HEALTHCARE FOR RESETTLED REFUGEES: BARRIERS, RECOMMENDATIONS, AND TWO THEORIES FOR APPLICATION

By

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Abstract

Refugees in the United States present a unique set of circumstances for their medical providers. This paper will overview the complex process for admission to the United States and the unresolved trauma that many refugees experience. It will discuss the barriers to achieving adequate healthcare experiences for refugees: language, health literacy, transportation, gender issues, provider cultural competency, and communication about trauma. These barriers confound each other and create a multidimensional challenge for refugee patients in the U.S. For this reason, this paper also explores current recommendations for providers. Finally, I will argue that employing the ideas in “The Danger of a Single Story” and Narrative Medicine will have positive impacts on the way refugee patients experience U.S. healthcare.

General Overview: What is a Refugee?

A refugee is often thought of through the lens of a single story. Some common misconceptions include uneducated, unmotivated, and unwilling to adhere to American culture. Many Americans think resettlement of refugees to the United States is unsafe. Refugees belong to a group whose existence is connotated. Contrary to this misperception, refugee stories and experiences are unique. When we generalize all refugees to one category, we reduce their individual lives and stories to one common narrative. Their personal story of trauma and resilience is negated for the misconceived story of the group.

However, in order to be legally defined as a refugee, these individuals must meet the criteria set forth in the 1951 Convention Relating to the Status of Refugees. The convention
states that a refugee is “someone who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of particular social group or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country” (Article 1, Convention Relating to the Status of Refugees, July 28th, 1951). This is distinct from asylum-seekers, who have also fled their home country for similar reasons and are seeking international protection, but have not been legally recognized as a refugee (“Migrants, asylum seekers, refugees”, 2018). The United Nations High Commissioner for Refugees (UNHCR) is the agency tasked with the protection of refugees. Once a person has achieved the status of “refugee”, they often spend many years, even decades, in a refugee camp. These temporary camps, created by the UNHCR, have the goal of providing protection to those people who have fled their home countries. They provide basic shelter, including tarps and tents to protect from exposure, but also to “help restore their personal security, dignity, and privacy”. Refugee camps provide refugees with necessary supplies such as clothing and hygiene items. They provide food with the intention of nutrient-rich ingredients that is necessary for vulnerable individuals, and clean water for drinking and bathing. Refugee camps also ensure access to medical attention. Lastly, registration as a refugee under the UNHCR is absolutely necessary for a refugee to obtain documentation and protection. Often, this registration is key to making sure families remain unseparated. (“What is a Refugee Camp?”, 2020). The focus of this thesis is healthcare for refugees. However, the following background information provided is necessary for a complete understanding of the complex processes experienced by a refugee prior to U.S. resettlement.
Refugee Resettlement Process Overview

The United States has resettled three million refugees since 1975, making it the world leader in refugee resettlement. In 2018 alone, the U.S. accepted 22,900 refugees. After a person has been designated a refugee and has been assigned the United States as their destination country, the process for U.S. resettlement can take up to two years with screening from eight U.S. governmental organizations. This process involves six separate screenings through U.S. security databases, a health screening, and three interviews with federal agents representing the Department of Homeland Security. (“Refugees in America”, 2020) For the United States Citizenship and Immigration Services (USCIS) to consider an individual an official refugee, they must obtain a referral to the U.S. Refugee Admissions Program (USRAP), a multiorganizational commitment of U.S. and non-U.S. agencies. The USCIS department lists three “processing priorities” for refugees:

- “Priority 1: Cases that are identified and referred to the program by the United Nations High Commissioner for Refugees (UNHCR), a United States Embassy, or a designated non-governmental organization (NGO).
- Priority 2: Groups of special humanitarian concern identified by the U.S. refugee program.
- Priority 3: Family reunification cases (spouses, unmarried children under 21, and parents of persons lawfully admitted to the United States as refugees or asylees or permanent
residents (green card holders) or U.S. citizens who previously had refugee or asylum status). (“The United States Refugee”, 2009)

When one is fulfilled, the applicant is not automatically accepted, but rather obtains help with filling out their application (without fee) and an interview with a USCIS officer, who will determine refugee status eligibility. (“Learn About the Refugee”, 2009). The USCIS states that this determination is on a “case-by-case basis” and is “non-adversarial”. The officer will listen to testimony while considering the context of the home country with the goal of determining if the individual:

- “qualified under a designated processing priority.
- meets the definition of a refugee.
- is not firmly resettled in a third country.
- is otherwise admissible under U.S. law.”

