better understand their mental wellbeing. The issues such as the strength of the refugee’s community, their ability to find a job, and their comprehension of the host country’s language were discussed. Difficulties in these areas were seen as factors that contributed to increasing the likelihood of PTSD.

In Newbold’s (2009) study, it was reported that “loss of socioeconomic status through unemployment, reduced income and deskilling (i.e., employers failing to recognize educational credentials, with immigrants forced into lower-status jobs) was associated with mental stress and poor health in the immigrant community” (p. 317). The author showed that “the health of new arrivals is high, with the majority of immigrants reporting excellent (42.0%) or very good (35.3%) health..., and only a small proportion (3%) reporting either fair or poor health” (p.321). Their study found that “economic immigrants were the most likely to report excellent health (45.8%), while family class immigrants were the least likely (36.9%)” (Newbold, 2009, p. 322).

A longitudinal study by Rousseau et al. (2004) conducted in Montreal employed qualitative and quantitative methodology using semi-structured interviews and a non-probabilistic sampling method (quasi experiment) to inquire about 12 Congolese families who were separated and then had the opportunity to reunite through sponsorship with those they had left behind. The focus of the study was to understand the pre-migration and post-migration impact on some of these

refugees. Rousseau et al., focused their attention on the impact caused by separation, the reunification process after the arrival of the family member, the changes in culture and the new way of thinking due to the change in the Canadian cultural experience. It was found that the longer the duration of separation the greater the reconfiguration of roles within the family. In addition to this, after reunification, the families were faced with new challenges in their primary relationships which made it difficult for them to find balance in their families (Rousseau et al., 2004).

The pattern that has emerged during this literature review has supported the results expressed by Stewart et al. (2011) and that is “refugees experience unmet needs, depleted social support networks, separation from families, difficulty establishing new ties in new communities, inadequate access to services, and lack of linguistically and culturally-appropriate support services” (p. 187). The majority of South Sudanese refugees and immigrants suffer deeply because they are disconnected from the larger society because of unmet needs (lack of communal identity, solidarity, sharing, and trust in the system) (Nolan, 2008; Stewart et al., 2011). On the positive side, it is known that both refugee and immigrant populations tend to be very resilient and hard-working and often continue sending money back to their family members in South Sudan to help them (Rousseau et al., 2004). They also tend to have affiliations with the Christian faith and often become involved in church life here in Canada. The research by Donnelly et al. (2011) revealed that participants “mentioned the powerful influence of religious beliefs and its healing power” (p. 285), allowing South Sudanese members to better cope with associated symptoms of PTSD. According to these authors, religious activities ensure that members of the South Sudanese Diaspora have the opportunity to see each other regularly, thereby promoting a continued desire for contact and engagement in their community life. These

authors have also argued that these social activities tend to promote social support, improved individual functioning, integration of both refugees and immigrants alike into Canadian society and even a willingness to accept treatment for mental health concerns if persuaded by a community member (Nolan, 2008). However, there is little data exploring the effectiveness of these kinds of social activities in helping to resolve PTSD in those who actually have it.

**Interventions.** In the literature, multiple treatment options were suggested. These included: social support, group support in the language known to the client, focus groups, receiving support through a paraprofessional with a strong understanding of the client's culture and language, community interventions and psychosocial, psychological and other trauma-informed treatment models (Nolan, 2008; Rousseau et al., 2012; Sekhon, 2009; Stewart et al., 2011; Stewart et al., 2012). However, it should be noted that very little has been published in the way of Canadian studies. Nevertheless, these types of interventions will be reviewed below:

**Culture.** A literature review was carried out by Nolan (2008) on Sudanese women refugees who may have "learning needs affecting their ability to learn to speak, read and write English" (p. 4). Her research concluded that, allowing members of the Diaspora to build a sense of community improved the mental wellbeing of the participants. This was measured by studying the culture, their experiences in the past, and a change in culture after arrival in Canada. Although this research reported improved social support and the strengthening of one's identity, Nolan stated that it was doubtful whether or not it could help resolve PTSD in those who were experiencing it.

Nolan (2008) and Rousseau et al., (2004) reported that refugees and immigrants find it effective to share cultural values because it enables some to better cope with their stressors and symptoms associated with PTSD. From this perspective, the literature review conducted

strongly supports “culture” as form of helping someone with PTSD in two cases: 1) If there is lack of knowledge about mental health treatment because of cultural differences and 2) if the person has limited knowledge of the language spoken by the therapists. However, it was still found that refugee and immigrant populations could draw on their informal support systems and related cultural practices to cope with mental illness (Donnelly et al., 2011). The literature review revealed “cultural competency” as important as other approaches in gaining a client’s trust and confidence. In the research by Donnelly et al. (2011) on assessing women experiencing emotional disturbance, one participant responded to the professional that “if I was going to kill myself, I wouldn’t be calling you. I am asking for help” (p.279). This quote reflected the refugees’ and immigrants’ experience during the time they were able to seek help. Culturally, the message was crystal clear: the woman was not suicidal, she was just seeking help because she might have exhausted all the other options available to her. Therefore, without culturally competent treatment, cultural support may be the only potentially effective intervention towards the healing of PTSD (Rousseau et al., 2004).

