Clinical Crossroads

Primary Care Management of Non-English-Speaking Refugees Who Have Experienced Trauma
A Clinical Review

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IMPORTANCE Refugees are a vulnerable class of immigrants who have fled their countries, typically following war, violence, or natural disaster, and who have frequently experienced trauma. In primary care, engaging refugees to develop a positive therapeutic relationship is challenging. Relative to care of other primary care patients, there are important differences in symptom evaluation and developing treatment plans.

OBJECTIVES To discuss the importance of and methods for obtaining refugee trauma histories, to recognize the psychological and physical manifestations of trauma characteristic of refugees, and to explore how cultural differences and limited English proficiency affect the refugee patient–clinician relationship and how to best use interpreters.

EVIDENCE REVIEW MEDLINE and the Cochrane Library were searched from 1984 to 2012. Additional citations were obtained from lists of references from select research and review articles on this topic.

FINDINGS Engagement with a refugee patient who has experienced trauma requires an understanding of the trauma history and the trauma-related symptoms. Mental health symptoms and chronic pain are commonly experienced by refugee patients. Successful treatment requires a multidisciplinary approach that is culturally acceptable to the refugee.

CONCLUSIONS AND RELEVANCE Refugee patients frequently have experienced trauma requiring a directed history and physical examination, facilitated by an interpreter if necessary. Intervention should be sensitive to the refugee's cultural mores.

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DR LIBMAN Ms P is a 48-year-old woman who was born and raised in Somalia. She experienced multiple traumas during the Somalian civil war before leaving as a political refugee in 2001. She resettled in the United States in 2003, has lived in 3 different cities, and now resides in Boston, Massachusetts.

During her initial examination, 2 years after immigration, Ms P reported chronic weakness, an inability to walk independently, and severe chronic pain in her head, arms, shoulders, and legs. Her symptoms started years ago and have progressively worsened. She was admitted to the hospital and had comprehensive evaluations, which revealed only mild osteoarthritis of the knees. Because the pain was debilitating, she was sent to a rehabilitation facility for physical therapy.

Since 2005, Ms P has been seen regularly by rehabilitation medicine clinicians and has received multiple knee and shoulder corticosteroid injections. She has tried many different pain medications and acupuncture. She was treated for depression and posttraumatic stress disorder (PTSD). Prior to coming to Boston, Ms P reported having a nephrectomy (for reasons she cannot recall), and once settled in Boston, she underwent a thyroidectomy for a large goiter with mediastinal component and right salpingectomy for hydrosalpinx causing chronic pelvic pain, likely from chronic pelvic inflammatory disease.

Ms P's family medical history is unknown. She receives disability benefits. She has had no formal education and speaks only Somali. Her religion is Islam. She does not smoke cigarettes and has no history of alcohol or drug use.

Ms P's medications include acetaminophen, acetaminophen with codeine, atenolol, doxepin, citalopram, hydrochlorothiazide, levothyroxine, omeprazole, vitamin D, milk of magnesia, docusate, capsaicin cream, and Somali black seeds. She is allergic to tramadol (pruritus).

Ms P: Her View

I was born in Somalia. When the war started, we moved to a small village close to Kismayo. My uncle gave me money for a ticket, and I moved to Egypt. I lived in Egypt for 3 years, and during that time my kidney began to die. I then came to Pennsylvania in 2003 with a group of Sudanese refugees.

Once in Pennsylvania, I fainted and some people took me to the emergency department. They did a CAT [computed tomography] scan to confirm that my kidney had died. At this time, there was no interpreter; therefore, I just signed the consent forms and had my kidney removed. After the surgery, I started having arthritis in my knees and pain in my lower back and decided to move to Boston to get treated. I was admitted to Boston Medical Center, and they found a big tumor from my thyroid to my mediastinum. Doctors did some tests because I was having discomfort around my uterus, and they found a swollen tube fibroid. They surgically removed the thyroid tumor and my right fallopian tube.

LEP *limited English proficiency*

PTSD *posttraumatic stress disorder*

SGBV *sexual and gender-based violence*

When there is no interpreter, it becomes very difficult to communicate, and staff may not be familiar with my culture. One main frustration I had was when male doctors tried to shake my hand. In my religion, women are not allowed to touch men. I would cover my hand with a scarf, but I didn't want the doctors to get offended. Another frustration was when nurses called me into the examination room by pointing their finger, which is considered impolite.

Overview

DR CROSBY Ms P is typical of many refugees. When she arrived at her clinician's office, she had many physical concerns and was in distress. Although the causes of her distress were not initially known, over time she revealed a history of personal assault, including rape, murder of family members, and kidnapping/loss of her children, and she met criteria for severe PTSD (reexperiencing, hyperarousal, and avoidance). Her symptoms included depressed mood, anxiety, anhedonia, poor concentration and memory, poor sleep, nightmares, intrusive recollections of her trauma, "seeing her missing children," being easily startled and afraid to be alone, and physical and emotional pain that she rated as 8 on a 10-point scale. There were culture, language, and literacy barriers that resulted in negative experiences in the health care system.

