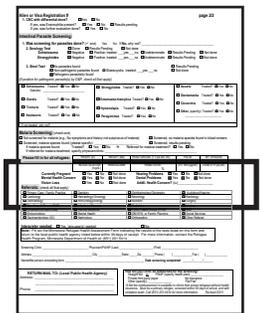


Refugee Mental Health at a Glance

Minnesota Initial Refugee Health Assessment

	BLOOD GLUCOSE (mg/dL)	HEMOGLOBIN	HEMATOCRIT %	VIT. B12 (pg/ml)	LEAD (<17 yrs old)
Currently Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done	Hearing Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done	
Mental Health Concern	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done	Dental Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done	
Vision Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done	Addtl. Health Concern? (list)	_____	
Referrals: (check all that apply)					
<input type="checkbox"/> Primary Care / Family Practice	<input type="checkbox"/> Dentistry	<input type="checkbox"/> Ophthalmology/Optometry		<input type="checkbox"/> Audiology/Hearing	
<input type="checkbox"/> Cardiology	<input type="checkbox"/> Hematology/Oncology	<input type="checkbox"/> Neurology		<input type="checkbox"/> Radiology	
<input type="checkbox"/> Dermatology	<input type="checkbox"/> Immunology/Allergy	<input type="checkbox"/> Nutrition		<input type="checkbox"/> Surgery	



Although the *Minnesota Initial Refugee Health Assessment* form does not have a mental health component at this time, it is critical that mental health issues be addressed in the screening process. While evaluating a refugee’s psychosocial history, ask questions about the patient’s concerns or worries regarding him or herself and family members. Ask about sleeping and eating difficulties. Ask about sadness, nervousness, and irritability. Be alert for signs of stress, isolation, and the profound grief of multiple losses that may accompany resettlement. Adult patients may describe low energy, insomnia, loss of appetite, nightmares, memory and concentration problems, bodily aches/pains, and general fatigue. Many refugees will not share a Western perspective or vocabulary in terms of psychology, so questions will need to be explained through specific examples or re-framed in culturally congruent terms with the assistance of an interpreter or bicultural worker.

Key Resources

Healing Resources for Refugees

www.mnchurches.org/refugee/healing

MDH Refugee Health Lending Library

www.health.state.mn.us/refugee/library

Centers for Disease Control and Prevention (CDC)

www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/mental-health-screening-guidelines.html

Refugee Mental Health

Background

Prior to World War II, immigrants were often driven from their countries by economic forces such as unemployment, famine, and poverty, often combined with various forms of prejudice and oppression. War and ethnopolitical conflict were not primary causes for emigration, due to less civilian involvement and impact compared to that of modern armed conflicts. Beginning with World War II, however, civilians were increasingly targeted as a strategy of warfare and political struggle (e.g., the civilian casualty rates for World War I and II and current armed conflicts are 5 percent, 50 percent, and 90-plus percent, respectively). Like previous immigrants, these recent arrivals to the U.S. have known social oppression, including inadequate education, lack of job opportunities, inability to practice their faith or marry whom they wished, and inability to live where they wanted. However, unlike most previous immigrants, many of them have also experienced or witnessed government-sponsored torture and/or terror. Amnesty International (2011) has estimated that at least 101 countries practice government-sponsored torture against their citizens. Refugees, asylum-seekers, and immigrants have historically been high-risk populations for survivors of torture.

The Center for Victims of Torture (CVT) conservatively estimates that at least 30,000 torture survivors live in Minnesota. CVT in Minneapolis was created in response to the needs of this population.



According to The Center for Victims of Torture there are an estimated 30,000 to 40,000 torture survivors in Minnesota and 500,000 in the U.S.

