

REFUGEE HEALTH MATTERS

A newsletter brought to you by the Refugee Health Fellows – November 2016

Managing Chronic Pain in Refugees

Prevalence of Trauma and Psychological Distress in Refugees

- Up to 30% of world's refugee population have had at least one experience of torture.¹
- A high percentage of refugee women have experienced sexual abuse or sexual torture²
- 7/10 refugees on assessment had experienced physical or psychological violence (Foundation House, 2010)
- High rates of PTSD and depression in both adults and children³
- Chronic pain in 65% (of 72 clients in Oslo clinic), 72% of those 'severe'⁴; in some studies chronic pain in refugee clients was found to be three times higher than in the general population.⁵

Mechanisms of Chronic Pain

- Pain lasting longer than 3 months is typically defined as chronic pain
- Changes in peripheral nerves and brain responses (peripheral and central sensitisation) are thought to be key reasons for persistent pain. (<http://www.chronicpinaustralia.org.au/index.php/chronic-pain/pain-physiology>)
- A useful explanation may be something like: "Even though the tests have not found a cause in your bones/body, your pain is real. It is due to your nervous system/brain sending the wrong signals, or being oversensitive/'volume turned up too high', telling you that (area of pain) is damaged when it is now ok."

Clinical Points

- Ensure adequate treatment of medical conditions, which may contribute to pain – such as the myalgia and headaches of Vitamin D deficiency, or undiagnosed problems such as TB osteomyelitis, or an inflammatory arthritis. Previous inadequate or inconsistent medical care may have resulted in significant problems being missed or not followed up.
- Be aware that if a patient has PTSD, their pain may trigger their traumatic memories, and may also be the end result of a traumatic memory.
- Exacerbations of pain and/or traumatic memories are more likely if the patient is worried about other problems, such as the well-being of family overseas or in Australia; or settlement stressors like inadequate housing, concerns with education and training.

¹ Anne Kalt, MSc, Mazeda Hossain, MSc, Ligia Kiss, PhD, and Cathy Zimmerman, PhD **Asylum Seekers, Violence and Health: A Systematic Review of Research in High-Income Host Countries** [Am J Public Health](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3673512/). 2013 March; 103(3): e30–e42. Published online 2013 March. doi: [10.2105/AJPH.2012.301136](https://doi.org/10.2105/AJPH.2012.301136) PMID: PMC3673512

"We performed a systematic review of literature on violence and related health concerns among asylum seekers in high-income host countries. We extracted data from 23 peer-reviewed studies. Prevalence of torture, variably defined, was above 30% across all studies."

² Alexander Vu, Atif Adam, Andrea Wirtz, Kiemanh Pham, Leonard Rubenstein, Nancy Glass et al **The Prevalence of Sexual Violence among Female Refugees in Complex Humanitarian Emergencies: a Systematic Review and Meta-analysis** Version 1. [PLoS Curr](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4012695/). 2014 March 18; 6: ecurrents.dis.835f10778fd80ae031aac12d3b533ca7. Published online 2014 March 18. doi: [10.1371/currents.dis.835f10778fd80ae031aac12d3b533ca7](https://doi.org/10.1371/currents.dis.835f10778fd80ae031aac12d3b533ca7) PMID: PMC4012695 Research Article

"The findings suggest that approximately one in five refugees or displaced women in complex humanitarian settings experienced sexual violence. However, this is likely an underestimation of the true prevalence given the multiple existing barriers associated with disclosure. "

³ Mina Fazel, Jeremy Wheeler, John Danesh **Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review**. *Lancet* 2005; 365: 1309–14

"Findings 20 eligible surveys provided results for 6743 adult refugees from seven countries, with substantial variation in assessment and sampling methods. In the larger studies, 9% (99% CI 8–10%) were diagnosed with post-traumatic stress disorder and 5% (4–6%) with major depression, with evidence of much psychiatric comorbidity. Five surveys of 260 refugee children from three countries yielded a prevalence of 11% (7–17%) for post-traumatic stress disorder. Larger and more rigorous surveys reported lower prevalence rates than did studies with less optimum designs, but heterogeneity persisted even in findings from the larger studies."