Because of mass conflict and displacement of populations around the world, physicians increasingly encounter refugee patients affected by trauma in the medical setting. The 1951 Refugee Convention establishing the United Nations High Commissioner for Refugees (UNHCR) was drafted to assist Europeans displaced in the aftermath of World War II and has subsequently provided assistance to tens of millions of refugees.[1] The UNHCR defines a refugee as "someone who has been forced to flee his or her country because of persecution, war, or violence."[2] A refugee has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion, or membership in a particular social group. Most likely, they cannot return home or are afraid to do so. War and ethnic, tribal, and religious violence are leading causes of refugees fleeing their countries.

The UNHCR reports that in 2012, 45.2 million people were forcibly displaced worldwide as a result of persecution, conflict, violence, and human rights violations, the highest number since 1994. This includes more than 10 million refugees. Women and children constituted 48% of the refugee population. By the end of 2012, the major source countries of refugees were Afghanistan, Somalia, Iraq, Syrian Arab Republic, Sudan, Democratic Republic of Congo, Myanmar, Colombia, Vietnam, and Eritrea. The major refugee-hosting countries were Pakistan, Islamic Republic of Iran, Germany, Kenya, Syrian Arab Republic, Ethiopia, Chad, Jordan, China, and Turkey.[3]

Although repatriation is the preferred durable solution, a small number of refugees are resettled to a third country because of persistent conflict and fear of persecution.

Since 1975, the United States has resettled more than 3 million refugees. The Federal Refugee Resettlement Program was developed following the enactment of the Refugee Act of 1980.[4] Its purpose was to provide for effective resettlement and asylum opportunities for those fleeing persecution in their homelands. Admission data have ranged from 40 000 to 75 000 annually. In 2012, 62 000 refugees from 80 countries and 40 000 asylum seekers were admitted to the United States through this program. The countries of origin for refugees admitted to the United States in 2012 were Bhutan, Myanmar, Cuba, Iraq, Democratic Republic of Congo, Iran, Eritrea, Sudan, and Ethiopia.[5] Refugee demographics vary from year to year and annual statistics for refugee numbers can be found at the UNHCR's website.[6] Additional information about refugee resettlement in the United States can be found at the Office of Refugee Resettlement's website.[7]

Asylum seekers meet the same criteria as refugees; however, they apply for asylum in their host country. The distinction between refugees and asylum seekers is important. Asylum seekers may be undocumented and ineligible for public benefits including health insurance, housing, and food stamps. Once asylum is granted to asylum seekers, they are afforded the same protection and benefits as refugees.[1] From a clinical perspective, asylum seekers may have lived in the host country for a prolonged period prior to seeking any medical care, whereas refugees arriving through the resettlement program are referred for screening shortly after arrival.

Violence

A refugee's experience of trauma/torture and displacement may present challenges to clinicians who are unfamiliar with refugee trauma and its clinical consequences. Humanitarian crises are often accompanied by a breakdown of law and protection of individuals, heightening the risk of traumatic events. Refugee populations are at high risk of exposure to traumatic events, including torture.

The UN Convention Against Torture defines torture as "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or her or a third person information or a confession, punishing him for an act he or a third person has committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising from, inherent in or incidental to lawful sanctions."[8]

The Amnesty International Annual Report of 2012 stated that torture and ill treatment occurred in 112 countries,[9] although tor-

Box 1. Physical Torture Techniques[11-20]

Conditions of Detention

- Isolation
- Containment in a cage
- Deprivation of food and water
- Deprivation of sanitary conditions (no toilet)
- Crowded cells
- No windows or ventilation

Methods of Physical Torture

- Beatings
  - Fists, kicks, canes, sticks, rifle butts
  - Head trauma
  - Falanga (beating to soles of feet)
    - Blunt trauma to soles of feet with batons, canes
    - Acute: bruising, swelling, severe pain, fractures
    - Chronic: pain, neuropathy, deformities
    - Examination: pain on palpation on ball of foot, heel pad destruction
- Burns
  - "Necklacing"—placement of gasoline-filled tire around the neck and lighting it on fire
  - Cigarette
  - Hot liquids
  - Acid
  - Heated plastic
  - Lighters
  - Heated metal
- Shaking
- Dental trauma
- Suspension (suspended from arms or legs)
- Administration of electric shocks
- Cutting wounds from knife, bayonet, or other sharp instrument
- Insertion of pins under nails
- Simulated drowning—eg, "waterboarding," "submarino" (head placed in water that may be contaminated with substances such as feces)
- Stress positions—forced unnatural positions for prolonged periods of time
- Sensory deprivation
  - Prolonged isolation
  - Blindfolded
  - Earmuffs
- Sensory stimulation
  - Temperature extremes (cold or hot)
  - Continuous loud noises
  - Continuous lights
  - Sleep deprivation
- Sexual trauma
  - Female
    - Rape
    - Instrumentation
    - Female genital mutilation
  - Male
    - Rape
    - Sodomy with instruments
    - Direct genital trauma (blunt trauma, use of instruments such as pliers, weights applied to the scrotum)
    - Mental assaults (forced nakedness)
- Forced to drink urine or human blood or to eat human flesh

