

Helping Refugee Trauma Survivors in the Primary Care Setting

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**Restoring the dignity of the
human spirit**

*“Although the world is full of suffering,
it is full also of the overcoming of it.”*

Helen Keller

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I. Refugees / asylees:

Potential trauma and torture survivors

How this clinical resource can help

This clinical resource is meant for primary health care providers working with refugees or other survivors of war trauma and torture. People who have lived through war, the refugee process, and torture often suffer needlessly. Their suffering is frequently attributable to lack of knowledge about the normal effects of trauma, incomplete awareness of potentially beneficial self-healing strategies, and various barriers to accessing appropriate care. Most traumatized refugees do not access western mental health services. Therefore, primary care physicians and other providers often must identify and educate survivors, as well as nudge them in the direction of seeking mental health services when appropriate. Using the information in this manual as a resource, primary care providers can ease refugees' suffering and help them to begin the process of healing.

Refugee experience

The United Nations' definition of a refugee is "a person who flees because of a fear of

persecution based on race, religion, nationality, social group, political opinion, armed conflict, and lack a durable solution" (UN, 1951/2003). Most of the world's refugees are forced from their homes because of war or the threat of violence. Refugees usually flee to save their lives and the lives of their loved ones. The United Nations estimated that in 2002 there were 12 million refugees worldwide, with an additional 5.3 million who were displaced within their home country, and an additional 940,800 asylum seekers. An asylum seeker is someone who is also fleeing because of war or persecution, but seeks refuge in another country without having legal authorization prior to arrival. Minnesota, in the last 30 years, has received refugees primarily from Southeast Asia, Eastern Europe, and now Africa. Minnesota is currently believed to have the largest communities of Hmong, Somali, and Liberians in the United States. There are also communities of many other cultural groups in this state.

Refugees versus asylees

Because asylees do not have legal status in the U.S., they typically face a number of additional challenges. These challenges include the arduous process of applying for political asylum in the U.S., and inability to work until such status is granted. As a result, asylees often have to rely on the good will of fellow compatriots for food and shelter. Often asylees flee without their families and subsequently lack the usual social support while at the same time worrying about the difficult experiences of persecution and poverty often facing their family members back home.

Experience of torture

Between five and thirty-five percent of the world's refugees and asylees are estimated to have been tortured (Eisenman, Keller, Kim, 2000). The percentage of torture survivors in particular cultural groups is even higher. If a health care provider is caring for refugees, the odds are great that that provider has worked with torture survivors but may not be aware of it. Torture is a global public health problem, and the use of torture "has reached epidemic proportions worldwide" (Laurence, 1992, p.301).

The World Medical Association defines torture as "the deliberate, systematic, or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason" (Gerrity, Keane, Tuma, 2001, p.6). While the media often portrays torture being used to extract information or the "truth" from individuals, the purpose of torture is to gain power or control, or to silence any opposition. Individuals are tortured as an example to communities of what will happen to anyone who opposes the regime in power.

Common methods of torture include:

- Beatings with hands, rifle butts, or clubs
- Application of electrical shocks to sensitive parts of the body
- Hanging by the arms, legs, or shoulders
- Being sexually humiliated and raped (men and women)
- Burned with cigarettes, hot water, or acid
- Being exposed to extreme environmental temperatures
- Forced standing for extended periods

of time

- Being forced to stare at the sun
- Having the head submerged in water
- Having an empty gun fired at the head
- Being threatened with violence to loved ones
- Being forced to watch or participate in the torture or death of others, including loved ones
- Forced nakedness
- Not being allowed the use of a toilet
- Forced into solitary confinement or over-crowded cells
- Exposure to continuous noise
- Being deprived of sleep
- Being forced to remain with dead bodies
- Undergoing interrogation at random and unpredictable times

(Holtan, Antolak, Johnson, Ide, Jaranson, Ta, 2002, 36).