Recent research by Stewart et al. (2011) suggested the creation of programs and resourcing of the community in order for the refugees and immigrants to interact among themselves. This means that South Sudanese who are struggling to understand the health care system because of many factors (Donnelly et al., 2011) will benefit from community resources and the use of paraprofessionals from the population needing mental health support. Behnia (1997) investigated distrust and resettlement of survivors of war and torture and supported the view that “refugees with a traumatic past can settle without serious difficulties if, in addition to the basic services, there are appropriate and specialized programs and services geared to their particular needs”

(p.55). This study focused more specifically on the gearing of resources to enable refugees and immigrants to meet some of the basic needs for their settlement.

Another coping mechanism discussed in the literature was refugees' and immigrants' resiliency. Recent research has shown resiliency to be helping some refugees and immigrants to cope better in Canada (Sekhon, 2008). The research by Simich, Roche, and Ayton (2012) argued that

“there are several common characteristics associated with refugee coping and resiliency. These include extended family, employment, human rights organizations, self-help groups, small scale communities and settlement, cultural practices, and situational transcendence (the ability to frame an adverse situation differently and give them meaning, e.g. as part of cultural identity or history).” (p. 7).

Simich et al. (2012) and Nolan's (2008) findings are an indication that South Sudanese refugees and immigrants who function well in exile have higher levels of resiliency which enable them to stay focused on reaching their goals. Even though their experiences may not be the same, those found to have survived lots of challenges were often able to engage and integrate more successfully. The literature review has also indicated that participants who attended various support meetings felt that their stress was relieved. Similarly, participants expressed that “we need people to talk to us if you come from places like that.....some people need to be trained so that they can work with a lot of people in our community because they can communicate in Arabic or our dialects” (Stewart et al., 2011, p. 12). Therefore, cultural interventions are found to be effective due to the fact that it brings people together and it gives them the opportunity to interact and socialize with peers, make friends, and learn from each other (Nolan, 2008; Stewart et al., 2011).

Some grounded theory research by Stewart, Dennis et al. (2015) was conducted on 36 Sudanese and 36 Zimbabwean participants in order to identify the interventions that were the most acceptable and culturally appropriate for these two communities. The recruitment of the participants in this pilot project allowed for children as young as infants, who participated together with all parents (single, father/mother, and males & females). Although the age range of the participants was ideal, factors associated with employability, mobility, and logistics influenced the participants' low turnout. It is also likely that the use of a questionnaire in English to collect data could have been another factor in preventing full participation in the study. As Magro (2009) stated, many South Sudanese refugee and immigrant parents have reading levels that are low compared to other refugees and immigrants coming from war-threatened countries. These results support the fact that is important to take into account verbal and written literacy levels when gathering any kind of data. If the researchers wish the results to be representative of the population, ways need to be found of reducing the other barriers related to participation that were mentioned above (e.g., mobility, employment, logistics).

***Psychoeducational Focus Groups.*** An example of this type of intervention was implemented by Wicleek (2015) and involved having regular meetings (1.5 hours per week for six weeks) with a small group (n=10-15) from the Diaspora. The topics covered included a discussion in the areas of: 1) how life was back home, 2) how it is here and 3) how it might be in the future. The language of delivery of this program was Thok Naath, one of the South Sudanese languages and all of the participants and leaders were fluent in it. Program effectiveness was measured by interviewing the participants to determine what they had gained. Analysis of this evaluative data from focus groups suggested that this intervention was effective in helping participants to feel better and to help them realize their potential (Wicleek, 2015).

***Psycho-social.*** This type of intervention focusses on the resilience of the participants by encouraging them to confront the traumatic event through discussion within a support group. It is assumed that allowing the person to be re-exposed to the traumatic event may result in the trauma losing impact and reducing the negative effect that it originally had which caused PTSD symptoms (Nolan, 2008; Sekhon, 2008). In the study by Nolan (2008) on Sudanese women refugees in Alberta, the focus was to determine if their needs were being met in ESL classes. This author found that the vital means of support that improved their resilience was their inclusion in a community, family support and their own community of friends.

