Developing a mental health programme for refugees based on participatory Action Research: An experience from São Paulo, Brazil

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The study aimed at developing a mental health programme for/with refugees based on an understanding of the refugees' perceptions about their experiences and psychodynamic aspects.. Data were collected through the combination of techniques as participatory observation, focal groups and deep interviews. A total of 24 focus groups and 12 in-depth interviews were conducted. Data analysis was based on a theoretical model of social representation combined with a psychodynamic perspective. Based on the results, a mental health programme was developed. The results demonstrated the importance of culture and social participation in health care.

Key words: Refugees, participatory action research, qualitative research, immigrants, mental health

1. Introduction

Immigrants are faced with a series of problems after their arrival in a new country, including language difficulties, cultural differences, ethnic, economic and religious discrimination, loss of social relations, broken families and the loss of valuable social roles, identities and occupational positions (Ryan, Leaveyg, Golden, Blizard, & King, 2006).

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In addition to the common problems of immigrants, refugees are often faced with additional burdens related to the circumstances that forced their relocation. This situation requires preventive approaches and specific therapies in all areas of health, especially mental health.

This study is a participatory action research aimed at developing a mental health programme with/for refugees living in São Paulo based on an understanding of the refugees' experiences and psychodynamic aspects.

Background

Studied context description

Brazil is home to the largest refugee population in South America, comprising approximately 5208 people (based on statistics of 2013) from 79 different countries. Women constitute 34% of the refugee population. The majority of the refugees in Brazil are concentrated in large urban centres. Most of them come from Colombia (1,154), Angola (1,062), Democratic Republic of the Congo (617) Syrian Arab Republic (333), Liberia (258) and Iraq (203) (UNHCR, 2014). In Brazil, the civil society is responsible for the reception of refugees. Caritas (an institution linked to the Catholic Church) is the reception centre for refugees, and this organisation assists with the documentation of refugees after they arrive in the country. The Caritas offices are located in the two largest Brazilian capitals, São Paulo and Rio de Janeiro.

Brazil is internationally recognised as a safe country for refugees. However, refugees still face difficulties as they integrate into society. The first obstacles are the language and culture. The main problems affect refugees and Brazilians alike, including difficulties in achieving employment, access to higher education and access to public health services and housing (UNHCR, 2011).

Problem statement and research question

In response to the request of the State Department of Health, a service to provide clinical psychiatric care and psychotherapy to the refugee population in São Paulo was set up. Three months after this service was offered, it had

not yet received any patients. On the other hand, according to observations of the staff who oversee the reception of refugees, almost all refugee applicants were in need of psychological and psychiatric support. Based on this initial experience, we sought to improve our knowledge of the characteristics of this population and their needs.

First, we designed a study to address the following research questions: What is the prevalence of mental disorders in this population? What is the most common type of psychopathology? How can we help the Caritas team provide better screening of cases? To answer these questions, we designed an epidemiological study that aimed at investigating the prevalence of mental disorders among refugees in São Paulo. We began by administering the Self Reporting Questionnaire-20 (SRQ-20) to refugees who receive financial support from the United Nations.

The SRQ (Self Reporting Questionnaire) consists of twenty-four short questions that are often used in psychiatric practice. This questionnaire was developed by the World Health Organisation (WHO) as a screening instrument for the detection of psychiatric disorders in primary care. This is a tool that was designed to "describe the presence or absence of symptoms clearly defined", and its format enables the questions be answered objectively by members of different cultures (Harding, De Arango, & Baltazar, 1980). Of the applied 44 questionnaires, we had 14 positive responses (indicating the possibility of a mental disorder due to the presence of symptoms) and 1 refusal to respond.

After administering the questionnaire, we conducted non-structured interviews that focused on what was asked in a systematised way. We found that several items of the SRQ-20 were not adequately answered, due to incomprehension of what was being asked, or due to fear or a feeling of distrust. According to staff members, the person who refused to answer was the most in need of treatment. We concluded that although the instrument was developed based on concerns related to the cultural aspects of psychiatry, it would not be appropriate for our purposes. There were obvious influences related to the political situation and the socioeconomic and cultural differences of the refugees, leading to apparent incomprehension or differences in the interpretation of the meanings of many concepts. Nonetheless, we recommended

carrying out the Schedules for Clinical Assessment in Neuropsychiatry (SCAN). None of the participants who had taken the SRQ-20 took the SCAN.

