

Healthcare Recommendations For Recently Arrived Refugees: Observations from EthnoMed

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INTRODUCTION

EthnoMed has been providing online information for clinicians caring for refugees since 1994. [EthnoMed](#) exists to provide clinical support and cultural context to clinicians caring for select populations of refugees. This information is retrieved from a network of case managers and clinicians engaged in ongoing refugee care and in refugee communities. Over the past 22 years we have observed successive waves of refugees entering and adjusting to U.S. health care. This article is intended to summarize common challenges to be anticipated by public health professionals and clinicians who will care for the next wave of arriving refugees. These are challenges for refugee families and therefore must be assessed and tracked for therapeutic success since challenges faced by patients are simultaneously challenges to patient care; from these we identified recommendations for providers.

These challenges are:

- Family integrity and social adjustments trump medical issues for most arriving refugees.

- Competing demands of distinct services such as: social welfare, education, housing, transportation, public health, mental health, primary care, and specialty care encountered by refugees overwhelm them and tax limited resources.
- Language barriers impede the adjustment process.
- Some refugees with urgent and complex medical conditions are unable to establish care and specialty referrals in a timely manner.
- Underdeveloped or eroding health care systems in the countries of origin or first asylum leave many refugees with poorly controlled or undiagnosed chronic medical conditions.
- Most refugees are unfamiliar with the biomedical practice of preventive medicine and primary health care.
- Public health's infectious disease screening results are not communicated to those providing ongoing medical care.

- Exposure to violence, torture, warfare, and internment is common, even among children.
- Loss upon loss is the nature of refugee life and so depression, PTSD, and anxiety are prevalent and often unrecognized.
- Anti-immigrant sentiments further burden refugee life in the U.S.

These challenges and our recommendations are intended to augment the [CDC guidelines for refugee care](#). We intend to alert clinicians to features of refugee life that interact with social and health system realities and impact refugees and their providers.

Background

The world is in the midst of the largest movement of displaced people since World War II. Millions of Syrian refugees are fleeing and joining the existing stream of refugees out of Asia, Central America, the Middle East and Africa to Europe and the West. President Obama said he will resettle 10,000 Syrian refugees in the U.S. this year (Harris, 2015). However, after the Paris terrorist attacks on November 13, 2015, and in the face of calculated political positioning, refugee resettlement itself became controversial. It is important to remember the U.S. accepts about 70,000 refugees most years and has for decades, long before 9/11 (Department of State, 2016). There is an extensive 2 to 4 year vetting process for selection. As we are seeing with Syrian refugees, each refugee group has a unique set of circumstances, and a unique history. That said, there are common challenges successive waves of refugees must work through as they arrive in the U.S. and encounter the American health care system. The authors collectively

have 100 years of refugee patient care experience with successive waves of refugees. Based in this experience and through dialogue with numerous other providers doing the same work we have identified 10 challenges common to resettling families and their providers. We discuss these challenges and make recommendations using the following case to illustrate the interactive nature of these hurdles.

Case

The A.S. Family: A.S. is a 45 year old Iraqi man resettled to Seattle from Turkey with his three sons and his wife. Arriving in 2014, the pre-departure health information sent by the State Department through the resettlement agency noted back pain and difficulty walking, nothing more.

A.S. grew up in Baghdad in a lower middle class family. He did not attend school as a child and began working as a young teen to help support the family. Consequently, A.S. never learned to read and write. He was investigated by the intelligence unit of the government. A.S. was held in detention for three months and tortured on a daily basis. Torture included:

- Pulling teeth out with pliers
- Pulling nails out of feet and hands
- Hanging from hands and being beaten on the head with blunt objects
- Forced stress positions

He was placed in Abu Ghraib, a prison in Iraq. He was jailed approximately a decade.

After release, A.S. spent two years in bed completely disabled before having a surgery which allowed him to walk again, but with a cane. A.S. bought a fuel truck and started to

distribute fuel for local generators. After the invasion of Iraq by U.S. forces he got a contract with the U.S. government to distribute fuel. Because of his involvement with the U.S. government he was threatened by militia groups and told to give up his work. He refused because it was the only source of income for his family. He and an employee were later attacked by a group of militia who surrounded the truck. A.S. and his driver ran and both were shot multiple times. His colleague died. A.S. was left for dead but survived.

