Promoting Resilience and Mental Health Among Resettled Refugees and Forced Migrants: Assessment, Treatment, Resilience and Recovery

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Disclosure of Commercial Support

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Learning Objectives

By the end of this presentation, participants will be able to:

✧ Understand the importance of using a cultural approach in assessment and treatment of mental health of refugees

✧ Identify pre-migration and post-migration stressors and recognize their importance in refugee mental health outcomes

✧ Consider diagnostic issues pertaining to refugee trauma, psychosocial distress, and common mental disorders

✧ Describe cultural psychiatry tools and resources for assessment and treatment of refugees
I Was Very Important

I remember my country, my last job I was very important if one day I did not go to work, people would say Mrs. Jean Charles, we missed you, Mrs. Jean Charles we needed you yesterday, Mrs. Jean Charles you have to do that today, I was really appreciated. But here I don’t have anything like that. Here I don’t feel important, I can’t do the same job. But in my country I used to be important.

Maggie used to be an accountant in Haiti. After 2 years in Canada, she is now taking a personal support worker course. Women’s Health in Women’s Hands, Immigrant Women’s Health Promotion Project, D. Gastaldo, ed., 2004.
“Immigration is like entering a bridge, when you get onto a bridge, you know there is an entrance and an exit. My problem is that I got onto the bridge, however I don’t know whether I am at the beginning, the middle or the end of the Bridge. I also don’t know where the bridge will take me, I feel anxious, I don’t know how much longer I have to keep going I can’t tell if I am just at the beginning or if I am almost out of the bridge, my only hope is to reach the end; this is what keeps me moving but this is such a hard process I never thought the bridge was this long…”

Maria Eugenia explained to the group how she understood her immigration process; she spoke in Spanish with an interpreter. Women’s Health in Women’s Hands, Immigrant Women’s Health Promotion Project, D. Gastaldo, ed., 2004.
I don’t worry about getting shot
I left the country
I feel safe even to walk at night
Kind of safe and good transportation
Easily accessible
Free medical treatment
Free education
I don’t have to worry about money for the kids schooling
And even myself
At least I can find a way somehow...
To study
Negative things...too much work
There is always too much work
You work too hard

Time is so fast
Everything is too fast
You have no time to relax
It makes you tired
You don’t enjoy even the good things
There’s no time
No family time
You’re always running
And eventually you find that families break up
That one makes me sad
So, what is life all about?
So there are good things
But if the family is breaking up
I get puzzled
And I don’t feel happy at all
I feel like I hate Canada so much for that
Chapter 4
The Debate About Trauma and Psychosocial Treatment for Refugees

Clare Pain, Pushpa Kanagaratnam and Donald Payne

Abstract  Accepted Western guidelines for the treatment of trauma survivors who are diagnosed with Posttraumatic Stress Disorder (PTSD) demonstrate an emerging consensus with regard to treatment. All of the guidelines cite strong evidence for the inclusion of an exposure component to treatment. However, the accumulated evidence base for the treatment of patients with PTSD is drawn from trials that almost exclusively do not include refugees. The question this chapter explores is the advisability of using an exposure component to the treatment of refugees who have suffered traumatic experiences and who remain symptomatic. Do we have clear evidence that exposure techniques are necessary or even advisable to resolve the psychological difficulties that refugees experience? Based on a number of reasons, the authors suggest that in the first years of resettlement and adaptation, successful treatment should be focused on settlement issues.
Reactions to war and systemic violence: Differentiating distress from mental illness.

Presenter: Dr. Clare Pain, MD, FRCPC, D.Sc (Hons); Director of the Psychological Trauma Program, Mount Sinai Hospital; Associate Professor, Department of Psychiatry, University of Toronto

Date: Wed., Jan. 13, 2016, 12pm - 1pm EST

Watch webinar

Summary

Refugees may feel emotionally or mentally distressed as a result of the difficult and traumatic experiences they have endured. Understanding the distinction between distress and mental illness is crucial for effective psychological support.
What is mental health?

“Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community”.