Identification of trauma or torture survivors

Most refugees do not conceptualize their trauma symptoms in terms of Western mental health concepts. Many are reluctant to access mental health services even when referred. Primary care providers are often the only health care professionals to detect

and treat the problems resulting from trauma. The roles of physicians and nurses are well known and accepted worldwide. Thus, it is critical that primary care providers identify trauma survivors needing help, provide treatment in the primary care setting if appropriate, and use their ongoing relationship to facilitate successful mental health referrals. Early intervention in treating trauma symptoms is important in preventing future disability and prolonged suffering. Patients having the potential for being trauma survivors need to be assessed for symptoms of posttraumatic stress disorder, major depressive disorder and substance abuse.

Common features seen among survivors of torture and war trauma alerting clinicians to the possibility of a traumatic history include the following:

- Status as a refugee, immigrant, or an asylum seeker
- History of civil war in country of origin
- Reluctance to divulge experiences in country of origin
- Patient or family member politically active in country of origin
- Family member who has been tortured or killed

- History of being imprisoned
- Any physical scarring that may be present
- Somatic symptoms with no known physical cause.
- Psychiatric symptoms of trauma – depression, nightmares, emotional numbing, irritability, easily startled, difficulty concentrating, avoidance, and trouble sleeping
- Avoidance or anxiety to being touched or examined.



Hand scars (CVT)

II. Health education topics for trauma survivors

Refugees frequently do not receive education about the effects of trauma or the treatment available despite being very symptomatic. Facilitating the healing of traumatized refugees involves helping them to rediscover their inner resilience and develop a feeling of optimism for the future. However, when refugees are severely affected they may need a catalyst to begin this process. A primary care provider can be this catalyst. Important initial goals for trauma survivors involve gaining an awareness of the effects of trauma, and utilizing helpful self-healing strategies. Trauma education for refugees should include information that:

- Normalizes trauma experiences and symptoms
- Reviews symptom course and prognosis
- Minimizes the stigma of mental health care
- Emphasizes medication compliance
- Reviews the effects of additional stress in exacerbating symptoms
- Relates trauma, stress and somatic symptoms

- Facilitates appropriate grieving
- Provides awareness of successful trauma treatment methods

Normalizing trauma symptoms

A wide range of symptoms has been associated with experiencing trauma. However, trauma symptoms are not always readily apparent to survivors. Changes in feelings and behavior often occur subtly over time. However, family members may observe these changes more clearly. The symptoms of trauma affect the survivor's relationships with family members and others. Moreover, survivors' existential views of the world, of human cruelty, and of their faith are often severely impacted by their experiences. They may never again feel the same level of trust or connection with human beings or the divine that they had prior to their trauma

Examples of trauma symptoms include:

- Recurrent intrusive daytime thoughts or images of the trauma
- Recurrent traumatic nightmares
- Severe emotional distress or

physiological reactions at reminders of the trauma

- Feeling watchful or on guard without reason
- Exaggerated startle response
- Marked irritability
- Concentration or short-term memory problems
- Feeling distant or cut off from others
- Numbing of emotions
- Lack of interest or pleasure
- Depressed mood
- Appetite disturbance
- Energy or motivational disturbances
- Hopelessness
- Suicidal thoughts
- Avoidance of thoughts or situations that serve as reminders of the trauma.

See Appendix B for a patient educational sheet listing common effects of trauma that can be utilized with survivors.

Trauma survivors need help in understanding the link between the trauma, their emotions, and how these affect the body. Survivors are usually relieved to hear that they are not abnormal, weak or crazy and that their symptoms are a normal human reaction to extreme stress.

Symptom course and prognosis

A variety of factors influence the symptom course, prognosis, and severity of symptoms of people who have experienced severe trauma. Among these are the intensity and duration of the trauma experience. In general, those refugees that have endured longer periods of trauma, and more severe trauma are more likely to be symptomatic. Those with a history of childhood trauma also tend to have more difficulties. Refugees without prior childhood trauma who had been functioning well prior to the trauma experience generally recover over time.

