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Compassionate listening

Managing psychological trauma in refugees

Background
The physical and psychosocial effects of trauma in refugees are wide ranging and long lasting. They can affect symptom presentation, the patient-doctor relationship and management of refugee victims of trauma.

Objective
This article discusses how refugees survivors of trauma may present to the general practitioner and gives an approach to psychological assessment and management.

Discussion
A strong therapeutic relationship built by patient led, sensitive assessment over time is the foundation to care. A management framework based on trauma recovery stages and adapted for general practice, is presented.

Keywords: doctor-patient relations; mental health; vulnerable populations, refugee

CPD

'Difficult as it is really to listen to someone in affliction, it is just as difficult for him to know that compassion is listening to him'.[1]

General practitioners are often the first and most accessible medical contact for refugees and humanitarian entrants in Australia. Refugees' history of trauma has profound effects on their physical and psychological health, ability to settle into Australian life and experience of the GP consultation. General practitioners can have a valuable role in managing both the physical and psychological effects of trauma. A strong therapeutic relationship built with a GP promotes recovery, settlement and trust toward the wider community.

Refugees in Australia

Australia's humanitarian program accepts 13 750 refugees per year.[2] Many individuals who enter Australia via the general migration program also have 'refugee-like' backgrounds. The vast majority of refugees are settled in New South Wales and Victoria, with close to 70% being less than 30 years of age. In Australia, seven in 10 refugee entrants were found to have experienced some physical or mental trauma.[3] The high mortality rates in their countries reflect this trauma (*Table 1*) which may affect them for years after arrival.[4]

Identifying the refugee patient

In the general practice context, a patient or family of refugee background may present as a new arrival or be a pre-existing patient (who may no longer identify as a refugee). The patient's country of origin suggests a likely refugee background and possible experience of trauma. Countries of transit, year of arrival, and period of time in a refugee camp or detention centre are also indicators, without the GP needing to ask specific details.

Types of traumatic experiences

Experiences of trauma are often repeated in many ways, over years.[5] These include:

- forced separation, disappearance or murder of family members[5,6]
- being subject to, or witnessing torture, physical and emotional abuse[7]

Table 1. Key health indicators of the top 10 countries of birth of the 2008–2009 Australian offshore humanitarian visa grants[3]

Country	Visa grants 2008–2009[4]	Life expectancy at birth (2007)	Under 5 years mortality rate (per 1000 live births) (2007)	Maternal mortality (per 100 000 live births) (2005)	Infant mortality (per 1000 live births) (2007)	Total fertility rate (average number of live children born to a mother during her lifetime) (2007)
Iraq	2874	63	45	300	36	4.3
Burma/Myanmar	2412	56	113	380	79	2.1
Afghanistan	847	42	257	1800	165	7.1
Sudan	631	58	109	450	70	4.3
Bhutan	616	63	84	440	56	2.2
Ethiopia	478	57	119	720	75	5.3
Congo (DRC)	463	52	161	1100	108	6.7
Somalia	456	52	142	1400	88	6.1
Liberia	387	56	133	1200	93	6.8
Sierra Leone	363	41	262	2100	155	6.5
Australia (comparative statistics)		82	6	4	5	1.8

- sexual assault
- mock execution
- imprisonment and solitary confinement, and
- illness and death of family members during flight or in refugee camps.

The trauma of food and water scarcity, lack of shelter, untreated illness and lack of legal redress is also common. The loss of household, educational opportunity, occupation and social structure can compound the experience of trauma. The insecurity of years in transition, in refugee camps, or in Australian detention centres, may also have profound psychological consequences.

Resettlement difficulties[6,8] cannot be overemphasised in regard to their contribution to psychological and social problems.[9] Newly arrived refugees are frequently socially isolated[9] and their ethnic and religious communities often lack the capacity to support them. Overcrowded, poor quality housing exacerbates their lack of security and may lead to homelessness. Employment and financial difficulties may cause hardship. Changes in roles and family structure may lead to domestic conflict. Experiences of racism are common. Unfamiliarity with basics of Australian daily life such as paying bills, public transport and negotiating with government bureaucracies can engender feelings of helplessness, dependency and frustration.

Ongoing grief and anxiety at family loss and separation is frequently overlooked.[6] Many refugees are under pressure to send money or assist with immigration to family in dire situations overseas.

The significance of resettlement difficulties, and ongoing grief and loss, is that the refugee experience – of uncertainty, flight, and fear – is perpetuated. The individual or family does not feel safe and is unable to begin to heal, grieve, or move into a new life and community.