It is important to note that the USCIS takes into account the individual’s “credibility” when making its determination. (“Refugee Eligibility Determination”, 2009)

The USCIS also performs numerous security screenings and background checks. This information is important to note, as many common misconceptions regarding refugees resettled in the U.S. involve their danger to the U.S. public. In reality, the security screenings performed by the USRAP are extremely thorough. First the U.S. Department of State (DOS) performs a CLASS name check to screen for criminal histories, immigration infractions, and other items. The USCIS interviewer includes any findings in their report and uses this in determination of refugee status. Another part of the preliminary screening process that occurs prior to the USCIS
interview is a Security Advisory Opinion (SAO) check, conducted by the Federal Bureau of Investigation (FBI). The final component of pre-screening prior to the USCIS interview is the Interagency Check (IAC), which was implemented in 2008, and involves biographic data that is provided to partner agencies such as the National Counterterrorism Center (NCTC). Additionally, the applicant’s immigration and travel history is screened when they are registered in the DHS Automated Biometric Identification System (IDENT). Lastly, the Department of Defense performs a biometric check which further screens applicants from territories where the DOD has formerly or presently had “significant military presence”. Once the USCIS has approved the refugee applicant, the U.S. Customs and Border Patrol (CBP) performs a final screening process and background check. After this final stage, they may be allowed to cross the U.S. border with refugee status. (“Refugee Processing and Security”, 2018). As demonstrated, the U.S. screening process for refugees seeking American resettlement is thorough and has expanded over the past two decades.

After the USCIS has approved a refugee for resettlement the U.S. State Department’s Bureau for Population, Refugees and Migration (PRM) assigns a refugee to one of nine resettlement agencies (“The U.S. Refugee Resettlement”, 2015). This point is a key difference between an individual of refugee status and an asylum seeker. An asylum seeker arrives at their own will and is not offered a partnership with a non-profit resettlement agency. The resettlement area for a refugee is determined by these agencies, who take into account family in the area, as well as availability of community services and opportunities for employment. The resettlement agency will place the refugee with a local affiliate for services. These include transportation to housing, help with social security, language services, and important to this thesis, scheduling
initial medical appointments. (“Reception and Placement”, n.d.) It is important to note that after six months of resettlement, refugees must begin payments to reimburse the U.S. government for their travel costs (U.S. Committee, n.d.).

The above information is pertinent to understanding the process an individual goes through to obtain refugee resettlement in the United States. However, the focus of this thesis is healthcare for refugees, from in the camp to years after U.S. resettlement.

**Refugee Resettlement: A Focus on Healthcare**

Refugees in the United States present a unique set of circumstances for their medical providers. However, before acceptance to the U.S. they must successfully complete an initial health screening performed by physicians under the Center for Disease Control (CDC). (Eckstein, 2011) A variety of conditions may prevent a refugee from being resettled to the U.S. such as syphilis, gonorrhea, leprosy, and tuberculosis, which are considered “communicable diseases of public health significance” by the CDC. As of 2017, a Presidential Executive Order listed quarantinable diseases that would also prevent acceptance as: “cholera, diphtheria, infectious tuberculosis, plague, smallpox, yellow fever, viral hemorrhagic fevers, severe acute respiratory syndromes,” and pandemic flu. Other diseases such as polio that are currently listed as a public health emergency of international concern (PHEIC) may prevent approval as well. Refugee applicants are also screened for vaccine-preventable diseases such as hepatitis A, meningococcal disease, and mumps, measles, and rubella. (“CDC- Medical Examination”, 2017) The CDC recommends that the accepting country complete additional domestic health
screenings. In the United States, these are performed by the health department in partnership with private physicians in each individual state. (Eckstein 2011).

Resettled refugees see a physician for a multitude of concerns. The most common presenting problems for refugee patients in primary care settings are: chronic pain, musculoskeletal problems, infectious diseases, mental health complications, social health problems that affect their care, and other chronic diseases also common to the general U.S. population.

One of the biggest challenges when discussing the U.S. resettled refugee population is how to make accurate generalizations for research purposes without disregarding the genuine and significant differences between distinct refugee populations within the U.S. Each geographic, ethnic, and cultural group have had distinct experiences unique to them. Refugee patients come from many cultures, but they collectively have shared experiences with trauma. (Eckstein, 2011)

For the purposes of this literature review, I define the word “trauma” as a “psychological, emotional response to an event or an experience that is deeply distressing or disturbing” (“Refugees in America”, 2020).