Cultural Issues in Refugee Mental Health

Many refugees come from cultures in which the indigenous psychology differs greatly from that of the United States. Depending on the refugee's exposure to Western concepts and belief systems within the home country, discussion of mental health issues may need to be more or less adapted to accommodate the refugee's frame of reference (e.g., a Somali person who traveled to Italy regularly on business before the war may be very different from a Somali person who lived a rural nomadic life). In many non-Western societies, concepts and beliefs regarding mental health are embedded within religious/spiritual belief systems, or cosmologies, that emphasize *supernatural* (vs. naturalistic) causes as well as the *indivisibility of physical and mental health*. Thus, a refugee may describe or express mental distress in

Somatic expression of emotional difficulties is more culturally acceptable than having mental problems in many societies (including our own!).

physical or spiritual terms (e.g., "I have pain in my heart," "The devil is busy with me," "My head feels heavy") or as a general, nonspecific sense of ill-health that encompasses physical and

mental well-being (e.g., "I feel weak," "I am not fine at all," "I no longer have the will"). It is very common for torture survivors to have chronic pain, often in areas of the body that were tortured or bear symbolic meaning in relation to psychological effects of the torture. Somatic expression of emotional difficulties is also more culturally acceptable than having mental problems in many societies (including our own!).

When screening for mental health, providers need to take into account that it may be completely foreign or unacceptable for refugees to disclose personal or family problems with a medical professional. In many parts of the world, persons with stresses related to life problems seek support in the same way our ancestors did upon arriving to the United States. This counsel was sought and received at the "kitchen table." Personal and family problems were discussed within the family, within the community social structure, or with religious/spiritual leaders or traditional healers.

Providers can address these differences and gain relevant information on mental health by inquiring about activities of daily living (appetite, sleep quality, employment, language acquisition, social contact) and levels of energy or fatigue. Asking about "stress" rather than mental problems and prefacing questions with normalization of common stress reactions can be helpful (e.g., "When people lose so much and have to start their lives over in a new country, it is normal for them to have difficulty with..."). Asking refugees about family members who are here, those left behind in the home country or other countries, and those who have died or

disappeared may help fill in a picture of the stresses involved in resettling in Minnesota. Finding out about the person's life before the war or persecution can be useful both in establishing rapport and in assessing changes in the person's level of functioning. Finally, asking the refugee, "What would you do to heal (from whatever difficulties are acknowledged) if you were in your country?" can be extremely informative. If the person describes culturally based practices, such as going to see a shaman or religious leader, the viability of such options here in the U.S. can be discussed. If the person replies that he or she would not have these problems if they were in the home country, exploring his/her beliefs about "Why not?" can be instructive in understanding the origin and maintenance of the problem(s).

Note: Each culture is different, as is every individual. In all cross-cultural work, it is extremely important to consult with persons who can serve as cultural brokers to facilitate communication between providers and refugees. Interpreters, bicultural workers, community leaders, and liaisons often have invaluable cultural expertise to offer. At the same time, except for critical circumstances, it is advisable to have these consultations outside of the medical/mental health encounter. Providers should be the ones solely responsible for the decisions made during their encounter with the patient and for the outcome of this encounter. Never underestimate the power of a single interaction between a refugee and a health care provider; it can be incredibly healing, or, it can also be damaging if the refugee is left feeling (unintentionally) misunderstood, unheard, or shamed. If trauma or loss is discussed, allow time for closure of these wounds before ending the interview. This can be a good time to emphasize your understanding of the refugee's strengths in surviving his or her ordeals and getting to this country.

Family Resettlement

Leaving behind all that is familiar and starting a new life in a new country with a different language and culture produces an immediate family crisis that can have long-term effects. This is true whether a family is coming from Europe, sub-Saharan Africa, or Central America. Studies indicate that stress prior to, or subsequent to, forced migration appears to have an independent impact on mental health. These studies suggest that each refugee movement should be examined in its own context and that predictions concerning the course of refugee mental health over time for a given population cannot be generalized.

As the primary social unit of most cultures, the family is charged with the task of feeding, clothing, nurturing, educating, and supporting its members. During and after any type of migration, these family tasks are difficult enough, but after traumatic war experiences, these tasks may become formidable.

Leaving behind all that is familiar and starting a new life in a new country with a different language and culture produces an immediate family crisis that can have long-term effects.