Physical and psychological presentations

The physical and psychological sequelae of torture and trauma are cumulative (*Table 2*). Some psychological effects such as inability to trust, poor concentration, emotional disconnection, hopelessness, guilt and agression may not fulfil diagnostic criteria for specific mental health disorders.[10] However, these may cause profound effects on family functioning, settlement and other relationships, including the patient-doctor interaction.

Effects of trauma on children and adolescents

Children and adolescents are usually not spared the horrors inflicted on their elders.[11] The effects of the trauma will depend on each individual and their developmental stage.[12] Common symptoms include:

- learning and behavioural problems
- poor appetite and sleep
- psychosomatic symptoms
- enuresis and encopresis
- low self esteem, guilt.

These may all be manifestations of an underlying anxiety, depression or post-traumatic stress disorder (PTSD). It is important to assess, support and treat the entire family.[13,14]

Factors affecting the response to trauma

The effects of trauma are cumulative. The intensity and duration of trauma affect an individual's response.[15] Response is also affected by cultural norms (see *Resources*, 'Cultural awareness tool'). However, an individual's 'culture' is determined by their family, personal history,

Table 2. Effects of trauma[5,7]

Physical	Psychological
• Musculoskeletal and soft tissue injuries damage • Head trauma • Chronic and regional pain syndromes • Impairment of vision/hearing • Dental problems due to trauma • Motor and sensory neuropathy, gait disturbance • Female: amenorrhoea/dysfunctional uterine bleeding, sexual assault injuries, pelvic pain, problems related to female genital mutilation • Male: erectile dysfunction, genital pain • Sexually transmissable infections, sexual dysfunction	• Post-traumatic stress disorder – re-experiencing phenomena: intrusive distressing memories, flashbacks, nightmares – avoidance and emotional numbing – hyperarousal: exaggerated startle response, poor sleep, irritability • Complex PTSD – dissociation, personality change, poor relationships, aggression, self harm, loss of meaning in life • Cognitive impairment • Somatisation • Anxiety disorders • Depressive disorders • Grief, may be complicated and chronic • Psychosis • Substance abuse

education, religious beliefs and ethnic group.[16,17] It is therefore not possible or necessary to be an expert in the culture of every patient we treat!

The impact of poor attachment and personality factors also affect the individual's response to traumatic events.[18] In addition, difficult relationships and family problems predating the traumatic events may be exacerbated by the trauma and the resettlement experience.

Assessing the traumatised refugee patient

Many refugees believe they have been permanently physically damaged by their experiences. History taking, physical examination and procedures may trigger traumatic memories. A sensitive and gentle physical examination with careful repeated explanation of investigation results may be immensely reassuring. A refugee patient is more likely to disclose a trauma history if the GP has displayed empathy, interest, and allowed adequate time.

A professional interpreter should be offered to all patients in whom English is a second language. The patient's preference for an interpreter's gender, dialect and ethnicity should be respected where possible (see the article, 'Using an interpreter – a guide for GPs' in this issue.) Not using a professional interpreter leaves GPs open to medicolegal redress.[19]

How to ask about torture and trauma

If a trauma history is suspected, based on the person's country of origin or presenting symptoms, the questions shown in *Table 3* may enable the patient to reveal some of their story in a 'safe' way, and to check any cultural differences in understanding. Further helpful questions include genogram construction, migration history and current household composition and functioning, resettlement difficulties and the plight of family overseas. Enquiry into sleep, energy levels, daily tasks, appetite, concentration, memory and

Table 3. Culturally appropriate screening for trauma[4]

'Are there any health problems for you/your children that you are very worried about today?'

'Has anything happened to you/your family in the past, that you think may be causing this problem you have today?'

'What was happening to you/your family when this problem started?'

'Many people in your situation have experienced… I do not need to know the details, but has anything like this happened to you?'

'Sometimes people's health problems in Australia are due to things which have happened in the past, such as violence or detention…' [or specify the difficult circumstances if you know them]… 'do you have any injuries or pain (from those experiences) which may need attention?'

'In your culture, is this problem considered serious? What is the worst problem it could cause you? What is usually done to make the problem better?'

'worries' are an appropriate and culturally acceptable mental health screen. If any answers are positive, screen for the psychiatric conditions listed in *Table 2*.