Symptoms of trauma fluctuate in severity over time. A survivor may be feeling very well for long periods of time when symptoms reappear after being triggered by a stressful event or situation. When presenting information on symptom course and prognosis, a useful analogy involves describing the treatment of trauma similarly to other chronic diseases such as diabetes or hypertension, which need continuing care and monitoring.

Reducing the stigma of mental health care

In most of the world, views of mental health

and illness are conceptualized differently than in the West. Mental health problems may be attributed to a wide variety of causes, including offending ancestor spirits, soul loss, witchcraft, voodoo, social circumstances, or even from “thinking too much.” Usually however, these are not thought of as mental illness. To most refugees, “mental illness” refers to persistent and usually psychotic states that they refer to as “crazy.” There is great social stigma in most cultures in being “crazy.” In some refugee cultures having a family member with severe mental illness brings shame on the entire family.

Psychotherapy and psychiatric treatment are also generally unknown in most of the world’s cultures. Many countries will typically have only one psychiatric institution for those with severe mental illness.

Education is required to modify survivors’ views of mental illness. Presenting emotional and psychological problems as a continuum of severity from low-level mental health problems to severe problems is often helpful for survivors. Conveying that each of us may move back and forth on this continuum depending upon current stressors

such as divorce, death of a child or even severe trauma facilitates understanding. Trauma survivors may gain hope as they realize that seeking professional assistance can diminish suffering and hasten recovery.

Increasing medication compliance

Many refugees have either never taken Western medications, or, as with antibiotics, have taken them for only short periods of time. Refugees and trauma survivors may lack an understanding of why medications may need to be taken for extended periods of time. Patient education on the long-term use of medications is needed.

Understanding the patient’s explanatory system of illness can help in comprehending a refugee’s reasons for not taking medications as directed. Developing a mutual understanding of rationales for using medications is essential to ongoing compliance. It can be helpful to begin follow-up appointments by establishing which medications the patient is still taking and why they have chosen to discontinue other ones.

Many refugees discontinue taking medications when they feel better or if they have not noticed any effects within several

days. With the use of antidepressants for example, patients need to understand that it takes several weeks to notice treatment effects. However, any side effects that might occur usually happen in the first two weeks and then resolve. Patients need to understand that if side effects occur, dosages can be adjusted or medications changed.

Effects of additional stressors

Refugees need an understanding of the role of current psychosocial stressors in increasing symptoms. Most refugees have the expectation that once they are in the United States their problems will be eliminated. This is because of the perception that the U.S. as a safe place with many opportunities. Many trauma survivors are therefore dismayed to find that their psychological and physical symptoms often are worse during their first few years in the US because of the additional stressors of rebuilding their lives in a new place. Examples of stressors of acculturation for refugees include:

- Worries about family back home
 - Loss of previous social status
 - Changes in family members' roles (e.g., children adopting American value of independence; wife now working outside of the home)
- Learning a new culture and possibly a new language
 - Lack of social and family networks
 - Financial and work difficulties
 - Concerns about their legal immigration status

Trauma, stress and somatic symptoms

Traumatized refugees frequently complain of unexplained pain and physical symptoms for which an organic cause cannot be found. A full examination is needed to rule out physical illnesses, but many times such somatic symptoms have an emotional origin in trauma. Presenting with somatic symptoms can also be a more culturally appropriate way of seeking help. Yet most refugees have survived tremendously difficult situations. Their unexplained pain and physical symptoms may be directly related to prior experiences of starvation, malnutrition, tropical infectious diseases, head injury, physical assault, or other untreated chronic illnesses.

Refugees benefit from awareness of connections between psychosocial stressors, pain and physical symptoms. With education and guidance survivors can learn to correlate these somatic symptoms with emotional trauma and stress. Knowing that with time,

as they begin to feel better emotionally their physical pain may also lessen. Refugees with chronic pain may benefit from physical therapy, massage or other physically based treatment modalities.

