An Empirical Analysis into the Link between Somatic Pain and Psychological Trauma amongst a Sample of Tortured Tamil Asylum Seekers

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Abstract

Health care services have become increasingly concerned for asylum seekers suffering physical pain, which medical examinations cannot explain. This is the case of a growing number of traumatized asylum seekers holding temporary visas, who experience debilitating, long-term pain. With increasing presentation of pain, it is imperative to investigate a possible link with past trauma, as it often remains underdiagnosed, hindering recovery. Furthermore, there is a need to examine the efficacy of interaction with general practitioners as first-point of contact. Acknowledging trauma by GPs can promote safety, trust in health professionals and compassionate care. For this study, Quantitative measures were used to obtain pain history: McGill Pain Questionnaire; Universal Pain Assessment, Wong-Baker Faces Pain Rating Scale, and Harvard Trauma Questionnaire. Results showed a link between somatic pain and PTSD, exacerbated by ongoing trauma such as visa insecurity. Semi-structured interviews revealed participants felt GPs, although caring, did not have sufficient time to explore trauma and listen to their trauma stories. Findings show that trauma exploration of asylum seekers presenting with pain can help better identify symptoms, providing comprehensive and empathic care. Addressing this link is important for devising effective referrals and developing appropriate and beneficial treatment programmes for improving overall health outcomes.

Keywords: Asylum seekers, temporary visa, Pain, Trauma, GP Assessment

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The last decade has seen a substantial increase in the number of displaced individuals seeking international protection. Refugees and asylum seekers have been forced to flee their countries of origin as a result of religious, political or ideological persecution, war, traumatic loss and human rights violations. The UNHCR report at the end of 2022 revealed that 108.4 million people worldwide remain forcibly displaced. This figure represents an increase of 19 million since the end of 2021 and includes both refugees, who have been recognised by law as qualifying for refugee status, and asylum seekers who also seek international protection but whose claim for refugee status has not yet been accepted. The number of refugees worldwide increased from 27.1 million in 2021 to 35.3 million at the end of 2022, the largest yearly increase ever recorded, according to UNHCR's statistics on forced displacement (UNHCR, 2023). Achieving durable solutions for displaced populations has become even more challenging, especially when conflicts remain unresolved, leaving uncertainty and danger widespread in many countries, such as the renewed conflict and security concerns in Afghanistan (UNHCR, 2023).

Refugee and asylum seeker women have been documented as some of the most vulnerable groups, reporting highest rates of chronic pain. Women often find themselves in desperate situations, having been subjected to displacement, sexual assault, poverty and other stresses (Altun et al., 2022). Their unmet health needs, poor conditions and strain of adapting to new environments are exacerbated by the uncertainty and instability of their visa and asylum claims which can exacerbate existing health issues, leading to new ones and contribute to increased physical pain. The relationship between the arousal factor of somatic symptoms and Post Traumatic Stress Disorder (PTSD) is not surprising, as arousal symptom (i.e., hypervigilance, exaggerated startle response), is a function of sympathetic hyperactivation (Yehuda, 2016). Similarly, headaches and potentially life-threatening somatic symptoms such as shortness of breath or chest pain may result in increased sympathetic activation, together with secondary symptoms such as hyperventilation and tension headaches (Hinton, Kredlow, Bui & Hofmann, 2013). During times of conflict, refugees may be in survival mode, focusing on immediate threats to their safety. This heightened state of alertness can suppress the perception of pain temporarily as individuals prioritize escape or protection. Additionally, the chaotic nature of conflict may overshadow physical discomfort. Once the immediate danger subsides and people transition to post-conflict environments, they may become aware of pain, due to the absence of acute stressors and the challenges of rebuilding their lives amidst the aftermath of conflict.

A study of Southeast Asian refugees by Wagner and colleagues (2013) found not only a link between elevated PTSD scores and high pain levels, but also discovered severe unexplained chronic pain persisting 30 years after resettlement. Similarly, Teodorescu and colleagues (2015) found a 66% rate of chronic pain in non-refugee samples with a PTSD diagnosis, compared to a significantly higher rate of 88% for chronic pain within the refugee sample with a PTSD diagnosis. Chronic pain has been shown to be related to the severity of PTSD symptoms (Hermansson et al., 2002) and have a negative impact on general functioning. (Prip et al., 2011). The highest rates of chronic pain are routinely identified amongst those who have been exposed to physical torture and psychological trauma (Carinci et al., 2010; Williams et al., 2010).

Studies have also described that the mode in which trauma is interpreted such as attentional bias, warning signs and triggers, recurrent memory of pain or traumatic event, can be associated with higher levels of PTSD, comorbidity and functional impairment in trauma-exposed individuals. This cycle of connection between trauma cues and physical pain could persist and pose hindrance to treatment amongst those who have been severely damaged by trauma. Tsur et al. (2017), observed such connection between severe back pain patients and ex-prisoners of war who had been physically and emotionally traumatized, indicating that amongst these survivors, the trauma that they had endured, shaped the manner in which they interpreted and related to pain and bodily sensations (Ruiz-Parraga & Lopez-Martinez, 2014), which could be another mechanism through which pain and PTSD interact and exacerbate each other, increasing symptoms and deteriorating overall condition of the sufferer (Nordin et al., 2019a; Asmundson et al, 2002). It has been suggested that PTSD and pain may interact in a mutually maintaining fashion through a combination of mechanisms, identification of which may assist in the development of more effective treatments (Nordin et al., 2019b).