The findings of this pilot study were consistent with data from another study that tested diagnostic instruments in western Africa (Kortmann, 1987). These results confirm that in many situations, a questionnaire is far from adequate for detecting psychopathological symptoms.

Based on the conditions presented, we concluded that the use of a quantitative methodology for a study of prevalence would be of little practical use. A description of the relevant components, which are not measurable with respect to the mental functioning of these individuals, would be impossible to obtain in this way. On the other hand, data on the mental life of these individuals are of fundamental importance for the viability of a treatment program.

In a second design, we adopted a qualitative method to address other categories of questions, including: What are the mental processes underlying the behaviour of the refugee in São Paulo? What were their motivations? The object of the study was not to determine the prevalence of mental disorders in this population, but rather to determine the psychodynamics of refugees. Based on these research questions, we developed a study based on participatory action research and qualitative methods.

2. Methods

2.1 Study design

Participatory action research

The fieldwork began with the identification of the need for a mental health programme for refugees during meetings with workers responsible for the reception of refugees in São Paulo. Data collection was performed in three consecutive stages by means of participant observation, focus groups and in-depth interviews. Ethical approval was obtained for this project and written consent was obtained from the participants.

Participant selection

The participant selection followed the strategy of maximum variation of the sample, (Paton, 2002), aiming to integrate the cases that present greater differentiation between themselves. The subjects represented the diversity of their country of origin, and their ages and racial groups were recorded by Caritas. A total of 24 focus groups and 12 in-depth interviews were conducted. We included individuals aged between 18 and 65 years, of both genders, from the following countries: Angola, Colombia, Liberia, Iraq, the Democratic Republic of Congo, Sierra Leon, Yugoslavia, and Nigeria.

2.2 Data collection

Participant observation

Each researcher had worked in the studied environment for one year, participating once a week in the process of refugee reception, to gather information necessary to develop the theme of this research. In this way, the researchers gradually acquired the confidence of the refugees and the support of the staff members.

We accompanied the refugees to their visits at the Caritas to maintain a critical point of view. We described all the activities carried out by Caritas and UNHCR. We delimited the context of the study and conducted informal interviews with the refugees and the staff team. We also performed psychiatric clinical evaluations. We began to work as a “consultant” to mediate the relationship between the staff and the refugees that were described as "difficult". Our activities were registered in the field diary, including interpretations, initial analyses and working hypotheses. We included comments about our feelings and reactions during our experience in the field.

Focus groups

We decided together with the staff team to begin with group interviews (focus groups). This decision was made based on data collected during the

previous phase, when we concluded that individual interviews lead to feelings of distrust among the refugees.

The 12 participants were purposely sampled using maximum variation or heterogeneity sampling (Patton, 2002). The sample presented diversity with respect to country of origin, age, and racial data. The research participants consented to take part in the focus group after they had been informed about the broad topic of the research.

First focus group phase – the exploratory phase: In this phase, 4 sessions were conducted. Eight hours of recorded interviews were transcribed literally. In total, 43 refugees were recorded in this phase. The groups were open, and all refugees were invited to participate. The groups were composed of six to twelve refugees, and at least one social worker on the staff. The goal was to determine the situations of the refugees with regard to what they were worried about and what situations were occurring in their mental lives. The instruction given at the beginning of each group session interview was: "Speak freely about your situation. Mention everything that comes to mind that you regard as important." Taking into account the different dynamics observed by the different staff member (social worker), we chose one staff member to participate in the next phase. During the third session of the exploratory phase, we observed the repetition of the subjects discussed. At that time, the exploratory phase of the group interviews was ended.

Second focus group phase – the thematic phase: In this phase, 20 sessions were conducted (10 with an all-male group and 10 with an all-female group of refugees). A total of 40 hours of recorded interviews was transcribed literally. Eighteen refugees participated in this phase. We elaborated a sequence of 10 issues to be discussed in greater depth in the 20 thematic focus groups. This sequence was derived from the categories abstracted from the exploratory phase.

