

THE MOST VULNERABLE AMONG US

Despite the growing numbers of survivors of torture and war trauma, U.S. health care professionals continue to receive little training in the medical and mental health needs of the refugee population. Combining creative interventions sensitive to cultural diversity with traditional Western psychotherapy can help refugees manage emotional and mental problems.

A woman we will call S. fled to the United States from one of the most politically volatile countries in Africa.* She applied for asylum for herself and her teenage daughter on the basis of reasonable fear that they will be killed should they return to their home country. Because S. seems unable to concentrate, goes off on "tangents" when telling her story, and is preoccupied by a fear that family members still in Africa are trying to kill her, her asylum lawyer has referred her to a therapist for supportive mental health services. Without mental health services, the lawyer fears, S. will not be able to testify in a coherent manner and possibly have her plea for asylum denied.

With the help of a bicultural, bilingual mental health interpreter, S. gradually shares her story with the therapist. She had genital removal with no anesthetic, when she was about 11. S. has had numerous infections since then, severe pain during her menstrual cycles, and pain during inter-

Mental Health Care Is One of the Great Needs of Refugees in the United States

**BY SR. LOUISE O.
LEARS, SC, PhD;
& SR. JEAN ABBOTT,
CSJ, LCSW**

course. She married and gave birth to a son. Twelve years later, her husband was killed in an automobile accident while driving S. to the hospital for the birth of their daughter, L. Her husband's family declared that the baby girl must die since her birth "took" her own father's life. S.'s family hid L., moving her from household to household and giving her various identities.

When L. was 10, the elders in S.'s family decided that L. should be circumcised. S. fled, and the family issued a death decree for both S. and her daughter. S. was accepted into an educational program in the United States, and she applied for asylum status when she and her daughter reached this country. She has since received several communications from her family with threats of death. S. lives in constant fear that her family will send someone to kill her and her daughter.

S. is often afraid during the night, interpreting normal night sound as someone seeking to harm her and her daughter. One time she was mugged and her purse taken. S. believes the mugger was sent by her family to steal her identity. Her fears become hallucinations when triggered by the stress of living in a poor, unsafe neighborhood. L. believes that she is cursed. She is anxious and, at times, depressed. She remembers being in hiding because "my family wanted me dead." L. has nightmares and headaches. She acts out at school and has a difficult time concentrating. Her greatest grief, however, is that her mother often seems out of control and accuses her of doing bad things.

Both S. and L. are in therapy. The therapist will write an affidavit for court. She will go to the



Sr. Louise is board president and Sr. Jean is clinical director, Center for Survivors of Torture and War Trauma, St. Louis.

*S. and her daughter, L., are clients of a mental health provider who specializes in providing services to survivors of torture and war trauma. The writers have changed some facts to protect S. and L.'s identities.

asylum hearing in the hope that she can testify about the nature of S.'s symptoms and explain why S. seems to offer inappropriate answers to questions about her experiences.

REFUGEES AND TRAUMA

S. and her daughter are among more than 17 million refugees and asylum seekers worldwide.¹ Although many refugees suffer physically from injury or hunger, many more of them experience *psychological* harm. The United Nations High Commissioner for Refugees estimates that 35 percent of refugees have been subjected to severe physical torture or psychological violation, including indiscriminate violence, forced displacement from their homes and communities, rape, and extended periods of deprivation.² Virtually all refugees have had traumatic experiences in their countries of origin, difficult escapes and refugee camp experiences, cultural conflicts, multiple losses, and adjustment difficulties in their countries of resettlement. As a result of these exposures, resettled refugees and their children in the United States are at significantly higher risk of developing mental health problems, particularly post-traumatic stress disorder (PTSD), depression, anxiety, and grief.³

Not all resettled refugees will develop mental health problems; however, many experience psychological symptoms that interfere with their day-to-day functioning. This may be due to a number of factors, including the severity of the trauma to which they were exposed, individual predisposing factors, and stresses in the resettlement environment. Symptoms often persist after arrival in a safe country; in some cases, they may persist throughout a lifetime. A significant factor influencing psychological responses to trauma

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and recovery is access to culturally appropriate mental health services. Such services help refugees deal appropriately with both the trauma from which they fled and the challenge of adjusting to life in the United States.

