



PERGAMON

Social Science & Medicine 52 (2001) 1709–1718

SOCIAL
SCIENCE
&
MEDICINE

www.elsevier.com/locate/socscimed

Emerging paradigms in the mental health care of refugees

Charles Watters*

*European Center for the Study of the Social Care of Minority Groups and Refugees, University of Kent at Canterbury,
Canterbury, Kent CT2 7LZ, UK*

Abstract

Over the past decade the approaches adopted towards the mental health care of refugees by a range of national and international healthcare organisations have been the subject of a sustained and growing critique. Much of this critique has focused on the way in which Western psychiatric categories have been ascribed to refugee populations in ways which, critics argue, pay scant attention to the social, political and economic factors that play a pivotal role in refugees' experience. Rather than portraying refugees as "passive victims" suffering mental health problems, critics have argued that attention should be given to the resistance of refugees and the ways in which they interpret and respond to experiences, challenging the external forces bearing upon them. In this paper a range of issues concerning the mental health care of refugees will be examined. These include the role of psychiatric diagnosis in relation to refugees' own perceptions of their need and within the context of general health and social care provision. In examining services the emergence of new paradigms in mental health care is identified. These include the growth of holistic approaches that take account of refugees' own experiences and expressed needs and which address the broader social policy contexts in which refugees are placed. A three-dimensional model for the analysis of the interrelationship between "macro" level institutional factors in the mental health of refugees and the individual treatment of refugees within mental health services is proposed. © 2001 Elsevier Science Ltd. All rights reserved.

Keywords: Refugees; Mental health; PTSD

Psychiatric diagnosis as strategic categorisation

Much recent debate in the field of refugees' mental health has centred on the role of Post Traumatic Stress Disorder (PTSD). PTSD was only recognised as a distinct psychiatric category in 1980. Young has pointed out that it arose in a particular social and economic context following the Vietnam war yet has gone on to be applied universally to victims of war and persecution regardless of cultural group and place of origin (Young, 1995). He argues that, far from being a homogenous, neutral and value-free category, PTSD and its treatment are crucially influenced by a wide range of historical, social and economic factors. According to Young PTSD is "glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated

and represented and by the various interests, institutions, and moral arguments that mobilised these efforts and resources" (Young, 1995, p. 5). Summerfield has examined the practical implementation of PTSD and has been vociferous in his condemnation of an approach which, in his view, pigeonholes refugees as suffering from PTSD but pays scant attention to their own perceptions and interpretations of distress and their choices in terms of treatment (Summerfield, 1999). He points out that typically when most refugees are asked what would help their situation they are much more likely to point to social and economic factors rather than psychological help.

The designation of refugee's problems to the PTSD category may form a basis for quantitative analysis despite a range of recent studies challenging the view that a high proportion of refugees suffer from PTSD. According to Silove, the highest rates of PTSD have been recorded within psychiatric clinic populations,

*Fax: 1227-763674.

E-mail address: c.watters@tizard.ukc.ac.uk (C. Watters).

intermediate rates have been recorded in sampled community groups and the lowest levels have been recorded in epidemiological samples (Silove, 1999). For example, in a recent epidemiological study Mollica found that only 15% of Cambodian residents in a refugee camp on the Thai border suffered from PTSD (Mollica et al., 1993). Silove has suggested that this may be due to the fact that much recent research has adopted “sound epidemiological approaches” and avoided the sampling biases in earlier studies (Silove, 1999). Current studies of refugees in treatment continue to suggest high levels of PTSD. Mollica has reported on findings for Bosnian refugees in treatment suggesting between 18 and 53% with PTSD (Mollica et al., 1999).

Despite this variability in findings, sociologists have pointed to the construction and use of statistics suggesting high levels of PTSD in arguing for resources to develop particular programmes of treatment. Stubbs has examined a phenomenon which he refers to as “talking up the numbers” whereby a range of interest groups located within or in association with international aid agencies, present statistics which suggest that PTSD is present among refugee populations in epidemic proportions. He examines assertions suggesting that “more than 700,000 people in Bosnia Herzegovina and Croatia...suffer from severe psychic trauma” and demonstrates that although these statistics are based on generalised and unscientific assumptions they nevertheless function as a major means for mobilising resources into mental health work (Stubbs, 1999).

This phenomenon highlights ethical and practical dilemmas that relate directly to the acquisition and allocation of resources. Bio-medical taxonomies are not merely scientific labels but are mechanisms whereby resources, be they professional help or financial support, can be directed in accordance with established norms of clinical need. Agencies concerned with the social welfare of refugees may have to identify the problems in the context of clinical categories in order to assist, for example, an asylum seeker to gain entry to a country or to mobilise resources to a refugee camp. In this context the agency may feel an overwhelming sense of *responsibility to act* and may eschew critical analysis in favour of a pragmatism that proliferates, and adds credence, to bio-medical taxonomies. In adopting this approach agencies fall well short of Bracken et al.’s “post modern ethic” which involves “a concern not to impose order on the world but instead to allow the emergence of other voices and visions, even if this involves increasing complexity and ambivalence” (Bracken, Giller, & Summerfield, 1997, p. 435). Those critical of bio-medical approaches thus may be faced with a stark choice. Either present the refugees problems in terms that highlight the range of social, political and economic concerns of the refugee but that may not mobilise any resources to support the refugee and place her/him in legal jeopardy,

or, alternatively, in full knowledge of the broader complexities, nevertheless present the refugee as a traumatised victim and enhance her/his claim for asylum and mobilise support.