The positive dimension of mental health is emphasized in WHO's definition of health: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

World Health Organization. 2014
MENTAL DISORDER

DSM-5 defines mental disorder as a syndrome characterized by clinically significant disturbances in an individual’s cognitive, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational or other important activities.
Distinguishing distress from disorder as psychological outcomes of stressful social arrangements

Allan V. Horwitz
Rutgers University, USA

Abstract Some studies in the sociology of stress conceptualize their outcome variables as distress, while others treat the same outcomes as mental disorder. This article focuses on the importance of distinguishing between the two. It argues that there are fundamental differences between distress that arises in non-disordered persons and genuine mental disorder but that studies
Distress versus disorder?

“…Suffering, sadness and distress are not mental disorders but natural responses to stressful social arrangements. There is nothing wrong with the psychological functioning of individuals who become and remain distressed because of their social contexts. Part of the sociological mission is to indicate the normal range of responses to disturbing social conditions. We should not pathologize these responses by calling them mental disorders but should distinguish the proportionate responses of distressed people to stressful social arrangements from the psychological disorders that these arrangements can sometimes produce”.

Horwitz, 2007
Five areas of concern in identifying mental health disorders in refugees

- Differences between the explanatory models held by refugees and western clinicians that may confound clinical assessment
- Lack of culturally valid assessment tools
- Complications of using interpreters
- Is PTSD the most appropriate illness construct for traumatized refugees?
- Dearth of studies on psychiatric/psychological treatment of refugees

Pain, Kanagaratnam and Payne, 2014
What’s in a name?

What does it mean – culturally?

What are the values of your cultural group?

What has your experience been like in “being different” from others?

How have your (multiple) cultural identities affect your power relationship with others?

*How might any of these issues interact with your clinical practice?*
What is culture?

- Meanings, values and behavioural norms
- Learned and transmitted within social groups
- Influences cognitions, feelings and self-concept

NIMH Culture and Diagnosis Group, 1993
Dimensions of Culture

Culture shapes:
- Communication style (direct, indirect, eye contact, gestures, verbal, nonverbal)
- Family roles (marriage, gender)
- Eating behaviours
- Beliefs and rituals
- Child rearing, sexual practices
- Ways of regulating aggression and punishment

- Pretty much everything we use to determine if someone is functioning ‘normally’ in a psychiatric assessment!
Cultural Competence

“A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations”

Terry Cross et al (1988)
Levels of Cultural Competence

- Micro
- Meso
- Macro

- Mi
- Me-P
- Me-I
- Ma

Clinical
Programmatic/Institutional
Societal
Cultural Competence Components

- **Attitudes**
  - Own cultural values & biases
  - Client Worldview

- **Power**
  - Client-therapist dyad (Micro)
  - Client-system (Macro)

- **Knowledge**
  - Generic
  - Specific

- **Skills**

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**Cultural Competence Components**

- **Attitudes**
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- **Power**
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  - Client-system (Macro)

- **Knowledge**
  - Generic
  - Specific

- **Skills**
Generic vs. specific

- **Generic**: Being able to work across cultures using general principles

- **Specific**: Having knowledge of specific groups

Lo and Fung, 2003
I. Cultural identity: Ethnicity, Language, Involvement with culture of origin and host culture

II. Explanatory Model - Cultural explanations of the illness; Help seeking experiences and plans (Kleinman’s 8 questions)

III. Cultural factors in the psychosocial environment: Stressors and supports

IV. Cultural elements of the clinician-patient relationship

V. Overall Cultural Assessment
L-E-A-R-N Model of Cross Cultural Encounter Guidelines for Health Practitioners

- Listen with sympathy and understanding to the patient's perception of the problem
- Explain your perceptions of the problem
- Acknowledge and discuss the differences and similarities
- Recommend treatment
- Negotiate agreement

Berry Model of Acculturation

<table>
<thead>
<tr>
<th>Acculturation Attitudes</th>
<th>- Is it considered to be of value to maintain cultural identity and characteristics?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Is it considered to be of value to maintain relationships with other groups?</td>
<td>Yes</td>
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<td>Integrated</td>
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<td></td>
<td>No</td>
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* Need to take into account issues of stigma, power, racism, discrimination
Cultural Formulation Interview (DSM-5)

- www.psychiatry.org
- More structured interview suggestions
- Supplementary modules with additional questions including special populations, children & adolescents, older adults, immigrants & refugees, gender identity
Supplementary Modules to the Core Cultural Formulation Interview

11. Immigrants and Refugees

GUIDE TO INTERVIEWER: The following questions aim to collect information from refugees and immigrants about their experiences of migration and resettlement. Many refugees have experienced stressful interviews with health professionals in their home country, during the migration process, and in the receiving country. It may take longer than usual for the interviewee to feel comfortable with and trust the interview process. When patient and clinician do not share a level of fluency in a common language, accurate language translation is essential.