POST-TRAUMATIC STRESS DISORDER

Sufferers of PTSD re-experience a traumatic event through recurring intrusive thoughts, dreams, or physical sensations, the onset of which can occur immediately after the traumatic event or years afterwards.* PTSD symptoms in refugees differ according to their cultures and backgrounds and to the intensity, repetition, and periods of exposure to the trauma. Refugees often have somatic symptoms, which may be culturally determined. Mario Gonzalez, clinical supervisor for the Marjorie Kolver Center for the Treatment of Survivors of Torture, Chicago, says that "people from Arabic countries often experience cardiac pain as an expression of their anxiety."⁴ Husam Al-Athari, MD, who treats Iraqi refugees at George Washington University Medical Center, Washington, DC, observes: "Whenever Iraqi refugees struggle emotionally, they tend to exhibit symptoms physically, such as headaches and stomachaches, so we find out about them first in the non-psychiatric medical setting."⁵

Some mental health practitioners take issue with the PTSD label. Mary Fabri, PsyD, of the Bosnian Mental Health Program, Chicago, says, "We need to recognize that victims of trauma exhibit a wide range of responses that aren't

*The term PTSD originally was developed to describe certain symptoms seen in U.S. soldiers who served in Vietnam in the 1960s and '70s.

SUMMARY

Although many of the more than 17 million refugees and asylum seekers worldwide are injured or hungry, many more of them suffer from psychological harm because of torture, psychological violation, forced displacement, rape, and extended deprivation. As a result, many resettled refugees in the United States are at significantly higher risk of developing mental health problems due to both the trauma from which they fled and the challenge of adjusting to their new lives.

Because of its emphasis on the individual, the Western

model of psychotherapy may seem foreign to many refugee populations. In many cultures, people disclose deep mental anguish only in the company of a few trusted individuals. Some refugees may also have difficulty confiding in medical professionals because they have learned not to trust authority figures. In order for mental health therapy to be successful with refugees, an appropriate interpreter—one who matches not only the language of the client but also the ethnic and political identity—is crucial.

pathological. I prefer to use the word 'response' rather than 'disorder' because it is a disservice to say that Post-traumatic Stress is a disorder. It is a response that we should expect. We need to take the denial out of the reaction."⁶

Other mental health providers find the word "post" in the PTSD label misleading. They contend that the trauma continues in the country of final resettlement. For example, some refugees suffer from high levels of stress because they are unable to locate or contact family members remaining in the countries from which they fled.

SOCIAL ADJUSTMENT PROBLEMS

Refugees resettling in the United States often must deal with an unfamiliar language, cramped living quarters, and the pressure to be self-sufficient. Uprooting causes culture shock, a stress response to a new environment in which former patterns of behavior may be ineffective and basic cues for social intercourse are absent or indecipherable.⁷ Rural refugees, for example, may find themselves in poorly maintained housing in urban areas, where crime levels are high. People who were professionals in their countries of origin may feel humiliated doing factory work or cleaning hotel rooms. Refugees for whom English is a second language may have trouble coping in a more highly skilled labor force and may not be able to support their families.

Although children and adolescents are resilient and usually are faster than adults in learning a new language, they often experience a psychological reaction to trauma similar to that found in adults.* Refugee children and adolescents may have witnessed or experienced the violent death of a parent, an injury to or torture of a family member, bombardments and shelling, detention, beatings, sexual assault, disappearance of family members or friends, famine, and forced migration. These experiences create vulnerability in children and adolescents due to their incomplete biopsychosocial development, dependency, inability to understand certain life events, and underdevelopment of coping skills.