A further implication of a Western bio-medical approach is that the refugees’ experience is condensed into that which is deemed “clinically significant”. The refugee’s story is structured within a framework of a bio-medical explanatory model. Furthermore the telling of refugees’ stories takes place within a clinical arena in which the process of telling the story is, in itself, viewed as having a therapeutic effect. For example, for many of those working in clinical settings the taking of “torture testimony” is viewed as therapeutic (Woodcock, 1995, p. 400). According to Turner “telling the trauma story serves not just to assist in the processing of the emotions with which it is associated; it is also the first step in the construction of a new story, a new understanding of the past and a new hope for the future” (Turner, 1992, p. 171).

However, the voice of the refugee is only present here within a predefined context. The voice is listened to under the gaze of the therapist and is normally directed towards exploring traumatic events in the past (WHO, 1996). Services rarely provide opportunities for refugee service users to identify on a broader level what they want from mental health services. For example, a survey of mental health services for refugees in Europe carried out in collaboration with the World Federation for Mental Health found that of 18 European countries only 2 had developed mechanisms for listening to the voices of refugee service users (Watters, 1998b). This finding accords with wider evidence of mistrust of, and a lack of involvement with, refugees within a wide range of health and social care settings (Daniel & Knudsen, 1995; Fadiman, 1999). Without an opportunity to articulate their own experiences in their own terms and to identify their own priorities in terms of service provision, refugees may be the subject of institutional responses that are influenced by stereotypes and the homogenising of refugees into a single pathologised identity. Eastmond, drawing on her work with Bosnian Muslims in Sweden argues that they “constitute an example of the tendency to conflate the terms of refugee and war victim into a generalised category of traumatised, associated with psycho-pathology” (Eastmond, 1998, p. 179). In so doing there is a tendency to ignore the resilience of many refugees (Muecke, 1992). The voice of the refugee is only heard within predefined and compartmentalised contexts that conform to and reinforce institutional structures within the health and social care field. To draw on an expression from health management literature, the response to refugees can be characterised as being distinctly “service-led” rather than “user-led”.

Social policy and mental health

A further area of concern is the extent to which investigation into the mental health of refugees takes circumstances in “host” societies into account. Studies of the mental health of refugees have tended to emphasise the impact of past events, particularly those in the country of origin and in the process of flight, as the key factors in mental health problems. Scant attention is normally paid to the impact of post-migration experiences on mental health. An exception to this is Silove’s examinations of the impact of post-migration factors on asylum seekers in Australia (Silove & Steel, 1998a). In a survey of 62 Tamil asylum seekers from Sri Lanka, Silove and colleagues (Silove, Steel, McGorry, & Mohan, 1998b) noted the negative impact of factors such as fears of being sent home, interviews with immigration officials, separation from a spouse, threats to family, poverty and discrimination on mental health. They argue that those refugees who had experienced the higher levels of trauma in their country of origin were more susceptible to experiencing mental health problems as a result of post-migration stressors. In another study conducted in Australia the impact of post-migration experiences, such as separation from family, under-employment, loneliness and isolation and concerns about the refugee application were identified as having a negative impact on mental health (Sinnerbrink, Silove, Field, Steel, & Manicavasagar, 1997).

Further research indicates not only the psychological impact of specific social policies directed towards refugees, but also the ways in which social policies and their implementation label refugees as pathologised individuals and have a direct impact on their well being and treatment. Within this context the study of TB treatment for refugees in the Netherlands is instructive. van Ewijk and Grifhorst have examined the interaction between policies relating to asylum seekers and the diagnosis, treatment and course of TB. The authors argue that the controlling effects of medicalisation have constructed asylum seekers in the Netherlands “as the contagious and diseased ‘other’ who is a threat to public health” (van Ewijk & Grifhorst, 1997, p. 242). According to them medicalisation “creates different patterns of experiences” among asylum seekers by transforming negative and hostile feelings into symptoms of new diseases such as PTSD (van Ewijk & Grifhorst, 1997, p. 245). They examine the way in which the TB patient is constructed through procedures of medicalisation embedded in the Dutch asylum policies and provide a compelling link between a macro-analysis of legislation and policies and a micro examination of individual asylum seekers’ experiences of illness and treatment.