The Australian Context

Unfortunately, there is no efficient or robust protocol established around safely transporting asylum seekers from countries of crisis to those of safety. Hence, asylum seekers often find themselves embarking on hazardous journeys involving danger, hardship, separation, loss and ultimately more traumatic exposure. Australia has received a large number of asylum seekers and refugees in the last decade, all searching for security and safety for themselves and their families (Karlsen, 2016; Masters et al., 2018). Hence there is a humanitarian duty of care that falls upon the Australian community, with regards to supporting these vulnerable individuals heal from their traumas and begin to rebuild their lives and work towards their future.

Milosevic et al. (2012) report that in Australia, most health assessments including management of pain for newly arrived asylum seekers occur at the primary care level. GPs visiting community health centres or refugee health services are often the first health professionals approached with complaints of physical pain. With this in mind, it is important for health care professionals, to continue providing the best care and to consider the physical and psychological effects of torture and trauma within this vulnerable populations.

Given the health impact of the asylum and resettlement process (Johnston, 2009; Steel et al., 2006) and the enduring burden on victims inflicted by trauma and pain-related sequelae, it is paramount for there to be an emphasis on building sound rapport between the GP and client to detect psychological effects of trauma with which the client may be struggling. There should also be a standard assessment where various presentations of trauma symptoms are identified and investigated. The consequent effects from these traumatic experiences, coupled with misdiagnosis of pain and psychological anguish, often burden asylum seekers in ways that hinders adaptation in the new country. Care must be taken not to overlook any underlying reasons causing pain that do not fit typical Western expression of pain. It is therefore vital to have an efficient and informed process to seek help from medical professionals.

An additional complication for asylum seekers is the situation of Medicare. Medicare is central to accessing health care in Australia, yet many asylum seekers are ineligible for this scheme. It is noteworthy that since the time of the assessments for this study, there have been some amendments in asylum seeker's access to healthcare, allowing marginally more access to urgent healthcare. In NSW at present, Medicare ineligible asylum seekers have some access to public health care under the Medicare Ineligible Asylum Seekers - Provision of Specified Public Health Services policy (Pilato et al., 2023).

Nevertheless, in light of the revised policy, Mengesha and colleagues (2023) conducted a study to investigate experiences of Medicare ineligible asylum seekers in accessing health care in NSW and found that this group still do not have optimal access to health care, which may worsen existing health disparities. Educational initiatives that improve service providers' and asylum seekers' awareness of the revised policy are necessary to improve asylum seeker health equity in NSW.

The New South Wales Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), one of Australia's leading organizations in refugee mental health, receives an average of 5000 refugees and asylum seekers annually from a large number of ethnicities and war-torn countries (STARTTS database, 2023), although these figures fluctuate depending on changes in policies, immigration schemes and global conflicts.

One such group requiring further research and exploration are that of female Tamil asylum seeker population. Amongst this population, many individuals hold Temporary Protection Visas (TPV) and other insecure visa categories such as Bridging Visas (BV), which limit their employment opportunities and offer no guarantee of their renewal (RCA, 2024). The uncertain nature of these visas has been shown to create uncertainty for asylum seekers, complicating their healing journey, imposing pressures and fear of forced deportation (Dangmann et al., 2022, Aroche et al., 2012a; Steel et al., 2011) with profound implications on their psychopathology (Jesuit Refugee Services, 2015; Johnson, 2009).

STARTTS data supports that the most common presentation amongst traumatized individuals during initial assessment is somatic pain, although it is sometimes expressed in various culturally idiosyncratic terms. Metaphorical or idiomatic expressions are used to suggest a state of emotional distress, sadness or deep despair, potentially implying comorbidity with depression and anxiety, such as: 'heaviness on chest', 'drowning of soul', 'pressure on head', 'flames burning in stomach', 'bleeding liver', suffocating lungs', 'weight on shoulders', 'numb head', 'shoulders on fire', 'water in heart has fallen'," (STARTTS, 2023). These statements are expressions capturing the intense and consuming nature of ongoing suffering, indicated by unique somatic expressions to explain ailments such as tension headaches, gastrointestinal problems, breathing problems, back and shoulder pain, general bodily or joint pains/aches, dizziness and sadness, which can understandably easily be misunderstood and misinterpreted. Often, although injuries are not visually evident on the body, the pain is rated as severe (Prip, et al, 2011). Research has shown that traumatic experiences can lend themselves to different interpretations from culture to culture and subsequently, ethnic groups may experience stressors differently from one another and exhibit dissimilar symptoms (Trepasso-Grullon, 2012; Aroche et al., 2012b). It will be important to further study and evaluate marginalized groups, in order to better respond to their needs using culturally appropriate assessment methods, leading to better treatment and rehabilitation.
This article aims to explore the link between traumatic experiences and pain in a sample of female Tamil asylum seekers, as pain is often a prominent manifestation of somatic symptoms most common among asylum seekers and displaced persons (Hurt, 2022) which impacts on every aspect of daily lives.