After this A.S. fled with his family (wife and four children) to northern Iraq and then they made their way to a refugee camp in Turkey where he registered for resettlement. A.S. described the next 18 months to two years in the refugee camps as very difficult with inadequate shelter and food. His infant child became very ill and was eventually admitted to a hospital where he died.

Upon arrival A.S. was brought by a resettlement agency to the attention of physicians in a refugee health promotion program. His spine injury from torture caused not only severe back pain, but also urinary incontinence. He found it difficult to walk, and painful to stand. He had to lie down when possible to take the weight off of his back. A.S. also reported poor sleep ranging from one to two hours per night, with nightmares 3-4 times per night. He had intrusive thoughts about being tortured, impaired memory and concentration, seeing shadows, hearing voices calling his name, and daily sadness and tearfulness.

His wife still grieving the loss of the baby, was his primary support, and with his limited help she manages the house, work, and

supervises their remaining three healthy boys ages 4, 7, and 10.

Family integrity and social adjustments trump medical issues for most arriving refugees.

Central to managing health care for refugees is to always remember that re-establishing family safety and integrity is their first priority. While this seems obvious and may also be true for U. S. born families, most families do not have to find housing, start a new job, locate new schools, learn a new language and culture, and navigate new social institutions simultaneously.

A.S. and his family have to do all these things. They receive food stamps, access to Medicaid Managed Care, and a monthly stipend with benefits totaling about \$1320 for a family of five. A.S. and his wife must begin working as quickly as possible to maintain stable housing. But he is in pain and unable to work and so he must first seek the medical care deferred for years in prison, an occupied Iraq, and in Turkey. His new physician wants him to get an MRI, see a spine surgeon, take medications, and be evaluated by Rehabilitation Medicine and Physical Therapy to be assessed for a walker. A.S. primary focus is on stabilizing his wife and sons, having a clean and safe place to live, to be able to get to places like the grocery store, learn a little English, enroll his children into school, and to get help with his pain.

Refugees are connected to market-rate housing upon arrival by resettlement agencies. Those unable to pay rent or who decide the housing was inappropriate for their family will find that there is a 2 year waiting list for public housing in Seattle and find themselves homeless, supported by

community members, or living in public shelters. Seattle, like many large cities is going through a rapid gentrification of the urban core. As a consequence, housing near centrally established social service and safety-net resources is unaffordable for most refugee families. The increased cost of rent in many US cities (Sparshott, 2015) has impacted refugee families as well. HUD rules prohibit more than 2 people per bedroom, meaning that a family of 3 must rent a 2 bedroom (Thompson, n.d.) increasing housing costs further. The affordable housing available nearer social services and jobs in the inner city can be tenement style housing infested with mold, rodents, and insects, where neighborhoods may face more issues with crime and violence. Research has found that in urban city low-income housing, more than 50% report three or more exposures to things like mold, combustion by-products (from cooking, for example), secondhand smoke, chemicals, pests, and inadequate ventilation (Adamkiewicz et al., 2013).

Children enrolled in school face learning English while at the same time keeping pace with studies. While this is often successful for younger children, older adolescents often fall rapidly behind and frequently drop out. While there are thoughtful refugee programs to facilitate integration into schools, children are adjusting to socio-cultural differences, not to mention instruction in a foreign language. So often the task of establishing normalcy falls to women. They must re-establish a household pattern, meals, homework routines, school schedules, at the same time as obtaining employment and learning English.

Unfortunately for A.S. the apartment found for him by the resettlement agency is on the

second floor, and there is no elevator. He frequently falls while going up and down the stairs. He lives far from the medical center where he gets specialty care. He therefore misses appointments because of transportation issues, falls, or because he is attending to the needs of a child. Regardless of his pain, and the terror his suffering engenders in his family, he prioritizes home, school, and training over frequent medical appointments.

Intervention: Clinical staff must take a history that includes current housing stability and appropriateness and an awareness of family integrity and safety to understand patient behavior. They should also assist advocating for housing safety when indicated.

Competing demands of distinct services such as: social welfare, education, housing, transportation, public health, mental health, primary care, and specialty care encountered by refugees overwhelm them and tax limited resources.