Responding to a disclosure of torture and trauma

As in any consultation where painful and distressing information is recounted, it is helpful to:

- allow adequate time
- convey to the patient an ability to hear painful material
- validate the patient's experience, eg. 'That must have been terrible. I cannot imagine what that must have been like'
- avoid pressing the patient to say more than they wish to as

premature recall of trauma may retraumatise the patient. Traumatic events have significant impact on memory, so the retelling of events may be inconsistent. Explain that the person's symptoms and thoughts are a normal human response to extraordinary, devastating events. It is likely that the GP or primary health care worker will never hear every detail of the trauma, nor is it necessary to do so.

Case study 1

Intersection of the physical and psychological

Rebecca is a 34 year old mother of five children, from Sudan, who has lived with her family in Australia for 3 years. Over the past few months you and the local infectious diseases physician have been investigating her continuing weight loss and persistent iron deficiency anaemia. She has schistosomiasis positive serology and a breath test has demonstrated *Helicobacter pylori*. Her vitamin D level remains at 45 nmol/L despite supplementation.

She and her husband have been served a notice of eviction and are frantically trying to find new accommodation, but each housing application has been rejected.

She presents today with headache and admits to nightmares and frequent waking; then begins to weep and on gentle questioning, describes her overwhelming fear and anxiety for her mother and sister who are refugees, living precariously in Cairo. The predicament of these relatives is in fact her primary concern.

Case study 2

Complex PTSD and psychotic presentation

Ali, 42 years of age, is an Iraqi refugee and former POW in Iran after the Iraq-Iran war. After his arrival by boat on Ashmore Reef in 2001, he was detained for 5 years in Woomera and Baxter Detention Centres. After his release he drove a forklift until a back injury ended this year long period of employment. He presents every few months for another prescription for SSRIs, but occasionally forgets, and may be without medication for some weeks.

He refuses to have counselling because he 'does not wish to discuss the past'.

Today he presents without an appointment, agitated and smelling of alcohol. You agree to see him briefly. He appears vague and distracted, and is somewhat confused. He describes hearing a male voice over the past 2 weeks, telling him to kill himself via electrocution; the pictures on his walls are moving and he finds the noise of the TV and radio overwhelming. He is drinking a bottle of whisky each day; admits to having broken up with his girlfriend because he hit her, and has pulled a knife on a housemate, who subsequently moved out. His rent is due and he has no funds to pay.

Case study 3

Examination causes flashback

Muna, 25 years of age, has been a permanent resident in Australia for 10 years. She is now a single mother of three children and is studying nursing. She presents for her first Pap test. After explanation and discussion she is keen to proceed. However, just as you are about to insert the speculum she cries out in fright and begs you to stop.

After she has dressed and regained her composure, she explains that she found herself reliving her experience of female genital mutilation when she was 5 years old, in Somalia. She returns in 3 weeks and is able to complete the Pap smear without further incident.

Management

Psychological recovery from trauma requires the establishment of physical and psychological safety, reconnection and acknowledgment of grief, reintegration into the community;[19,20] and recognition of the patient's experience of injustice and loss of trust and meaning. A framework for the management of the traumatised refugee in general practice is presented in *Table 4*. The process for recovery may not be linear. Symptoms often settle dramatically when basic needs such as housing and income are met, and the patient may not need further psychological assistance. Tasks that seem bureaucratic to the GP, such as assisting with Centrelink or housing forms, may powerfully enhance a sense of safety and reinforce trust. Enlisting a team of colleagues (eg. refugee health or mental health nurse, practice nurse, settlement services) may provide more effective patient care and GP support. Severe and refractory symptoms require specialist referral.

Cognitive reprocessing of traumatic memories is considered central to recovery. It is achieved by developing a coherent trauma narrative;[21] examining painful emotions (particularly shame and guilt) around the 'hotspots' of the most distressing memories; allowing desensitisation to the material and more rational cognitions to be developed.[13] Trauma focused cognitive behavioural therapy (CBT) and other complex psychological techniques should not be attempted in general practice without specific training and expert supervision, as the risk of retraumatisation is very high. However, the patient may choose to share their story gradually with a trusted GP, facilitating psychological healing.

Medication and compliance issues

Psychotropic medication may provide symptom relief and management protocols should be followed as in the general population, with a few caveats. As people of ethnic backgrounds may respond in varying ways to medication,[22] it is reasonable to 'start low and go slow' when introducing an antidepressant. Selective serotonin reuptake inhibitors (SSRIs) and serotonin/noradrenalin reuptake inhibitors (SNRIs) are first line medications in the management of PTSD, anxiety and depression,[23] with no place for benzodiazepines as a sole treatment.