***Psychological.*** Psychological intervention consists of a number of different therapeutic techniques such as: Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), Exposure Therapy (Sekhon, 2008), Integrative Restoration (iRest) (Stankovic, 2011) and Trauma-Focused –Cognitive Behavioural Therapy (Cohen, 2008). Each one of these approaches tends to approach treatment differently.

***Cognitive Processing Therapy (CPT).*** This form of therapy is a combination of exposure therapy and cognitive restructuring. The research conducted by Sekhon (2008) in Lethbridge, Alberta, on PTSD and treatment, found that use of CPT resulted in marked improvements for victims with PTSD symptoms.

***Eye Movement Desensitization and Reprocessing (EMDR).*** Several studies from the United States and Australia have outlined a number of methods that can be used in the treatment of PTSD. One of the most highly recommended approaches is that of EMDR (Sekhon, 2008). This is a process that combines exposure with the exercise of the eye movements to alleviate PTSD symptoms. Sekhon (2008) and Cohen (2008) reported on the changes in pretreatment and post treatment scores after EMDR which was conducted on children, war veterans and people with

multiple traumas. Their findings revealed that EMDR improved the symptoms of PTSD. The results quoted for the effectiveness of EMDR tend to support Sekhon's (2008) belief in the importance of EMDR in alleviating the negative effects of the trauma. However, in order to use EMDR, the stressful event also needs to be over before the trauma can be addressed (Sekhon, 2008). In the case of members of the South Sudanese Diaspora, the situation of ongoing civil war means that people are continuing to be traumatized when they hear of the deaths of loved ones and therefore, EMDR may not be the most appropriate modality of treatment for this population.

*Exposure Therapy.* Sekhon (2008) also found that "continual exposure may result in the traumatic event losing all meaning and becoming a manageable event for the victim over time" (p. 29). The intention of exposure therapy is for the client to be exposed to the trauma repeatedly while being encouraged to maintain a state of calmness. In Sekhon's (2008) research, the procedure was to re-expose clients to trauma and this was done through discussion and how they felt their thoughts and behaviors were altered. Also, the treatment was meant to create a deeper understanding of their feelings and how they contributed to inappropriate behaviors (Sekhon, 2008).

*Integrative Restoration (iRest).* Stankovic (2011) studied iRest, which uses a guided meditation format that can be delivered to individuals or in groups. It is a relatively new form of treatment that is being used for trauma. In this study, 15 Vietnam veterans and one active-duty soldier returning from the Middle East had signed up after finding out about the treatment program that involved iRest. The "participants reported feeling more calm and peaceful, less reactive to situations beyond their control and more able to enjoy life" (Stankovic, 2011, p. 24)

*Trauma-Focused–Cognitive Behavioral Therapy.* Cohen (2008) studied Trauma Focused – Cognitive Behavioral Therapy (TF-CBT) and compared it with Non-directive Supportive Therapy (NST) in Pittsburgh, Pennsylvania. The participants in this study were 86 preschool children from three to seven years of age who were experiencing many problems. They had been exposed to trauma from sexual abuse and had lost trust in others. This research by Cohen found that “all TF-CBT groups experienced more improvement than the (NST) community groups” (p.2). Although there was a large sample size, there was no control group for this study.

The literature cited above considered interventions for PTSD for any refugee and immigrant population as well as in general for anyone who suffers from this disorder. Unfortunately there were few Canadian studies that focused on the treatment of PTSD with members of the South Sudanese Diaspora and those that did exist tended to combine both the refugees and the immigrants being studied (Donnelly et al., 2011; Nolan, 2008; Stewart et al., 2011; Stewart et al., 2012). Therefore, when the results of any studies were evaluated, it was difficult to assess the validity of the conclusions for these two differing populations.

Although there has been some research in the treatment of PTSD, there is a paucity of information on which techniques are available and how effective they actually are. Despite the effectiveness of these modalities in treating PTSD, very little is known about how successful these interventions could be with South Sudanese refugees and immigrants. Finally, much of the above-mentioned research was done on populations in addition to South Sudanese which included Congolese, Cambodian, Somalian and Zimbabwean refugee populations. It may be that a similar result would be found with people from South Sudan, but there is no evidence to support this to date. Lastly, it should be noted that in order to benefit from any type of treatment, members of the South Sudanese Diaspora would have to first engage in therapy. As will be

explained below, there is a general misunderstanding of what counselling involves, a reluctance to trust professionals and many other factors that can pose significant barriers to treatment for this population.