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: Leaving one’s country of origin and resettling elsewhere can have a great impact on people’s lives and health. To better understand your situation, I would like to ask you some questions related to your journey here from your country of origin.

Background information

1. What is your country of origin?
2. How long have you been living here in (host country)?
3. When and with whom did you leave (country of origin)?
4. Why did you leave (country of origin)?

Re-migration difficulties

5. Prior to arriving in (host country), were there any challenges in your country of origin or your family found especially difficult?
6. Some people experience hardship, pressure, or even violence before leaving their country of origin. Can you tell me something about your experience?

Migration-related losses and challenges

7. Of the persons important to you, who stayed behind?
8. Often people leaving a country experience losses. Did you or any of your family members experience upon leaving the country? If so, what are they?
9. Were there any challenges on your journey to (host country) that you or your family found especially difficult?
10. Do you or your family miss anything about your way of life in (country of origin)?
Refugee Mental Health

“The Healthy Immigrant Effect”
This is the accepted, unedited article as supplied by the author. The final edited and typeset version of record will appear in future. Posted December 8, 2015.

**Practice**

**Caring for a newly arrived Syrian refugee family**

Kevin Pottie MD MCISc, Christina Greenaway MD MSc, Ghayda Hassan PhD, Charles Hui MD, Laurence J. Kirmayer MD

**Affiliations:** Bruyere Research Institute, Department of Family Medicine, University of Ottawa (Pottie); Infectious Diseases and Microbiology, McGill University (Greenaway); Psychology, Université du Québec à Montreal (Hassan); Pediatric Infectious Diseases, University of Ottawa (Hui); and Psychiatry, Division of Social & Transcultural Psychiatry, McGill University (Kirmayer)

Correspondence to: Kevin Pottie, kpottie@uottawa.ca

Fatima, Omar and Ruya, the Sarraf family, from Syria are newly arrived refugees to Canada. They have an appointment with their new family doctor. The family spent three years in a United Nations High Commissioner for Refugees refugee camp in Jordan and is now in Canada as part of a humanitarian resettlement program.[Box 1][1–10]

**Box 1: The Syrian context and the Canadian response**

The ongoing Syrian civil war ranks as the worst humanitarian catastrophe in modern times. More than half of the citizens of Syria have been forcibly displaced, with nearly eight million people internally displaced and 4.5 million refugees, most of whom have fled to the neighbouring countries of Jordan, Lebanon, and Turkey.[1–3] More than half of forcibly displaced people are children and, of these, nearly 75% are under the age of 18. [Box 1] [1–10]
Should the Serraf family be screened for mental health issues?

Members of the Serraf family may experience mental health problems prompted by violence and displacement and by the post-emergency context or due to pre-existing mental disorders. For Syrian refugees, adaptation and recovery for both pre-existing mental disorders and those brought on by the difficulties they have experienced may be aided or impeded by the conditions of migration.

The most prevalent mental health problems among Syrian refugees include depression, prolonged grief disorder, post-traumatic stress disorder (PTSD) and various forms of anxiety disorders. Evidence of impairment of social functioning and/or a high level or long duration of suffering is essential for the diagnosis of common mental health disorders, such as PTSD or depression, in order to avoid over-diagnosis in this group.

Particularly vulnerable populations include unaccompanied Syrian refugee children, Syrians who have been victims of sexual- and gender-based violence or torture and older Syrians or those with special needs. Sexual- and gender-based violence and rates of torture have increased substantially due to the conflict and are associated with medical, psychological, social, economic and legal problems for refugees.