A.S. suffers from debilitating worry about finances and being able to support his family. As a family they receive benefits and cash of \$1320 a month plus food stamps. Their rent and utilities totals \$1010. He cannot work due to physical and psychological issues. His spouse must work, but also needs to be home to take care of A.S. It may seem obvious to most Americans that transportation, housing, medical care, employment, education, and language training are separate institutions and will not communicate with one another on a person's behalf. That is, these systems are not integrated. But to resettling refugees it is not clear how to manage this lack of integration and the demand of each of these essential domains on the time and limited

finances of refugee families. Appointments are made for them at a time when a child is starting school, and the housing office wants to do an intake, and the refugee screening program has scheduled them for phlebotomy. In the first three months Resettlement Agency case managers might help with this, but soon families are left to their own devices to manage their competing demands in a foreign system and with little English.

A.S. was scheduled to see his physician on a day when the Department of Social and Health Services made an appointment for him to apply for disability benefits. His finances support his entire family and so his income is vastly more important to him than his health. He did not know the telephone etiquette or have the language skills to reschedule and so he was a “no show” at his appointment. This inconveniences the medical system that has limited time and finds a missed appointment a waste of valuable resources.

In Seattle public transportation costs \$2.50 per person to ride, \$1.25 for children or \$8.75 for a family of five. A round trip downtown can cost \$17.50. This adds up for a family living on \$1320 a month for rent and food and clothing and transportation. Poor coordination can cost families a great deal of their monthly stipend.

In this way the constant juggling and re-negotiation of expectations, appointments, and conflicting demands overwhelm refugee families. It is not clear to them what should be prioritized.

Intervention: Clinicians or their medical assistants must take a history that includes competing demands and schedule conflicts with therapeutic plans. Active assistance

helping families navigate appropriately the varied demands will facilitate the chance of clinical success.

Language barriers impede the adjustment process.

A.S. and his family are fluent in Arabic, but are unable to communicate in English. A.S. dropped out of elementary school and is unable to read or write in any language. In Iraq, he worked as a successful auto mechanic and was able to support his family.

Unfortunately, social isolation from language and cultural barriers can make resettlement traumatic for refugees. A.S.’s story follows the “triple trauma paradigm” (Weibe, 2014) – the primary trauma occurs in the home country, leading to flight, the second trauma occurs during flight or time in refugee camps, and then the third trauma takes place during resettlement with isolation and unmet expectations. For A.S. and his family, there is a high risk of isolation given his lack of prior school success and his inability to communicate easily in his new surroundings. He is not alone in this challenge. Many refugees did not have the opportunity to complete their schooling, whether because of lack of universal education or because of instability in their home country or lack of opportunity in refugee camps (Unicef, 2013; Tran, 2013). Even highly educated refugees can struggle with language and cultural barriers.

In the healthcare setting, some of these barriers can be bridged with a trained professional interpreter (Crosby, 2013). Especially because of traumatic histories the use of family members, children, or friends as interpreters is unacceptable. However, lack of health literacy and lack of shared

understandings of medical and mental health care can still form a barrier even in the setting of outstanding [interpretation](#) and [cultural navigation](#). Recent studies of Iraqi refugees in Australia and the United States found low mental health literacy, reducing utilization of appropriate services (Slewa-Younan, 2014; Wright, 2015). Untreated mental health problems created more barriers to developing English proficiency in these populations (Slewa-Younan, 2015), thus further prolonging isolation. It is important to educate carefully about mental and medical health care with clear explanations and interpretation to increase the likelihood of success.

Intervention: Trained professional medical interpreters, in-person or by phone, are essential for refugee clinical care. Because of language and literacy barriers, medical reconciliation with medicine brought to every encounter is critical for patient safety.

Some refugees with urgent and complex medical conditions are unable to establish care and specialty referrals in a timely manner.

Although many refugees are healthy upon arrival to the United States, there are subsets that have complex medical conditions, which warrant prompt evaluation and specialty referral. About 3000 refugees arrive in Washington State most years, approximately 2000 of these arrive in the Seattle-King County metro area (State of Washington, 2015; Balk, 2015), and [\[1\]](#) less than 200 of these have complex medical conditions.