Methods for the examination of the relationships between macro- and micro-levels of analysis have been suggested by Duster in the context of an examination of

health screening programmes for black and ethnic minority groups in the USA and by Watters in the context of a study of the mental health care of South Asian communities in Britain (Duster, 1981; Watters, 1994). Duster suggests an approach in which macro- and micro-analysis are linked incrementally like “rungs” on a ladder. He suggests that an appropriate approach consists in identifying four levels which move from an examination of programmes at a federal and state level to “micro-observational” studies of interactions between patients and doctors, and between families and communities. These levels are linked by what Duster refers to as “intermediate steps to vertical integration” involving study of the roles of local organisations such as hospitals, public health departments and clinics (Duster, 1981, p. 109f).

An approach that combines an examination of micro- and macro-level analysis may be achieved by examining mental health interventions with refugees in the context of a three-dimensional model. On a macro- or “institutional” level there is a broad legal and policy context in which health and social care purchasers and providers present views about the health needs of particular populations and make decisions about the allocation of resources. At a secondary “service” level arrangements are put in place within localities for the deployment of health and social care professionals and arrangements governing the interaction between these professionals. The third level may be identified as the “treatment level” which focuses on the direct interaction between health and social care professionals and their clients/patients. The model suggests ways in which the context in which refugees receive mental health treatment is crucially influenced by a “macro-level” in which “common sense assumptions” regarding the needs of these groups construct the very contexts in which services are available. Consideration of the potential uses of this approach will be given below.

The above studies indicate that the broad social policy context of receiving societies in which asylum seekers and refugees find themselves may have a direct bearing on their mental health. Ager has suggested that policies that seek to rapidly integrate asylum seekers into a host society have poor mental health outcomes. The best approach may be one in which the particular cultural characteristics of groups are recognised and efforts are made to ensure the maintenance of refugees’ cultural identities and networks, while at the same time encouraging a positive relationship between refugees and the host society (Ager, 1993). This approach compliments Goldberg and Huxley’s wider identification of poor social relationships and social adversity as factors which made individuals vulnerable to mental health problems (Goldberg & Huxley, 1992, p. 101). Drawing on Rutter’s work they identify resilience to mental health problems as being linked to “a sense of

self-esteem and self-confidence; an ability to deal with change and adaptation; and a repertoire of social problem solving approaches” (p. 100). They go on to say that in order to develop resilience “an individual needs experience of secure, stable, affectionate responses, and an experience of success and achievement”. These factors accord with Summerfield’s examination of refugees’ own perceptions of what would be helpful to them. For example in commenting on war injured ex-soldiers in Nicaragua, Summerfield observes that “what interested them was their prospects for work and training” (Summerfield, 1999, p. 1454).

Examination of the implications of current policies towards asylum seekers within the UK suggests that asylum seekers will have less and less control over their own lives. At the time of writing government proposals include the continuation of a voucher based system which prevents or at least minimises the opportunities for asylum seekers to have access to any cash. The voucher system ensures that asylum seekers are only able to shop in certain specified supermarkets, use certain types of transportation and have personal matters like haircuts in certain designated places. Because of their unique method of payment it is quite possible for asylum seekers to be identified in a range of social settings. Further provisions include measures aimed at dispersing asylum seekers to different parts of the UK on a “no choice” basis. Social support of any kind is dependent on the asylum seeker giving up any element of choice as to place of residence. These measures can be seen as fundamentally disempowering and having a negative impact in terms of the development of resilience to mental health problems.

Cultural sensitivity and categorisation

Services often respond to the perceived mental health and social care needs of refugees by trying to develop “culturally sensitive” services. Components of these services include the employment of health and social care workers from similar cultural backgrounds to the refugees themselves, the provision of interpreting services, advocacy services and specific training in cultural issues for mental health staff. The development of culturally sensitive services is presented as a means of overcoming barriers between professionals and refugee clients and developing methods of therapeutic intervention, which are meaningful and effective to refugees (WHO, 1996). However, even in these contexts representations of refugees’ cultures may homogenise a diverse range of refugees and essentialise their cultures in ways that ignore the dynamic interaction between the cultures of minority groups and those of the “host” societies (Eastmond, 1998).

The appointment of workers from similar cultural backgrounds is not necessarily an effective means of responding to the needs of refugees. Ong has described the role of a Khmer war refugee who was being trained as a bilingual therapist in a mental health centre in San Francisco (Ong, 1995). According to Ong his job “is to interview Khmer women referred to his clinic, and using the Diagnostic and Statistical Manual for Mental Disorders 3 (DSM 3) as the measurement sort the patients according to DSM 3 categories of “major depression, schizophrenia” “conduct disorder” and “bipolar disorder”. His role is thus not to translate refugees’ experiences in their own terms but to construct parameters so that experiences fit into predefined biomedical categories. Bilingual therapists thus operate within well defined and circumscribed contexts. They listen to the stories of the refugees but they translate them in such a way that they can be operationalised as mental illness categories within a medical hierarchy. Thus, while the employment of people from similar ethnic and cultural backgrounds to the refugees themselves may be cited by services as evidence of cultural sensitivity, they may in fact be seen as agents of de-culturalisation and de-politicisation in that they transfigure the refugees’ accounts into individualised pathology. In this process refugees themselves may not be averse to such categorisation as it may be the only avenue available to secure wider legal and welfare benefits. Ong, for example, refers to refugees who “hang on to government subsidized clinics because it is a key institution that helps secure their other needs” (Ong, 1995, p. 1254).