There are many examples of specific trauma that affect refugees including: sexual assault, forced labor, war, torture, lack of food, water, or shelter, loss of loved ones/separation from family, and loss of community, physical injuries, infections, or diseases without medical care, and lack of access to schools. Refugees may also experience trauma after they have escaped their home countries such as detention, stresses of living in a refugee camp, harassment by authorities, traveling by foot and others. The National Child Traumatic Stress Network has listed four “core stressors” that affect refugee children specifically: traumatic stress, resettlement
stress, acculturation stress, and isolation stress. They relate traumatic stress to a specific event such as war or family violence that often occurs before resettlement. The resettlement stress category can be any number of items that occur during the resettlement process like difficulty finding community resources or transportation to work and appointments. Acculturation stress begins during resettlement and can continue throughout the refugee’s life. Often a resettled refugee may have difficulties assimilating the culture and values of American society with those from their country of origin. Finally, isolation stress is the result of “experiences as minorities in a new country” and can include the basic struggle of fitting in or “loss of social status” as well as tangible harassment. (Griffin, 2018)

**Refugee Healthcare: Trauma and Health Outcomes**

What does a high rate of trauma for this population mean for refugee healthcare? Literature throughout decades has made the connection between traumatic experiences and adverse health outcomes. In particular, a tremendous volume of literature exists that establishes the connection between adverse childhood experiences (ACEs) and higher risks of diseases later in adulthood which contribute to earlier mortality. An ACE is defined as a “potentially traumatic event” (“Preventing Adverse Childhood”, 2020) and can be any number of experiences such as sexual abuse or being a witness to violence.

The landmark study exploring this connection was the CDC-Kaiser Permanente ACE study titled “Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults”. Researchers surveyed 9,508 people for ACEs after a
standard medical examination at one health maintenance organization (HMO). Their findings show a significant connection between traumatic events in childhood and disease risk in adulthood. There was a positive correlation between the number of adverse childhood experiences and conditions in adulthood including “ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease.” In particular, “persons who had experienced four or more categories of childhood exposure, compared to those who had experienced none, had 4- to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt; a 2- to 4-fold increase in smoking, poor self-rated health, ≥50 sexual intercourse partners, and sexually transmitted disease; and a 1.4- to 1.6-fold increase in physical inactivity and severe obesity” (Felitti, et al., 1998). These findings represent a significant connection between trauma and pathophysiology.

Other studies performed after the CDC-Kaiser Permanente research confirms this connection. A study from Kathleen Kendall-Tackett from the American Psychological Association found that “People who have experienced traumatic events have higher rates than the general population of a wide range of serious and life-threatening illnesses including cardiovascular disease, diabetes, gastrointestinal disorders, and cancer” (Kendall-Tackett, 2009). The mechanism of this connection is rooted in the physiology of what trauma does to body processes. When a person undergoes trauma, the sympathetic nervous system, which is the key player in a person’s involuntary response to environmental stress, becomes dysregulated. Recent research has also shown that the body’s natural inflammatory response is disrupted during extensive trauma, and will lead to health problems later in life. Kathleen Kendall-Tackett explains that a traumatic event will train the body’s inflammatory response to be quicker- an
event referred to as “priming”. Thus, in future life stressors, not deemed “traumatic”, this inflammatory response is quicker. The connection lies in the fact that many chronic diseases can be caused by an increase in inflammation. (Kendall-Tackett, 2009)

It is estimated that as many as 35% of resettled refugees are survivors of torture. Similarly, 30.6% live with post-traumatic stress disorder and another 30.8% with depression. (Shannon, 2014) It is reasonable to conclude that the resettled refugee population, who may have experienced more traumatic events than the native U.S. population, would be at an even higher risk for negative health outcomes.

**Barriers for Healthcare**

It is clear that refugees resettled to the United States experience a unique set of circumstances that affect their health and many barriers are present that prevent refugees resettled in the United States from achieving adequate healthcare. Some of these are difficulties with cross-cultural medicine, inadequate health insurance, a maze of different systems of service (lack of health literacy), and language and communication problems (Eckstein, 2011; Mirza, et al., 2013). Often these barriers compound each other, leading to difficulty in analyzing the independent effects of each barrier.
Language Barriers

It is a federal law that all providers who see patients with federal payers are required to have translators present for patients when needed (Eckstein, 2011). However, this does not prevent language barriers from affecting refugee healthcare. In fact, language appears to be one of the most prevalent barriers. In a 2009 study published by the Journal of Community Health, researchers interviewed 40 informants consisting of resettled refugees, healthcare workers, and members of refugee resettlement agencies in San Diego County. They found that “language and communication affect all stages of health care access-from making an appointment to filling out a prescription” (Morris, et al., 2009). All 40 interviewees identified language as a key barrier, with many identifying it as the most prevalent. Although physicians are mandated, in theory, to provide interpretation services for their refugee patients, this proves less simple in practice. Employees of resettlement agencies recognize that it is the provider’s responsibility to provide interpretation services, however they cite growing need for their interference in this task. In fact, half of the interviewees in this study said that “clinics do not follow through on this responsibility.” With decreasing resources allocated to refugee serving agencies, many find it difficult to provide interpreters. Many refugee patients in this study reported that they almost always use friends or family members as their interpreters. This practice presents another layer of communication problems as friends or family are often prone to misrepresentation of information and confidentiality problems in the medical setting.