Refugee children and adolescents must adapt to drastically different school environments and

*Nearly half the world's refugees are children and adolescents. But we know relatively little about them and their special problems, which may in part be due to their reluctance and that of their parents to trust researchers.

may encounter conflict with other ethnic groups, such as Latinos and African Americans. Refugee youth often assume responsibility for their parents, because they are the first to be bilingual. These youth pay the bills, do the shopping, and serve as interpreters for their parents in various settings.

THE WESTERN MODEL OF PSYCHOTHERAPY

In many cultures, people disclose deep mental anguish only in the company of a few trusted individuals, such as spiritual leaders or close family members. Psychiatric help from medical professionals is reserved for the most serious mental illness. Some cultures do not even have a word for "psychologist" or "psychiatrist." Survivors of torture and war trauma arriving in the United States may attach a stigma to receiving help from a mental health professional. Coupled with this resistance, many refugees have learned not to

Working with Refugee Clients

Points to consider when treating asylum seekers or refugees:

- Issues of trust may be problematic
- The client may be extremely anxious about the security of personal information
 - Never contact the local embassy of their country of origin for information; instead, use such organizations as Human Rights Watch or Amnesty International
 - It is usually unwise to put patients from the same country in the same therapeutic group
 - Spend a few minutes with the interpreter before and after the session to clarify objectives and review the meeting afterward
 - Try to use the same interpreter for all meetings with each individual or family; it is important to consider matching on age, gender, and religious issues
 - Using an interpreter may mean that extra time should be allocated for the meeting
 - Avoid specialist terminology
 - Use trained and experienced interpreters whenever possible; remember that interpreters are part of the consultation and respect their contribution and different training
 - Always remain aware that you are interviewing a person from a different culture and who therefore may put different interpretations on events and feeling
 - Remember that words may not translate exactly across language

—From R. Tribe, "The Mental Health of Refugees and Asylum Seekers," *Advances in Psychiatric Treatment* (Great Britain), vol. 8., no. 4, 2002, pp. 240-248.

trust authority figures because in their own countries such people inflicted torture and trauma.

The Western model of psychotherapy is based on individual therapy and an understanding of oneself as an individual. For many refugee populations (Africans, for example), this individualistic perspective is foreign. We Americans expect the client to arrive on time (assuming that transportation is available), talk with the therapist (assuming that a bicultural, bilingual interpreter is available), and leave after the session (assuming that he or she, realizing that therapy usually entails a series of sessions, will return at the same time the following week). But our common assumptions may not fit the refugee experience.

BICULTURAL, BILINGUAL INTERPRETERS ARE ESSENTIAL

Mainstream mental health providers often do not have access to professionally trained bicultural, bilingual interpreters. Successful programs employ trained interpreters, many of whom were themselves refugees. Such programs also educate psychotherapists about their clients' cultural background. Good cross-cultural therapists do not need to know everything about every culture—but they need to be aware of cultural differences. (They should not be surprised if some refugee clients give them gifts, for example.) Therapists should also be aware of the danger of overgeneralization of cultural or group characteristics.

The distinction between “bicultural” and “bilingual” is crucial. Choosing an appropriate interpreter for mental health therapy involves matching not only the language of the client and interpreter but also their ethnic and political identities. An interpreter from the same country—but from an opposing ethnic group (a Kurd Iraqi interpreter for a Sunni Iraqi client, for example)—might damage the trust needed in the therapeutic alliance. Client, interpreter, and therapist need to trust one another.*

MAINSTREAM PROVIDERS NEED TRAINING

Despite the growing numbers of survivors of torture and war trauma, U.S. health care professionals continue to receive little training in the medical and mental health needs of the refugee popula-

*There is a legal basis for the provision of interpreters for patients and clients whose English is limited. The federal Civil Rights Act of 1964 requires health care providers to furnish interpreters for such people. Many states have laws reinforcing the federal law.