Facilitating appropriate grieving

Many traumatized refugees have had loved ones killed, or are separated from family members. During the flight to safety there may not have been time for refugees to bury their dead in culturally appropriate ways or mourn for them. Survivors can benefit from education on the grieving process and by being given encouragement to mourn all the losses they have endured. Health care providers need to learn the culturally appropriate means of dealing with grief and loss in the refugee's culture. This can be discovered through questioning patients and family members. Such information can be useful in determining when grieving has become inappropriate and the individual needs assistance.

Successful trauma treatment methods

Trauma survivors can benefit from learning about the variety of treatment methods that can help their recovery. Primary care health

providers can assist survivors in determining which treatments may be beneficial for them.

A wide range of psychological therapies are often available to assist refugees in gaining better control over their anxiety or fear, in reframing their trauma-related experiences, and with reintegrating back into stable social networks. The services of social workers or social service organizations can also be helpful in assisting refugees with English language classes, job and school counseling, insurance and financial issues, housing, and resources for obtaining food. Psychotropic medications may be beneficial for refugees who are very symptomatic. Antidepressants are often helpful for symptoms of posttraumatic stress disorder, depression and anxiety. Occasionally, use of additional targeted sleep medications is needed.

With understanding about how current difficulties with functioning may relate to past traumas, and gradual encouragement to take advantage of available mental health treatments, refugees and their families are often willing to engage in more significant treatment despite existing stigmas.

III. Self-coping strategies for trauma survivors

In addition to gaining an awareness of the effects of trauma, survivors benefit from learning strategies that they can use to help themselves. These self-coping strategies include:

- Rediscovering innate resiliency
- Participating in physical exercise
- Experiencing relaxation techniques
- Practicing spirituality and religion
- Recreating meaning in life
- Finding employment and hobbies
- Strengthening social connections
- Minimizing maladaptive coping
- Limiting exposure to trauma reminders

Rediscovering innate resiliency

Most survivors were competent, well-functioning individuals prior to their trauma. It is helpful for trauma survivors to reflect on their strengths and past achievements. Focusing on strengths rather than deficiencies enhances healing. Similarly it can also be helpful for clinicians to learn about patients lives before the trauma. One of the most important aspects of healing from trauma involves survivors shifting their attention

from the traumatic events to a focus on the present and planning for the future.

Working toward future goals and having a sense of control over life are important aspects of healing from trauma.

Physical exercise

For many refugees from developing countries, physical exercise was a part of daily life. People walked many miles each day and performed heavy labor routinely. In the U.S., physical exertion is not as much a part of daily life. As a result, refugees in the U.S. frequently do not have the level of physical activity that they previously had.

Health care providers can educate refugees on the benefits, physically and mentally, of daily exercise. For those suffering the effects of trauma, physical exertion can be beneficial in facilitating recovery. Refugee trauma survivors who are physically active have reported improved sleep, better energy level, increased mood state and a better overall sense of well-being.

Relaxation techniques

Learning relaxation techniques can be

helpful in coping with trauma symptoms. Such techniques can help to reduce anxieties from distressing memories, and promote a sense of well-being. Numerous informal relaxation strategies can help. Examples include taking walks, gardening, caring for pets, drinking tea, burning incense, taking a warm bath, or listening to music. There is no end to the variations and combinations of natural relaxation strategies. Health care providers can encourage trauma survivors to discover what activities are calming and help them to deal with stress.

During periods of excessive stress breathing exercises, use of imagery, progressive muscle relaxation, or yoga, can be helpful in reducing anxiety. There are many relaxation tapes available that health care providers can provide or recommend. Health care organizations can have relaxation tapes, translated by interpreter staff, available for survivors.