The topics addressed in the second phase of the focus groups included the following: Thoughts about Brazil; Family relations before and after the exile; Conjugal relationships and gender relations before and after the exile; Frustrations experienced before seeking refuge; Current refugee experiences and their influence on physical and mental health; Religiosity; Memories from the

country of origin; Relationship with the Caritas / UNHCR staff; Most important values, including "What I want, What I am"; and Life projects.

Each category or topic was explored in a thematic focus group. We used the group dynamics to explore these themes. As each issue was investigated during the thematic focus groups, we promoted concomitant meetings with the staff members, including the board of directors. Small changes were suggested and implemented during this period of research.

At the end of this phase, we met with the staff team to present a list of suggestions for improving the mental health of the refugees. These suggestions were used for the development of strategies for the implementation of these proposals.

In-depth interview

We conducted 12 in-depth interviews. In total, 12 hours of recorded interviews were transcribed literally. The interviewees were the same refugees who had participated in the thematic focus groups. An interview guide was developed with the main purpose of providing a deeper approach to the individual themes discussed at the previous stage. We designed the questions based on categories of analysis that would allow for the construction of a psychodynamic profile of these subjects. The interview included items such as: Please describe yourself, emphasizing your individual aspects (are you timid? uninhibited?)? How would your father describe you? What about your mother? What about your companion? Who can you count on if you have a problem (Emotional, financial, health, housing, relationship)? What is your religion? Do you believe in God? Tell me about your beliefs. Are you participating in some religion in Brazil? Do you experience any kind of prejudice (colour, religion, the status of a refugee)? What aspects of your physical and mental health have influenced your experience of refuge?

Each interview lasted approximately one hour. Ten men and two women consented to the more in-depth interview. One of them did not allow the interview to be recorded, but he did allow the researcher to take notes as he answered the questions. The other participants of the groups did not attend the scheduled day and were not interested in re-scheduling for another day.

2.3 Data analysis during and after data collection

Empirical data from the individual interviews, the focus group discussion, and the field notes were manually analysed for their content. During the content analysis, several themes had emerged, which were discussed with the staff members as the research was conducted.

Theoretical framework for data analyses: the social representations and the psychodynamic perspective

The assumptions underlying the data collection were that the focus group data reflect the collective notions and understandings of the topic, which were shared and/or negotiated by group participants, whereas interview data reflect the views and opinions of an individual. It is also assumed that group data do not necessarily imply a group consensus.

The organisation of the data was carried out in accordance with the methodological structures proposed by Lefevre and Lefevre (2005) for discourse analysis. The aim was to assemble a complex universe composed of different types of social representation.

First, we separated the central idea from the related ideas.

The Central Idea is an abstracted idea that constitutes speech synthesis. It can be expressed in the words of the researcher or in the words of the interviewee.

After we highlighted the central idea, we grouped (or clustered) the interviewers' words (the key expressions) that expressed the central idea. Using these expressions, presented exactly in the way that the individual spoke during the focus group and interviews, we recovered the full idea. This discourse, produced by the key expressions collage, constitutes the Discourse of the Collective Subject (DSC). The assembly of the DCS is the discursive form that expresses the social representation. It is presented as if it was a single subject speaking. The DCS represents the whole of the speech more than the sum of the parts. The data are presented by means of the speech (a set of words articulated), and not by the word itself. The minimum unit of meaning is the sentence, not the word. All interviews must be contained in the DSC.

To obtain a deeper understanding of the refugees' mental condition, we applied the lens of psychodynamics to the Discourse of the Collective Subject.

Psychodynamics and identity

Psychodynamics is the study of the mental and emotional processes underlying human behaviour (Cushman, 1995). It is the study of human motivation, especially when it is manifest as an unconscious response to environmental influences. We chose the concept of identity as the central idea of our approach.

The term "identity" has been used with different meanings in the psychiatric and psychological literature (Strauss, 1997). Identification is the process responsible for the construction of an image, or groups of images, that an individual consciously has about himself at a given moment, in a determined context. The important role of environmental factors, including biological factors and the relationships with other human beings, should be taken into consideration with regard to identity construction. Identity is a concept or idea that an individual builds about himself, about who he is and how he relates to the world in which he lives (Novaes, 1993). This concept encompasses all the qualities, beliefs and ideas that make him feel different from others or like he belongs to a particular group.