The role of bicultural therapist in this context does not conform to characterisations of “intermediaries” proposed by Grillo on the basis of an influential study of the relationship between North African migrants and institutions in France. Grillo suggests that an identifiable category of “messengers” function at the interface between migrants and institutions such as social services. These messengers are drawn from the majority population in the host society and not from the migrant communities themselves. Grillo has suggested that such “messengers” develop a role akin to brokerage (Grillo, 1985, p. 259). In Ong’s description the “messengers” are themselves from the same cultural background as the refugees, but unlike brokers, act in the service of biomedicine in articulating refugees’ problems. In this mental health service context cultural sensitivity is used in a limited strategic way to win the patients co-operation, facilitate diagnosis and buttress the doctors’ authority.

The development of holistic approaches

The widespread distinctions made between health and social care may be particularly unhelpful in responding

to the needs of refugees. For example, a medicalised approach emphasising a diagnosis of, say, PTSD, and treatment through counselling or psychotherapy may be unhelpful to someone whose immediate concerns relate to social and economic issues. An asylum seeker with grave concerns regarding communication with family members in another country, or who does not know where resources to feed her family will come from, is unlikely to be receptive towards treatment in the form of counselling or psychotherapy (Boomstra & Kramer, 1997). It is unlikely that approaches that are based primarily on Western techniques such as counselling and psychotherapy will be successful unless the therapist or institution in which the therapist is based is perceived to have addressed some of the more fundamental issues facing the refugee first.

For this to be achieved there will, necessarily, need to be a blurring and overlapping of professional roles. A worker who, for example, helps a refugee family through the benefits system or helps them to gain access to accommodation is more likely, through the trust that is built up in the relationship, to engage the refugee in counselling and psychotherapeutic work if this is wanted by the refugee.

Besides having an impact in lowering the boundaries between health and social care, a holistic approach has implications for the oft-cited Cartesianism embedded in health and mental health services. A dualistic approach that categorises health problems as being related to either mind or body underpins assertions that members of certain minority ethnic groups are prone to “mask” or “repress” psychological problems through the presentation of somatic symptoms (Rack, 1982). Within this context Kleinman, for example, has referred to the “remarkable” tolerance of the Chinese in relation to the “somatic masquerade” (Kleinman, 1980). However, the presentation of physiological symptoms by people who are also experiencing psychological and/or emotional problems is not necessarily related to an attempt to mask or suppress the latter (Watters, 1996b). Indeed, in many cultures, a direct and explicit relationship is seen to exist between physiological problems and emotional and social problems (Scheper-Hughes, 1992, p. 186). When questioned about the possible cause of the physiological problem a patient may respond by, for example, drawing an explicit link to some problem associated with their social relationships. A clear link is thus recognised between a range of adverse circumstances and the direct experience of changes in the body. Scheper-Hughes, citing the work of Boltanski, identifies the presentation of somatic problems as being common among those who extract their basic subsistence from physical labour. This contrasts with the middle classes in which “personal and social distress is expressed psychologically rather than physically, and the language of the body is silenced and denied” (p. 185). The

masking and repression may thus be present among those who focus on the psychological.

A move from Cartesian dualism towards a more holistic approach incorporating mind and body is being suggested by research in the field of psychoneuroimmunology which reveals the impact of psychological influences on measurable physiological change. Recent research in this field has, for example, highlighted the impact of psychological factors on the cardiovascular system and on recovery from surgery (Lyon, 1993; Kiecolt, Janice, Page, Marucha, & MacCallum, 1998). Writers such as Goldberg and Huxley have pointed to the importance of an examination of the interrelationship between mind and body in the analysis of common mental disorders (Goldberg & Huxley, 1992). They contend that, “it now seems clear that stressful life events are not merely important in determining onsets of anxiety and depression, but also realize episodes of physical illness” (Goldberg & Huxley, 1992, p. 133).

A holistic approach suggests that, rather than impose a dualism which seeks to define whether the client has a physiological or a psychological problem, it may be more appropriate for clinicians to ask refugee patients for their own views regarding the etiology of their conditions. As suggested above, people may in fact draw explicit links between their physical symptoms and preceding social circumstances. In the context of a holistic approach, clinicians will function less as detectives trying to uncover the “real” causes of the presentation of physical symptoms, but will instead be open and receptive to the explanations given by patients as to the causes of their distress.