Pushing for disclosure of traumatic events in well-functioning individuals who have survived torture or sexual- and gender-based violence could be harmful; this increases the risk of inducing trauma, as well as raising issues of stigma and consequent ripple effects on family and community. We recommend against systematic screening for PTSD, but suggest that practitioners be alert for associated signs and symptoms (e.g., unexplained somatic symptoms, sleep disorders or mental health disorders such as depression or panic disorder).
“Pushing for disclosure of traumatic events in well-functioning individuals who have survived torture or sexual- and gender-based violence could be harmful…

This increases the risk of inducing trauma, as well as raising issues of stigma and consequent ripple effects on family and community…

Recommend against systematic screening for PTSD, but suggest that practitioners be alert for associated signs and symptoms (e.g., unexplained somatic symptoms, sleep disorders or mental health disorders such as depression or panic disorder).”

Pottie et al, CMAJ, posted Dec. 8, 2015
Appendix 11: Post traumatic stress disorder: evidence review for newly arriving immigrants and refugees

Cécile Rousseau MD, Kevin Pottie MD MCIsc, Brett D. Thombs PhD, Marie Munoz MD, Tomas Jurcik MA; for the Canadian Collaboration for Immigrant and Refugee Health

Department of Psychiatry, Division of Social and Transcultural Psychiatry (Rousseau), McGill University, Transcultural Research and Intervention Team, CESS de la Montagne, Montreal; Departments of Family Medicine and Epidemiology and Community Medicine, Centre for Global Health, Institute of Population Health and C.T. Lamont Primary Health Care Research Centre, Élisabeth Bruyère Research Institute (Pottie), University of Ottawa; Departments of Psychiatry; Epidemiology, Biostatistics, and Occupational Health; and Medicine (Thombs), McGill University and Jewish General Hospital, Montreal; PRAIDA Clinic, CSSS de la Montagne-site Côte-des-Neiges (Munoz), Montreal; Clinical Psychology Program (Jurcik), Concordia University.

ABSTRACT

Background: Exposure to premigratory traumatic events is common in refugees and non-refugee immigrants who have left their countries to escape socio-political turmoil. We conducted an evidence review to determine the burden of post traumatic stress disorder (PTSD) within immigrant and refugee populations, to evaluate the effectiveness of screening and treatment and to identify barriers for primary care.
Recommendations on PTSD from Canadian Collaboration for Immigrant and Refugee Health

1. Do not conduct routine screening for exposure to traumatic events (unless it is pt’s primary complaint)...“pushing for disclosure of traumatic events in well-functioning individuals may result in more harm than good”.

2. Be alert for signs and symptoms of PTSD, esp. in context of:
   - unexplained somatic symptoms,
   - sleep disorders,
   - depression or panic disorder,
   - *address functional impairment*

- Many persons having had a trauma exposure do fine once they find safety and social supports.
- Family perspective is essential.
- Remember: Phase 1 trauma treatment is safety and stabilization…Most people recover after reaching safety.
Importance of cultural approach in refugees: working with trauma and PTSD

- Subjectivity is embedded in definition - need event
  - Perception of events is key
  - Awareness of cultural Identity of client and clinician is starting point
Does everyone who is traumatized get PTSD?

General population:  
60.5% of men and 51.2% of women had one Criterion A event.

Life time prevalence of PTSD:  
5.0% for men and 10.4% for women
Longitudinal Course of PTSD Symptoms

6% recovered
53% recovered
58% recovered
15-25% UNRECOVERED

Weeks 3 months 9 months YEARS

Shalev & Yehuda, Psychological Trauma 1998
Risk Factors for PTSD  Brewin 2000, Shalev 2002

Pre Trauma:  
- Gender
  - Younger age at trauma
- SEC
- Education
- Intellect
- Race
  - *Psychiatric History
  - *Childhood abuse
- Other previous trauma
- Other adverse childhood events
  - *Family Psychiatric History

Trauma:  
- Trauma Severity

Post trauma:  
- Lack of social support
  - 0.4
- Ongoing life stressors
  - 0.3
More than PTSD –

The breakdown of the social fabric, family loss and disruption of daily life, lack of shelter and food shortages, the dismantling of basic services and destruction of the local infrastructure all contribute to extreme forms of suffering and disability.

Peri-urban relocation results in shanty towns, poverty, unemployment, incomplete families, drugs and alcohol. Domestic and street violence dominate.

*Desjarlais, Eisenberg, Good and Kleinman 1995*
Suffering can’t be usefully reduced to a psychiatric diagnosis of PTSD (Kleinman et al, 1997).

“Social suffering results from what political, economic, and social issues. Included under the category of social suffering are conditions that are usually divided among separate fields, conditions that simultaneously involve health, welfare, legal, moral and religious issues.