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tion.⁸ Mainstream providers usually do not tailor their programs for the refugee population. Still, if a clinic does not have someone on staff who speaks Farsi, it is unlikely that Farsi-speakers with mental health problems will seek help in that setting. That said, care providers must be prepared to interact with clients from other cultures even if they do not speak the same language. Obviously, public health nurses, school counselors, clinical social workers, and teachers need information and training regarding refugee mental health needs because they are likely to come into contact with refugees.

CARING FOR HIGHLY TRAUMATIZED CLIENTS

Caring for highly traumatized clients can evoke emotional reactions in mental health workers, and these reactions influence the provision of appropriate support as well as lead to personal stress on the workers' part. Experience suggests that those working with resettled refugees are better able to deal with this stress if they have opportunities to debrief with other professionals. Mental health workers who see large numbers of refugee clients, or whose roles involve a high level of disclosure of trauma, may need more structured debriefing opportunities. Interpreters who share experiences in common with refugee clients or have friends and relatives in unsafe circumstances in their countries-of-origin also need regular debriefing sessions.

INNOVATIVE APPROACHES

Mental health professionals who serve refugee populations have found that combining creative interventions sensitive to cultural diversity with traditional Western psychotherapy can help their clients manage emotional and mental problems. Creative therapists and centers use multiple treatment therapies, including occupational, physical, massage, music, drama, and art. The choice of therapy depends on the client's culture, age, gender, family, and symptoms. Some clients will do well in group therapy, for example, whereas others will not.

OUR TRAVELING COMPANIONS

Our sisters and brothers who flee to the United States remind us of the pilgrim state of the church, made up of all who are invited to the “wedding banquet.”⁹ They teach us about loss, persecution, flight, courage, and perseverance. They call us to be their traveling companions, offering the Word that rekindles hope in their hearts and peace in their minds.

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NOTES

1. See www.unhcr.ch/cgi-bin/texis/vtx/basics, the website of the United Nations High Commissioner for Refugees, for estimated numbers of refugees, asylum seekers, and similar people as of January 1, 2004. A "refugee" is a person who has crossed international borders fleeing war or persecution for reasons of race, religion, nationality, or membership in a particular social or political group. An "asylum seeker" is a refugee whose status is yet to be determined by the host society. The United Nation's 1951 Convention Relating to the Status of Refugees is the key legal document defining the refugee, refugee rights, and the legal obligations of nations toward refugees.
2. See www.unhcr.ch/cgi-bin/texis/vtx/basics.
3. According to the United Nations, the rate of post-traumatic stress disorder for refugees ranges from 39 percent to 100 percent, whereas the rate in the general population is 1 percent. See *Refugee Resettlement: An International Handbook to Guide Reception and Integration* at www.unhcr.ch/cgi-bin/texis/vtx/home?page=PROTECT&id=3d4545984&ID=3d4545984&PUBLISHER=TWO
4. Mario Gonzalez is quoted in "A Cry for Help: Refugee Mental Health in the United States," which can be found at www.refugees.org/world/articles/mentalthh_rr97_9.htm.
5. Husam Al-Althari is quoted in "A Cry for Help."
6. Mary Fabri is quoted in "A Cry for Help."
7. J. G. Lipson, "Afghan Refugees in California: Mental Health Issues," *Issues in Mental Health Nursing*, vol. 14, no. 4, 1993, pp. 411-423.
8. Two surveys, one conducted by medical schools and the other by public health schools, found little attention paid to refugees' needs. See J. Sonis, D. W. Gorenflo, P. Jha, et al., "Teaching of Human Rights in U.S. Medical Schools," *JAMA*, vol. 276, no. 20, 1996, pp. 1,676-1,678; and J. Brenner, "Human Rights Education in Public Health Graduate Schools: 1996 Surveys," *Health and Human Rights: An International Journal*, vol. 2, no. 1, pp. 129-139.
9. U.S. Conference of Catholic Bishops, *Welcoming the Stranger among Us: Unity in Diversity*, November 15, 2000, which can be found at www.usccb.org/mrs/unity.shtml#summary.