Emerging paradigms in service provision

Much of the above examination has focused on ways in which the voices of refugees are either not listened to at all or are listened to only so that their problems can be re-presented in ways that are palatable and operable within health and social care services. Current critiques of mental health services for refugees implicitly or explicitly pose the question as to how services can be developed which respond to refugees’ own articulation of their experiences and their own views as to their mental health and social care needs. It may be helpful to consider emerging paradigms in mental health service provision by drawing on the three-dimensional model of interaction between services and refugees proposed earlier. As noted above, the model provides a framework for examining the provision of mental health services that examines the interrelationship between “macro” level factors such as the institutional context in which decisions are made regarding the funding and organisation of services and, at a “micro” level, the local organisation of services and the provision of treatment

to individual refugees. A potential benefit of the model is that it places the mental health treatment offered to refugees within a broad institutional context and indicates ways in which the appearance (or non-appearance) of refugees in mental health settings may be influenced by wider factors. Examples are considered below in relation to the way in which the three dimensions may operate in listening and responding to refugees' views of their mental health needs. Specifically, we consider ways in which the voices of refugees play a part in developing services at an institutional, service and treatment level.

Institutional level

The institutional level refers to the context in which decisions are made about developing and financing specific mental health services. In this context a number of initiatives have developed relating to the involvement of service users in the development of mental health services. Two major initiatives from the Netherlands were the development of patients' councils and the Hearing Voices Movement. The former involved "a support group of ex-patients going into hospital wards to enable in-patients to meet without staff present and formulate and take action about their grievances" (Sassoon & Lindow, 1995, p. 95). In the Hearing Voices Movement "people who hear voices have themselves taken up the activity of learning from each other to understand the personal meanings of their voices and different ways to live with this experience" *ibid.* Over the past decade there has been a rapidly increasing emphasis on mental health services consulting with users in a formal way in the process of drawing up plans for the development of services. Sassoon and Lindow have identified the involvement of users in "planning and development committees" as part of an emerging "empowerment model" in mental health care (Sassoon & Lindow, 1995, p. 98).

However, while there is an increasing official recognition of the role of service users in the development of services, there is little evidence of involvement of settled minority ethnic groups let alone refugees. As noted above, in a recent survey of mental health service provision for minority groups and refugees any form of consultation with minority groups and refugees about the type of mental health service they receive was extremely rare throughout Europe (Watters, 1998b). This is despite the fact that in most European countries there are well-established organisations to represent the views of minority groups and refugee groups. Furthermore, there is evidence to suggest that consultation which is focused on listening to the experience of refugees can be a fruitful means of identifying service priorities and innovative strategies to respond to needs

(Watters, 1999). What appears to be crucial here is that refugees themselves, rather than those who see their role as articulating their needs on their behalf, are central to this exercise. One mechanism for consultation that has been tried out in refugee communities is the development of focus groups. These have proved to be useful forums for addressing issues relating to healthcare provision.

My and Cuninghame have described ways in which focus groups have been used to help identify the mental health needs of a Vietnamese refugee community (My & Cuninghame, 1996). They established two focus groups, one concerned with Vietnamese women's issues and one with Vietnamese elders. They describe the setting up and running of these groups as being successful, commenting that "participants appeared to share factual, personal information readily" (p. 264). As a result of the groups, health commissioners identified focus groups of this kind as a useful means of influencing health authorities' purchasing plans in a routine way. The establishment of such groups among refugee communities may be a useful means of prioritising proposals for the setting up of specific services relating to the mental health and social care needs of refugees.

Focus groups were a central part of a study into the mental health implications of the detention of asylum seekers in the UK (Pourgourides, Sashidharan, & Bracken, 1996). Among the benefits of this approach the authors cite its potential to "give a voice" to people who would not normally have the opportunity to have their views sought or listened to. They argue that focus groups may provide a sense of "safety in numbers" and individuals may "feel less anxious, or more inclined to discuss sensitive topics. Such a format gives a voice to disempowered groups or those in fear of negative feedback" (p. 20). The results of the work with focus groups suggests that, handled skilfully, the establishment of such focus groups may counter the prevalence of stereotypical views and assumptions regarding the needs of particular refugee groups. They may also suggest ways in which refugees can be active participants in identifying priorities and delivering services. There is clearly a need for more detailed research in this area but the evidence of My's and Cuninghame's and the studies of Pourgourides et al. indicates the potential of such an approach with refugees and asylum seekers. Indeed, the very process of consultation may in itself have some therapeutic value in a context in which asylum seekers and refugees may be increasingly disempowered members of society.

One challenge involved in the establishment and running of such groups is to ensure that the parameters of discussion are not truncated and channelled into narrow pre-defined decision-making processes. For example, the establishment of a group whose purpose is limited to trying to establish whether refugees are

more favourably disposed to one service option rather than another is of limited use. It is important here to move beyond the mere rhetoric of “service led” or “needs led” services and use groups as a means of opening discussion about the needs of refugee communities and the types of services the communities feel would help to address these needs. Health service commissioners could then attempt to address the practicalities of setting up such services and consider, for example, the potential of involving refugee communities themselves as service providers.