### **Barriers to Treatment**

Both the South Sudanese refugee and immigrant populations are similar in the barriers they face prior to seeking treatment (Stewart et al., 2012). These include:

- An incorrect understanding of Canadian “counselling”. They are likely to think of it as it was in the “old country”, as being a process in which the first level of intervention is from informal support from family, friends and/or one’s religious community. If that doesn’t work, one meets with an elder and is provided with advice about what to do.
- Resistance to engagement with mental health services due to fear of negative repercussions. This attitude seems to be based on the negative experiences of other families in which they have noticed that children were removed from the home after a social worker becomes involved.
- It is difficult to be counselled in a language with which you are unfamiliar. As a refugee or immigrant you may not have the words to express your feelings, and you may not understand what the counsellor is telling you.
- Traditional gender roles dictate that the women stay home and look after the children, meals and other demands of the household while the men work to provide income. This means that women often lack exposure to English and have a much harder time learning the language of the new country. They are busy looking after children and with the lack of support from the older generation or other community members, it is difficult to attend counselling even if they wish to do so.

- Economic pressure on the families means that they may have several jobs, and even lack of transportation both of which makes time for treatment very difficult.

Factors such as those listed above result in a lack of engagement of the South Sudanese in the Canadian counselling experience. People tend not go to counselling unless referred by a third party and, even if it happens, it is very common for them to attend once and then not return (Donnelly et al., 2011; Stewart et al., 2011; Stewart et al., 2012). There are also numerous barriers to effective research in the treatment of PTSD with South Sudanese refugees and immigrants. Many of the factors listed above that have resulted in resistance to accessing counselling, also contribute to difficulties in doing research on the effectiveness of treatment for PTSD or any other mental health issue.

### **What is Not Known About South Sudanese Refugees and Immigrants with PTSD**

Even though much of the research has been done on many different types of refugee and immigrant populations (Rousseau et al., 2003), there is still a lot that we do not know about this area of significant need. Things that are not yet known are:

- How to help South Sudanese refugees and immigrants that have a problem with PTSD
- Which clients have the most the potential to be treated successfully
- Which techniques will help to resolve their symptoms
- How to help them to understand how the process of counselling works in Canada, and
- How to facilitate trust with the therapists that are available.

### **South Sudanese Populations Most Researched**

In general, the studies have shown that South Sudanese refugee men, youth, and women with young children are the populations most researched; whereas older men and women and small children have not yet been studied. Most of the research that has been done has been

qualitative and quantitative in nature. It has consisted of data collected through surveys, semi-structured interviews, narrative and interviews while the participants were in programs of various kinds. The reason for the absence of representation by older men and women is that they tend not to have the chance of participating in program due to language barrier and some other challenges facing them. In addition, there are actually very few living here as most have stayed back in South Sudan where they are either living or were killed during the civil war.

### **Critique of Research Methods in the Literature**

Most of the research that has been done to date on the experience of refugees and immigrants and the treatment of PTSD has used a combination of quantitative and qualitative methodologies.

Quantitative research helps us to understand patterns by studying large groups of people in a scientifically sound manner. If the experimental design is rigorous and the research well-done, we can measure the effects of particular types of interventions and understand which ones might be more effective to use. We can achieve an understanding of an issue from a broad perspective. It is like a telescope can help us to see the constellation of stars in the sky. The strength of this approach is that it allows us to analyze samples in a quantified manner. The limitation is that quantitative research needs a large sample size and tends not to be sensitive to the differences in individual experience.

Qualitative research, on the other hand, helps us to understand the individual's experience. It is like taking a microscope to help us know what it is like on the inside of a cell. It relies on anecdotal evidence, ethnographic study, story-telling, case studies and other methods to help us understand someone's personal experience and to identify patterns that could be studied further in large groups. The strength of this approach is that it allows us to understand social constructs

and the environments in which we live. The limitation is that it is difficult to know how broadly the conclusions can be applied to others.

Theoretically, paradigms construct our worldview and inform our professional understanding from the knowledge a single research study has produced. Moreover, theoretical paradigms help inform us about this knowledge by identifying strengths and weaknesses in a research study presented. It also allows us to identify research limitations and a need for further research in the future. In the following section a thorough critiquing of the research methods will be offered, in order to be able to understand research theories that inform our practice about the treatment of PTSD in Canadian South Sudanese refugees and immigrants.

The difficulty in many of the studies that were cited above, relates to the inability of the researchers to involve the number of participants that were initially targeted (Magro, 2009). Although the research designs were good, there were many challenges that prevented the researchers from obtaining the kind of input they desired. The logistics of getting to appointments, economic considerations of the cost of transportation, babysitting and other factors prevented many people from participating. From a quantitative viewpoint, this reduced the sample size, whereas from a qualitative viewpoint, exploring the reasons for non-participation helped us to understand the personal experience of the target group and increased an awareness of the stressors faced by the entire population under study.