Through these interviews, the Journal of Community Health elucidated that language barriers not only prevent effective doctor-patient communication, but also affect healthcare
utilization, with some interviewees citing that refugee patients will often sacrifice quality of care for a provider who speaks their native language. They also cite a systemic problem where refugee patients only seek care in the emergency setting. This discontinuation of necessary steps for proper healthcare management is often due to continued frustration. Most interviewees in this study reflected this idea from a former refugee, “a lot of times refugees will get so frustrated that [they don’t] bother going to the doctor unless something is really seriously wrong” (Morris, et al., 2009). When this is the case, all preventative health measures are discarded, contributing to chronic disease. Evidence of this is shown in the fact that, as a result of a combination of factors including language barriers, refugees are screened for cancer less often than native-born Americans (Jackson, et al., 2016).

It is important to note, as the Journal of Community Health points out, that language barriers are highly dependent on the community and culture a refugee belongs to. For example, refugees placed in a more established ethnic community within their resettlement location may have less difficulty with this barrier. (Morris, et al., 2009)

**Health Literacy Barriers**

The American healthcare system is undoubtedly difficult to navigate, even for native born citizens. From insurance complications, to follow-up appointments, to medication instructions, Americans find it complicated to keep track of how to best manage their health concerns. When a refugee patient is unfamiliar with these processes, compounded with struggles with the English language, the barrier of health literacy affects their care. Of significant note is
the fact that, while refugee resettlement agencies help with transportation, housing, employment searches, and other services, the responsibility of navigating the U.S. healthcare system often falls solely on the refugee (Gilmer & Turnbull, 2018).

In a comprehensive overview of problems for refugee patients, Dr. Barbara Eckstein sheds light on the health literacy barrier. She cites the example of medication refills. Many refugee patients, because of language barriers and a natural misunderstanding of pharmacy practice, assume that a medication may be complete when it actually requires many refills for long-term use. (Eckstein, 2011) This misunderstanding is propagated by the lack of interpretation services available at pharmacies (Morris, et al., 2009). Additionally, Dr. Eckstein highlights a key issue regarding insurance compliance: many states require a reapplication for Medicaid annually. This leads to a significant “lapse in insurance coverage” as refugees may be unaware of the reapplication deadline or cannot complete the reapplication. (Eckstein, 2011)

Christin Gilmer and Nancy Turnbull’s research found that the system of referrals that the American healthcare system relies on is extremely unfamiliar to refugees (Gilmer & Turnbull, 2018). In their home countries, people usually show up to one doctor and wait in line for services (Eckstein, 2011). The idea of subspecialists who require referrals is often confusing for refugee patients. Gilmer and Turnbull interviewed a former refugee, now interpreter in Tucson, AZ, who detailed their confusion during this process. The informant described the common situation of seeing a primary care physician, who writes a referral to a specialist, where the insurance needs approval before the appointment. She said that this chain is often not followed through. (Gilmer & Turnbull, 2018) When it is commonly agreed upon by native Americans that the complexities
of the U.S. healthcare system makes it nearly impossible to navigate, this idea is only more
impossible for populations such as refugees.

**Transportation Barriers**

In the same interviews with key informants, Gilmer and Turnbull found that a majority of
interviewees believed transportation to be a significant barrier to healthcare access. Although
refugee resettlement agencies attempt to limit transportation barriers as much as possible by
helping with initial tasks like getting a bus pass and navigating the city, it persists as a significant
challenge. Gilmer and Turnbull specifically discuss transportation difficulties for refugees
resettled in Los Angeles County. They note that many refugees are resettled through agencies in
the Glendale area, but do not actually live in Glendale. Thus, specialist appointments that are
outside the Glendale area are difficult to attend as the refugee patient is unfamiliar with getting
there and transportation in some cases can take up to two hours. Many refugees have family or
community members with vehicles that they rely on for these visits. (Gilmer & Turnbull, 2018)
Still many have to continually navigate the confusing public transportation systems. Gilmer and
Turnbull also found that in Tucson, Arizona, transportation is often cited as one of the three
largest barriers for refugees to healthcare access.
Gender Barriers