ture is known to be underreported.[10] Torture has been documented in the main countries from which the United States is receiving refugees through its resettlement program. Common methods of torture are listed in **Box 1**. Torture is an assault of a person's mind, body, and sense of security and may cause long-lasting effects.

The prevalence of torture among refugee groups resettled in the United States varies with the population studied.[21-23] Jaranson et al[24] reported that the prevalence of torture in Somali and Oromo refugees in Minneapolis-St Paul, Minnesota, was 36% and 55%, respectively.

Programs such as the Torture Victims Relief Act of 1998, administered by the Office of Refugee Resettlement,[25] provide services and resources to "torture survivors" but exclude refugees who have had other types of trauma and who do not meet the strict definition requiring state participation. For example, many Somalian refugees have experienced trauma and sexual violence because of tribal warfare.

Sexual and gender-based violence (SGBV) is a significant worldwide problem in refugee populations.[26] Sexual and gender-based violence is defined by UNHCR as "violence that is directed at a person on the basis of gender or sex. It includes acts that inflict physical, mental, or sexual harm or suffering, threat of such acts, coercion and other deprivations of liberty." Although the majority of people who experience SGBV are women, boys and men are also targets. Rape has been used as a weapon of war in Democratic Republic of Congo,[27] Rwanda,[28] Sierra Leone,[29] Liberia,[30] and Darfur.[31] Reports of sexual violence against women are now emerging from Syria.[32] Sexual and gender-based violence has important consequences on sexual, reproductive, physical, and psychological health, as well as destructive effects on entire communities. Not only can rape spread HIV/AIDS but it may result in social stigma and even ostracization of women from families and/or communities. Refugees may continue to be at risk of SGBV after arrival in their host countries.[33]

Obtaining a Migration and Trauma History

Empathetic engagement with refugee patients is facilitated by obtaining an emigration history including the complete migration history and any traumatic experiences. Prior to the encounter, the clinician should seek information about conditions in the refugee's country of origin so as to ask sensitive and informed questions

Box 2. Resources for Specific Country Conditions

United Nations High Commissioner for Refugees
www.unhcr.org

US State Department
www.state.gov

Amnesty International
www.amnesty.org

Human Rights Watch
www.hrw.org

Box 4. Four Questions Providing a Guide to Assess Extent of Self-healing[36]

What traumatic events have happened?

How are your body and mind repairing the injuries from those events?

What have you done in your daily life to help yourself recover?

What justice do you require from society to support your personal healing?

(**Box 2**).[34] In Ms P's case, Somalia has been in civil warfare since 1991. Civilians experienced multiple traumas, including witnessing murder, rape, and forced displacement, in addition to starvation and collapse of the medical infrastructure.[35] Furthermore, many have lived in dangerous and deprived refugee settings prior to resettlement, where they may have continued to experience trauma, poverty, and discrimination. Clinician engagement with patients who have experienced trauma is needed to facilitate recovery.[36] An important element in recovery is the ability of the clinician to understand the full trauma story, including the personal and cultural relevance to the individual. Inviting the patient to tell his or her trauma story establishes trust and also enables the clinician to formulate an accurate differential diagnosis for symptoms. Understanding the trauma history allows the clinician to assess and strengthen the patient's self-care and support systems to foster recovery and well-being. The level of detail a refugee is willing to discuss depends on the individual circumstances. He or she should be given an opportunity to tell his or her story in a way that is comfortable. Details of the trauma may be suppressed for many years. Physicians may assume that patients do not want to talk about traumatic experiences. One study found that when physicians did not ask about trauma, refugee patients did not believe it appropriate to initiate conversations about their experiences.[37] Physicians can initiate the discussion about past trauma by asking patients about life in their home country and circumstances of their escape. An inquiry should be made about personal or family involvement in dangerous situations.[38] To Ms P, I would say "I know many people from Somalia whose families were hurt or killed in the war; did anything like that ever happen to you or your family?" **Box 3** outlines questions for refugees when obtaining a history of torture experiences, and **Box 4** lists 4 questions that assess the extent of self-healing that may facilitate the recovery process.