Spirituality and religion

Trauma survivors overwhelmingly attribute their survival and ongoing personal strength to their spiritual and religious beliefs. However, at the same time they may question why such events were allowed to occur. Human responses to pain, suffering,

and loss are central themes of most of the world's religions. Many survivors find that religious or spiritual practices are powerful means of healing from trauma and in coping with trauma symptoms. Attending formal services, meeting with religious leaders, reading passages of holy books, and listening to religious tapes have all been reported as beneficial in coping with trauma symptoms. Health professionals can support and encourage refugees' practices of religion / spirituality.

Recreating meaning in life

Trauma and suffering often create a loss of meaning in life. Beliefs of safety in life and the goodness in other humans may have been shattered. Health care providers can play an important role in encouraging survivors to seek ways to recreate meaning in life. Holocaust survivor Viktor Frankl (1963), wrote in *Man's Search for Meaning*, that for anyone to truly recover from horrific trauma they must find a deep sense of purpose and meaning in life. In those so inclined,



Buddhist healing ceremony (BBC)

creative activities such as painting, drawing, writing, or poetry can be helpful both in expressing feelings and conveying past experiences. Volunteerism, political activism, giving talks on their experiences, or helping to ease the suffering of others are examples of ways that survivors can begin rebuilding a sense of purpose in life.

Employment and hobbies

Initially, refugee trauma survivors may find it difficult to tolerate the demands of the workplace. Health providers can reaffirm work as a way to provide daily life with structure. Without the routine of having to get up at a certain time and having to be at a certain place, people often feel more disconnected from the world. Survivors who are not working may have too much time available in the day for thinking of their losses and suffering. Work and hobbies can also provide survivors with a sense of purpose in life and offer opportunities for socialization.

Although there are occasions where short-term disability can be helpful in recovering from trauma or unexpected psychological setbacks, prolonged disability status is generally not helpful to long-term recovery from trauma.

Strengthening social connections

Developing and maintaining healthy relationships with others is essential to recovery from trauma. However reconstructing such relationships is often difficult for trauma survivors. Their trust in other human beings has often been damaged by horrific experiences. It can be frightening to try and trust others, especially strangers, again.

Most refugees are used to living with extended family members. Here in the United States many survivors are separated from remaining family members while others may have been killed. Because of cold weather, language differences, the nature of housing in the U.S., and transportation problems there are often less natural opportunities for social interaction compared with their home country.

Health care providers can be helpful by reminding survivors of the importance of recreating or maintaining healthy social connections in recovering from trauma. Trauma survivors' family members, if possible, also need to be included in the individual's recovery from trauma. Community support groups and refugee

organizations can sometimes be a useful starting point.

Minimizing ineffective coping

Survivors will sometimes use alcohol or street drugs to help with sleep and anxiety symptoms. Initially this can seem helpful, but often becomes a separate equally severe problem. Long-term recovery from trauma is hampered by the use of alcohol and street drugs.

Chewing the leaves and stems of the mild amphetamine khat is viewed by many East African refugees as benign when used as part of the traditional socialization groups. However, in countries of resettlement, khat addiction has been observed when people use the substance outside of traditional social contexts and with increased frequencies. Such use should be discouraged.

Isolation from others as a form of coping is commonly observed among trauma survivors. This strategy has progressively destructive effects through limiting opportunities for positive interactions that might change feelings of mistrust, as well as

through allowing increased time to brood over past experiences.

Limiting exposure to trauma reminders

Symptoms experienced by refugee trauma survivors commonly become reactivated after a reminder of their trauma, or when stressed. After the events of September 11, 2001, for example, some trauma survivors felt a renewed sense of insecurity and experienced an increase in symptoms. Many survivors may feel compelled to watch excessive amounts of television coverage of current events in their home country, which are often upsetting. Continual re-exposure to news or even violent movies can be harmful to many survivors by reactivating past trauma memories. Health care providers can assist refugees by advising them to limit their exposure to media containing violence.

See Appendix B for a patient educational sheet on self-healing strategies that can be utilized with trauma survivors.