The general categories of analysis (which emerged from the content analysis) were the following: the participants' descriptions of themselves; their country of origin; their families, their experience as a refugee; place of refuge; their feelings about Brazil; their current relationships; their relationships with the staff team; support; self-perceived changes after obtaining refuge; difficult life events; fears; religion; life project.

3. Results

With the goal of recovering social representations relating to identity, we will present the DSC for the items of self-description and life project. These DSC were assembled from the interviews. We used the words of the interviewees in the DSC that follows.

Self description

DSC 1: Silence

What happens is that I have been afraid to talk and I will not talk about anything. I am a quiet person who does not like to talk too much. I will not answer, I ask myself now. I confess to the pastor: Oh, I suffered much, I left my house, I saw blood, I saw death. And why should I talk? I prefer to keep this to myself. I do not know. I'd rather not say. I would rather say: I am still walking today. I follow my path today. And we can follow together.

DSC 2: Negative

I don't know. I didn't understand. I can't, you know? You are watching me now, and now, can you say who I am? I don't know anything about this subject and I do not think this is important. What represents me? I think that this is an inappropriate question because I cannot see my face. Nothing else matter to me, I want to work. It is very difficult to talk about something else.

DSC 3: Stressed

I don't know how you see me, I'm afraid to talk now. I like to observe people, as someone who knows about the persons unknown. I don't like any person. One thing that makes me angry is a liar and false words.

I am thinking about what will happen to those people who remained there. And I am not like the other brothers who are struggling. I think that it makes the difference. I owe my family everything. The family is what I miss most, when I left that situation, I did it just to save my life. I have many things to think about, a lot of things…

This stress is like this: I have many important things to think about. I don't like to relax. My mind has no peace. We live with a big problem with nothing to do, to forget everything. You have to keep it with you, and then it is hard to forget. You don't have the money; if you have money you become afraid: how to spend this money? If you don't know if you're going to eat; I am always feeling like this: at the limit. That is how I sometimes spend money that I don't want to spend. We have to buy certain things that we did not use to buy just to be better treated, not to be treated as an animal.

I am lost now, I am thinking about what will happen to me in the streets today. Then, I think: what will happen to me? What experiences will I have?

And then I think: Why? And what should I do? What do I mean for myself here?

However, I don't live here. My life isn't safe, understood? Do you understand me? I am afraid, I'm afraid when the night comes, where I live.

DSC 4: Unhappy

I'm not Brazilian; I am like the last on the team. I don't see myself as part of this society. We have different cultures, we have different reasons. Everyone is proud to be pure African. Then, I look at the black people in Brazil and I don't identify myself with them. I don't look like them.

I am very different from you. I have my way of dealing; I have a support that is the belief in my ideal and my fight for it. However, frankly it draws the attention of the people. I have never experienced this before in my life.

I find myself as someone who wants to bring people in and be close to those who are friends. I have many friends here, but I do not think that any of them could help me. I am very much alone, without a husband and without family. My friends have already died.

Look, I had a mother, I had a father and it was a lot. And now I have nothing, neither the respect of people I need.

And you don't owe me anything. And you need not give me anything. There is no dependency between us. And then there is no understanding. If there is any understanding, then we are able to accomplish the same goals, but if you have something different in your mind, then there is no relationship or religion to make us build the house of God together.

And how can I be able to be the friend of a Brazilian? Love, have a boyfriend; begin to talk to someone or something like that? I'm not succeeding, I can't.

Sometimes I speak the truth, sometimes I lie. Sometimes I cannot speak the truth, and I have to lie. Because, if I speak the truth, nobody will want to go out with me.

I never asked anything of anyone in my life, I don't like to talk about this kind of thing. I'm ashamed to talk about the problems, but as I cannot do anything, I am explaining what we are going through to you.

I am a refugee. Sometimes I have a friend who helps me, but if I have no friends, how could I wear clothes? We have a social disability. It is not a

mental disability. It is a social deficiency, for example, to be a black person in a society where there is racism.