The research by Dossa (2002) illustrated how useful it could be to use storytelling as a possible method of inquiry prior to collecting information about the kind of approaches to be used when offering treatment of PTSD to immigrant and refugee populations. In this way, her research informed the counselling field about the amount of potential knowledge that could be gained through storytelling as a method of inquiry.

A descriptive exploratory qualitative research study at the University of Calgary, based on the theoretical foundation of an ecological conceptual framework, investigated the mental illness of 10 immigrant women (5 born in China and 5 born in Sudan). This method is used when a problem is in its early stages and data is difficult to collect (Donnelly et al., 2011). Interviews with these 10 immigrant women focused on their understanding of mental health care. The emerging details revealed that “immigrant and refugee women’s personal experiences with biomedicine and their fear and lack of awareness about mental health issues influence how they seek help to manage mental health problems” (Donnelly et al., 2011, p.282).

Donnelly et al. (2011) found that counselling was often perceived as intrusive and might not be a suitable treatment modality for immigrant women due to the cultural belief of “keeping honor within the family” and not talking about their problems to others. Conversely, Donnelly et al. also found that immigrant and refugee women who accessed mental services benefited from the services if it was delivered in a culturally sensitive way and professional interpretation support was available. The use of culturally-sensitive investigators, the formulation of the items (questions) based on interviews, the respect for individual participants and the amount of time required, informed our counselling practices that the exploratory method of inquiry used in qualitative research could inform the counselling field about mental illness and the South Sudanese refugees' and immigrants' experiences of help seeking and the barriers surrounding this help seeking. The limitations in this study were the recruitment of diverse groups (Chinese and Sudanese Women) with two distinctive cultural norms and values. The research should have been limited to a specific group (Sudanese).

An ethnographic study in Montreal employed nonprobabilistic sampling methods to understand complex social phenomena such as the reunification process of 12 Congolese

families with some members of their families left behind in their country of origin (Rousseau et al., 2004). Qualitative analysis involved four steps: 1) transcription of interviews, 2) marking up of text to indicate categories of information sought using NU-DIST software, so that passages in each category could be extracted separately, 3) re-transcription of information in each category, indicating characteristics of respondent (age, sex, position in family, settled or new arrival) and the characteristics of the family, and 4) qualitative analysis of content in order to determine response profiles for each specific category of information (Rousseau et al., 2003). The authors concluded that the suffering due to uprooting and the traumatic pre-migration experience was a cause of their major trauma (Rousseau et al., 2003). This research contributed to the field of counselling with refugees and immigrants because it informed the professionals about the separation and the reunification process during the pre-migration and post-migration process, and as a basis for understanding the emergence of symptoms associated with PTSD in members of a group or community.

A phenomenological study conducted in Montreal focused on 57 Khmer Rouge refugees undergoing adjustment during adolescence and the association of war related experience by their family before the migration period (Rousseau et al., 2003). Baseline data was collected during early, mid, and late adolescence to investigate the pre-migration exposure to political violence and this was then related to post migration measures of mental health and social adjustment. The results indicated that the adolescents whose families were more highly exposed to political violence tended to report a more positive social adjustment and less mental health symptoms than those less exposed (Rousseau, Armand, Laurin-Lamothe, Gauthier, & Saboundjian, 2012). This research increased our understanding of the pre-migratory period of Khmer Rouge families exposed to political violence. The research's strength was the baseline study employed and the

experiences of the adolescents which were collected. This data informed the field of counselling that the belief expressed by Gojer et al. (2014) that 100% of all refugees and immigrants are said to have PTSD may not be true, since Rousseau et al. (2003) showed that some of them seem to be able to maintain healthy attitudes and adjust to their daily life in the new country. However, it may have been interesting to examine the levels of resiliency for those who were less exposed to pre-migration trauma, but whose mental health seemed to suffer more.

A quantitative and qualitative method rooted in grounded theory was employed in 2 Canadian provinces, to examine the social needs of African refugee parents who recently experienced the birth of a new baby in Canada (Stewart, Makwarimba et al., 2015). The data were collected using in-depth, semi-structured interviews on 85 participants (48 from Sudan and 37 from Zimbabwe). Questions like “What has your experience of immigrating and having a baby in Canada been like?” fit as a research question to understand the experience surrounding the lives of these parents (Stewart et al., 2015). It emerged that giving birth, loneliness, language barriers, day care and parenting were the major issues causing stress to parents.