IV. Case study

Mrs. M.'s Story

Mrs. M. is a 42- year- old married female originally from Somalia, who receives health care at a local community clinic. She frequently comes to the clinic with complaints of headaches, body pain, indigestion, and tachycardia. Extensive work-up has revealed no medical explanation for her symptoms. Medications provide little relief. Mrs. M. appears frustrated with not being told what is causing her symptoms and this, in turn, frustrates her physician. She has missed several appointments despite having urgently requested to be seen. Her physician has become apprehensive about upcoming clinic visits and tries to schedule them as far out as possible.

Mrs. M. had not spoken much about her experiences in Somalia or as a refugee other than to say she was fleeing the civil war. Upon further questioning by her primary health care provider Mrs. M stated that her house was looted by rebel groups prior to fleeing the country. During that time her family was held at gunpoint while valuables were taken from the home. At the same

time, two rebel boys took her younger daughter into the next room and presumably raped her. Mrs. M. could hear her screams but could do nothing to help her. Mrs. M. became tearful, and said “bad things happened in the refugee camp, too.” The physician empathized with her during the story, and helped redirect her focus toward her strengths and what helped her survive such experiences. The physician also explored the possibility of talking in more depth about her experiences with a mental health professional. She was reluctant to do so at that time.

Mrs. M's physician then took some time to review common symptoms that trauma survivors may experience, and asked whether she had experienced any of them. She identified with many of the symptoms. The physician eventually steered the conversation toward self-coping strategies and various treatments available to her.

Mrs. M. stated that she was a devote Muslim and that her beliefs were her most important means of coping with these experiences. However, she was interested in learning

about other ways of easing her suffering. Mrs. M. said that she had been working hard to forget the terrible things that happened, and re-build a life for her family. Mrs. M. shared that she had thought many times recently that she was “going crazy.” The physician reassured her, that she was not crazy, and that her symptoms are a natural human reaction to the terrible events she had lived through. Mrs. M. appeared visibly relieved. An extended follow-up appointment was scheduled with a clinical nurse specialist.

Mrs. M. continued to meet periodically with the clinical nurse specialist to review her progress in implementing some of the self-coping strategies. She continued to have difficulties attending appointments on time despite reminder calls. She reported that when in distress she would call to make an appointment, hoping she could be seen that same day. Often however, by the time her appointment came around, she was feeling better and did not want to take un-paid time off from work for the appointment.

Several months later, after the September 11, 2001 terrorist bombings in New York, Mrs. M. began to have even more symptoms of posttraumatic stress disorder. Mrs. M.

stated that the pictures of New York City reminded her of what Mogadishu looked like when they fled. Her chronic insomnia and nightmares caused her to miss a great deal of work and she was functioning poorly on the job. She received several warnings from her employer that her job was in jeopardy. Mrs. M. was frequently irritable and easily angered by her husband and children. Her relationship with her family was becoming increasingly strained.

Mrs. M. agreed to meet with the mental health specialist who had an office in the community clinic two days a week. After a full evaluation, Mrs. M. was prescribed a combination treatment consisting of a selective serotonin reuptake inhibitor (SSRI) antidepressant and several weeks of psychotherapy. Initially, Mrs. M. learned to relax through imagery and progressive muscle relaxation exercises. She progressively became more aware of how her trauma-related reactions were contributing to difficulties with family members and problems at work. Her sedating antidepressant improved her sleep, but she discontinued taking the medication because of nausea and headaches. Mr. M. remembered being told of these possible side effects however, and called the clinic.

After a conversation with her doctor, Mrs. M. was instructed to decrease the dose of medication, but reminded of the importance of daily dosing. She was able to stay on the medication and eventually tolerated a therapeutic dosage.

After several weeks of combined treatment with psychotherapy and psychotropic medication her symptoms began to

progressively decrease and her work and family life gradually improved. She was also able to gain increased insight into the relationship between stressors and her physical complaints, pain and panicky feelings. This awareness, along with new skills for coping with symptoms, allowed Mrs. M. to better manage her chronic symptoms and experience fewer crises.