Difficulty is different because if you have any difficulty, you're just like everybody else. Everyone has difficulties. However, if he has difficulty now and you give him attention, the difficulty is replaced. However, if it is a disability, you can do everything and it will not pass. He will not go beyond where he is now. Then, difficulty is not disability.

Life project

DSC 5: The uncertainty

What about my future? I know nothing about my future.

All this suffering that I am experiencing now is because the past doesn't have plans. I never planned this; I never thought that some day, I would be outside my country going through all this. You see the ghosts of your plan, you see your friends dying, and they didn't have the opportunity to be here.

I have dreams. Everyone has dreams. I think that what I dreamed has already changed a little. I think that it has already changed too much. The most difficult thing was dreaming that I could not achieve. At that time, I was dreaming of being a person in my community, but now there is nothing else. I was sent back.

My dream here is to survive. We are intelligent, but we don't have money. I want to marry, be peaceful. And with this life, we cannot. I would like to make a family, but not to make a poor family. All of us want to have conditions to live. I dreamed that one day we would have money to eat. I would like to work, but we don't have a job. We have no chance of working. You see that it is very difficult for us to have success.

I'm not with my life here. And what am I going to do with this?

The war has invaded and dissolved all my future. And now, I am not in my future, I have no future here. This is violence, the worst of all. I could say: tomorrow we have a future, I will be rich, I will have my companion, I can say anything. However, it is not the way I feel.

4. Discussion

Complex mental health care interventions include social processes that can be difficult to investigate using quantitative methods. (Campbell, Murray, Darbyshire, Emery, Farmer, & Griffiths, 2007; Lewin, Glenton, & Oxamn, 2009; PLOS medicine, 2007). Awareness regarding the ways in which context affects the validity of research may facilitate the implementation of realistic and effective methods to reduce uncertainty in the findings of transcultural studies (Batniji, Van Ommeren, & Saraceno, 2006).

Turner, Bowie, Dunn, Shapo, & Yule (2003) found that approximately half of a sample of 842 refugees in the UK had a depressive and anxiety disorder. This result was challenged by Summerfield (2003), who participated in some of the open-ended questions in the same study. According to Summerfield, only a "tiny number of refugees saw themselves as having a mental health problem of any kind, bearing out observations by refugee workers in the reception centres housing them that there was no interest in counselling (…) Moreover, refugees in distressed and insecure circumstances may be particularly susceptible to the demand characteristics of questionnaires".

Psychiatric categorisations risk distorting the "pathologisation" of refugee distress, and what is social and collective may be considered as individual and biological. How each individual experiences life events, and what he or she says about them, is a function of the social meanings (Summerfield, 2003).

We faced a similar dilemma in Brazil and sought to resolve the issue through participatory action research. The theory of social representations applied in the discourse analyses allowed the construction of psychodynamic profiles and the identification of collective models based on these profiles. The self-description analysis and observed changes in the life project provided an understanding of the psychodynamic aspects, which is important for an adequate approach to refugee mental health. Many of these subjects are based on the construction and articulation of the social representations.

4.1 A reflexion on the role of the researchers, stakeholders and refugees in the research process

The research process promoted democratic participation of all the professionals involved in the reception of the refugees. This professionals participated in decisions about study design, helped during data collection, and helped interpret findings emerged throughout data analysis. In the beginning researchers met with all team of workers in the reception center for refugees aiming to recruit members for a "reference team" that serves as the voice of the staff among the researchers. The researchers and the reference team participated developing the research question and creating a research plan. The researchers and the reference team move the project forward and carry out the plan by conducting the focus groups and the individual interview. The data has been analysed by the researchers, who worked together with the reference team to co-ordinate community action. Researchers also work with professionals to use research findings about refugee's psychodynamic for positive action within the community.

On the other hand the participation of the refugees did not occur at all stages of the research. At the beginning the relationship between the professional team and the refugees were very tense and the researchers didn't know how to deal with it. As the research was developed, the participation of refugees was growing in the process. During the data collection refugees participated in the dialogue proposed by researchers between the various stakeholders of the reception center. Through this dialogue several significant changes in services occurred.