“Family” may be defined quite differently in other cultures as well as in war situations, and can include extended family members, unaccompanied minors who have been

“adopted” or taken in, tribal/clan/village members, etc. Family separation and/or reconfiguration, lack of extended family support, and the collision of the old and new cultures frequently lead to confusion among parents, elderly, and youth regarding the proper behavior expected of each generation in the resettlement country. Gender role upheaval is also common, especially as it relates to the greater social/economic freedom of women and the loss of the “family provider” role for men, and it can be a source of marital stress and conflict.

Intergenerational conflict can be marked between adolescent refugees and their families because adolescents tend to have more contact with the majority culture and are more likely to try out new roles. Intergenerational conflicts due to different rates of acculturation and parent-child role reversal can result in strained relations within the entire family. For parents, traditional expectations of respect from their children and deference to authority can conflict with the imposed reality of a disempowered position due to illness and lack of fluency in English and American culture. Women who have lost their husbands during war or migration bear the additional stresses of single parenting. Normal developmental struggles of adolescence are heightened by the elders’ diminished authoritative role and limitations in preparing the young person for the transition to adulthood in this culture. Traditional expectations of deference to parental authority can conflict with the more egalitarian relationships that children frequently observe among parents and adolescents in North America. Likewise, the resettlement society’s expectations for increasing independence among adolescents can conflict with traditional cultural expectations to provide support and care for elderly or disabled parents.

Dating, a core activity of American adolescence, is nonexistent and/or taboo in many traditional cultures.

Finally, family relations are often profoundly affected by traumatic events and their ongoing effects. The shame and horror of traumatic experiences has a silencing effect on families; they are often unable to talk about what happened and why it happened. As a result, confusion and strong negative feelings (sadness, anger, blame, guilt, unresolved grief) can smolder under the surface and exert negative effects on family relationships that are all the more powerful as long as they are unacknowledged or shrouded in secrecy. Parental functioning may be compromised by ongoing post-trauma symptoms, most commonly those of post-traumatic stress disorder (PTSD) and depression.

Post-Traumatic Stress Disorder and Other Mental Health Outcomes

One of the most common causes of post-traumatic stress disorder (PTSD) is trauma of “human design.” War represents one of the most ancient and devastating forms of human-made violence. Since WWII, *there have been at least 150 major conflicts* and 21.8 million war-related deaths. The Red Cross estimates a total twice as high, or about 40 million people killed in wars and conflicts since WWII. In terms of geographical distribution, 130 of the 150 conflicts have taken place in developing countries. Studies to assess the rates of PTSD among community samples of refugees worldwide have consistently found high rates of this disorder (usually between 30 to 60 percent, depending on the population and measurement methods).

There is great variability in the effects of war and torture, ranging from a few transitory symptoms to chronic psychiatric conditions; however, research has consistently found refugee populations to be at substantially elevated risk for PTSD

One of the most common causes of PTSD is trauma of “human design.”

and other psychiatric disorders. These include depression, other anxiety disorders, substance abuse, somatoform disorders, sexual dysfunction, and organic impairment (brain damage) due to head injury during torture, combat, or flight. More rare, but not unheard of, is brief reactive psychosis (a short-lived psychotic condition that occurs as a reaction to trauma/severe stress, with full return to premorbid functioning within 30 days). Idioms of distress, or culture-specific syndromes, also exist and can occur as a response to trauma.

Providers who are conducting health screening for refugee populations should be familiar with the symptoms of PTSD and depression. Of the three main categories of PTSD symptoms (re-experiencing, avoidance/numbing, hyperarousal), cross-cultural research on PTSD has found the re-experiencing and hyperarousal symptoms to be the most universal or robust across cultures; the greatest degree of ethnocultural variation in PTSD symptom expression has been found among the avoidance/numbing symptoms.

Children in War

Any modern war can be considered a war on children. Based upon data about civilian casualties in recent wars and the proportion of children in populations, one can say that for every 10 people who die in current wars, nine are civilians, children and women make up an estimated 80 percent of displaced populations. Children show the full range of post-traumatic symptoms; however, the effects vary by age and developmental level. The appendix includes a summary of the general findings from research in this area, and a summary of effects by age.