A qualitative participatory study was conducted in Edmonton, to pilot test culturally congruent interventions that met the needs of Sudanese and Somali refugees (Stewart et al., 2015). Data were collected from 68 participants (39 Somali and 29 Sudanese) during peer support sessions held on a bi-weekly basis for 12 weeks. Qualitative methodology was used in this study to understand the sensitive issues, beliefs, and perceptions of the support interventions. The strengths in this study were the use of peer supporters and interventionists who were fluent in either language the participants spoke. The limitations in this study were related to factors that reduced the number of participants. These included: lack of transportation, work related conditions as some could not make it to the session because of a time conflict, and feeling

sick. These factors influenced the outcome the study was able to achieve because some participants did not complete the workshops.

A grounded theory based on a qualitative and quantitative analysis of participant observation was performed in two classrooms in Montreal. Semi-structured interviews and observations were used to explore the adolescent immigrant and refugee experience of academic delay and the impact it had in the life of these students (Rousseau et al., 2012). Through quantitative analysis, it was found that “the impact of the workshops through paired t-test indicates that ... the total Strengths and Difficulty Questionnaire (SDQ) symptoms score did not change” (Rousseau et al., 2012, p.189). The details that emerged when analyzing the data informed our understanding of the adversity academic delay may cause in the life of immigrants and refugee people.

Both quantitative and qualitative research helps us to reach conclusions that inform our practice in different ways. In the area of treating PTSD in the South Sudanese refugee and immigrant populations, both of these types of research methodologies will most likely continue to be useful and will help us in the identification of best practices for treating PTSD in the refugee and immigrant populations such as South Sudanese in Canada.

However, further research is required in the South Sudanese community using similar forms of inquiry with regard to expanding our understanding of refugees’ and immigrants’ well-being. When doing this research, it may be more helpful to distinguish between refugees and immigrants in further research on treatment techniques, since these are two very different populations.

### **Issues Related to Clinical Practice and Ethical Considerations**

Working with South Sudanese refugees and immigrants can be challenging to health care professionals and therapists. The literature review revealed certain considerations to be used in order for the therapists to help the South Sudanese get their needs met. The following considerations are: social support (informal peer group support, family, and religious assistance), cultural competency in counselling and resourcing of community agencies (Stewart et al., 2011; Stewart et al., 2012). For counselors/therapists to have a better knowledge and understanding of refugees' and immigrants' suffering, they should be able to consider the experiences brought to the counselling room. This process will help reduce the incorrect expectations that might disrupt counselling interventions. For example, South Sudanese perceive counselling as being negative, carrying a stigma, and non-appealing. Therefore, things like mental problems and all kinds of disorders are not understood, despite their prevalence. They think that it is a way of putting a label on a person. So, a professional who is culturally different from a client and hasn't had refugee or immigrant experience will need to develop a better understanding of PTSD from the South Sudanese refugees' and immigrants' perspective.

The literature review revealed that "familiarity with the cultural background of the patient is recommended, and assessment should involve a professional interpreter if the patient's language ability is inadequate to express psychological distress and narrate the experience" (Pottie et al., 2011, p. E54). Like all other factors facing refugees and immigrants, South Sudanese with limited literacy skills experience difficulties in accessing health care and other resources. The provision of an interpreter will reduce the struggle because they would be able to receive service in their language of origin (Rousseau et al., 2012). Furthermore, in offering treatment to South Sudanese clients, counselors/therapists are faced by the following: lack of understanding of counselling, fear of counselling - that their children will be taken away, lack of trust in mental

health professionals, fear of the stigmas of being diagnosed with a mental disorder, a language barrier which results in an inability to for a client to express one's feelings accurately and to understand what the therapist is saying, and fear of privacy being violated due to the potential lack of confidentiality, particularly when psychological services are being delivered by another member of the Diaspora.

According to the Canadian Code of Ethics (Canadian Psychological Association, 2000), there are four main principles to be followed when offering psychological services. These are: Respect for the Dignity of Persons, Responsible Caring, Integrity in Relationships and Responsibility to Society. The Canadian code is to be used to assist mental health professionals and our regulatory bodies in ethical decision-making, professionalism, regulation and accountability codes and guidelines (Canadian Psychological Association, 2000). Each of these principles will be explained and addressed when considering treatment for PTSD in the South Sudanese refugee and immigrant populations.

### **Respect for the Dignity of Persons**

This principle refers to the right everyone has to have their

“innate worth as human beings appreciated and that this worth is not enhanced or reduced by such differences as sexual preference, physical or mental abilities, age , socio-economic status, sexual preference, physical or mental abilities, age, socio-economic status and/or any other characteristic or condition or status”(p. 7).

In the case of the South Sudanese, there are economic barriers and many who are living in poverty or at the level of the working poor may not be able to afford services, to pay for transportation to appointments, to hire baby-sitters.