4.2 Psychodynamic considerations on the analyzed discourses: The portrait of an identity crisis

Some studies have included in-depth interviews and focus groups to assess refugee health issues (Dolma, Singh, Lohfeld, Orbinski, & Mill, 2006; Cohn, Alenya, Murray, Bhugra, De Guzman, & Schmidt, 2006), but none has analysed the refugee experience from a psychodynamic perspective. The psychodynamic approach to the focus group is an efficient strategy to observe

and interpret the unconscious behaviours of a group to obtain the deeper meaning of the group experience (Cillier & Smith, 2006). Below, we will discuss some aspects of the psychodynamic elements of refugee psychology abstracted from the discourse described above.

Data derived from participant observation, focus groups and in-depth interviews demonstrated projection, idealization of the country of origin and devaluation of the destination country as the most common defence mechanisms used. The defence mechanisms are automatic psychological processes that protect the individual from anxiety and awareness of the dangers or stressors. These mechanisms mediate the individual's emotional reaction to conflicts and stressors. The subjects are often not aware of these processes when they operate (APA, 1994).

The feeling of distrust and of being persecuted described during the participant observation was confirmed in the speeches and can be interpreted in the light of projection theory. Gambini (1988) wrote that " ... When a human being does not know the other, it projects the self in the strange. If a few Martians appear here, we will design on them our own psychology. This is a psychic law: in front of an unknown, what is in me will be projected in another being".

In the case of refugees coming from a country of war and persecution, it was observed that the feeling of being persecuted is first feeling to appear in any unknown environment. The lower the knowledge about the other person, the easier it will be to passively project the unconscious aspects onto it (in an automatic and non-intentional way). The effect of the projection is to isolate the subject in his environment. It promotes a predominance of imaginary relationships, at the expense of real relationships.

The data collected during the participant observation enabled us to recognise the main difficulties in the care of the refugee. In addition, we found that many of the cases considered by the staff to be in need of psychiatric treatment, in fact expressed staff's difficulties in handling and interacting, due to the high complexity of the psychological issues. The team is also subjected to a situation that causes psychological stress, and they need help learning how to cope with the stress. According to the results of the research, the psychodynamic structure of the staff has a major influence on the relationship of the

refugees with the officials from Caritas – UNHCR and the difficulty presented by many refugees in their pursuit of autonomy.

From the point of view of relationship transference, the identification with the archetypes of the victim (on the part of the refugee) and of the saviour (on the part of the staff) is common. The crystallisation of these positions in the transference process makes the work unproductive, further strengthening the dependence and the depressive feelings of the refugee.

The relationships between the staff and the treated population can also be observed in the light of projection theory. However, often unconsciously, the person on whom the projection is made will encourage its appearance (Sharp, 1991). Often we see that the object offers an opportunity to choose the projection, or it even causes the projection. This happens when the object (person) is not aware of the quality projected. In this case, the projection acts directly on the speaker's unconscious. In fact any projection causes a counter projection whenever the object is not aware of the quality projected on him by the subject. "The transference and counter transference dynamics, when its contents remain unconscious, create relations unsustainable that tend to their own destruction" (Jung, 1991).

Working within a different culture presents the opportunity for projection from both sides. It is not only the unconscious contents that are projected on the other. Not only what is unknown but also what is meant to be human, may be projected. "Isn't true that someone who is pacific always sees others as pacific? Anyone who is aggressive thinks that aggressive is the other? There is always a mirroring human. Both the aggressiveness and affability follow the same mechanism. However, what has to unconscious there? It is the unconsciousness regarding the other. Unconsciousness means does not know, does not perceive" (Gambini, 1988).

Idealization was also a common defence mechanism used by the refugees to address the symbols of the country of origin. Idealisation is the mental process by which the qualities and the values of the object are considered perfect. The role of idealisation as a defense mechanism consists of the exaggerated positive value of the object to defend it from destructive impulses. For Melanie Klein, the idealisation would amount to an extreme division between a good object that is idealised, endowed with all qualities, always

available and inexhaustible and a bad object whose persecutor traits are also extreme (Laplanche & Pontalis, 1996; Segal, 1975).