Given his profound limitations in ambulation and evidence of neurological compromise, A.S. was evaluated with spine imaging, as well as referral to multiple specialists

(including physical therapy, rehabilitation, and neurosurgery). Through an innovative pilot collaboration with the WA State Department of Health, incoming refugees to King County like A.S. are screened for complex medical needs and referred to the Refugee Health Promotion Program at Harborview Medical Center for expedited complex medical evaluation. Until last year this was not the norm in the county or the state. Establishing care with an outpatient physician familiar with refugee health care issues, who could facilitate his medical management, was essential in providing efficient care for A.S. This is an unusual program, and most refugees across the U.S. are expected to establish care with a primary care provider upon arrival with the assistance of the Resettlement Agency case manager who may not completely understand the nature and implications of the refugee's medical problems, and is not part of the medical establishment.

A.S. was able to be seen within a week of arrival, but there are many delays in most states because of limited capacity in health care institutions that take Medicaid which is provided to refugee families upon arrival.

Intervention: Establish clinical connections to fast track sick new arrivals into appropriate clinical settings with available specialty services.

Underdeveloped or eroding health care systems in the countries of origin or first asylum leave many refugees with poorly controlled or undiagnosed chronic medical conditions.

In addition to the medical complications that A.S. suffered due to his torture, he was incidentally found to have uncontrolled

Diabetes Mellitus, hypertension, and multiple pulmonary nodules. While present in their country of origin, poor health infrastructure often results in refugees being unaware of their chronic medical conditions until arrival in the U.S. Public health programs for refugees have traditionally focused on identification and treatment of infectious disease in the interest of the host countries' national health. However, there has been increasing awareness of the burden of chronic non-communicable disease (NCD) in refugees (Amara, 2014).

Estimates of diabetes in [Bhutanese refugees](#) range from 11-14% and data on US bound [Iraqi refugees](#) revealed that 35% had at least one of three chronic medical conditions, including hypertension, diabetes, or obesity (Bhatta, 2014; Kumar, 2014; Yanni, 2013). Exposure to tobacco as well as poor air quality increases the risk of chronic lung disease in refugees. Women, who spend hours indoor cooking in poorly ventilated homes, can develop obstructive lung disease (Kodgule, 2012). In addition, even previously treated pulmonary tuberculosis can result in subsequent airflow obstruction, as well as chronic restrictive lung disease (Ehrlich, 2011).

Unfortunately, even after adjusting for demographic data and access to health care, U.S. foreign-born residents are less likely to be aware of their diagnosis of hypertension and overweight status than U.S.-born patients (Langellier, 2012).

A.S. may have had these problems for years but the [destruction of health care services in much of Iraq](#) by warfare, and the congestion of the available clinics in Turkey, his country of first asylum, meant that only acute conditions received attention and chronic

conditions went undiagnosed and unmanaged.

Intervention: Have high clinical suspicion for common chronic conditions immediately in risk populations: diabetes, cardiovascular risk factors, chronic lung disease, hypothyroidism.

Most refugees are unfamiliar with the biomedical practice of preventive medicine and primary health care.

Primary care providers are increasingly scrutinized on a range of quality care metrics including whether their patients were offered preventive screenings. And like any other American, refugee patients should be offered evidence-based preventive services, such as vaccinations, counseling on healthy lifestyles, and screening tests for breast, colon, and cervical cancers.

A.S. and his children did not receive the full spectrum of pediatric immunizations and preventive measures we would expect American children to have received and so needed to be caught up with MMR, varicella, TDAP, and polio vaccines. His pulmonary nodules were initially concerning for tuberculosis. Fortunately his turned out not to be the case, but he was diagnosed with [latent TB, a condition unfamiliar](#) since he knew of the active disease, but not the inactive form. Explaining the need for treatment of a blood test based on the possibility of future disease seems like a low priority given the many demands on refugees, and the life threatening conditions from which they recently emerged. As noted, newly arrived refugees suffer from on-going stresses of building a new life while coping with the anxiety about friends and family who were left behind in refugee camps or war zones. Based on

numerous conversations with patients who express the immediacy of their lives and concerns, and the very uncertain sense that the future is preventable or controllable, it seems that the concept of “the future” and “the self” may appear an unaffordable luxury and somewhat ludicrous. For new refugees there is disconnect between a well-meaning provider who imagines his patient’s future in terms of decades and the patient who still views survival on a day-to-day basis.