Service level

The “service level” relates to the organisation of services at a local level and includes the interaction between primary health care services and mental health teams, and interactions with social services and voluntary organisations. A feature of the service level may be the existence of short-term projects aimed at addressing the mental health or social care needs of refugees. Such projects may be the subject of short-term special funding from central government and stand outside mainstream mental health and social services. Whilst special projects can have advantages in that they can offer a more flexible service which crosses the boundaries between health and social care, there are a number of disadvantages arising from their marginal position in relation to mainstream services. These include the difficulties in recruiting appropriate staff on short-term contracts, the problem of introducing a new service which has to prove itself successful within a very short period of time and difficulties in influencing the policies of mainstream mental health services from a marginal position (Watters, 1996a). Operationally there can be particular difficulties in developing referral arrangements with existing services and the potential conflicts that may arise through the different expectations of services and refugee groups. For example, local GPs may see a refugee mental health project as having an essentially supportive role in relation to the provision of primary health care. An appropriate service may be viewed by local professionals as one that confines its activity to the provision of interpreting and facilitates rather than challenges the continuation of existing services.

A holistic model by contrast may challenge the status quo by working across traditional health and social service boundaries in ways that address the expressed needs of clients. Given that these needs are likely initially to concentrate on issues such as welfare provision and accommodation, it would seem appropriate that workers are introduced who not only speak appropriate languages, but who can provide welfare advice and act as advocates to refugees within the health and social care systems. Henderson has described the development of a

responsive advocacy service to refugees within a London borough and has demonstrated that, through taking positive steps to engage with local refugee communities, the establishment of advocacy services can be very effective and popular with refugee clients (Henderson, 1999). However, an approach which is limited only to advocacy can have severe disadvantages. Advocacy can help clients to find their way around or gain access to a pre-existing system but it does not, in itself, produce new models of service provision, which may be desired by the client. Henderson comments that many asylum seekers present with multiple disabilities and “hence do not fit neatly into the pre-defined categories of need adopted by the local authorities social services department. As a result users and advocates often find themselves being “shunted from one social services team to another, without anyone accepting responsibility for assessing or providing services to individuals” (Henderson, 1999, p. 61).

An ideal approach may be the combination of advocacy services to ensure that refugees gain the maximum benefits from existing health and social care services, combined with the provision of specific holistic services, which respond to the social care and mental health care needs of refugees. A useful way of approaching this may be through the construction of a Maslowian hierarchy of needs wherein workers attend initially to needs relating to physical well-being, such as food and shelter and safety, before “higher-level” needs relating to self-esteem and self-actualisation are attended to. Those focusing exclusively on providing services within pre-defined parameters of mental health care are likely to find that these more basic needs have to be addressed before refugee clients are interested in seeking help for mental health problems. The provision of help at this level may help to generate a feeling of trust between refugees and professionals in a context in which this is often absent (Knudsen, 1995). As a number of studies have concluded, trust is an essential pre-requisite for the development of any therapeutic mental health work with refugees (Turner, 1995).

Thus, at the service level there may be a need for more than interpreting services which provide support to health care workers and community mental health teams. There may also be a need for an approach that recognises a hierarchy of need in response to the immediate physiological and safety needs of refugees as a pre-requisite for delivering more specialised mental health care. Such an approach could consist of three components. Firstly the provision of training to mental health workers in the mental health needs of refugees. This may include information on the views and needs of refugees developed through activities such as focus groups and not be confined to broad generalisations about refugees of the kind referred to above. A second component is the provision of advocacy services, which

may help refugees to navigate through existing health and social services. Finally there is the need for more specialised services run by refugees which are responsive to the particular needs of refugee communities (Watters, 1998a). Such services may be enhanced by training refugees in skills relating to advocacy, welfare benefits and counseling. Counseling training is likely to be effective if it eschews the imposition of narrow diagnostic categories and pays attention to forms of social support and therapeutic activity which may already exist within refugee communities (Woodcock, 1995).

Treatment level

The third level or “treatment level” relates to the context in which refugees have face-to-face contact with mental health or social care professionals. This is a further context in which generalised stereotypes about pathologised refugees can be present. Such face-to-face encounters may take place with different professionals and within different contexts in the mental health care system. Given general practitioners roles as crucial gatekeepers to mental health services, the perceptions of GPs regarding the particular problems of refugees are likely to be a pivotal factor in determining the types of access to services which refugees receive (Goldberg & Huxley, 1992).

Kleinman has considered these encounters in terms of the different explanatory models (EMs) held by professionals and by patients. Explanatory models are “the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process” (Kleinman, 1980, p. 105). There is a dynamic relationship between professionals’ and patients’ EMs “in clinical transactions, practitioners commonly do not elicit the patient EM but spontaneously transmit at least part of their EM. While patients frequently do not spontaneously disclose their own EMs, they may elicit the practitioner EMs” (Kleinman, 1980, p. 111).

While patients’ EMs tend to have the status of beliefs or opinions, those of professionals assume the status of “facts”. The social determinants of perception are denied by professionals “by an ideology or epistemology” which regards its creations as really lying “out there—solid, substantial things in themselves” (Taussig, 1992, p. 87). Treatment contacts may be not so much sites of negotiation and transaction between EMs, rather contexts in which sustained activity is focused on ensuring that patients’ problems are located within the parameters of pre-determined bio-medical categories.