⁴ Dahl S, Dahl CI, Sandvik L, Hauff E. **Chronic pain in traumatized refugees** [Tidsskr Nor Laegeforen](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1468888/). 2006 Feb 23;126(5):608-10.

⁵ Dinu-Stefan Teodorescu, Trond Heir, Johan Siqveland, Edvard Hauff, Tore Wentzel-Larsen and, Lars Lien **Chronic pain in multi-traumatized outpatients with a refugee background resettled in Norway: a cross-sectional study** *BMC Psychology* 2015;3:7 DOI: 10.1186/s40359-015-0064-5 © Teodorescu et al.; licensee BioMed Central. 2015 **Published:** 15 March 2015

"In our study of 61 psychiatric outpatients, forty (65.6%) reported chronic pain at clinical levels. This is three and a half times higher than rates of chronic pain found in the general population (19%) (Breivik et al. 2006), similar to rates found in other investigations of refugee populations (Jamil et al. 2006; Cheung 1994), and even still higher than a study of pain in refugees resettled in Sweden (Hermansson et al. 2001)."

Pain has many Meanings

For some refugee survivors of torture and trauma, bodily pain may be a metaphor for psychological suffering.

- The body bears the psychic scar of the event, and the pain bears witness to grief and injustice suffered.
- In some clinical encounters, the clinician may be gently and subtly tested by the patient who offers their pain: what will the doctor do with my symptom? Will the nurse take me seriously?

Ask the right question...

- "What was happening when this problem started?"
- "I have met many people from ... who have had a very difficult time. Has something happened to you in the past, which you think may be affecting your health today?"
- "What do you think is wrong? How is this problem understood/treated in your community? Do you think it is serious?"
- "Is there anything else worrying you at the moment?"
- "Do you have any worries at present about family or friends overseas?"

Other useful questions include

- Genogram and current household structure
- Family functioning
- Activities of daily living
- "Big worries"
- Social support network, case workers
- Ask about symptoms of depression, anxiety and PTSD
- *Use a professional and gender- appropriate interpreter*
- *Get history from family where appropriate*

Strategies for Management

- Address both physical and psychological causes of pain
- Where possible, assist the patient to feel safe
 - In environment: housing/education/work/financial security;
 - Physically: a thorough physical examination and explanation of results, and why further investigations are not needed, may be very helpful.
 - Psychologically: psycho-education to explain traumatic symptoms and simple CBT techniques such as sleep hygiene, activity scheduling, mindfulness strategies.
 - Empower the patient wherever possible to draw on their inner strengths, resources, interests, and spirituality.
- An integrated approach where a treatment 'team' is established, comprising clinician, physiotherapist, dietician, psychiatrist, psychologist and whoever else is required, seems to be most effective. A GPMP and TCA may be used.
- Many patients find natural therapies, acupuncture and massage extremely helpful, and when done by an experienced practitioner familiar with refugee patients and their concerns, such therapies may enhance and facilitate more traditional physiotherapy and psychological therapies.

Resources

<http://www.aci.health.nsw.gov.au/chronic-pain/health-professionals>

<http://www.aci.health.nsw.gov.au/chronic-pain/translated-resources>

http://www.paintoolkit.org/downloads/PTK-AUSTRALIA_New.pdf

<http://www.painaustralia.org.au/for-everyone/videos.html>

<http://www.racgp.org.au/afp/2015/september/managing-medically-unexplained-illness-in-general-practice/>

References

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2. Bethany Taylor, DCLinPsy, Kenneth Carswell, DCLinPsy, and Amanda C. de C Williams, PhD. The Interaction of Persistent Pain and Post-Traumatic Re-Experiencing: A Qualitative Study in Torture Survivors; 2013 *Journal of Pain and Symptom Management*
3. Louise Stone Managing medically unexplained illness in general practice, *Australian Family Physician*, Volume 44, No.9, September 2015: 624-629