[Cancer screening in particular can be a challenging conversation between a refugee patient and provider.](#) For many, a discussion of preventive services may not be in line with the context of their lives. How can one even begin to discuss the incremental survival benefits of a mammogram to a person who has lived through unimaginable danger? The notion of a screening test, which is predicated on the hope of detecting and treating an early stage cancer before it spreads, may be well familiar to some refugees, particularly if they were from a more affluent and urban background of a middle-income country. Based on our experience, for the majority of refugee patients this concept of testing in the absence of symptoms can be difficult to accept. Based on our experience, the majority of refugee patients find this concept of testing in the absence of symptoms can be difficult to accept.

Several studies have shown that immigrants and refugees tend to receive less cancer screening compared to their American-born counterparts (Percac-Lima, 2013; Jenkins, 1990; Taylor, 2000; Morrison, 2012). This problem is an interaction of limited patient understanding, inadequate provider knowledge about refugee life, and systems issues around language and culture. System-

level barriers (see number 2 above) tend to affect those who are poor, non-English speaking, with low literacy, or suffer from mental health conditions. Provider factors can be personal biases and preconceptions about the patient’s willingness to accept testing, their inherent vulnerability to the disease and frustrations with having to take the time and effort to engage in a complex discussion. Patients, in turn, may balk at cancer testing for a number of reasons including underestimating the risks of not screening, poor understanding of benefits of early detection, poor understanding of the available treatment for cancers, or the perception that the testing itself is too painful or risky.

For these discussions to be meaningful trust is essential and building trust across language, power, and culture requires additional time and skill. This takes multiple visits over months and years where the relief of symptomatic conditions creates trust and buys one credibility for hearing about the prevention of asymptomatic and potential illnesses. For A.S. the relief of his pain and assistance with ambulation gives the clinician an *entrée* to discuss the management of hypertension and latent TB.

Intervention: Culturally tailored materials and outreach will help identify and explain asymptomatic chronic disease management, disease prevention and health promotion to new arrivals. Also, providers may consider temporarily deferring discussions on prevention and screening until a later point when rapport and credibility has been built up through the attention to symptomatic relief of suffering.

Public health’s infectious disease screening for refugees is not

communicated to those providing ongoing medical care.

Sick immigrants arriving in American ports and thought to be a risk to the general population were routinely quarantined. This policy was eventually formalized through the General Quarantine act of 1863. In the 1700s it was the public fear of yellow fever, plague, cholera, tuberculosis, and syphilis among immigrants that resulted in quarantine on various islands in the New York harbor. Federal legislation in 1878 was the foundation for the [current practice of refugee screening](#). Fast forward to the present and now quarantine has been replaced by proactive screening abroad for a few infectious diseases to be treated before relocation, leaving domestic programs to screen for asymptomatic infections like latent tuberculosis, HIV, and chronic hepatitis B. These programs also address completing immunization records for adults and children. In recent years refugee programs added non-infectious conditions with a primary care orientation to their screening portfolio such as screening for PTSD/depression, anemia, and lead toxicity.

The population orientation of screening, data collection, and other public health programs by nature are not funded for, or directed toward, the immediate care of the person screened positive for the disease. Instead the patient is given their results and encouraged to inform their provider of these conditions and receive appropriate [care in a primary care setting](#). While this makes programmatic sense, refugees frequently express to us surprise and confusion that these systems are separate and their information is not communicated for them. That said, another pilot effort in King County has addressed this

as have a few select other programs in Spokane and Philadelphia. Still, logistics, funding, comorbidities, and privacy concerns make it impractical in many settings to attempt definitive care of disease states in a public health setting. This leaves a gap between the screening for asymptomatic conditions and the provision of treatment for a chronic occult state. As outlined above, for a number of reasons these asymptomatic states are of little immediate concern for resettling refugees and are easily deferred or forgotten. Refugees may assume that given the effort to screen, the system must communicate results between screening programs and doctors. Unfortunately, this is the exception more than the rule.