In considering the treatment level as it applies to refugees it is important to reiterate that many refugees who present themselves to services may not view

themselves as suffering from sickness but rather from a range of social, political and economic circumstances. As we have noted, within a holistic approach there is considerable blurring and overlap between the realms of social care and mental health. This suggests that an appropriate response by services at the treatment level may be to offer initially a broad assessment of needs that focuses on the refugees’ own EMs. It may be beneficial if this is offered by generic workers who do not exclusively inhabit realms of social or health care. On the basis of this, treatment may consist of help with welfare benefits, accommodation, health or mental health care, education and training and incorporate a wide range of approaches. For some refugees there may be a need for intensive professional involvement of one kind or another, for others the provision of a befriending service or simply the opportunity to go away somewhere quiet for a period of rest and recuperation may be what is needed (Westin, 1999). This approach suggests many of the elements traditionally associated with care management, but, in keeping with the particular needs of refugees, implies an even wider range of potential care givers and resources than would normally be involved in this approach (Cambridge, 1992). It also highlights the importance of employing workers who are responsive to the particular needs of refugees without informing their practice by stereotypes and broad generalisations.

Conclusion

The epistemology and structures of mental health services remain oriented towards the labeling of clients in accordance with biomedical categories. In recent times the range of psychiatric categories continues to expand to encompass an ever-wider range of behaviours. While categories and sub-categories continue to be refined in relation to general populations, refugees tend to be encapsulated within the ubiquitous designations of PTSD or trauma-related problems. The labeling of refugees is supported by a system in which tabulation of numbers with psychiatric labels forms a crucial basis for the mobilisation of broader social supports. This may operate within contexts in which refugees are rarely given opportunities to articulate their own needs or play active roles in the development of mental health or social care services.

While current mental health services support the idea of providing culturally sensitive services, in practice this may result in the use of cultural knowledge only as a tool to facilitate psychiatric diagnosis. As such “cultural sensitivity” is ultimately governed by an epistemology in which cultural factors are viewed as potential barriers to be overcome in a process of psychiatric classification. In the diagnostic process etiological factors are usually located in past events in far off places with little

attention given to the influence of post-migration factors such as the social policy contexts of host societies.

In contrast to this approach, a three-dimensional model for the analysis of refugee mental health is proposed. The aim of the model is to highlight the interrelationship between the treatment of refugees in mental health services and the broader social policy contexts in which services for refugees and refugees themselves are located. It is also to suggest that emerging holistic approaches to the treatment of refugees exercise a critical reflexivity in respect to the institutional contexts in which refugees are located and the stereotypes and assumptions that may underpin professional practices.

