Tidsskriftet Tidsskrift for Den norske legeforening

How do doctors engage with refugees with mental disorders?

PERSPECTIVES

SAMANTHA MARIE HARRIS

samantha.harris@uib.no
Samantha Marie Harris, psychologist and researcher at the Department of Psychosocial Science, University of Bergen.
The author has completed the ICMJE form and declares no conflicts of interest.

ESPERANZA DIAZ

Esperanza Diaz, specialist in general practice and professor at the Department of Global Public Health and Primary Care, University of Bergen.
The author has completed the ICMJE form and declares no conflicts of interest.

PER-EINAR BINDER

Per-Einar Binder, specialist in psychology and professor at the Department of Clinical Psychology, University of Bergen.
The author has completed the ICMJE form and declares no conflicts of interest.

GRO MJELDHEIM SANDAL

Gro Mjeldheim Sandal, clinical psychologist and professor at the Department of Psychosocial Science, University of Bergen.
The author has completed the ICMJE form and declares no conflicts of interest.

Norwegian society has become more diverse. Everybody is entitled to medical care on equal terms, but what does this mean, and how can it be achieved?

The Norwegian welfare state is committed to providing health care to all inhabitants on equal terms, irrespective of their background. This also includes mental health care. But is this feasible in a diverse society? What does care on equal terms mean when inhabitants come from widely different backgrounds and have very different needs?

Meet Mari and Hodan

Mari and Hodan are two fictitious female patients. They are both 31 years old, with a job and two children. Mari is a native Norwegian, while Hodan came to Norway from Somalia three years ago. Each is consulting their GP because they suffer from headaches, and report feeling fatigued and unable to sleep. They are lethargic and feel guilty about this affecting their jobs and families. Both feel helpless and express worry that their lives will never improve. Mari's GP suspects depression and recommends sick leave and further assessment. Hodan's GP suspects post-traumatic stress and recommends therapy and further assessment.

In this fictitious situation, which is based on our recently published study (1), the women reported identical situations, but were nevertheless given different treatments. Does this mean that Mari and Hodan do not receive mental health care on equal terms from their respective GPs?

Inequalities in treatment

Due to experiences before, during and after migration, refugees may have a higher prevalence of certain mental disorders than the general population (2, 3). A recent study reported that 33 % of Syrian refugees in Norway and Lebanon showed symptoms indicating anxiety or depression, while 7 % had symptoms of post-traumatic stress disorder (PTSD) (4). These figures show a significantly higher prevalence than in the general Norwegian population, where it is 10–15 % for anxiety and depression (5) and 1–1.7 % for post-traumatic stress disorder (6).

> ***«The doctor's decisions can be influenced by the patient's refugee background»***

Moreover, refugees and other immigrants have poorer access to health services (7). The reasons may be linked to challenges that affect refugees and some immigrant groups to a greater extent than the general population, for example language barriers. The interaction between the doctor and the patient may also have a bearing on the choice of treatment and further follow-up. Communication problems may sometimes occur because the doctor and the patient have widely different ways of explaining mental health problems and symptoms and differing views of what constitutes appropriate treatment (8, 9). The patient's presentation of symptoms may also deviate from what the doctor would normally consider typical of the condition in question. Therefore, doctors may feel that they have to make clinical decisions on an unsound basis (9). It is thus difficult to tell whether the observed differences in health, including mental health, between persons from a refugee background and the general population are attributable to different needs and treatment preferences, poorer access to healthcare services or lack of adequate treatment. Is something other than different needs causing refugees to receive other diagnoses and treatments than the population in general? To find out, we

need to compare patients who have identical symptoms but differ in having a refugee or a non-refugee background. Such comparisons cannot be made in real practice, but can be simulated in an experiment.