The article also discusses the significance of General Practitioners within the Australian context, who play a vital supportive role in the assessment and ultimately the healing phase of their resettlement. Given the suffering and the impact of torture and trauma (Nordin & Perrin, 2019a; Gerdau et al., 2017) such traumatized individuals particularly present with symptoms involving physical pain in addition to PTSD symptoms, and high rates of comorbid psychiatric

disturbance including depression (Fazel et al., 2005; Teodorescu et al., 2015). Experience has shown that PTSD is often accompanied with comorbid conditions, and physical ailments are often among reported symptoms in traumatized individuals with PTSD (Rohlof et al., 2014). When both PTSD and pain are present, the severity, duration and functional impact has been shown to increase in intensity (Ruiz-Parraga & Lopez-Martinez, 2014). Nordin and Perrin (2019b) suggested that chronic pain in asylum seekers has significant impacts on their daily functioning and quality of life.
This highlights the need for increased clinical awareness to help inform health care and settlement services when managing and planning programs for women and their families.

Aims

1) To investigate if asylum seekers with elevated levels of PTSD will be significantly more likely to report higher levels of somatic pain, the outcome of which, will ultimately influence treatment programmes chosen for clients.

2) To explore what asylum seekers think of their GP care and how their pain is managed in the absence of obvious physical injury or illness. The ultimate objective of this study is to raise awareness amongst GPs regarding the significance of psychological trauma, its potential link with pain among asylum seekers and the significance of GP acknowledgement and assessment for past trauma.

Methodology

Mixed Method of research was adopted in this study, in order to enable conceptual and analytical integration of qualitatively and quantitatively collected data. It was intended to have richer results and to allow for contextualized qualitative insights and measurable quantitative content to cover all aspects.

Participants

Ethical permissions and approval were granted by the Research Directorate of the Research and Ethics Committee at South Western Sydney Local Health District (SWSLHD), Liverpool; (protocol #2019/ETH04342). Information statements in Tamil language were provided to all participants and Consent letters, prepared in Tamil language, were signed by all participants prior to the commencement of the study. Health interpreters were present for those participants who did not speak English.

Participants included 21 female asylum seekers, aged between 31 and 39 years. Participants were all ethnic Tamil women from Sri Lanka and Indonesia. All participants held temporary and insecure visas, such as Temporary Protection Visa (TPV) or Bridging Visas. These participants were existing clients of STARTTS attending a women's Yoga group, with four currently receiving individual counselling. Although they had already provided signed consent for participation in STARTTS yoga groups, a separate consent process was followed for participation in the current study. Consent was sought after all participants clearly understood the aims and objectives of the study. Upon completion, those who needed counselling, were immediately referred to STARTTS's counselling service and were provided with appropriate individual treatment.

All participants spoke Tamil, with eleven out of twenty one, requiring an interpreter. The sample of 21 Tamil asylum seekers had been in Australia for an average of 4.1 years. All participants were married with an average of 2.5 children under the age of fifteen years.

Measures

For the quantitative segment of this study, participants were administered the following questionnaires to assess for type and description of pain and indication of PTSD.

1) *Pain Rating Index from the McGill Pain Questionnaire (Melzack, 1975)*
   This subscale allows individuals to describe the quality of pain they are experiencing by circling descriptions such as 'cramping', 'aching' and 'tender' and rating each term on a four-point Likert scale from "mild" to "severe".
2) *Universal Pain Assessment Tool (UPAT) – revised (Hicks et al., 2001)*
   In this visual analogue pain scale, individuals point to a display of faces to rate their pain intensity from 0 ("no pain") to 10 ("worst pain possible").
3) The Wong-Baker Faces Pain Rating Scale (Baker & Wong, 1987) is a pain scale that shows a series of six faces ranging from a happy face at 0, representing 'no hurt' to a crying face at 10, which represents 'hurts like the worst pain imaginable'. Based on the faces and written descriptions, the individual can choose the face that best describes their level of pain. This pain scale was originally developed for children, however, it can be used with all age groups 3 and above. The scale is applicable across various cultural groups and is useful for populations where English knowledge is limited and it is easy to match the level of pain to the emotion presented. Moreover, it is inexpensive and easy to use.
4) Harvard Trauma Questionnaire: Part IV (trauma symptoms). The Harvard Trauma Questionnaire (HTQ) (Mollica et al., 1992) is a self-report scale for assessing experiences of torture and trauma and associated distress. Part IV of the measure was used, which consists of 16 items based on the diagnostic criteria for PTSD in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994). Respondents indicate whether they have been bothered by each symptom in the past week on a four-point Likert scale from "not at all" to "extremely". The HTQ has been translated into multiple languages and validated for use with refugees from a variety of cultural backgrounds (Kleijn et al., 2001). Part IV is used routinely at STARTTS as part of clinical assessment.
5) Body Map: The Michigan Body Map (MBM), (Brummett et al., 2016) is a self-report measure to assess body areas where chronic pain is experienced and to specifically locate and quantify the degree of widespread body pain when assessing for centralized pain features. For the purpose of this study, only specific locations of pain were assessed.

The purpose of using three different pain measures was to conduct a more comprehensive assessment, and to capture various aspects of the pain experience, such as intensity, quality and the impact on daily functioning. Moreover, although all participants were ethnic Tamil, they had lived in different regions of Sri Lanka and Indonesia. As pain can be subjective and individuals might experience and report it differently, using multiple pain measures allowed a richer understanding of the pain sensation.