References

- Ager, A. (1993). *Mental health issues in refugee populations: A review*. Working Paper of the Harvard Center for the Study of Culture and Medicine, Harvard.
- Boomstra, R., & Kramer, S. (1997). *Cultuurverschillen in de interacties tussen hulpverleners en vluchtelingen*. Utrecht: Centrum voor Beleid en Management.
- Bracken, P., Giller, J. E., & Summerfield, D. (1997). Rethinking mental health work with survivors of wartime violence and refugees. *Journal of Refugee Studies*, 10(4), 431–442.
- Cambridge, P. (1992). Case management in community-based services: Organizational responses. *British Journal of Social Work*, 22, 295–517.
- Duster, T. (1981). Intermediate steps between micro and macro integration: The case of screening for inherited disorders. In K. Knorr-Cetina, & A. Cicourel, *Advances in social theory and methodology: Towards an integration of micro and macro sociologies*. London: Routledge.
- Eastmond, M. (1998). Nationalist discourses and the construction of difference: Bosnian muslim refugees in Sweden. *Journal of Refugee Studies*, 11(2), 161–181.
- Ewijk, M. van, & Grifhorst, P. (1997). Controlling and disciplining the foreign body: A case study of TB treatment among asylum seekers in the Netherlands. In K. Koser, & H. Lutz, *The new migration in Europe: Social constructions and social realities* (pp. 242–259). London: MacMillan.
- Fadiman, A. (1999). *The spirit catches you and you fall down*. New York: Noonday Press.
- Goldberg, D., & Huxley, P. (1992). *Common mental disorders: A bio-social model*. London: Routledge.
- Grillo, R. D. (1985). *Ideologies and institutions in urban France: The representation of immigrants*. Cambridge: Cambridge University Press.
- Henderson, R. (1999). Developing a more culturally aware and responsive advocacy service to people from black and minority ethnic communities. MA dissertation. Tizard Centre, University of Kent at Canterbury, unpublished.
- Kiecolt, G., Janice, K., Page, G., Marucha, P., & MacCallum, R. (1998). Psychological influences on surgical recovery: Perspectives from psychoneuroimmunology. *American Psychologist*, 53(11), 1209–1218.
- Kleinman, A. (1980). *Patients and healers in the context of culture*. Berkeley CA: University of California Press.
- Knudsen, J. C. (1995). When trust is on trial: Negotiating refugee narratives. In E. V. Daniel, & J. C. Knudsen, *Mistrusting refugees* (pp. 13–55). Berkeley: University of California Press.
- Lyon, M. L. (1993). Psychoneuroimmunology: The problem of the situatedness of illness and the conceptualization of healing. *Culture, Medicine and Psychiatry*, 17, 77–97.
- Mollica, R. F., Donelan, K., Tor, S., Lavelle, J., Elias, C., Frankel, M., & Blendon, R. J. (1993). The effect of trauma and confinement on functional health and mental health status of Cambodians living in Thailand–Cambodia border camps. *Journal of the American Medical Association*, 270, 581–586.
- Mollica, R. F., McInnes, K., Sarajli, N., Lavelle, J., Sarajli, I., & Massagli, M. (1999). Disability associated with psychiatric comorbidity and health status in Bosnian refugees living in Croatia. *Journal of the American Medical Association*, 282(5).
- Muecke, M. A. (1992). New paradigms for refugee health problems. *Social Science & Medicine*, 35(4), 515–523.
- My, T., & Cuninghame, C. (1996). Focusing on health: focus groups for consulting about health needs. In T. Heller, J. Reynolds, R. Gomm, R. Muston, & S. Pattison, *Mental health matters: A reader* (pp. 31–265). London: MacMillan.
- Ong, A. (1995). Making the biopolitical subject: Cambodian immigrants, refugee medicine and cultural citizenship in California. *Social Science and Medicine*, 40(9), 1243–1257.
- Pourgourides, C. K., Sashidharan, S. P., & Bracken, P. J. (1996). *A second exile: The mental health implications of detention of asylum seekers in the United Kingdom*. Northern Birmingham Mental Health Trust, Birmingham and Department of Economics, Bradford: University of Bradford.
- Rack, P. (1982). *Race, culture and mental disorder*. London: Tavistock.
- Sassoon, M., & Lindow, V. (1995). Consulting and empowering black mental health system users. In S. Fernando, *Mental health in a multi-ethnic society: A multi-disciplinary handbook* (pp. 89–106). London: Routledge.
- Scheper-Hughes, N. (1992). *Death without weeping: The violence of everyday life in Brazil*. Berkeley: University of California Press.
- Silove, D. (1999). The Psychosocial effects of torture, mass human rights violations, and refugee trauma. *Journal of Nervous and Mental Disease*, 187(4).
- Silove, D., & Steel, Z. (1998a). *The mental health & well-being of on-shore asylum seekers in Australia*. Psychiatry Research and Teaching Unit. Liverpool, Australia: University of New South Wales.
- Silove, D., Steel, Z., McGorry, P., & Mohan, P. (1998b). Psychiatric symptoms and living difficulties in Tamil asylum seekers: comparisons with refugees and immigrants. *Acta Psychiatrica Scandinavica*, 97(3), 175–181.
- Sinnerbrink, I., Silove, D., Field, A., Steel, Z., & Manicavasagar, V. (1997). Compounding of premigration trauma and postmigration stress in asylum seekers. *The Journal of Psychology*, 131(5), 463–470.
- Stubbs, P. (1999). *Transforming local and global discourses: Reassessing the PTSD movement in Bosnia and Croatia*.

- Paper presented at a Symposium on The Mental Health Care of Refugees, Utrecht.
- Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science & Medicine*, 48, 1449–1462.
- Taussig, M. (1992). Reification and the consciousness of the patient. In *The Nervous System*. London: Routledge.
- Turner, S. (1992). Therapeutic approaches with survivors of torture. In J. Kareem, & Littlewood, *Intercultural Therapy*. London: Blackwell.
- Turner, S. (1995). Torture, refuge and trust. In D. Valentine, & J. Knudsen, *Mistrusting Refugees*. Berkeley: University of California Press.
- Watters, C. (1994). Asians and psychiatric services in Britain. Avenues of access and parameters of treatment. Ph.D. thesis. University of Sussex, Unpublished
- Watters, C. (1996a). Inequalities in mental health: the inner city mental health project. *Journal of Community and Applied Social Psychology*, 6, 383–394.
- Watters, C. (1996b). Representations of Asians' Mental Health in British Psychiatry. In C. Samson, & N. South, *The social construction of social policy: Methodologies, racism, citizenship and the environment*. London: MacMillan.
- Watters, C. (1998a). The mental health needs of refugees and asylum seekers: Key issues in research and service development. In F. Nicholson, & P. Twomey, *Current issues in UK asylum law and policy*. Ashgate.
- Watters, C. (1998b). *Mental health services for minority groups and refugees in Europe*. London: MIND/World Federation for Mental Health.
- Watters, C. (1999). *Report of a consultation on the social care and mental health needs of refugees and asylum seekers*. London: Refugee Council.
- Westin, C. (1999). *Thinking the unthinkable*. Paper presented at a symposium on the mental health care of refugees, Utrecht.
- Woodcock, J. (1995). Healing rituals with families in exile. *Journal of Family Therapy*, 17, 397–409.
- World Health Organization (1996). *The mental health of refugees*. Geneva: WHO.
- Young, A. (1995). *The harmony of illusions: Inventing post-traumatic stress disorder*. Princeton: Princeton University Press.