When discussing the barriers that limit refugees’ American healthcare experience, of particular importance is the experience of refugee women. While gender barriers can affect any person in a healthcare setting, many refugees come from cultures that have extremely different perspectives on gender than the U.S.. Gilmer and Turnbull’s interviews uncovered that the primary way gender impacts a refugee’s experience with U.S. healthcare is in relation to the woman’s caretaking role. When a family is resettled in the U.S., the primary caretaker of the family often falls on the woman. This presents difficulties in attending doctor’s appointments because of a lack of childcare services. Interviewees in Gilmer and Turnbull’s study also note “shortages of culturally appropriate and/or competent female providers”. They cite the particular difficulty of this barrier when they discuss Islamic refugee women and their discomfort with male physicians. (Gilmer & Turnbull, 2018) Gender-matching in appointments with refugee patients, especially females, is a common theme in the literature. In the same 2009 study as previously referenced, “Healthcare Barriers of Refugees Post-Resettlement”, six out of eight female refugees interviewed placed important cultural and religious importance on seeing a female physician (Morris, et al, 2009). While researchers note this as an easily resolved barrier, it is extremely important due to its prevalence and cultural significance.

Culture Differences and Provider Cultural Competency

How an individual interacts with the very idea of “health” is a product of the culture that formed their worldview. This presents unique conflicts for refugees in the American healthcare
system. Similarly, provider cultural competency is a significant barrier to adequate refugee healthcare that affects almost all other barriers.

In “Healthcare Barriers of Refugees Post-Resettlement” researchers found the concept of preventative care highly affected by a refugee’s culture. As mentioned previously, many refugees only seek medical treatment when their condition is severe, as this is what was custom in their home country. Another cultural difference they found was related to expectations of western medicine. For example, interviewees commonly mentioned that refugee patients often expect doctors to simply cure their condition. The reality of medicine is very different, involving a plethora of interdisciplinary care management plans. When improvements were not seen immediately, some refugee patients lost faith in their doctors as a result of these unmet expectations.

This study also opens up an interesting discussion about the perceived barrier of western medicine from the refugee and provider perspectives. Of the ten healthcare providers interviewed, four said that they believe that a refugee patient’s negative outlook on western medicine is a significant barrier to their care. These interviewees discussed their refugee patients’ reliance on homeopathic remedies as a barrier. However, when refugees were asked about this topic, researchers found that the refugee patients themselves do not see western medicine in direct opposition to their cultural treatments. In other words, these interviewed patients do not see their homeopathic remedies as a replacement to their doctor’s opinion. (Morris, et al., 2009) This presents an interesting contrast of perceived barriers from the two perspectives.

Provider cultural competence is a reoccurring barrier in the literature. While complete cultural competence is virtually impossible, it is important for healthcare providers to make a
determined effort to understand how their refugee patient’s culture affects their health. Gilmer and Turnbull explain that many providers have ignorance about how their patients’ cultural practices impact their health through an example from a physician in Seattle. This interviewee provided the example of caring for Muslim patients during Ramadan. It requires cultural competence to understand how the fasting process might affect the health of a refugee patient with diabetes, for example. (Gilmer & Turnbull, 2018)

Of central importance to this thesis is the fact that it is impossible to generalize cultural differences as a barrier for healthcare as each refugee community experiences a unique interaction with American healthcare.

**Communication about Trauma**

As discussed above, various forms of trauma affect the resettled U.S. refugee population to a high degree. This trauma leads to greater prevalence of a variety of chronic diseases such as PTSD, major depression, heart disease and more. Identifying the risk factors for such conditions often falls on the primary care team, but both physicians and refugees have acknowledged communication problems that prevent these discussions about trauma from occurring (Shannon, 2014).

In a 2012 study for Mental Health and Family Medicine, Patricia Shannon and other researchers interviewed refugee patients in a primary care clinic located in a suburban area. Among their findings, they state that “doctors and patients do not initiate conversation about war trauma”. They found that 64% of interviewed refugee patients have never had a primary care doctor inquire about their experience with and personal relationship to political conflict. When
these patients were asked what prevents them from initiating a conversation about their trauma. They produced three main responses: they will only discuss if the physician initiates the topic, they do not believe their trauma is relevant to their healthcare, and they do not want to relive the trauma through explanation. Other reasons included a lack of time and language barriers.

Perhaps of the greatest significance from this study is the refugee patients’ desire to communicate with their doctors about their personal histories and desire to receive education about the negative health impact of traumatic experiences. According to Shannon, 74% of patients said they “want to talk to their doctors about war trauma.” She also notes that more than half of these “yes” responses were followed by an “if” statement such as “if the doctor asked”. 80% of patients said they were interested in education about how trauma affects their health.