V. Barriers in treating trauma survivors

Several areas have been identified in terms of health care organizational structure and services that can improve the willingness of trauma survivors to access appropriate treatments.

Incorporating mental health services into primary care

Refugees are often reluctant to seek mental health services despite gaining insight into their troubles because of the social stigma around mental illness. Many primary care clinics are beginning to incorporate mental health services into their clinics. Trauma survivors may have less resistance to mental health care when these services are in the same location as and not differentiated from other health care.

Walk-in appointments

In many countries, health care visits are not scheduled in advance. People will travel to the health care provider on the day they wish to be seen, arriving as early as possible, and wait for an appointment. Despite sometimes having to wait many hours before meeting with a health care worker, patients at least know they can be seen on the day when their

symptoms or concerns are greatest.

Health care clinics in the U.S. that treat large numbers of refugees are beginning to accommodate same-day patient visits. Two models of accommodating walk-in appointments can be utilized by clinics: there can be designated times each week for staff to be available for same-day visits; or, staff members may have some slack time built into their daily schedules, enabling them to accommodate same-day visits.

Evening hours

The availability of evening hours for health care appointments is important for many refugees. In many low paying jobs, employees cannot take off from work without losing pay or putting their employment at risk.

Time for patient education

It may be helpful to allot 45 – 60 minutes for providing trauma-related health education to survivors in the primary care setting. Having a designated staff member conduct patient education sessions, as is commonly done with diabetes education, can be useful.

Educational time may be done in one session, or divided into several sessions.

Lack of physical treatment modalities

Increasingly, clinics treating refugees are recognizing the benefits of physical modalities such as physical therapy and massage therapy in helping with chronic pain.

Community referrals

Establishing long-term relationships with staff at local refugee community organizations can sometimes provide primary care staff with additional referral resources. Staff in such community organizations can also be a source of information for providers when they need expert or inside information pertaining to a particular cultural group. Some mutual assistance associations have developed their own educational and supportive groups for a particular community.

Minimizing potential stressors

Routine events in a clinic or hospital such as electrocardiogram testing for a survivor of electrical torture, or a gynecologic exam for a rape survivor can be severely stressful. Additionally, unexpected loud noises can sometimes trigger an exaggerated startle

response in survivors. If given emotional support and prior education on what to expect many refugees can endure tests and procedures without being severely stressed. For others, some procedures are best done under anesthesia.

Sensitivity to gender issues is also important. Women who have experienced sexual assault may prefer female providers, especially for gynecological care. Moreover, some refugees who were persecuted by members of their own cultural group may be more comfortable with health care providers from a different cultural group. Furthermore, trauma survivors may experience a temporary increase in trauma symptoms after telling their story, or during certain medical procedures. Fortunately symptom exacerbation is generally temporary.

Using interpreters

Not being able to communicate with health care providers is a major barrier for refugees. Health care providers need the services of trained interpreters to accurately convey medical and psychiatric concepts. Using family members to interpret for trauma survivors is not recommended.

Providers need to keep in mind that although

an interpreter may speak the same language as the survivor, there are other factors that may interfere with the development of a trusting relationship between the patient and the interpreter. It is best if the same interpreter is used for all of a refugee's health care appointments. Lack of trust between the interpreter and survivor will diminish the refugee's willingness to talk openly with a health care provider. Factors that can affect the development of trust include membership in different ethnic groups that have been adversarial prior to arrival in the U.S., gender differences, age differences where a much younger person is interpreting for an older person, and class differences in the home country.

Childcare assistance

For many refugee women, lack of childcare during health appointments prohibits them from receiving care in anything but emergency situations. Helping them to problem-solve around these issues can sometimes be useful. Some clinics have found it helpful to provide childcare, or to contact a community organization that may have childcare available.