For example, the trauma, pain, and disorders to which atrocity gives rise are health conditions; yet they are also political and cultural matters. Similarly, poverty is the major risk factor for ill health and death; yet this is only another way of saying that health is a social indicator and indeed a social process.”
The use of psychiatric words to describe suffering – implies that PTSD is universal and context-independent. This medicalization of suffering infers all suffering is pathological, an illness or disease, and must be treated within a medical model…It obscures the political and economic causes.

PTSD tools are based on the DSM IV, applied to non western cultures they export our understandings by assuming and prescribing answers, failing to consider different cultural experiences.

Suffering is inevitable for human beings and traumatic experience ubiquitous – to heal we have always needed the institutions of society where meaning and culture is sequestered: schools for our children, mosques, temples, churches, synagogues, work, health care, sport, community centers, pubs… Less “treatment” more assistance with rebuilding the infrastructure which houses the culture’s system of meanings.
CRITERION A: Stressor

i. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

ii. The person’s response involved intense fear, helplessness, or horror (not in DSM-V).
Posttraumatic Stress Disorder

B. INTRUSION/REEXPERIENCING
- Intrusive recollections
- Dreams
- Reliving
- Psychological distress
- Physiological reactivity

C: AVOIDANCE OF TRAUMATIC TRIGGERS/ NUMBING OF GENERAL RESPONSIVENESS
- Avoids triggers (internal & external)
- Can’t recall aspects of event
- Diminished interest
- Detached/ estranged
- Restricted affect
- Foreshortened future

D. Negative alterations in cognitions/mood

E: AROUSAL/REACTIVITY
- Sleeping difficulties; concentration difficulties
- Irritable/ angry; hypervigilence
- Exaggerated startle

*Significant distress/imairment - social/occupational
*More than 1 month post trauma
*With or without dissociative sxs
*Not due to substances or general medical condition, etc.

http://www.ptsd.va.gov/professional/PTSD-overview/dsm5_criteria_ptsd.asp
The effects of trauma are not usually “pure”

- PTSD is precipitated by a fearful event – criterion A
- PTSD alone is rare, comorbidity is the rule
- Most people suffer a series of events – some frightening some frustrating, humiliating, shameful…
- Guilt about survival
- Anger is an inevitable accompaniment/fall out of unresolved traumatic experience
- Refugees and new Canadians represent a very special group of highly resilient people – treatment needs to be modified to take this into account, (as it does for other vulnerable groups: geriatric patients, perinatal women, children, etc).
What is Refugee Resilience?
Begins with early experiences and solid attachment
Settlement services are vital

CCVT Programs and Services

- Mental Health
- Settlement Services
- Children & Youth
- ESL
- Computer Training
- Public Education
- East Toronto Downtown

Local Immigration Project

International Projects
Community support is essential

Syrian newcomers find support in refugees already settled in Canada

VICTORIA — The Globe and Mail
Published Sunday, Jan. 17, 2016 8:40PM EST
Last updated Sunday, Jan. 17, 2016 8:40PM EST
Sharifa (left), 12, from the Syrian city of Homs, studies by the sheep pen in her tented camp in Turbide, Bekaa Valley. Her textbooks are in French, like many in Lebanese schools, and pose a challenge. But Sharifa enjoys learning. When she grows up, she wants to be a paediatrician. © UNHCR/L.Addario
Image 1 of 13
Considerations for psychological support and enhancing resilience

How the experience of war, trauma, or torture can impact:

- Adjustment to life in a new country
- The experience of getting help
- Expectations for psychotherapy
- Family life
- Sense of one’s own future
- Both physical and mental health
Treatment Barriers

- Issues of fear and mistrust
- How trauma and torture affects self-concept:
  "Broken spirit, shattered mind and heart"
- Loss, fear, loneliness, fear of deportation

Treatment Directions:

- Recovering sense of trust, agency and self-reliance
- Importance of social support
- Being empowered to heal
- Spirituality as means of survival
- Exploring cultural identity in the new setting
- Reconnection with family and community
Trauma Treatment of Refugees

