

REFUGEE MENTAL HEALTH: BUILDING TRUST & A WORKING RELATIONSHIP

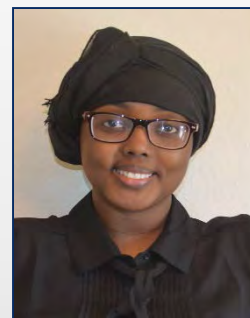
Andrea Northwood, PhD, Director of Client Services
Amal Hassan, BA, Somali Community Liaison
Center for Victims of Torture

Presenter backgrounds



**Andrea
 Northwood
 PhD, LP**

- Mental Health Provider with 20+ years of experience working with refugees and asylum seekers
- Director of Client Services, Center for Victims of Torture (CVT)
- Researcher and collaborator with refugee mental health initiatives in clinics and counties in Minnesota
- Experience in pre-resettlement contexts (urban and camp-based) in the Middle East and Africa



**Amal Hassan
 BA**

- Somali Community Liaison, Center for Victims of Torture (CVT)
- Extensive experience as a domestic violence advocate, cultural navigator, and community leader in St. Cloud

Objectives

- Background – Webinar 1
- Awareness of Common Challenges to Building Trust
- Proactive Steps to Addressing These Challenges
 - Best Practices in Working with Interpreters
 - Attending to Secondary Trauma
 - Opening & Closing Short Conversations on Mental Health
 - Providing Psychoeducation
 - Dealing with Unexpected Turns in the Conversation
 - Obtaining Consultation, Debriefing and Team Support on a Regular Basis
- Case Examples

Background Resources

- Working Group's Recommendations:
<http://www.health.state.mn.us/divs/idepc/refugee/guide/mhguidelines14.pdf>
- Webinar 1: The screener
<http://www-stage.health.state.mn.us/divs/idepc/refugee/guide/10mentalhealth.html#pilot>
- CDC Guidelines:
<http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/mental-health-screening-guidelines.html>

Challenges to Trust & Talking*

- History of Political Repression Can Render Refugees Speechless
- Fears Silence Refugees (examples)

*Shannon et al. (2014) Beyond stigma: Barriers to discussing mental health in refugee populations. *J of Loss & Trauma*, doi: 10.1080/15325024.2014.934629

Challenges to Trust & Talking*

- Talking Does Not Help - Everyone Has Been Through Trauma

1993 (Northwood): *“Every Cambodian has nightmares. Why would I complain about nightmares?”*

- Avoidance is Adaptive Under Life-Threatening Conditions

“My father was put in prison. My mother died....I don’t want to talk about Bhutan because I can’t talk and I don’t want to listen about Bhutan.”

“We are so angry about what happened in the refugee camp....we don’t want to talk about it....very painful in the camp.”

*Shannon et al. (2014) Beyond stigma: Barriers to discussing mental health in refugee populations. J of Loss & Trauma, doi: 10.1080/15325024.2014.934629

Challenges to Trust & Talking*

- Culture

“In the Karen culture, we don’t share something unless the doctor asks. It’s not respectful.” (CVT Healing Hearts project)

- Shame

- Lack of Knowledge about Mental Health

*Shannon et al. (2014) Beyond stigma: Barriers to discussing mental health in refugee populations. J of Loss & Trauma, doi: 10.1080/15325024.2014.934629

System Factors that Affect Trust

- Limited Time

“In the Somali community, the problem that we faced, if we start talking about it, it would take a year to talk about it.”

“The doctors are not listening to us, they give us only 15 minutes or probably the interpreter is not telling them right.”

- The U.S. “Paper Culture”

- Medical settings contain reminders of war trauma

The Good News: Fears Can Be Overcome!

SUCCESS STORIES FROM ST CLOUD

Cross-cultural Dialogue & Secondary Trauma

- It is normal & expected to not want to hear about it
- It is normal to feel overwhelmed / frustrated in the face of trauma & cross-cultural communication complexity
- It is normal to feel afraid / uncomfortable with mental health topics that expose us to human distress and vulnerability
- We convey all this non-verbally and verbally; trauma survivors across cultures are highly skilled at picking up on this – their survival depended on it
- Positive & negative stereotypes are flip sides of the same coin

The ABC's* of Self-Care & Trauma

- Awareness
- Balance
- Connection

*Saakvitne, K., & Pearlman, V. (1996). *Transforming the Pain: A Workbook for Vicarious Traumatization*. Norton Professional Books.