To collect qualitative data for this study, participants engaged in Semi-structured interviews. Questions focused on pain management in the individual's country of origin as well as information regarding seeking and receiving treatment in Australia. In addition to this, participants were asked about any subsequent changes in psychosomatic symptoms and what they believe they could attribute the change.

Data Analysis

The data for this study was analyzed using the STATA software version 16 (Stata corporation, USA). The female participants were grouped into women with PTSD symptoms (clinical group) and women without PTSD symptoms (non-clinical group), based on the recommended clinical cut-off score of 2.5 (Mollica et al., 1992). Continuous variables were defined as means and standard deviations (mean ± SD). An independent t-test was run on a sample of 21 Tamil female participants attending STARTTS social groups and individual counselling to determine if there were differences in the level of pain between clinical (n=12) and non-clinical (n=9) groups. The level of significance was set at $p<0.05$. Data is mean ± standard error. The effect size was computed to examine whether there is a magnitude of differences between the two groups or not. The Cohen's d result of 0.2 is considered small effect, 0.5 was medium effect and 0.8 was large effect.

Results
Quantitative

Participants had an average score of 2.54 on the HTQ, suggesting high levels of PTSD symptoms (clinical indicator for PTSD is ⩾2.5 on the HTQ). Twelve of 21 participants scored above the clinical cut-off, indicating symptoms that may warrant clinical attention. The analysis found that women who had clinical PTSD scores had higher pain scores than women without it for all three pain measurements (McGill, Universal Pain, Wong Baker) though not significant. Examination by the effect size by McGill however reports that the magnitude of difference between the two groups is large with effect size 0.863.

<u>Reported somatic pain between two groups : measured by McGill Score</u>

Figure 1 Average McGill Pain Score for Participants with Clinical and Non-Clinical PTSD Scores

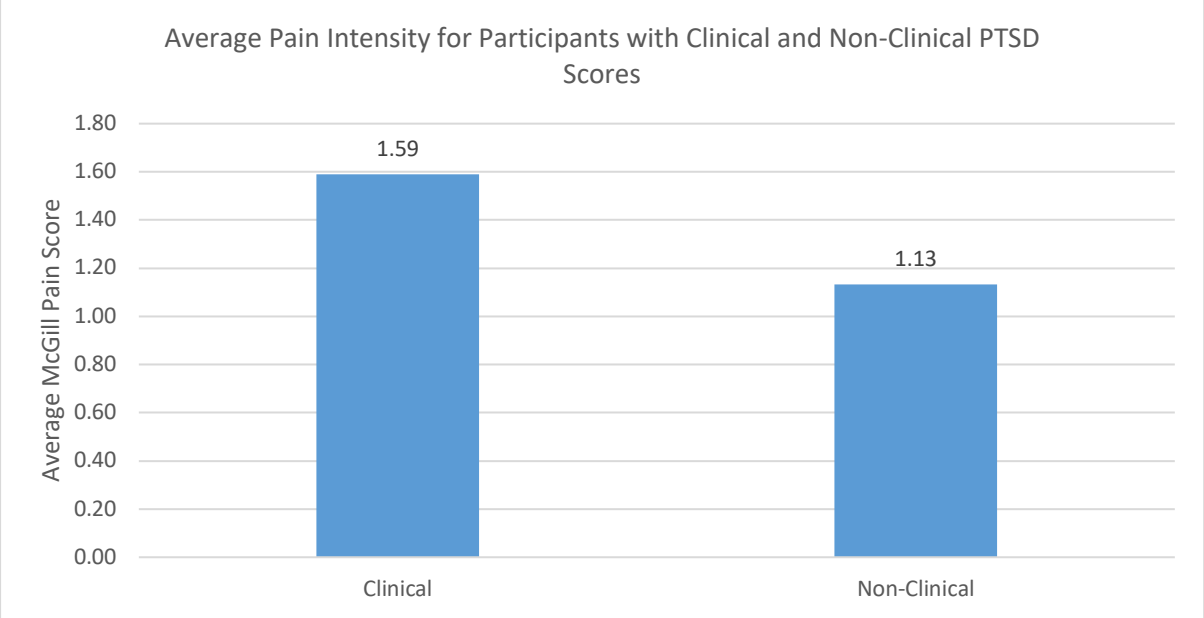

Figure 1 illustrates that individuals who had clinical PTSD scores, as indicated by the HTQ, measured by McGill pain scores, had on average higher pain scores compared to individuals who had a non-clinical PTSD score when comparing the mean difference between the two groups (1.59 vs 1.13).

An independent sample t-test was conducted to compare the McGill pain scores for clinical and non-clinical groups. Women from the clinical group (those with PTSD diagnosis) had a higher mean pain score, measured by McGill, than women from the non-clinical group (those without PTSD diagnosis).

There were no significant differences for clinical (M= 1.59, SD=0.53) and non-clinical groups (M=1.13, SD=0.53; t (19) = 1.96, p= 0.08, two-tailed. The magnitude of differences in the means (mean difference= 0.46, 95% CI [-0.94,0.03]) was large with 0.863, suggesting the finding has practical significance between the two groups.