In the focus group sessions, as well as during the individual interviews, the country of origin is considered (mainly by the Africans) most of the time to be a paradise compared to Brazil. In the refugee's original country, the people are more respectful, there is no disease or any social problems, the food is better, the culture is unique, and so on.

During the focus groups, on the rare occasions where one of the participants tried to state that malaria was present in his country, he was strongly repressed by the group. In the following sessions, the tendency of the group was to isolate this man.

Within this pattern of idealisation, there is a position of superiority of some refugees in relation to the Brazilians. This mechanism makes it difficult for the refugees to adapt because the identity remains attached to the previous idealised situation. The person, identified with the previous image, tends to isolation and depressive experiences.

This idealisation of the original country, which was common among the refugees from Africa, was not observed among the Latin American refugees. The Latin Americans identified themselves with the image of a refugee. Sometimes they saw a refugee as a romantic hero or a martyr.

We also observed a different pattern or vision about themselves and their situation among the European refugees. Probably because of the Eurocentric orientation of our culture (the aesthetic values, for example, to prefer people who are white, blond, and tall with light eyes), these individuals often report feeling better and more valued in Brazil than in their country of origin.

Although the DSC has been constructed to express the various refugees' identities, it is worth pointing out that there were many instances of inconsistent statements made by the same subject.

This ambivalence was pervasive in the speech of all the interviewees. The apparent division of the ideas about oneself is the basis of an identity crisis. This crisis is expressed visually in many of the pictures produced during art therapy. This identity crisis may culminate in dissociative and paranoid syndromes.

On the other hand, the introjection of the Brazilian identity is legally hampered by virtue of the ambivalence of the legislation itself. On several occasions, the refugees complained about their identity card in Brazil. The word refugee appears with an emphasis in the document. According to the participants, this favours discrimination. The emphasis placed on the word refugee in the identifying document emphasises the position of the legislation, which considers the situation as transitory.

4.3 Clinical implications: Factors to consider in the treatment of refugees

Medicine and psychology are themselves cultural products. They need therefore, to be adapted and relativistic. The errors of transcultural communication can perturb the establishment of a therapeutic relationship, which is a key element of psychiatric and psychological practice.

The risk of ethnocentrism is inherent in psychotherapy practices in intercultural settings, because the main instrument of the psychotherapist is his own psyche.

From a practical point of view, the question arises: how to we address people who do not want to be treated because they are too terrified or even just suspicious? The psychotherapist must abandon traditional "settings" and assume a flexible posture. The contract needs to be as clear as possible, establishing the limits in an affective but firm way.

Although psychotherapy can be carried out at deeper levels, that is, addressing issues of the unconscious, it is important that the therapist focus on an approach to strengthen the ego. The therapist needs to understand and accept the fact that, most of the time, this group of patients refuses to talk about past events. The main task of the psychotherapist here is to facilitate the redemption of aspects of the battle for life by strengthening the memory of the struggle for survival that propitiated the refuge. At first sight, it seems difficult to draw up a proposal that includes the required level diversity, but this work supports the importance of simplicity and the humbleness of the therapist with respect to the patient.

In many cases, the most important aspect of therapy is the presence of the therapist. The silence must be respected and not treated as a defence, as repressed aggressiveness or as an attempt to escape. Rather, it should be seen as an excellent opportunity for reconciliation with the internal dignity, a process that is extremely necessary for the new identity to move beyond the marginalisation.

4.4 Activities implemented

Based on the analysis of the results (which in large part occurred concomitantly with the field work) we drew up the refugee mental health programme. It covers therapeutic and preventive activities in the mental health area:

- Psychiatry and psychological care for refugees at transcultural clinic located at University of São Paulo
- Psychological support for Caritas/UNHCR staff
- Art therapy groups for refugees at Caritas

As the experiences of various dynamics were carried out in the focus groups we considered art as a vehicle for the psychotherapeutic approach for refugees. As predominantly use non-verbal language, it is useful to the dialogue on events that are extremely painful. In addition, the possibility of construction and symbolic expression facilitates the contact and adaptation to the new reality.

Art therapy guarantees the possibility of expression for the refugee in spite of the barriers of language, and thus allows support to emotional trauma too strong to be verbalised.