Trauma communication is a barrier composed of the combination of cultural differences, language proficiency, and other aforementioned barriers. Specifically, in Shannon’s study, she found that the two main reasons that refugee patients do not initiate conversations about trauma are the lack of understanding of how trauma interacts with physical health and the cultural phenomenon of strictly believing in the doctor’s authority and only staying on the topics that they initiate. (Shannon, et al., 2012)

In another study, Patricia Shannon and researchers conducted focus group discussions with refugees to further elucidate reasons that prevent refugees from openly discussing their mental health with care providers. She acknowledges that stigma is the most commonly cited reason for these failed or nonexistent discussions. She lists the following reasons for this barrier: “history of political repression, fear, the belief that talking does not help, lack of knowledge about mental health, avoidance of symptoms, shame, and culture”. For example, the history of political
repression means that refugees spent decades unable to speak about their experiences and thus feel uncomfortable finally opening up about them. Many refugees cited that speaking to their doctors was unhelpful because they were interrupted or felt that their doctor did not have the time to listen. (Shannon, et al., 2014)

The barrier of communication about trauma is inextricably wound with the barrier of cultural differences. While the importance of mental health is becoming more widely accepted in American society, this is not always the case for the culture of a refugee. As discussed above, many refugees express interest in learning more about mental health services, but there still exists a widespread and multifaceted lack of understanding about the importance of mental health as well as intense mental health stigma among refugee populations. Researchers in “Healthcare Barriers of Refugees Post-Resettlement” spoke to a former refugee and employee of a resettlement agency who explained that a “mental problem” from the perspective of a refugee is often a term reserved for extreme conditions such as Down’s Syndrome. Many refugees do not think depression or anxiety is a condition that falls under “mental health”. Furthermore, a quarter of refugees interviewed voluntarily mentioned the stigma associated with speaking about mental health issues and trauma. (Morris, et al., 2009)

**Current Recommendations for Providers**

Many scholars recognize the need to improve healthcare for resettled refugees in the United States (Morris [2009], Gilmer and Turnbull [2018], Eckstein [2011], Issacson [2014], Shannon [2012, 2014]). In fact, much of the referenced literature was created with the purpose of supplying up-to-date recommendations for healthcare providers. Although many improvements
can be made in a variety of spaces to impact refugee healthcare, the most pressing recommendations for providers will be discussed.

Language

As discussed previously, language persists as one of the most tangible barriers affecting refugees. Although the complexity of this barrier suggests that more work needs to be done in addition to simply expanding interpretation services, this is a practical starting place to begin mitigating this barrier. Face-to-face interpretation quality improvement is of paramount importance, but many professionals have commented on the ability to improve translation through technology. Increasing the availability of language line services that provide interpretation through the phone or through video-call could alleviate the lack of available in-person translators. The interviewees that participated in the study from the Journal of Community Health also suggested that an increase in English classes for refugees would mitigate language barriers in the doctor-patient setting. These classes would not only improve a resettled refugee’s experience with healthcare, but would also improve their overall acculturation process. (Morris, et al., 2009) Christin Gilmer and Nancy Turnbull have offered a national policy suggestion to directly address language problems for refugees. They suggest implementing a program for refugee medical interpreters at the federal level. They note that some states have similar programs where providers are not mandated to use refugee interpreters. A federal certification program would mean that providers who accept federal funds would be required to hire trained refugee interpreters. They argue that this policy would not only impact medical
situations, but would have positive effects on refugee employment opportunities. (Gilmer & Turnbull, 2018)

Christin Gilmer and Nancy Turnbull acknowledge that speaking generally when using the term “language barrier” is not an efficient way to solve the problem. The complexities brought about by language barriers must be acknowledged. They offer the suggestion that more time be made to accurately understand the nuances of language barriers. (Gilmer & Turnbull, 2018)

Thus, to make tangible improvements in the healthcare experiences of resettled refugees, more research must be devoted to how language impacts doctor-patient interactions and how language problems interact with other common barriers.

Cross-Cultural Medicine

The role of a doctor in American society is expanding as the composition of the United States continues to diversify. Doctors are no longer simply healers; they are increasingly required to be culturally competent advocates for their patients. This role is brought to the forefront of doctor-patient interactions when that patient is a resettled refugee. It is important for providers to understand that each patient’s personal history interacts with their healthcare and their basic perceptions of health and illness.