We conducted such a study, where we showed doctors a video clip of a simulated consultation with a patient who presented with symptoms of depression (1). We randomised the doctors to watch either a Somali refugee or Norwegian patient. Within these categories we also varied the patient's sex. The findings showed that the doctors made different clinical decisions for Somali and Norwegian patients. The differences were small but noteworthy. Norwegian patients, especially women, were more frequently given sick leave, while Somali patients were more often prescribed medications for somatic ailments. Moreover, only Somali patients were diagnosed with PTSD, while Norwegian patients tended to be diagnosed with 'feelings of depression'.

In real-life consultations, many factors can play a role in the treatment of mental disorders; for example, the doctors will be able to ask follow-up questions to verify diagnoses. The study nevertheless indicates that the doctor's decisions can be influenced by the patient's refugee background (in this case from Somalia). This is corroborated by research showing that doctors may react differently to patients who have a refugee background than to patients with another immigrant background and the general population. For example, doctors tend to be less optimistic about the recovery of patients who have a refugee background (10). Our findings do not necessarily mean that Somali patients receive inadequate treatment, but that when the patient has a refugee background, some information may be taken for granted. Health personnel should therefore be aware of this issue in order to avoid contributing to stigmatisation, and in the worst case to systematically erroneous diagnosis and treatment of certain groups.

Cultural awareness

Would a patient with a refugee background be treated differently if the doctor had broad knowledge of the culture in the patient's home country? It is unrealistic to expect doctors to have knowledge of all cultures and world views in order to work in a diverse society. However, it is almost certainly the case that refugees would receive better treatment if the doctors felt comfortable with establishing a respectful conversation on the possible impact of fleeing from conflict or persecution and any experiences of trauma before and after migration to Norway. Health personnel can achieve this by increasing their cultural awareness, competence and humility.

> ***«A culturally aware, competent and humble approach can support the establishment of a relationship of trust between doctor and patient»***

Cultural awareness is about insight into how perceptions of reality, including views of normality and deviation, may vary between cultures, and that the therapist's understanding is also culturally situated, and hence not neutral. Cultural competence is the ability to communicate effectively with people from different cultural backgrounds (11). Furthermore, cultural competence includes knowing how to build dialogical

bridges to other cultures, willingness to engage with patients from other cultural backgrounds, and ability to draw on experiences from such encounters (11). Such competence can be trained through trial and error, but also through expert guidance.

In addition, another concept has recently attracted increasing attention: cultural humility. Humility in an intercultural context requires openness, self-confidence and self-reflection (12). To achieve this, one needs a critical and conscious view of the values, expectations and mindsets that are embedded in one's own culture (13). Furthermore, cultural humility is associated with acknowledging that health personnel are responsible for minimising the effect of cultural differences and misunderstandings that can lead to suboptimal diagnosis and treatment.

A culturally aware, competent and humble approach can support the establishment of trust between doctor and patient and help create a dynamic whereby the patient becomes more open to sharing their experiences and their own understanding of their problem (9). In turn, this could help the doctor identify the most appropriate treatment (9). In this context, patient-centred communication and adequate use of an interpreter will go a long way. However, other tools are also available. The Cultural Formulation Interview (CFI), developed by the American Psychiatric Association, can help health personnel work in a more culturally competent and humble way (14). The Cultural Formulation Interview includes questions that investigate explanatory models, level of functioning, social network, psychosocial stressors, spirituality, religion and moral traditions, coping and help-seeking, and other relevant factors in the patient. The Cultural Formulation Interview should not be the only information basis for making a diagnosis, but this person-centred approach could be an aid in contextualising mental disorders. Research supports the claim that using the Cultural Formulation Interview can be useful for obtaining important information on the patient's understanding of the problem, for developing and maintaining the therapeutic alliance and communication, and for implementing the treatment plan (15).

Is equality in mental health care, and not least equity of patient outcomes, feasible in a diverse society? It is a challenge when different inhabitants have widely differing starting points and needs. The road ahead must start with removing barriers to accessing medical care for persons with a refugee background. Furthermore, an increased focus on cultural competence and humility in medical education and training and in doctors' surgeries all over the country, for example in the form of more widespread use of the Cultural Formulation Interview or similar, is also crucial. We can all contribute to this, and we should challenge ourselves to reflect on cultural issues, for example what kind of cultures we belong to (medical culture, Norwegian culture etc.), how our education, culture and world view can impact on our understanding of mental health problems, and how our answers may differ from those of persons from another cultural background.