### **Responsible Caring**

This principle refers to the basic tenet of any therapeutic intervention and that the activity will benefit a member of society or at least “primum non nocere” - above all, do no harm. Psychologists need to protect the welfare of all who are involved in their service, teaching or research activities and they need “to proceed only if the potential benefits outweigh the potential harm, to use and develop methods that will minimize harms and maximize benefits, and to take responsibility for correcting any harmful effects that have occurred as a result of their activities” (p. 15). Ensuring that the therapist is competent and has self-knowledge about the limitations of their practice are important aspects of responsible caring. Is it promoting the welfare of clients and avoiding doing harm, if, in the course of treatment, a client is diagnosed with a “mental disorder” which results in feeling stigmatized - either as self-perception or in the eyes of the rest of the Diapora?

### **Integrity in Relationships**

This principle refers to the mutual expectations of integrity, including reciprocation on the part of the therapist and client of: fairness, impartiality, straight-forwardness, avoidance of misrepresentation, avoidance of conflict of interest; and the provision of accurate information (p. 22). While being accurate and honest on the part of the therapist is essential, the use of psychological terminology or use of the word “therapy” may elicit fear on the part of potential clients and discourage them from seeking assistance. Nevertheless, one’s role as a researcher or therapist must be clearly explained. It is also important to do research, provide psychological services and/or the results of psychological assessments in understandable language (p. 22). The language barriers that exist for any new refugee or immigrant, including the South Sudanese, make it difficult to communicate in completely understandable manner. The other factor to consider is that there are a total of over 60 different languages in South Sudan. Most people in

the Diaspora speak the language of the two main tribes – Naath (Nuer) and Jieng (Dinka) and some other languages. Many have learned Arabic and could possibly communicate in this language.

### **Responsibility to Society**

This principle refers to the expectation that psychology as a discipline will increase knowledge and that it will conduct its affairs in such a way that it will promote the welfare of all human beings (p. 28). This includes having respect for social structures and avoiding an unnecessary disruption of these. In the situation where psychological services for the treatment of PTSD are being offered to South Sudanese refugees and immigrants, there is a strong possibility that this is currently being done in a way that does not acknowledge and respect the values of the group mentality of the original social structure of this culture.

### **Recommendation for Practice**

This part will be based on the results of the research available at this time and will be organized into three sections of recommendations for practice: Individual and Group Interventions, Further Research and Policy Development.

#### **Individual and Group interventions**

Offer “cultural education” to the providers and receivers of any kind of therapy including that for PTSD. The professionals need to understand the values and practices of the South Sudanese culture and the receivers need to understand the cause of the PTSD symptoms they are experiencing, how they can be treated and the results they can expect. If this education could be done in a setting close to home - such as the South Sudanese community centre or in homes (in the case of the women) with child care provided, this should increase the receptiveness to treatment. Since immigrants tend to have higher levels of pre-morbid functioning, it is predicted

that they would respond more quickly to interventions. At this point, this question has not yet been answered and would be a recommended research question. Given the barriers caused by low literacy skills, it could be very beneficial to have the opportunity to receive services provided by someone who is from South Sudan and speaks the same language as the person suffering from PTSD.

### **Further Research**

Whether or not one is a South Sudanese refugee or an immigrant, the recommendations offered in this paper will be the same. However, in future research it is recommended that the distinction be made between refugees and immigrants in the analysis of the data.

1. Are there different information needs in the “cultural education” provided before treatment, based on age and gender of South Sudanese refugees and immigrants?
2. Does the successful treatment of PTSD result in increased levels of functioning in South Sudanese refugees and immigrants?
3. Are there factors that facilitate an optimal outcome in the treatment of PTSD? If so, are there important issues in the training and assignment of therapists that need to be addressed (e.g., developing a working alliance, cultural awareness, knowledge and sensitivity, gender-matching and/or common language).
4. Is the multi-modal approach to PTSD a “best practice” in the treatment PTSD for South Sudanese refugees and immigrants?
5. Are there differences in the approach to treating PTSD for South Sudanese refugees versus South Sudanese immigrants?
6. Can paraprofessionals from the Diaspora be trained in effective trauma treatment for members of their community with PTSD?

### **Policy Development**

The process of helping refugees and immigrants integrate into the mainstream is time-consuming, costly and as is evident from the research, it requires more resources to be put in place in order to safeguard and promote their mental well-being. Developing appropriate policies will inform the treatment process. For example, Pottie et al. (2011) suggested that services that can reduce stressors if provided adequately include: social welfare, health insurance, affordable and reliable childcare, affordable and safe housing, affordable clothing and transportation, language classes and other educational and vocational training opportunities. Therefore, if community grassroots organizations can provide information and support groups in appropriate languages and in a culturally-competent manner, the South Sudanese refugees and immigrants suffering from symptoms associated with PTSD may be less impacted by the types of disturbances noted above.