HEALTH PLANNING FOR IMMIGRANTS

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Committee to address the perinatal care needs of all uninsured low-income women, including recent immigrants, in the greater Richmond area. Both BSR's Community Health Services and the CVHPA are represented on this committee, as are numerous other providers and interested organizations (including many of the original steering committee members) that deal with perinatal needs. The committee is currently working with the Richmond OB/GYN Society's physicians and other providers to establish a network of perinatal care services to provide comprehensive obstetrical care, including medical care, diagnostic testing, transportation services, and social supports.

This comprehensive health planning approach has been a catalyst in identifying and meeting immigrant health care needs. BSR's leadership of and support for the initiative is widely recognized in greater Richmond as an important contribution to the improvement of the health of the communities the system serves. Moreover, the report's data and findings have been extensively used by community organizations, health care providers, state government agencies, and others for both planning and resource development. □

The complete report can be found at www.bonsecours.com/newsevents/pdf/RichImmHlthPlnRprt.pdf and www.cvhp.org/Richmond%20Immigrant%20Health%20Planning%20Report.pdf. For additional information, or for assistance in conducting an assessment in your own community, contact Eletta Hansen, Bon Secours Richmond Health System's Office of Community Health Services (804-287-7343; Eletta_Hansen@bshsi.com), or Karen Cameron, Central Virginia Health Planning Agency (804-233-6206; kcameron@cvhpa.org).

PLANNING FOR THE AGE OF GENETICS

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2. National Task Force on Genetic Testing, "Promoting Safe and Effective Genetic Testing in the United States," Washington, DC, May 1997. The task force is part of the Working Group on Ethical, Legal, and Social Implications of HGP research; see www.genome.gov/10001733.
3. Catholic Health Initiatives, *Understanding Gene Testing: A Primer for CHI Ethics Committees*, Denver, 2002, p. 6. This document is based upon (with the department's permission) U.S. Department of Health and Human Services, *Understanding Gene Testing*, Washington, DC, 1995, which is available at www.accessexcellence.org/AE/AEPC/NIH.
4. National Task Force on Genetic Testing.
5. Steven Jones, *Genetics in Medicine: Real Promises, Unreal Expectations*, Millbank Memorial Fund, New York City, June 2000, p. 3.
6. H. Gilbert Welch and Wylie Burke, "Uncertainties in Genetic Testing for Chronic Disease," *JAMA*, vol. 280, no. 17, 1998, p. 1,527.
7. See M. Therese Lysaught, "Genetic Testing's 'Soft Underbelly,'" *Health Progress*, March-April 2001, pp. 54-59.
8. Lysaught, p. 55.
9. Lysaught, p. 57.
10. Jones, p. 7.
11. Welch and Burke, pp. 1,525-1,527.
12. Welch and Burke.
13. Welch and Burke.
14. Welch and Burke.
15. Welch and Burke.
16. Lysaught.
17. U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 4th ed., Washington, DC, 2001, pp. 4-5.
18. The Science and Human Values Committee of the National Conference of Catholic Bishops, "Critical Decisions: Genetic Testing and Its Implications," *Origins*, May 2, 1996, p. 70; Pope John Paul II, "The Ethics of Genetic Manipulation," *Origins*, November 17, 1983, pp. 385, 388-389.
19. Lysaught, p. 57.
20. U.S. Conference of Catholic Bishops, p. 7.
21. See Pope John Paul II, as quoted in the Science and Human Values Committee, pp. 1-5.
22. See Richard P. McBrien, ed., *Catholicism*, vol. 2, Winston Press, Minneapolis, 1980, p. 1,048. In this passage, Fr. McBrien outlines the position of Fr. Charles E. Curran.

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