Reported somatic pain between two groups: measured by Universal Pain Score

Figure 2 Average Universal Pain Score for Participants with Clinical and Non-Clinical PTSD Scores

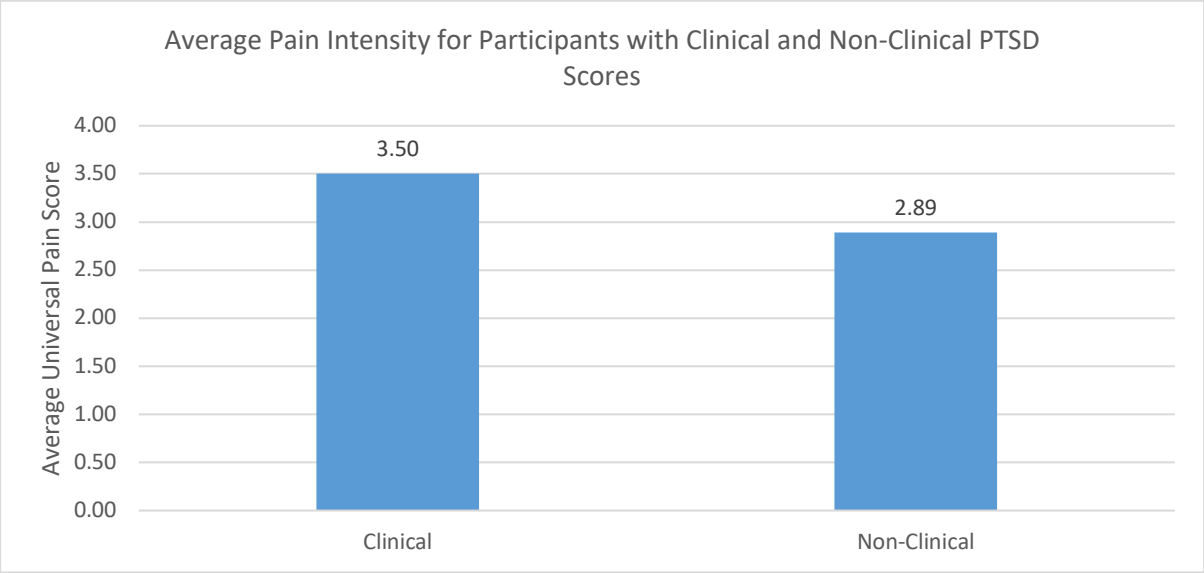

Figure 2 illustrates that individuals who had clinical PTSD scores as indicated by the HTQ, also had on average, higher pain scores, measured by the Universal Pain scores, compared to individuals who had a non-clinical PTSD score with 3.50 vs 2.89.

An independent sample t-test was conducted to compare the Universal Pain scores for clinical and non-clinical groups. Women from the clinical group had a higher mean pain score than women from the non-clinical group. There were no significant differences for clinical (M= 3.50, SD=1.57) and non-clinical groups (M=2.89, SD=1.54; t (19) = 0.89, p= 0.38, two-tailed. The magnitude of the differences in the means (mean difference = 0.61, 95% CI [-2.05,0.82]) was small to medium effect (0.393).

Reported somatic pain between two groups: measured by Wong Baker Faces Pain Rating Score

Figure 3 Average Wong Baker Pain Score for Participants with Clinical and Non-Clinical PTSD Scores

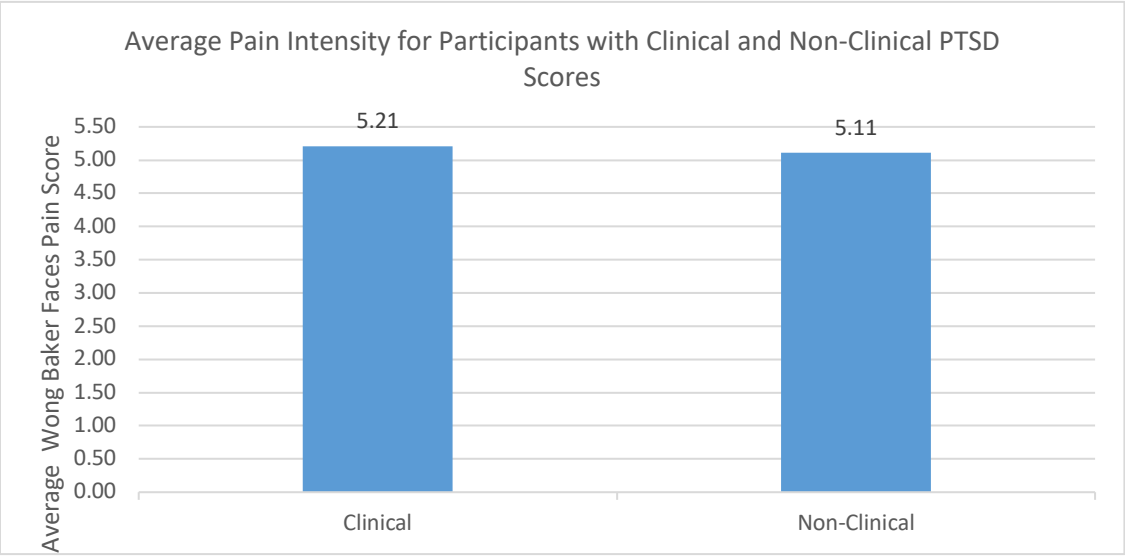

Figure 3 illustrates that individuals who had clinical PTSD scores as indicated by the HTQ, also had on average, higher pain scores, measured by Won Baker pain scale, compared to individuals that had a non-clinical PTSD score with 5.21 vs 5.11.