Best Practices in Building Trust: Interpretation

- Always speak in the first person to the patient ('Mr. X, How are you sleeping?' *Not* 'Ask him how he is sleeping')
- Do not speak to the interpreter about the patient in front of the patient; do not say anything in front of the patient that you do not want interpreted, including asking the interpreter personal questions (eg., Where are you from?)
- Speak slowly and pause every 1-2 sentences
- Remove colloquial language ("out of the blue", "every now and again")

Best Practices with Interpreters

- Ethics of Interpreting: Accuracy, Completeness, Confidentiality can be covered quickly in front of patient and interpreter via “rules” for “any interpreted conversation at our clinic”
 - The interpreter is going to interpret everything said in the room
 - The interpreter is not going to add information you or I did not say
 - The interpreter will not share this information outside the room, including that s/he interpreted for you here today, your name, or anything you or I said
- Be aware and responsive: interpreters may have their own trauma histories; give choice where possible
- Be aware and responsive: interpreters can feel pressure to “fix” a confused patient’s words

Best Practices Working with Interpreters

Every interpreted conversation in a medical setting has 3 phases; attend to each when possible:

- | | |
|--------|--|
| PRE | (provider & interpreter; interpreter & patient in waiting room) |
| DURING | (provider, interpreter, patient)
Of the 3 parties, the interpreter is the only one who understands everything said in the room. |
| POST | (provider & interpreter; interpreter & patient) |

Short conversations on mental health

- Keep it simple
- Convey warmth and genuine interest
- Provide a brief introduction - something like:
 - Now I'd like to ask you a few questions about normal reactions people have to war and political violence. We serve many people who come as refugees from (Country). These reactions are so common that we ask everyone these questions. Your answers have no effect on your papers or benefits or future. Your answers help the doctor understand you better in order to help you.

Psychoeducation

- ✓ Validation (reactions are common, real, legit, expected)
- ✓ Normalization (they are normal responses to war)
- ✓ Information that establishes you as a resource (awareness of political context of the refugee's journey; of the effects of war; help is possible; needs can be addressed; support matters; time alone is not enough)
- ✓ Situate problems within a collective or group political context – this is a clear finding across research and clinical settings

Provide closure

- Thank him/her for answering that set of questions, which are now finished
- Provide simple, brief, slow explanation of what will happen next in response to what the patient shared (follow through is critical – do not create an expectation for something unless you are sure it will occur)
- Acknowledge his/her strength and courage in surviving difficult times and coming to a new country
- Ask if s/he has any questions about the questions

Unexpected Turns....What to Do?

- Active listening – stay calm, present, receptive, curious
- Validation – yes, it's natural to feel that way (however, try to avoid assuming you understand)
- Provide “containment”: receive, hold, summarize, reflect back, redirect
- Offer to convey info on basic needs/current crises back to case manager if appropriate/necessary to re-direct

Dissociation

- Patient may look disoriented, lost, blank, “offline”
- Patient may stare off into space, stop talking (rare)
- Provider should become very active: Use first name, repeatedly if needed, and ask the patient to focus on the senses (Can you feel the chair?) Touch, smell, hearing, sight – use to re-orient to the present moment)
- Remind that they are in a safe place, in Minnesota, at the doctor’s office
- Focus on care plan: Where will you go after you leave the doctor’s today? Who will be with you? Recommend being with others & rest

Consult, Consult, Consult

Case Example: Unexpected Turn

When asked if she has felt sad in the past month, an Iraqi woman in her 30s reports that yes, she feels sad because she is not staying with her children at night. Her husband's mother has "turned against" her and her husband cannot overrule his mother. She begins crying about missing her children, that she goes over to feed them but has to leave at night. She has been staying on a distant relative's couch. She does not want this shared with the case manager because she is afraid "I will get in even more trouble with my husband's family and then I will not see my children at all, I will have no place to go."

Case Example: Unexpected Turn

In response to the question about thinking too much about the past, a young man from the D.R.C. starts laughing and explains the past is behind him, he came to this country for a future. He asks the interviewer why she is asking these questions, there is no problem. He declines each of the remaining questions but seems dazed, less responsive, and “zoned out.”

Case Example: Interpreter Dilemma

Over the course of the screener, you notice that the patient's answers are far longer than the interpreter's responses. You also notice that the interpreter is not interpreting your shorter comments to express validation and normalization in response to the patient.

Presenter contact information



**Andrea
Northwood
PhD, LP**

- ANorthwood@cvt.org



**Amal Hassan
BA**

- AAHassan@cvt.org

For questions about the mental health screening pilot, please contact:

Ellen Frerich

Refugee Health Nurse Consultant

651-201-5827

Ellen.Frerich@state.mn.us