When considering recommendations for providers concerning cultural competency, Dr. Barbara Eckstein argues that the very notion of “cultural competency” be discarded. Cultural competency at its very literary root implies that someone can be “competent” in the culture of another, often a culture of which they have had little or no experience with. Instead, Eckstein
suggests practicing what scholars now refer to as “cultural humility”. She describes this as the process of respectfully exploring commonalities and differences in the cultures between the doctor and patient. This practice has the possibility of reducing dangerous stereotyping often seen when someone attempts to learn all the details and nuances of another’s personal background. (Eckstein, 2011) Instead of relying on these premature stereotypes to inform an opinion about a patient, cultural humility emphasizes “attentive listening and openness to other cultures” (Isaacson, 2014).

Another simple recommendation is that physicians who work with refugee patients attend local refugee information sessions. For example, in Tucson, Arizona, many resettlement agencies hold “refugee 101” nights that are open to the public and provide basic information about the refugee resettlement process. Through these sessions, a provider can gain a basic understanding of what their patients may have gone through. They may understand the importance of a refugee’s complete situation including housing, acculturation, food access and other factors that directly affect their care. At the very least, attendance at these sessions could foster empathy in the medical setting.

*Communication About Trauma*

Perhaps the greatest improvements in healthcare for refugees can be made in how doctors communicate with them about trauma. As discussed previously, refugees have experienced a level of trauma that may be hard to understand for many native Americans. When this trauma is ignored, it can lead to devastating health outcomes.
Patricia Shannon conducted focus groups with 111 resettled refugees in the United States with the purpose of gathering their advice to physicians about how to ask about mental health concerns. The found four main recommendations that were endorsed by all refugee participants:

“(1) make refugees comfortable
(2) ask about the historical context of symptoms
(3) ask direct questions about mental health distress
(4) provide psychoeducation” (Shannon, 2014).

Shannon argues that making refugee patients comfortable involves establishing a trusting relationship by asking about their life in general and refraining from interrupting. Because refugees have demonstrated interest in discussing the historical context of their symptoms, physicians should ask about their personal histories during the initial visit. One participant in Shannon’s focus groups stated, “Don’t just focus on pain. There are histories that are causing pain. Connect pain to our problems back home, freedom back home, the political issues is one of the causes of depression” (Shannon, 2014). As discussed previously, many refugee patients do not initiate direct conversations with their doctors about trauma and mental health. Because of this, it is the physician’s responsibility to initiate these important discussions that have a tremendous impact on their patient’s care. Refugees recommended that physicians ask direct questions. They offered examples of questions they would be willing to answer in a medical setting: “What kind of life did you have in the refugee camp?” “Do you remember any events in the past that have affected you?”, and “Do you still have fear from the past?” (Shannon, 2014). Finally, by providing an opportunity for education about the physiological effects of trauma and
mental health management, refugee patients may be empowered to make their mental health and healing a priority in their medical care. (Shannon, 2014)

In addition to the four main categories of recommendations provided by all refugee participants, Shannon also found that many focus group members suggested using the family of the patient as an ally. Specifically, Somali refugees stated that many patients will be more receptive to mental health interventions if someone from their community and culture also agrees with the provider. (Shannon, 2014)

While these recommendations for asking about trauma and mental health may appear simple in theory, the complexities of these conversations makes the reality much more difficult. Physicians may need special training in caring for trauma survivors. Shannon suggests that doctors, if they have the ability, work alongside a mental health professional for office visits with refugee patients (Shannon, 2014). This would create a multidimensional, coordinated care plan for a refugee patient and clearly establish the importance of recognizing the relationship between trauma and health.

Two Theories for Consideration: The Danger of a Single Story and Narrative Medicine

The ideas presented in “The Danger of a Single Story” by Chimamanda Adichie and Narrative Medicine by Rita Charon represent an important contribution to the discussion of how to reduce healthcare barriers faced by resettled refugees.

In her 2009 TED Talk, Chimamanda Adichie tells her story of growing up in Nigeria, becoming a writer, and facing the damaging stereotypes about her home. She warns of the
dangers of generalizing an individual to the stereotypes of a group. She says, “The single story creates stereotypes, and the problem with stereotypes is not that they are untrue, but that they are incomplete. They make one story become the only story.” When we assign a person to a collective, “Grace is an immigrant”, “Joseph is a republican”, “Imad is a refugee” we assign them a history. We remove their individuality and we risk the fatal mistake of not doing justice to a person’s story. (Adichie, 2009)

Refugees belong to a group who’s very descriptor, refugee, carries a connotation. When we generalize the experience of refugees, as done in the prior literature review, we reduce their individual experiences to one entity. We negate the trauma of a person and their deeply personal story of resilience. While the literature detailed previously describes the main challenges facing refugees in navigating the American healthcare system, the barrier of doctor communication about trauma, and possible interventions that may improve trauma care for refugees, it fails to capture the stories of the people it generalizes. Not all refugee trauma is the same. Some individuals are torture victims. They have intense physical scarring, mutilation, and post-traumatic-stress-disorder for the rest of their lives. Others escaped without physical harm, but have had to cope with the trauma of a loss of community and assimilation into the culture of a foreign land. Most have a combination of many traumas.