An independent sample t-test was conducted to compare the Wong Baker Facial Pain Rating score for clinical and non-clinical groups. Women from the clinical group had a slightly higher mean pain score than women from the non-clinical group. There were no significant differences for clinical (M= 5.21, SD=2.10) and non-clinical groups (M=5.11, SD=2.36; t (19) = 0.10, p= 0.92, two-tailed. The magnitude of the differences in the means (mean difference) = 0.10, 95% CI [-2.14, 1.95]) was very small (0.044).

For all pain scores results, measured by the mean differences and by different methods, the clinical groups had higher pain scores than the non-clinical group, albeit no significant difference. Small sample size might be one of the limitations of this study and for this finding. The McGill pain score shows a large magnitude of the mean difference while Universal Pain score shows a small to medium magnitude and the Wong Baker pain score shows a small magnitude between the mean difference of the clinical and non-clinical groups. Among this specific sample of Tamil asylum seekers with insecure visas, a higher PTSD score might increase the likelihood of the individual having a self-reported pain score.

The results from a series of t-tests were also reported in the below table as a supplementary table.

Table 1 Clinical group (PTSD present or not) differences in Measures of McGill Pain Score, Universal Pain Score and Wong Baker Facial

	Non-Clinical			Clinical			Mean Difference	95% CI		df	t	p	Cohen's d
	n	M	SD	n	M	SD							
McGill Pain Score	9	1.13	0.53	12	1.59	0.53	0.46	-0.94	0.03	19	1.96	0.08	0.86
Universal Pain Score	9	2.89	1.54	12	3.5	1.57	0.61	-2.05	0.82	19	0.89	0.38	0.39
Wong Baker Pain Rating Score	9	5.11	2.36	12	5.21	2.1	0.10	-2.14	1.95	19	0.10	0.92	0.04

Moreover, a quantitative analysis of the Body Map, among the given 13 regions, participants with clinical levels of PTSD symptoms nominated all 13 body regions while participants from the non-clinical group nominated 10 body parts. The clinical group had nominated more average areas of pain than the non-clinical group with 3.50 vs 2.90. Within the Clinical group, lower back had the highest level of pain (83%), following Headaches (58%) and shoulder pain (33%).

Qualitative Findings

Thematic analysis (Braun & Clarke, 2006) was used to interpret the data gathered during the semi-structured interviews. A few simple steps were carried out, such as translation of the interviews followed by reading transcription of the data, noting and highlighting major points. The most interesting and notable points provided by the participants were coded and collated into potential themes, which could be extracted from the data. This process was carefully repeated in order to limit and reduce the number of codes and categorize them into identifiable themes. Thematic analysis facilitated the extraction of findings that captured the context within which pain and trauma amongst asylum seekers existed. In the current study, participants reported a high incidence of pain symptoms and an awareness of possible links between past trauma and current pain, despite having received no relevant psychoeducation. In addition, few participants sought psychological help for pain, highlighting that primary healthcare workers such as GPs are often the first point of contact for people suffering from somatic and psychosomatic pain.

Quotes from Participants

Attitude towards GP care

Participant 'a') *"I went to see doctor for my headaches, he prescribed Panadol…he said my headache was because of thinking too much. He told me just calm down and relax…that I am safe now, just forget the past. He didn't ask where I come from, why I don't have Medicare card, why I have no visa, no questions about my pain… I am so scared of being sent back to Sri Lanka…my head explodes every time I think of being sent back".*

Participant ‘b’) *“The headaches come when I’m stressed …got worse in Australia…, my shoulders feel on fire. I need more than Panadol. I am on bridging visa for 5 years, what if I am deported? I wish doctor would ask me questions so I can tell him my story…he asks me for medical documents…I don’t have any...please ask me why I have chain marks on my ankle, ask me why my ankle is throbbing when I remember things…I need to tell you”.*

It is widely accepted and acknowledged that General practice has a key role to play in undertaking asylum seeker’s health assessments and provide ongoing care. Asylum seekers with complex needs and poorer health may require assistance as a first point of contact, which makes Primary care ideal for managing referrals and provision of services. The expectation of asylum seekers such as in the case of participant ‘a’, would be to receive compassionate and culturally sensitive care, address their physical and psychological health needs, and help document necessary information to assist their asylum claims. Deportation seems to be one of the main fears of asylum seekers who are on temporary visas such as bridging visas, which although the GP is unable to assist with, documenting consequences and exacerbation of pain as a result of psychological strain might be helpful in their legal journey.

Part of the crucial compassionate caregiving process is to ask relevant questions and listen to their trauma stories, as could have been done in the case of participant ‘b’, who displayed obvious restraint marks on her ankle. Having been chained while being raped (participant ‘b’ personal communication and interview, October 10, 2021). As a result, participant ‘b’ would have felt empowered and heard, consequently receiving the correct referral path (such as torture and trauma or sexual assault services) and a tailored treatment program with more effective outcomes.