Clinical Consequences of Torture

There are no unique psychological or psychiatric effects of torture that are not seen in refugees and others who have survived severe trauma of human design. All the information described in this section applies to torture survivors as well. PTSD and major depression are the most common diagnoses received by clients at the Center for Victims of Torture. Chronic pain, somatization, and dissociation are also quite prevalent. Common psychological effects of torture that do not, by themselves, constitute symptoms of psychiatric disorders include the following: loss of trust; helplessness; shame and humiliation; disbelief, denial, and shock; disorientation and confusion; existential challenges (e.g., loss of, or threat to, one's sense of identity, meaning, and purpose); and rage.

In studies of torture survivors, beatings, kicking, slapping, punching, and blows with objects comprise the most common forms of physical torture. Many of these strikes are delivered to the head and can cause brain damage. Injury to the brain may also ensue from lack of oxygen to the brain through asphyxiation from practices such as choking, hanging, or putting a bag over the head. Memory disturbances may involve recent, intermediate, or long-term memory loss, depending on the etiology and locus of the injury; they may also be part of PTSD.

Women are no less likely to be tortured than men. Among female torture survivors, almost all have either been raped or threatened implicitly or explicitly with rape. A majority of male torture survivors have also been sexually tortured (the genitals are frequently targeted during torture as a highly sensitive area of the body and as a core component of individual identity). Rape has a very high rate of acute PTSD and can lead to high rates of chronic PTSD, especially if left untreated. Children and adolescents may be torture victims, either as a means of demeaning and demoralizing the children themselves or as a means of torturing their parents. Child/adolescent torture survivors are at extremely high risk for chronic trauma-related symptoms/disorders.

Treatment and Recovery

Three basic stages of recovery from psychological trauma have been identified: (1) establishing safety/stabilization, (2) going through a stage of remembrance and mourning (“coming to terms with” the trauma), and (3) reconnecting with life (rejoining the worlds of work and love). Moving through these stages can be facilitated through individual and/or group therapy; groups can be particularly helpful in providing peer validation and reducing isolation. Effective mental health treatment of adult refugees/torture survivors often involves the following components: psychoeducation; validation of the trauma and normalization of the trauma reaction; symptom stabilization and relief, often through psychiatric medication; assistance with social service needs (food, clothing, shelter, finances, health care, social support network, vocational training/rehabilitation); psychotherapy; and medical treatment to address the physical injuries, disfigurement, or disabilities caused by the torture. Acknowledging irreversible loss together with strengths and hope for the future is key to developing trust in patient-provider interactions. For children, play and art therapy, as well as parental counseling and school-based interventions, are effective tools in facilitating recovery.

In therapy, it is of paramount importance to give patients control over the course of therapy as much as possible

because one of the most harmful consequences of trauma is a profound feeling of lack of control and helplessness. In mental health services the patient should be able to make informed decisions about the pace and direction of therapy. In primary care, patients’ ability to say “no” to what they perceive as invasive procedures and treatments should be given a very serious consideration.

The course of trauma-related symptoms and disorders is variable and difficult to predict, though it typically waxes and wanes in accordance with the degree of life stress. Even when trauma survivors are functioning well and are relatively asymptomatic, they remain vulnerable to reactivation of symptoms triggered by stressful life events, such as being involved in a car accident or being the victim of a crime. However, we know from studies of Holocaust survivors that, despite the presence of chronic PTSD symptoms such as nightmares 50 years after the trauma, most survivors go on to lead productive and fulfilling lives. Refugees and torture survivors are, fundamentally, survivors who possess amazing resiliency, strength, and resourcefulness. Accessing their strengths, right from the start, is a foundation for successful treatment (“What gave you strength to survive it all?”). They can, and do, recover from their experiences. Early assessment and intervention reduces their suffering and facilitates this recovery.

Refugees and torture survivors are, fundamentally, survivors who possess amazing resiliency, strength, and resourcefulness.

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