There are notable exceptions to this rule: programs where screening is conducted on behalf of the government in a limited number of primary care settings that capture most of the arriving refugees. In many regions of the country this is not feasible or funded in this way. In Washington the results from screening are placed in a web site known as the [Washington State Immunization Information System](#). To be useful this requires providers to know this and seek the results on this site. The city of [Spokane in Washington](#), and other municipalities across the country, like [Philadelphia](#) have recognized this treatment disconnect, and innovated programs to bridge the gap by nesting screening programs in a few central primary care settings.

A.S. screened positive for tuberculosis upon arrival, his chest x-ray was suspicious for active TB, which turned out not to be the case. Given the complexity of his immediate social, medical, and emotional state it is not surprising that this information is de-

emphasized in the list of issues to be addressed, eventually it could be forgotten by A.S. if he relocates his care.

Intervention: Link screening programs to immediate clinical care and do not rely on refugees to communicate the screening information to their clinicians.

Exposure to violence, torture, warfare, and internment is common, even among children

Unfortunately, A.S.'s experience of torture is not unique. Despite international declarations and conventions prohibiting torture, it remains a frequent practice around the world and is an experience shared by many refugees and asylum seekers. Torture is defined by Article 1 of the United Nations Convention against Torture as an act committed by a person under the color of law specifically intended to inflict severe pain or suffering, whether physical or mental, upon another person within their physical control for any reason based on discrimination of any kind (UN General Assembly, 1984). A meta-analysis of 5 studies including refugees and asylees from various countries in Africa, Cambodia, Burma, and Iraq surveyed from 1999-2013 suggested that there are up to 1.3 million survivors of torture living in the U.S. Prevalence of torture in the refugee population varies widely, but the overall prevalence is estimated to be around 44% (Higson-Smith, 2015). As U.S. physicians see greater numbers of refugees, they will need familiarity with the sequelae of [torture and the implications for medical care](#).

A past experience of torture, even when remote, can affect medical care in several key ways:

1) Physical sequelae

U.S. physicians who care for refugees will encounter the long-term physical sequelae of torture, which varies by the type and severity of torture performed. The most common methods of torture include beatings, blunt trauma, cutting, positional torture, electrical torture, asphyxiation, sexual torture, and psychological torture including threats, mock executions, and witnessing the torture of others (Walker, 2007). While some survivors of torture have scars or visible deformities, others lack visible evidence of torture but still suffer from chronic, debilitating pain. One study of refugee torture survivors in the UK showed that 78% reported persistent multiple pains, mainly in the head and low back (Williams, 2010).

2) Psychological sequelae

For A.S. as well as many other refugees and asylees, the psychological effects of torture can be even more debilitating than the physical sequelae. Mental health disorders occur frequently in survivors of torture, with rates as high as 81.1% with clinically significant anxiety, 84.5% with clinically significant depression, and 45.7% with symptoms of post-traumatic stress disorder (Keller, 2006). Often a patient's psychiatric symptoms can wax and wane depending on other medical or life stressors, and it's not uncommon for torture-related symptoms to recur even decades after the initial event.

3) Retraumatization and nonadherence

Many survivors of torture are reluctant to discuss their experiences, and clinicians may fear retraumatizing patients by inquiring about their past. However, unawareness of a patient's history of torture has the potential for even greater re-traumatization. The

medical setting can trigger painful memories, as torture often has medical overtones (e.g. the performing of procedures, administration of drugs such as psychoactive compounds, and participation of physicians in the practice of torture). For A.S., lying still in a loud MRI scanner evokes claustrophobia and flashbacks to his experience of forced postures and imprisonment in confined spaces.

This re-traumatization by the medical setting can contribute to nonadherence for many survivors of torture. Encounters with the US health care system create many of the same feelings of powerlessness that occurred during their torture, which can lead to lack of follow-through with appointments, labs, studies or referrals.

[Awareness of a patient's torture history](#) can assist physicians in understanding the background of certain physical and psychological symptoms, anticipate and prevent re-traumatization, troubleshoot barriers to adherence, and further a path to healing. For A.S. who spent years in a cell too small to extend his legs or stand up placement in the MRI scanner to evaluate his spine meant potentially re-traumatizing him in an effort to help him. Giving him permission to take control in the scanner helped mediate a sense of powerlessness reminiscent of conditions in Abu Ghraib.