Escalation of Pain Symptoms in Australia

Participant ‘c’) *“I want my headaches to stop, I didn’t have this before, I am on bridging visa for 3 years and they tell me to just relax… How do I move on and relax when I could be deported? My GP is kind, but has no time… I am young and healthy, but I am scared and lonely and now my head feels numb, like there are rocks inside, I have no Medicare, no money, I just take Panadol when I can’t cope”.*

Participant ‘d’) *“I asked doctor why I have so much headaches in Australia, why this much pain in my lower back and shoulders, like fire burning. He says it could be from my back. So he gives me painkillers. I said pain gets worse when I listen to news about bombing and killings…Doctor said the answer is less stress…How do I have less stress? I feel like my insides are burning, I want to keep busy, but I can’t find a job, I am not allowed with my bad visa, I am lonely”.*

In addition to resettlement complications such as language and cultural barriers, asylum seekers such as participant ‘c’ experience limited access to healthcare, insurance and other essential health services which are mostly taken for granted. The most commonly reported types of chronic pain amongst asylum seeker women have been back pain, shoulder pain, headaches and indistinct general lingering pain. Women have been found to be more

likely to report lower pain tolerance and more baseline symptoms following severe physical and psychological trauma, as well as depression, anxiety, and PTSD (Hurt, 2022).

In addition, the uncertainty about their visa conditions and insecure future, compounded by social isolation and lack of support networks, such as in the case of participant 'd', exacerbate their existing pain symptoms manifesting as fire burning inside the body, increases pain perception and intensifies other health conditions.

Significance of Attentive Listening and Taking a Comprehensive Trauma History

Participant 'e') *"I think GPs in Australia are excellent, they really care about our health, just please listen to us more…I told him my mind is heavy, he said just empty your thoughts… …we are isolated and scared… ask us about our history, listen to our trauma stories, I was tortured, raped…you need to listen to me. I don't need Panadol, I need to tell you about me".*

Participant 'f') *"I really want to share my torture experience with my GP, he really cares, he is clever and doesn't care about money… but he has no time to listen…, I feel like want to tell how I was hit and tortured, I am not alone but I feel so lonely, my heart is torn and my soul is wasted, I feel isolated, frightened to be kicked out of Australia".*

A common suggestion for participants' pain seemed to be analgesic medication, which did not address the long-term effects or cause for intensification of the pain. The relationship between GP and asylum seeker can be strengthened by comprehensive trauma history taking, including potential impact of trauma on physical and mental health, such as in the case of participant 'e', in order to facilitate appropriate trajectory to treatment. Listening attentively and empathically to trauma stories and paying attention to culturally idiosyncratic terms used to depict a state of pervasive sadness or profound desolation, as suggested by participant 'f', the GP could build rapport and trust, creating a safe space for communication and managing the pain.

The overriding theme however that came through from all participants' interview responses, was an overwhelming sense of appreciation of medical profession in Australia. Participants reported being generally satisfied with the medical care provided by their GP in Australia and they had sufficient trust and willingness to speak about their traumatic past, although they felt that the scope of their GPs examination and assessment did not extend to their trauma history.

Discussion

This study sought to understand the management of pain for a small sample of traumatized Tamil women living in Australia, awaiting resolution to their protection visa status. During this period of ambiguity and legal uncertainty, concern has been raised regarding their mental health needs, and whether they have been adequately met by the community and health professionals, which may compound the effects of settlement and recovery.

Despite multiple healthcare services in Australia, the asylum seeker's ability to access mainstream health services is limited for various reasons, such as restrictions within their legal

status, permission for employment, access and knowledge about seeking appropriate help. As pain and other immediate physical conditions are commonly presented during GP visits and medical check-ups, it is possible that underlying PTSD or other trauma related conditions remain concealed and unexamined. Therefore, it is essential to raise awareness among GPs and other health professionals in relation to trauma accounts, in order to encourage comprehensive assessment and early intervention into specialized trauma services.

Thematic analysis in the present study highlighted that for most participants, pain began or intensified in Australia, especially when under emotional stress. This is an interesting, although not a surprising finding, as we know that under stress of survival and flight, people may overlook their physical pain, however once they are in the safety of the host country, the toll of their experiences can manifest in physical discomfort such as headaches and back pain, and heightened levels of pain may resurface as they confront new challenges. Moreover, although resettlement in host country offers opportunities for stability, asylum seeker women and their families still have the burden to adapt to the new environment, language barriers, financial stress and cultural adjustment, while the psychological trauma, unresolved grief and the burden of current insecure visas, are potentially exacerbating the pain, post resettlement.

This study emphasised the importance of the relationship between asylum seekers and general practitioners, where more efficient assessments would help detect physical and psychological effects of trauma (Morina et al., 2018). Findings highlighted that asylum seekers may have pre-existing pain sensations before travelling to Australia, however, following settlement, away from dangers of war, pain re-surfaces. Moreover, sometimes feelings of anxiety, depression and post-trauma may manifest as somatic pain, due to the immense stress and trauma they have experienced. Somatic pain can often serve as a manifestation of their emotional distress, as well as a way to communicate their suffering when verbal expression is difficult (Rohlof et al., 2014). Most commonly affecting head and back areas, it can further exacerbate their mental health struggles, creating a vicious cycle of pain, discomfort and distress.