- When and How?
  - Traditional forms of trauma therapy may be very difficult while waiting for asylum due to uncertainties around safety and unknown future and likely contraindicated
  - Importance of psychiatric assessments for refugee hearing reports rather than treatment
  - Role of non-MD counsellors and settlement workers
  - Need to focus on basic needs: housing, finances, ESL, schools, daycare, jobs
  - Psychoeducation can be very normalizing
  - May require extended period of Phase 1 safety and stabilization- antidepressants for sleep, depressive symptoms, severe anxiety; if therapy is used, consider NET model
  - Reconnection with families or social network very important
Psychoeducation & Normalization

COMMON RESPONSES TO TRAUMA – AND COPING STRATEGIES
www.drpattilevin.com

[Please feel free to disseminate this handout in any way, including electronically.]

After a trauma, people may go through a wide range of normal responses. Such reactions may be experienced not only by people who experienced the trauma first-hand, but by those who have witnessed or heard about the trauma, or been involved with those immediately affected. Many reactions can be triggered by persons, places, or things associated with the trauma. Some reactions may appear totally unrelated.

Here is a list of common physical and emotional reactions to trauma, as well as a list of helpful coping strategies. These are NORMAL reactions to ABNORMAL events.

PHYSICAL REACTIONS

- aches and pains like headaches, backaches, stomach aches
- sudden sweating and/or heart palpitations (fluttering)
- changes in sleep patterns, appetite, interest in sex
Post-traumatic growth

Changes in perception of the self:

- Identify strengths and new possibilities

Greater intimacy in relating to others

Changed philosophy of life:

- New priorities, appreciation and spirituality

Tedeschi and Calhoun, 1995

Weiss and Berger, 2010
Improving resilience and mental well-being

- **Self-care:** sleep, food, daily routine, going out, ESL, volunteering
- **Values:** What keeps you going?
  - Family, children, religious beliefs, political beliefs
- **Finding connection** (Berry model)

Also known as Kintsugi
Psychological Principles for ‘PTSD Prophylaxis’ in Canada

Foster a sense of security and self-efficacy:

- Protection from further threat or fear of further threat
- Reliable supply and access to basic needs
- Reinforce the natural support systems e.g. the informal community leaders who might be spiritual leaders, teachers, physicians etc e.g. appropriate places of worship, foster societal groupings that are comfortable for Syrians e.g. musical evenings, Syrian cooking evenings, men’s checker board evenings…
- Inclusion of the refugees into decisions that involve them
- Information and education to orientate them to Canada
- Respond to the needs as voiced by the refugees

(Slide credit C. Pain)
Treating refugees in Canada: lessons learned

❖ Do whatever you reasonably can to help solve the problem.

   “Nonspecific supportive interventions”

❖ Do whatever you can to facilitate function and optimize mood.

   “Empathy, advocacy, reassurance”

❖ All new Canadians will feel better as they learn the language, English or French:

they can then read the newspapers, make phone calls to services, talk to their children’s teacher, read food and medication packaging – learning English or French is excellent psychological treatment and mental health prophylaxis

(Slide credit C.Pain)
Treating refugees in Canada: lessons learned

- Awareness of the culture of biomedicine – the “culture of no culture” - which looks for pathology (not resilience) leading to a medical diagnosis in refugees which may overlook social determinants of health and cultural concerns (Taylor 2003 in Pain 2014)

- “Look beyond the refugees’ symptoms and explore and ameliorate the causes of distress in the ‘here and now’ of the complexity of resettlement in Canada” (Pain 2014)

- Focus on the “balms of resettlement” especially social support and integration with the receiving society (Beiser, 2011)
Resilience in cultural context

“In the context of exposure to significant adversity, whether psychological, environmental, or both, resilience is both the capacity of individuals to navigate their way to health-sustaining resources, including opportunities to experience feelings of well-being, and a condition of the individual’s family, community, and culture to provide these health resources and experiences in culturally meaningful ways”

Ungar, 2008 in Pickren, 2014
Syrian Telemental Health Network

Kids New To Canada
(Canadian Pediatric Society)

Multicultural Mental Health Resource Centre (MMHRC)
Selected References


Selected References


Caring for a newly arrived Syrian refugee family. Kevin Pottie MD MCISc, Christina Greenaway MD MSc, Ghayda Hassan PhD, Charles Hui MD, Laurence J. Kirmayer MD. CMAJ. Posted December 8, 2015.