Transportation difficulties

Lack of transportation is a common issue. It

is very difficult taking the bus to appointments, especially with children, in the winter, or when in pain. Health care providers can explore community programs and health care plans to locate alternative transportation. Some health care plans will pay for taxi rides to and from medical appointments. Some communities also have programs for medical appointment transportation. Religious groups can also be a source of volunteers to provide transportation to appointments.

Mental health costs

The cost of mental health services may be prohibitive to refugees. Health care providers need to know of therapists in their area that might accept refugees on a sliding-scale fee structure.

Assessment of refugees

Refugees usually want to know what is wrong with them physically, what symptoms they can expect will improve, and what symptoms they should learn to live with. The recommended medical assessment of all refugees includes:

- History and complete physical exam, including genitourinary system
- Skin test for tuberculosis and/or chest x-ray

- Vision and hearing screening
- Dental evaluation
- Stool for ova and parasites
- Urinalysis
- Hemoglobin
- Cholesterol
- Serological test for syphilis
- Hepatitis B screening tests; possibly hepatitis A and hepatitis C screening tests
- Explanation of and offer of HIV testing
- Explanation of and offer of STD testing other than syphilis
- Immunization assessment
- Thyroid function testing in some cases

Furthermore, health care providers need to keep in mind the major infectious diseases present in the refugee's country of origin, the prevalence of rape among refugees, and practices of traditional female cutting (female circumcision) in many cultural groups.

See Appendix A for assessment questions to detect a history of torture that can be utilized with patients.

VI. Summary

In summary, health care providers in the primary care setting have the greatest opportunity for impacting both the physical and mental health of refugee trauma survivors. Through knowledge of the physical and emotional effects of trauma, skills in identification of trauma survivors, routine provision of timely trauma-related health education, discussion of self-coping strategies, and the application of basic treatments, primary care providers can do much to alleviate their suffering. Furthermore, by understanding the many barriers faced by refugees in obtaining both physical and mental health treatments, providers can facilitate changes in clinic systems to address these barriers.

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VIII. Appendices

Appendix A: Assessment Questions for Refugee Trauma and torture

(These can be incorporated into the standard assessments that providers normally use with new patients.)

1. In what country were you born?
2. What cultural group or tribe do you come from?
3. Can you tell me what made you leave your country?
4. Have you ever had problems because of your culture or tribe?

your political beliefs?

your religion?

your gender?
5. Have you even been arrested or put in jail?
6. Have you ever been beaten or attacked by soldiers, the police, or rebel groups?
7. Have you ever seen or heard others being beaten or attacked?
8. Have any members of your family been arrested or attacked because of their culture/
tribe, political beliefs, or religion?
9. (If history of torture or trauma). What problems are you having now from being beaten or
attacked?

Appendix B: Self-Healing Strategies for Survivors

Things you can do to help heal yourself

Getting help from a health care provider is an important way to heal from the problems you have because of the difficult times you have lived through. There are also many things you can do for yourself.

Here are some things that you can do to help feel better:

- Think about what things you were good at before the problems began and how you can use these skills again in re-building your life. Instead of just looking back on all that you have lost in life, also think of how you want the future to be in your life.
- Do some kind of exercise every day such as walking, riding a bicycle, working in a garden, or playing sports.
- Try to eat foods similar to the foods you ate in your country and avoid American fast foods like hamburgers, potato chips, cookies, and cake.
- Think of ways to help yourself relax. Some people like to walk near a lake, work in a garden, listen to music, or drink a cup of tea. When you are thinking too much about your problems, try to do something that is relaxing to you.
- Many people find that going to a church, temple, or mosque helps them to deal with their problems.
- Try to find ways to meet new people, either from your own group or from other groups. Being alone too much of the time is not good.
- Avoid drinking a lot of alcohol or using drugs. People sometimes use alcohol or drugs to help them feel better, but this can often cause more problems.
- Try not to watch a lot of television that shows pictures of war or violence. Watching violent programs can make you feel worse.