The daily challenges which asylum seekers endure, such as lack of access to health services, can compound these issues, making it crucial to provide comprehensive support for both their mental and physical well-being.

The participants' wishes for physicians to acknowledge past trauma histories and their valuable suggestions and insight were noteworthy, highlighting the need for more communication with their GPs. It seems vital that GPs screen for post-trauma symptoms with patients who present with non-specific somatic symptoms with trauma backgrounds. This can be achieved by further GP training, in order to enhance the provision of culturally competent care, creating a supportive environment with appropriate cross-cultural communication, use of Health interpreters, and referral to a specialist torture and trauma service such as STARTTS. GP trauma training not only will enrich their ability to provide high-quality trauma-informed

care, but will also promote health and well-being and increase help-seeking behaviour among asylum seekers with unstable visas.

Strengths and Limitations

One of the strengths of the study was that participants were from the same cultural background and were all female which made comparisons more interesting to study. Another strength of the study was that clinician administered questionnaires and semi-structured interviews were used to assess for PTSD, pain symptoms and pain histories, which helped build better rapport with the participants and obtain richer and detailed information about their trauma and pain histories.

In this study, the efficacy of data may have been limited due to the small sample of participants. We acknowledge that a sample of 21 is small to make statistical inferences; however, this study is a part of a larger study, which will be consolidated with the present database. In addition, as all participants were female, findings may present a gender bias with regards to the expression of pain. This may incorporate cultural attitudes of dismissing personal affliction or verbal expressions of wellbeing. The inclusion of men in further studies may unveil additional information as to the nature of pain and men's experiences with medical support.

Moreover, a control group of a similar client cohort was not used in this study to provide a baseline for comparison. The reason for this was that having a group of asylum seekers in a non-treatment control group (or recruited from clinic's 'Waiting List') is implausible and ethically incorrect in a clinical setting. It would be unethical to deny or delay assessment solely for the purpose of research as it would violate their rights to receive proper assessment and timely treatment and it would undermine STARTTS's fundamental principles of protecting client's human rights and promote well-being.

Upon completion of the present study, future research is planned to investigate the linkage between somatic pain and psychological trauma among amongst female Burmese asylum seekers. Given the escalating human rights violation after 2021 Myanmar's coup d'etat, Myanmar ranked as the number three country receiving refugee support and Global Special Humanitarian Program visas in 2022-2023. Similar to the present study, somatic pain amongst a female Burmese cohort will be investigated, to provide valuable insights into the manifestation of pain and consequently physical and psychological well-being. These studies may benefit from exploring a more holistic understanding, and addressing research gaps and the needs of these vulnerable groups may help unfold their traumatic history, explore their physical pains further, and find culturally appropriate solutions and beneficial treatment programs.

Conclusion

Somatic and mental health problems are interrelated and affected by social circumstances. Forcibly displaced individuals are often subjected to profound psychological distress, which may manifest as both mental health problems and somatic experiences such as pain. Providers of healthcare services to asylum seekers should be attentive to the adverse effects of postmigration stressors and acknowledge the interrelations between pain and mental health. It is noteworthy that the lengthy and complicated nature of securing a visa and residency documents, exacerbate asylum seeker's existing conditions, introducing additional complications. Delays and rejections in their visa application process can prolong sense of insecurity and disrupt their resettlement progress.

Is it possible that the exacerbation of somatic pain in Australia could be a result of the perpetual fear of deportation, pervasive sense of uncertainty and unrelenting feelings of insecurity for asylum seekers, rather than the allostatic load of war, torture and the overall refugee experience?
The cumulative psychological strain which asylum seekers endure can have profound implications for their health and well-being. The additional ingoing complications of insecure visa can certainly intensify the already exhausted individual's elevated existing anxiety, creating a state of chronic stress, depression and post-trauma symptoms, significantly impacting their mental well-being.

It seems that forced displacement of asylum seekers at present is not only widespread, but is no longer a short-term and temporary phenomenon. Clinical work with vulnerable individuals recognizes that there are multiple factors that must be explored when seeking to understand and rehabilitate such clients.

The implications of such findings should encourage enhancement of mental health proficiency in healthcare providers, building capacity to respond to complex needs of asylum seekers, consequently having precise referral paths, treatment plans and culturally sensitive, trauma-informed interventions. When presented with non-specific somatic complaints, physicians should be encouraged to build sufficient rapport with asylum seeker patients, initiate direct conversations about mental health, validate and consider trauma sequelae, with the ultimate goal to best support them. Such approach would encourage help seeking behaviour, empower patients to take an active role in their own treatment, and avoid future complications. This can also promote better understanding of symptom presentation of traumatized people and contribute to the provision of ongoing, coherent support and treatment.

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Acknowledgements

We would like to extend our sincere gratitude to the Tamil women who participated in our study and provided their valuable time. We are deeply humbled by their trust and generosity. Their willingness to share their traumatic experiences and insight is much appreciated. Their courage to tell their stories provided critical perspectives that enriched our understanding of their challenges.

We would also like to sincerely thank Ms. Sivaharani Mayuran of STARTTS (Counsellor and Project Officer), who introduced the idea and purpose of the study to her clients for voluntary participation, and kindly referred her clients, explaining to them the long-term benefits of such clinical investigations for survivors of traumatic events in similar circumstances.