Poor compliance may result from the patient not realising that each month they must fill the prescription or see the doctor again when the prescription runs out or from a mistrust of western medical authorities and proposed treatment. High rates of illiteracy and lack of confidence in dealing with authority may affect the patient's acceptance. There may be unrealistic expectations of immediate improvement, or a low tolerance of side effects, which may trigger memories of torture and helplessness.

How and when to refer to specialised mental health services

Many non-Western cultures are unfamiliar with the concept of mental health care, and fear that talking about their problems might make them worse. In discussing a referral initially, avoid terms such as 'counselling', and be specific: 'you have been worrying for a long time'; 'your nightmares may improve with help from someone who

Table 4. A framework for GP management of refugee survivors of trauma

	Environmental	Physical	Psychological
Short term	Engage with the patient Offer to use a professional and gender appropriate interpreter Allow for adequate time Reassure the patient about confidentiality Encourage familiarity with local services (eg. pharmacy, emergency, settlement service, transport)	Focus on the patient's concerns first Perform a comprehensive refugee health assessment and develop a problem list (see *Resources* for a guide) Take time to explain examinations, investigations and results	Avoid premature recall of the trauma; let the patient lead A genogram and current household composition may enable the patient to talk about who is missing or in trouble overseas Allow the patient to ventilate and validate their experience Give psycho-education in the appropriate language
Medium term	Review regularly Assess and assist with housing, educational and financial concerns (eg. Centrelink) and liaise with local agencies if needed Encourage participation in culturally and gender appropriate groups and hobbies Encourage spirituality and observance of the patient's preferred religious practices to assist with the feeling of connection with community	Refer to allied health and alternative therapies if needed and acceptable to the patient For chronic pain and somatic symptoms investigate physical pathology adequately. Remember vitamin D and physical trauma effects Careful and repeated explanation of results may be required	Medication may be required for distressing symptoms and contribute to a sense of safety Suggest relaxation strategies: progressive muscle relaxation, breathing exercises, sleep hygiene Chronic pain may be a reminder of torture and trauma Consider the effect of intercurrent stressors, early childhood experiences and family separation: 'What was happening when this problem started?'
Long term	Parenting/family strengthening may be needed Offer to assist with migration and sponsorship issues via letters of support or referral to appropriate agencies Refer for family tracing to the Red Cross	Specialist review if needed for persistent and distressing symptoms Review regularly to screen for development of chronic disease (eg. NIDDM, hypertension) which may occur at a young age Encourage and promote healthy lifestyle choices (eg. smoking cessation, physical activity)	Use CBT techniques in a limited way, eg. cognitive reframing, reality checking, problem solving, activity scheduling Reinforce the patient's own resources and strengths. Do not attempt trauma exposure Assist with grief and bereavement counselling (losses may be multiple including property, status and vocation)

specialises in these difficulties'. It is important to address fears and to explain confidentiality.

General practitioners should refer for persistent or complicated psychological, behavioural or social problems, and if they are inexperienced in this area. When referring, include information regarding the patient's refugee experiences and consider practical difficulties including the service's use of interpreters, cost, transport, child care and gender specific workers.

General practitioner self care

Over time, GPs may suffer from vicarious trauma by bearing witness to distressing narratives.[24] Supports such as debriefing with colleagues, professional supervision; and Balint mental health and/or refugee interest groups are invaluable.

Conclusion

General practitioners have a valuable, central role in the recovery of traumatised refugees. The continuity and longevity of the patient-doctor relationship can be the foundation of managing trauma victims' complex physical and psychosocial symptoms. This relationship starts with a sensitive approach to consultation, which may form part of the patient's broader recovery by rebuilding trust. Refugees open the world to the GP, and their daily resilience and dignity becomes a source of renewed humility and awe.

Resources

- Telephone Interpreting Service Doctors Priority Line: 1300 131450
- The Forum of Australian Services for the Survivors of Torture and Trauma lists specialised services for refugees: www.fasstt.org.au/resources/index.php
- Victorian Transcultural Psychiatry Unit website for translated mental health information and cultural and ethnic group information: www.vtpu.org.au
- The Harvard Program in Refugee Trauma has useful resources and links: www.hprt-cambridge.org/
- Refugee health assessment template: www.gpv.org.au/resources.asp?cat=17
- Translated health information: healthtranslations.vic.gov.au
- Multicultural Mental Health Australia has many useful resources and the cultural awareness tool: www.mmha.org.au.

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