REFERENCES

1. Harris SM, Binder P-E, Diaz E et al. General practitioners' management of depression symptoms in Somali refugee and Norwegian patients: a film vignette experiment. BMJ Open 2021; 11: e055261. [CrossRef]

2. Richter K, Peter L, Lehfeld H et al. Prevalence of psychiatric diagnoses in asylum seekers with follow-up. BMC Psychiatry 2018; 18: 7. [PubMed][CrossRef]

3. Straiton ML, Reneflot A, Diaz E. Mental health of refugees and non-refugees from war-conflict countries: data from primary healthcare services and the Norwegian Prescription Database. J Immigr Minor Health 2017; 19: 582–9. [PubMed][CrossRef]

4. Strømme EM, Haj-Younes J, Hasha W et al. Health status and use of medication and their association with migration related exposures among Syrian refugees in Lebanon and Norway: a cross-sectional study. BMC Public Health 2020; 20: 341. [PubMed][CrossRef]

5. Tesli MS, Handal M, Torvik FA et al. Psykiske lidelser hos voksne. Folkehelserapporten [oppdatert 3.12.2021]. https://www.fhi.no/nettpub/hin/psykisk-helse/psykiske-lidelser-voksne/ Accessed 21.3.2022.

6. Lassemo E, Sandanger I, Nygård JF et al. The epidemiology of post-traumatic stress disorder in Norway: trauma characteristics and pre-existing psychiatric disorders. Soc Psychiatry Psychiatr Epidemiol 2017; 52: 11–9. [PubMed][CrossRef]

7. Lebano A, Hamed S, Bradby H et al. Migrants' and refugees' health status and healthcare in Europe: a scoping literature review. BMC Public Health 2020; 20: 1039. [PubMed][CrossRef]

8. Harris SM, Sandal GM, Bye HH et al. Integration is correlated with mental health help-seeking from the general practitioner: Syrian refugees' preferences and perceived barriers. Front Public Health 2021; 9: 777582. [PubMed][CrossRef]

9. Harris SM, Binder PE, Sandal GM. General practitioners' experiences of clinical consultations with refugees suffering from mental health problems. Front Psychol 2020; 11: 42. [PubMed][CrossRef]

10. Schlechter P, Hellmann JH, Wingbermühle P et al. Which psychological characteristics influence therapists' readiness to work with refugees? Clin Psychol Psychother 2021; 28: 334–44. [PubMed][CrossRef]

11. Alizadeh S, Chavan M. Cultural competence dimensions and outcomes: a systematic review of the literature. Health Soc Care Community 2016; 24: e117–e130. [PubMed][CrossRef]

12. Foronda C, Baptiste DL, Reinholdt MM et al. Cultural humility: a concept analysis. J Transcult Nurs 2016; 27: 210–7. [PubMed][CrossRef]

13. Mosher DK, Hook JN, Captari LE et al. Cultural humility – a therapeutic framework for engaging diverse clients. Pract Innov (Wash D C) 2017; 2: 221–33. [CrossRef]

14. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. DSM-5. Arlington, VA: American Psychiatric Association, 2013.

15. Aggarwal NK, Desilva R, Nicasio AV et al. Does the Cultural Formulation Interview for the fifth revision of the diagnostic and statistical manual of mental

disorders (DSM-5) affect medical communication? A qualitative exploratory study from the New York site. Ethn Health 2015; 20: 1–28. [PubMed][CrossRef]

Publisert: 21 April 2022. Tidsskr Nor Legeforen. DOI: 10.4045/tidsskr.22.0165
Received 25.2.2022, first revision submitted 10.3.2022, accepted 21.3.2022.
Copyright: © Tidsskriftet 2026 Downloaded from tidsskriftet.no 10 July 2026.