

Helping refugees integrate into our community

Reflections from general practice

'All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of Brotherhood'.

Article One of the Universal Declaration of Human Rights

Since World War II, 5.5 million people have migrated to Australia, about 600 000 of them as refugees.¹ Most arrive with the same hopes of safety, economic stability, a better life for their children, freedom, and education to improve their opportunities. They experience adjustment problems such as finding accommodation, learning a new language, learning how to shop, opening a bank account, understanding the education system, and finding and keeping a job.

For refugees, this steep learning curve must be faced with personal resources diminished by the effects of their experiences of loss, dislocation and grief, torture and trauma, and cultural differences.²

The most common psychiatric condition I see in refugees is post-traumatic stress disorder (PTSD) with associated depression and anxiety. Patients have nightmares, insomnia, concentration difficulties, bouts of uncontrollable anger, withdrawal, and flashbacks of their abuse. The difficulties of detention, racial prejudice, bureaucratic technicalities, a foreign culture and language and poverty contribute to a 'continuous traumatic stress disorder'.³ A failure to adapt to a new culture, the disintegration of family and continued environmental isolation can prevent integration into a new society. The aim is not assimilation *per se* but to retain basic ethnic identity while coming to respect and understand the values of the new country.⁴

Caring for refugees in general practice

The importance of stories

I use a number of techniques to assist new arrivals and refugees. A vital strategy is developing an inter-personal relationship built around the stories they tell me. This gives me clarity and insight into the complex physical and psychological problems confronting this unique group of patients.

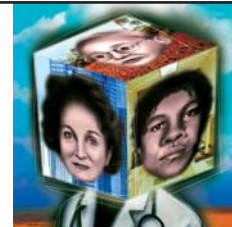
Western psychiatric classifications pay little attention to narrative accounts of illness⁵ resulting in traditional psychiatric categories being overly ascribed to refugee and migrant populations who come from a different cultural and health paradigm.⁶

One of the great ironies is that for those with PTSD the language centre is one of the main areas of their brain that has been affected. This means that not only are they unable to learn a new language, they struggle to express their pain and suffering in their native language.

Combining cultural awareness and medical skills

Most refugees come with a complex array of physical and mental problems. Dealing with these problems and including an interpreter may seem beyond the time, experience and financial expectations of many general practitioners. Yet assessment and treatment decisions must be made on sound clinical evidence. We need to have the knowledge, skills and ability to use appropriate cultural as well as medical diagnostic skills to guide treatment. Mistakes can be made if we do not take the time to respond effectively to language, cultural or psychosocial concerns.

Many of those who have suffered trauma continue to



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complain of physical symptoms and disabilities that are difficult to explain and where medical investigations are negative or ambiguous. Therefore, the doctor–patient relationship may become strained or even break down as both parties become frustrated with each other.⁷ Doctors may feel the patient is disabled for psychological reasons, whereas the patient may feel that the GP does not believe their symptoms are real, that they are unsympathetic, and are not offering appropriate treatment.

Restoring sense of control

A sense of control over their lives, both internally and externally, is an important goal in recovery. Often refugees are portrayed as ‘passive victims’ but part of recovery can be in helping them to move their problems to the ‘outside’, locating their success in surviving internally.⁸ Even in a busy practice, a GP can ask questions about the skills a distressed patient used to survive their trauma and help them to access those skills in other situations. This will enhance the patient’s sense of their own power and control and build a healthy internal resilience to cope with the current problems of living. Despite what has happened to them some refugees have kept this resilience throughout their plight by maintaining their healthy childhood histories, adaptive style, faith, sense of humour and strong sense of personal identity.³

Restoration of sense of identity

For many refugees, meaning and purpose to life, and sense of identity has been destroyed. Their lives seem empty and futile despite the fact that day to day life is going well.⁹ Restoring dignity and value involves an exploration of the guilt and shame often carried as a burden into their new lives. Good active listening skills and a firm nonjudgmental stance are the most useful therapeutic techniques to use in these situations.

Many refugees have come to Australia because of religious persecution. To lose their faith in God leaves them at enormous risk of suicide. Many health workers believe there is a certain taboo about speaking about religion. However, it is sometimes only by taking the personal risk of leading the patient back to their religious beliefs that they can have a renewed sense of meaning, both for their torture and trauma, as well as for life in their new country.

A team approach

It is of the utmost importance that the GP maintain a strong coordinating position as there will need to be a consistent, collaborative plan with all parties concerned. A team approach utilising rehabilitation services, pain clinics and other specialists can provide high quality cognitive and behavioural psychological treatments.⁷

General practitioners do not have to be ‘experts’ but can coordinate counselling, psychotherapy, pharmacotherapy, social agencies, tactile therapies such as massage and other specialist services, as we do with any patient with a chronic illness. This teamwork between the GP and

other health professionals can help bring about a balanced rebuilding of personal, family and social life.

Self care

The complex lives and past history of asylum seekers present particular challenges for the GP. Adequate training and reflection about the way we practise are important to help us deal with torture sequelae in our patients. Listening to refugee’s stories can be traumatic, and GPs must have their own support system and be aware of the risks of burnout and compassion fatigue.

Conclusion

Restoring attachment and connections to other people who can offer emotional support and care is of the utmost importance. As GPs we see people at the very point of their distress. We cannot undo the past, nor can we always make a major impact on the policies of our own government. But by working in a collaborative, supportive way we can encourage patients to locate their own protective emotional factors for mental and physical health. Every encounter with a survivor of trauma, even those of a purely medical nature, has the potential to promote the restoration of a meaningful connection with another human being.

Acknowledgment

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