Intervention: Take torture histories, record the relevant details, and integrate them into patient care for affected individuals. Realize that torture trauma has a chronic nature and can recur years after the event.

Loss upon loss is the nature of refugee life and so depression, PTSD, and anxiety are prevalent and often unrecognized.

When A.S. recounts his traumatic past, it's not his own beatings that resulted in the most lasting suffering, but rather it was the [loss of his infant son](#). During the family's escape from Iraq into a refugee camp, his son fell ill from cold exposure in Turkey and didn't have access to the renal dialysis and transplant needed to save his life. Likewise for many refugees and asylees, loss upon loss is a common experience that continues even into resettlement.

A.S. was diagnosed with Post-Traumatic Stress Disorder and major depression. This is not uncommon for refugees as stress and loss profoundly influence the development of depression, while exposure to violence contributes to traumatic stress disorders. Since refugees and asylum seekers have experienced intense violence, deprivation, and loss, they are at high risk of developing mental health problems (Thao, 2009). Common diagnoses include post-traumatic stress disorder (PTSD), major depressive disorder, and general anxiety or adjustment disorders. Refugees have been found to have 10 times the rate of PTSD as the general population (IRCT News, 2011; McGuire, 2008). For those who have been tortured the risks of mental health distress are even greater (Gonsalves, 1992; Center for Victims of Torture, 2006). The rate of torture in Iraqi refugees like A.S. is estimated at 56% (Willard, 2014).

Many refugees believe that their physical and mental suffering should start to improve upon their much-awaited arrival to the US. However, resettlement brings its own stressors (Ringold, Burke & Glass, 2005). Because resettlement is such a pressured adaptation with little financial supports, survivors often have excessive stress due to

attempting to establish a new life in the U.S. while concurrently trying to meet basic needs, adjust to a new culture, and heal from psychological and physical distress. The toxic stress that is part of this resettlement makes any pre-existing mental health issue worse. Many refugees eventually find a tenuous balance, only to have it disturbed by news of a relative's death overseas or by the diagnosis of a new chronic illness such as diabetes or cancer.

A.S. Treatment Plan was designed as a phased approach, with an attempt to stabilize his basic needs and introduce psychotropic medications before moving onto more therapeutic PTSD and depression symptom reduction.

Intervention: Psychiatric and behavioral medicine services nested within primary care programs are ideal for integrating care, especially since these services may be unfamiliar or stigmatized in many home countries and since mental health problems are very likely to be present.

Anti-immigrant sentiments further burden refugee life in the U.S.

A.S. arrived in the U.S. long after 9/11, but just as the rhetoric around immigration has again reached a fever pitch. Migrant children fleeing intolerable gang and domestic violence in Central America have crowded the Southern border. Refugees fleeing Syria are swarming over Eastern Europe and a chronic flow of migrants from East Africa stream north and cross the Mediterranean in precarious flotillas. The West feels under siege and frightened (Hanson, 2015; Faiola, 2015).

Ironically anti-immigrant sentiment is not new in this nation of immigrants. In 1880 the

Irish and were accused of bringing in cholera, Italians of typhoid fever, and Chinese immigrants were blamed for bubonic plague. Recently Phil Gingrey, a physician and Congressman from Georgia, accused [migrant children](#) of bringing measles, dengue, small pox, and Ebola across the Mexican border. These are completely unfounded claims. The result is to stir up fear in an uninformed population that suspects many immigrants are here illegally and are dangerous.

Muslims in particular face discrimination. The distinctive *hijab* that A.S.'s wife wears makes her an easy target of jeering and suspicious looks on the street and in stores. Names like Mohammed and Hussein prompt bullying in schools. The attacks by fundamentalist Muslims in Egypt, Mali, Nigeria, France, and in the U.S. promote an atmosphere of hatred and fear. On December 6, 2015, President Obama was forced to call Americans to their founding values of religious tolerance and inclusion.

This is the atmosphere in which A.S. and his family must address the above issues and attempt to adjust to American life. The stress and isolation families endure compounds the other issues from transportation, and language barriers, to depression.