Through art therapy we created a social space in which the refugee would move away from a situation of isolation due to the refuge, expand its forms of expression and redeem an individual identity through which it can continue to relate to the world in a healthy way. This way it was intended to act in the field of preventive and promotion of mental health.

We observed that each participant recognises often fragments of the former identity, clippings of the new reality, the difficulties, the dreams, and

hopes inside the artwork carried out in the therapeutic process. This way, it clarifies for the refugee with his own way of thinking and feeling the world.

The first exhibition of pictures done in art therapy by refugees was fully part of the psychotherapeutic approach. The refugees have participated from the idealisation until the display of the works and the contact with the public. This exhibition has played a positive role in refugees' social ability.

– Seminars on African Culture

– Training of staff members to motivate a posture since the initial interviews that places emphasis on the responsibility that each refugee has about himself. The main purpose is avoiding paternalism that can reinforce the dependence of the institution and make it difficult to achieve autonomy

4.5 Limitations of the study

The limitations relate to our ability to draw descriptive generalisations. Furthermore, we do not claim to have identified all the possible psychodynamic issues involving the refugee situation. The theoretical framework in itself, the psychodynamic perspective, which assumes understanding behaviour as a vehicle of "access" to other peoples' knowledge, views, and attitudes, could be restrictive for the field text interpretations, and ultimately, for the findings of this research.

5. Final considerations

The overall aim of the study was to develop a mental health programme for refugees based on their needs and perceptions. The participatory action research method enabled us to develop this programme and improve our understanding of the mechanisms of this complex social situation. This approach can be seen as Participatory Action Research, because the whole project was built with the practitioner team of the reception centrr for refugees. The initial approach of the prevalence study proved unsatisfactory to meet the practical needs of this team, which had sought the researchers because they considered that almost all refugees were in need of psychiatric

or psychological treatment. In the process we learned together (researchers and the several stakeholders involved in the reception centre: lawyers, social workers, volunteers, security guards) that simple operational changes can greatly influence the way the refugees feel and behave towards the staff. On the other hand, the participation of the refugees in the process from the beginning (which is an important aspect and aim of the PAR) did not occur. This was mainly because of the tension between the service providers and the refugees, the existing rivalries between some refugee groups in the country of origin, difficulties with the language, and difficulty of some people to work in groups because of suspicion. But as the research was developed, the participation of refugees grew in the process.

The research process also brought to us some insights about our role as therapists and researchers. In the beginning we wondered whether it is possible to build a mental health programme fot an extremely heterogeneous population and, mostly, who did not consider themselves mentally ill. We wonder about the value of psychotherapy in such circumstances, mainly because psychotherapy itself is an instrument produced by culture. These experiences also made us question ourselves about psychoanalytic assumptions, such as the need to talk about the trauma to overcome or elaborate experience. We realize that in some cases there are profound experiences of loss, too painful to be described in words. For this group, traditional psychotherapies were not appropriate. We realise that dialogue promoted in the focus groups allowed everyone to better understand the situation and think about strategies for change. Such strategies can be collectively constructed and involves actions that otherwise could not be thought. The possibility of intervening in small everyday actions enabled a significant improvement in the tensions between refuges and staff, promoting mental health of both sides. As researchers and therapists, we learn the value of listening, free of preconceived ideas about mental functioning. We learned that in extreme situations the fact of realising they are not alone, offers to refugees the conditions for their mental health improvement.

The discourse analysis based on a theoretical model of social representation combined with a psychodynamic perspective has identified important clinical considerations for the mental health approach to refugees. The results

demonstrated the importance of culture and the social experience in ego development. To work with individuals who do not belong to the so-called "western world" and who are victims of violence, we must revise the concept of the individual from classical theories of personality.

The results illustrate how unconscious behavioural dynamics could interfere with the relationship of the refugee to his or her new country. Evidence was given for splits and different types of defence mechanisms, such as projection and idealization, which adds to our understanding of refugees' relationship to health services.

The study raised questions concerning the relationship between psychotherapy and culture, the risk of "medicalising" social situations and the issue of power among the health and social workers. These are important fields for future research.

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