If “cultural education” is supported by further research to facilitate engagement in treatment, then it is recommended that a policy of cultural education take place as a prerequisite to treatment on the part of the clients and therapists. An appropriate curriculum needs to be developed for clients and therapists. For clients, it might include an explanation of the PTSD symptoms to the members of the Diaspora (in their original language), what options are available, how to access them, how many sessions might be required and what they can expect after treatment. For professionals it would involve an understanding of the culture, how to develop trust and work best with members of the South Sudanese Diaspora.

The following policy recommendations are offered:

- One needs to find a balance between being honest about “treatment” with the clients while being very careful about the use of labels during a diagnostic process. In treating PTSD,

would it be honest and potentially less harmful to call any intervention “stress-management” rather than “treatment for PTSD”?

- In order to build trust and ensure that clients understand the process of treatment, it can be helpful for the therapist to meet the client in person when obtaining written consent for various interventions.
- Where possible, treatments should be provided at little to no cost, at a community health centre, in a location as close as possible to where the clients live and where babysitting is provided by trusted members of the community.
- Anyone working with this population needs to have adequate knowledge of the culture, social structure and customs of a community before beginning any work there. It is also important that respect be conveyed for prevailing community laws, mores, social customs and cultural expectations in all professional activities, provided that this does not contravene respect for the dignity of persons, responsible caring and integrity in relationships. These considerations reinforce the need for reciprocal cultural education - educating professionals in the South Sudanese culture and educating the South Sudanese community in how counselling works in Canada.
- There is a need for more effective methods of treatment. Therefore, when developing new procedures and techniques, it will be important to carry out pilot studies to determine their effectiveness and to assess their potential benefits and risks before considering their use on a broader scale.
- When doing research or providing any type of psychological service, every effort should be made to conduct these in the original language of the clients. Training in trauma treatment for

paraprofessionals who can speak English as well as the language of the participants is recommended. These individuals could be supervised by professionals.

New ways need to be found in treating refugees and immigrants that involve and empower religious leaders and community elders from the Diaspora. In creating any new approach, however, we must be alert to the balance of cost and benefits and make sure that innovative approaches are properly developed, first on a pilot basis and then on a larger scale if the results are warranted.

### **Conclusion**

In this integrated research paper, the focus was on the issue of treating PTSD in the population of South Sudanese refugees and immigrants. In the first section, definitions were given for refugees, immigrants, Diaspora and PTSD. Following this, a review of the literature took place in which we reviewed what we know in terms of the problem, interventions and barriers to treatment for the South Sudanese refugees and immigrants, then what we don't know at the present time and subsequently, the South Sudanese populations most researched. This was followed by a critique of the research methods used in the studies that were reviewed, their strengths, limitations, what kind of research produces what kind of knowledge and what is left to research and understand. The implications for individual and group interventions that arose from this research were discussed alongside salient ethical and policy-related considerations. The paper concluded with a series of recommendations for practice, research, and policy development.

**The following are the Key Take Away Messages**

- PTSD is a significant clinical problem in the refugee and immigrant populations from South Sudan and from other countries
- PTSD is often accompanied by other disorders such as depression, anxiety and substance abuse
- There are multiple barriers to successful treatment
- More research is needed on finding cost-effective ways to treat PTSD

### **Role of Quantitative and Qualitative Research**

Most of the research that has been done to date uses a combination of qualitative and quantitative methodologies and these types of methodologies will most likely continue to be useful. However, it may be more helpful to distinguish between refugees and immigrants in further research on treatment techniques, since these are two very different populations.

### **Personal Statement**

#### **a) What I have learned from both a clinical and research perspective**

From a clinical perspective, I have learned that:

- PTSD is an even more significant clinical issue than I had originally realized; that it affects the people with it and their loved ones as well.
- that there are many cultural and economic barriers to effective treatment and “cultural education” is needed for recipients of psychological services and those providing it to immigrant populations

From a research perspective, I have learned that:

- that there is very little formal research being done in Canada, but there may be research that could inform our practice that is being done in the United States and Australia

- There are a number of research questions arising out of this literature review that would be worthy of further investigation

**b) What it means to my professional practice**

By doing this research paper, I have learned that as a member of the South Sudanese Diaspora, I bring a lot of personal knowledge about the South Sudanese culture that will probably continue to help me in work as a psychologist with clients from South Sudan and those from other cultures. Many of the practices that I already incorporate into my work with clients were supported in the literature in terms of trust-building. I am involved in learning innovative techniques to trauma treatment and it will be important to create ways of evaluating these methods that use a combination of quantitative and qualitative methodologies.

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