Intervention: Be aware that anti-Muslim and anti-immigrant attitudes impact patient health and behaviors. Their experience must be elicited to be addressed. Identify safety strategies for patients, for example establishing phone trees, learning how to dial 911 and preparing emergency contact information. Identify advocacy programs that can support targeted communities.

Discussion

The intention of the EthnoMed team is to remind health care professionals in all disciplines (pharmacy, public health, nursing, and medicine) that a therapeutic plan that works with refugee families must attend to these interactive domains. Each of these 10 challenges alone is daunting, together, as in the case of A.S., they can be overwhelming. The provider is advised to solicit these details and factor them into their treatment plan. If one fails to work with an understanding of these critical details then there will be numerous missed appointments, untaken medications, failed studies, and unnecessary competing demands to frustrate all and further complicate the care of an already complicated patient population. These issues must be explored in history taking, factored in during scheduling, and considered in the treatment plan. If one considers these issues, then new arrivals and patients like A.S. and his family will have greater success in their adopted home, and clinicians will better appreciate the complexity of their lives and more successfully adapt evidence based care to the needs of the person in front of them.

A.S. and his family are now together, in stable housing, his wife works, he attends ESL and supervises his sons who are happily in school. The burden of illness he carries is an ongoing struggle, but he and his varied providers understand the issues and coordinate their efforts together.

Summary of Practice Recommendations

1. Clinicians or their medical assistants must take a history that includes current housing stability and appropriateness and assist in advocating for safety when indicated.

2. Track competing demands and schedule conflicts with therapeutic plans. Active assistance helping families navigate appropriately the varied demands will facilitate the chance of clinical success.
3. Trained professional medical interpreters, in-person or by phone, are essential for refugee clinical care.
4. Establish clinical connections to fast track sick new arrivals into appropriate clinical settings with available specialty services
5. Have high clinical suspicion for common chronic conditions immediately in risk populations: diabetes, cardiovascular risk factors, chronic lung disease, hypothyroidism.
6. Culturally tailored materials and outreach will help identify and explain asymptomatic chronic disease management, disease prevention and health promotion to new arrivals. Also, providers may consider temporarily deferring discussions on prevention and screening until a later point when rapport and credibility has been built up through the attention to symptomatic relief of suffering.
7. Link screening programs to immediate clinical care and do not rely on refugees to communicate the screening information to their clinicians.
8. Take torture histories, record the relevant details, and integrate them into patient care for affected

individuals. Realize that torture trauma has a chronic nature and can recur years after the event.

9. Psychiatric and behavioral medicine services nested within primary care programs are ideal for integrating care, especially since these services may be unfamiliar or stigmatized in many home countries.
10. Be aware that anti-Muslim and anti-immigrant attitudes impact patient health and behaviors. Their experience must be elicited to be addressed. Identify safety strategies for patients. Identify advocacy programs that can support targeted communities.

Future Research

There are many features of refugee resettlement and the resultant barriers and facilitators to health that are poorly understood. While there is a large body of evidence describing infectious disease issues (see: [CDC's Immigrant and Refugee Health page](#)) and substantial work on mental health and related resources for refugees (see: Pathways to Wellness's [Refugee Health Screener-15 \(RHS-15\) Packet](#); William & Westmeyer's *Refugee Mental Health In Resettlement Countries – Series in Clinical and Community Psychology*; and, *Review of Child and Adolescent Refugee Mental Health* by Lustig et al.), there is limited evidence and therefore great opportunity to clarify many of the systems issues and contextual features of refugee life and the impact of these on long term care. For example, research is needed on domestic refugee housing and its impact of families, their mobility, and their health. Assessments of delays to diagnosis and care for newly

arriving refugees are also needed, as well as pilot innovations to triage and address delays. Studies assessing information transfer and duplication of services could include streamlining the transfer of overseas information into the electronic records of refugees in their eventual medical homes. This electronic linkage of information could include the screening results and immunization records of domestic refugee public health programs. Research on the impact of a torture history on health care delivery, chronic pain, and chronic disease as well as novel approaches to treatment is a largely un-investigated domain ready for exploration.

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