When doctors are faced with a “single story” about a patient: “That patient is a refugee. They are going to be unable to follow my directions, their symptoms will be described in vague, whole-body pain, this appointment will take forever,” these interactions become unpleasant, possibly dangerous. I use an analogy from Adichie, “In this single story, there was no possibility of Africans being similar to her in any way, no possibility of feelings more complex than pity, no
possibility of a connection as human equals”. Similarly, one can say in the single story of a refugee patient, “there was no possibility of refugees (the patient) being similar to her (the doctor) in any way, no possibility of feelings more complex than pity, no possibility of a connection as human equals.” (Adichie, 2009)

Adichie says, “the consequence of a single story is this: it robs people of their dignity…stories can also be used to empower and to humanize” (Adichie, 2009). When healthcare providers understand this idea and use it in practice with their refugee patients, meaningful doctor-patient relationships will form and tangible improvements can be made for refugee healthcare.

Rita Charon’s Narrative Medicine presents these ideas in the context of the doctor-patient relationship. Narrative medicine is a multi-disciplinary frame of healthcare in which a patient’s narrative of their life and illness is at the center of a provider’s discourse with them. It is when providers genuinely listen to, attempt to understand, and honor a patient’s stories in order to bridge the professional-patient divide by connecting to the human experience. She says, “Only when the doctor understands to some extent what his or her patient goes through can medical care proceed with humility, trustworthiness, and respect” (Charon, 2008). In the end, this provides deeper, more effective care as it emphasizes building lasting trust between doctor and patient. Charon’s ideas have the ability, once put into practice, to make a difference in healthcare for refugees.

Charon argues that it is imperative that conversations about physiology and illness be contextualized. That is, it is just as necessary for doctors to understand the human story of their patients as it is the test results or symptoms that led them to the consultation room. She writes,
“...medicine had to take into account not only biological changes of illness but also the familial, community, and societal consequences of disease” (Charon, 2008). No where else is this more true than in caring for a refugee patient, whose community and story contribute to their health.

Charon argues that doctors and other healthcare professions have a “special responsibility to those who survive trauma” (Charon, 2008). That responsibility comes in the form of bearing witness to suffering. In other words, actively listening to the narratives of their patients. Health does not happen in a vacuum. A person’s interaction with healthcare at all points is a product of everything that has happened in their life up to that time. It is informed by their culture, worldview, and personal perspective on life in general. Thus, for a doctor to actually make meaningful progress with their refugee patients, who are most likely trauma survivors, they must be willing to open their 15 minute consultation to the presence of narratives. Charon speaks to America’s physicians when she writes, “We can no longer espouse a system in which the content of the medical conversation is limited by ICD-9 codes, where it is deemed the work of the social worker to enquire about emotions and of the ethicist to enquire about values” (Charon, 2008).

When refugees have acknowledged a desire to speak with their physicians about the conflicts in their home country, their trauma, and the relationship between their physical and mental health, it is the physician’s duty to actively pursue these conversations with their refugee patients. These intimate conversations can coordinate care and give the doctor deeper insight into the plight of their patients. These conversations can reduce the danger of a single story by letting the patient reveal their personal, subjective experience. It is Charon’s idea that “no story... replicates any other story” (Charon, 2008). By telling a history about oneself, that patient becomes irreducible. This act removes them from the stereotypes Adichi warns about.
Conclusion

If healthcare providers introduce the concepts presented in “The Danger of a Single Story” and Narrative Medicine in their interactions with refugee patients, meaningful differences can be achieved in the way resettled refugees experience U.S. healthcare. Using these frameworks, providers would be more sensitive to language differences, one of the most common barriers facing resettled refugees. Providers would be more willing to work with refugees to navigate the American healthcare system and to create multidisciplinary care plans. They would have a greater understanding of how transportation barriers and gender differences affect their patients. Finally, if providers use these frameworks, they would be better able to open up conversation about how trauma affects their patients’ lives. After living through the trauma present at a high incidence in this community, it is imperative that these patients have providers that understand the empowering effect of sharing narratives. Eventually, employing the practices of “The Danger of a Single Story” and Narrative Medicine with refugees may result in decreases in negative health outcomes that directly impact refugee communities. It may be a genuine, authentic way of mitigating the established barriers that prevent resettled refugees in the United States from achieving adequate healthcare experiences.
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