Box 5 provides resources available to assist clinicians caring for refugee populations. Specific country condition information can be found on websites for Amnesty International,[43] Human Rights Watch,[44] the US State Department,[45] and the World Health Organization[46] (Box 2).

Box 3. Questions When Inquiring About Experiences With Torture[12]

In what country were you born?

Can you tell me what made you leave your country?

Have you ever had problems because of your culture or tribe? Your political beliefs? Your religion? Your gender?

Have you ever been arrested or put in jail?

Have you ever been beaten or attacked by soldiers, police, or rebel groups?

Have you ever seen or heard others being beaten or attacked?

Have any members of your family been arrested or attacked because of their culture, tribe, political beliefs, or religion?

What problems are you having now from being beaten or attacked? (if a history of torture or trauma is elicited)

Box 5. Resources Available to Assist Physicians Caring for Refugee Patients

Webinars on refugee health available through the Massachusetts Technical Assistance Center[39]
http://refugeehealthta.org/webinars/

Massachusetts Department of Public Health Refugee and Immigrant Health Program Clinical Guide[40]
www.mass.gov/eohhs/docs/dph/cdc/refugee/health-assessment-5-online.pdf

Minnesota Department of Public Health Refugee Health Provider Resources[41]
www.health.state.mn.us/divs/idepc/refugee/hcp/index.html

Tool kit for primary care clinicians caring for traumatized refugees, developed by the Harvard Program in Refugee Trauma[42]
http://hprt-cambridge.org/

Physical Signs of Trauma

Clinicians should familiarize themselves with medical conditions resulting from trauma and torture. These medical conditions may overlap with or have an effect on other health conditions, including those common to the countries of origin. An example is musculoskeletal pain from beatings, which might be compounded by profound vitamin D deficiency.[47]

Identifying the subtle signs of torture requires heightened awareness. Diagnosis is guided by the refugee's trauma history and experiences with violence and deprivation. Potential medical sequelae of torture are listed in the **Table**. Physical evidence of torture is frequently absent after the acute injuries have healed.[48] Examples include rape, falanga (beatings to the soles of the feet), soft tissue injuries, and forced stress positions. Genital discomfort and male erectile dysfunction should alert clinicians regarding potential genital trauma/sexual assault. Resources for clinicians on evaluating the signs of trauma exist and include the Istanbul Protocol[49] and the Istanbul Protocol Model Medical Curriculum.[50]

Clinicians caring for refugee populations should be familiar with the cultural health practices that might be discovered on physical examination that are not a result of torture or physical abuse. These may include scarring from circular burns administered with burning sticks, hyperpigmentation or bruising from coining or cupping, or linear cutting marks (**Figure**).

Approximately 140 million women worldwide have undergone female genital cutting, commonly known as female circumcision, and it is most commonly practiced in the western, eastern, and northeastern regions in Africa.[51] Clinicians caring for refugee women from these areas should be familiar with the appearance of female genital cutting and potential complications.[52,53] Clinicians should inquire about any symptoms from the potential complications of female genital cutting, provide education if necessary. Some women believe that if they have had female genital cutting, they cannot undergo a speculum examination, and education may be required.

Mental Health

Posttraumatic stress disorder and major depression are the most common psychiatric conditions in refugee populations, but the spectrum and prevalence of mental health disturbances vary with the population studied and methodological approach used for sampling and diagnosis.[21] In a systematic review and meta-analysis of PTSD and depression prevalence in refugee and postconflict populations with 81 866 individuals, the prevalence of PTSD was 30.6% and of depression was 30.8%.[21] Torture emerged as the strongest predictive factor for PTSD, and cumulative exposure to potentially traumatic events was the strongest factor associated with depression.

Mental health sequelae may persist for years following conflict and resettlement.[54-56] A meta-analysis of preplacement and postplacement factors associated with refugee mental health found that psychological effects are influenced by acute trauma and the economic, social, and cultural conditions from which refugees are displaced and in their country of refuge.[57] Traumatic brain injury is prevalent following torture[58] and is correlated with depression.[59]

Trauma and violence are expected before and during flight; however, refugees may have their trauma exacerbated by additional losses associated with disconnection from cultural/social traditions, loss of language and communication skills, and loss of career and social status. Refugee parents may also experience the stress of raising second-generation children, who may acculturate more quickly and abandon their parent tradition and cultural values. Refugees may also experience marginalization in the host country.

Potential Causes of Symptoms in Patients Experiencing Trauma

Chronic pain is a common symptom reported by survivors of torture and traumatized refugees[60] and can have a debilitating effect on individual well-being including physical, psychological, and social health. Compared with a World Health Organization sample of general primary care patients in which chronic pain was reported in 22% of 25 916 individuals, 3 studies of refugee populations reported chronic pain in 78%, 65%, and 83% of individuals.[61]

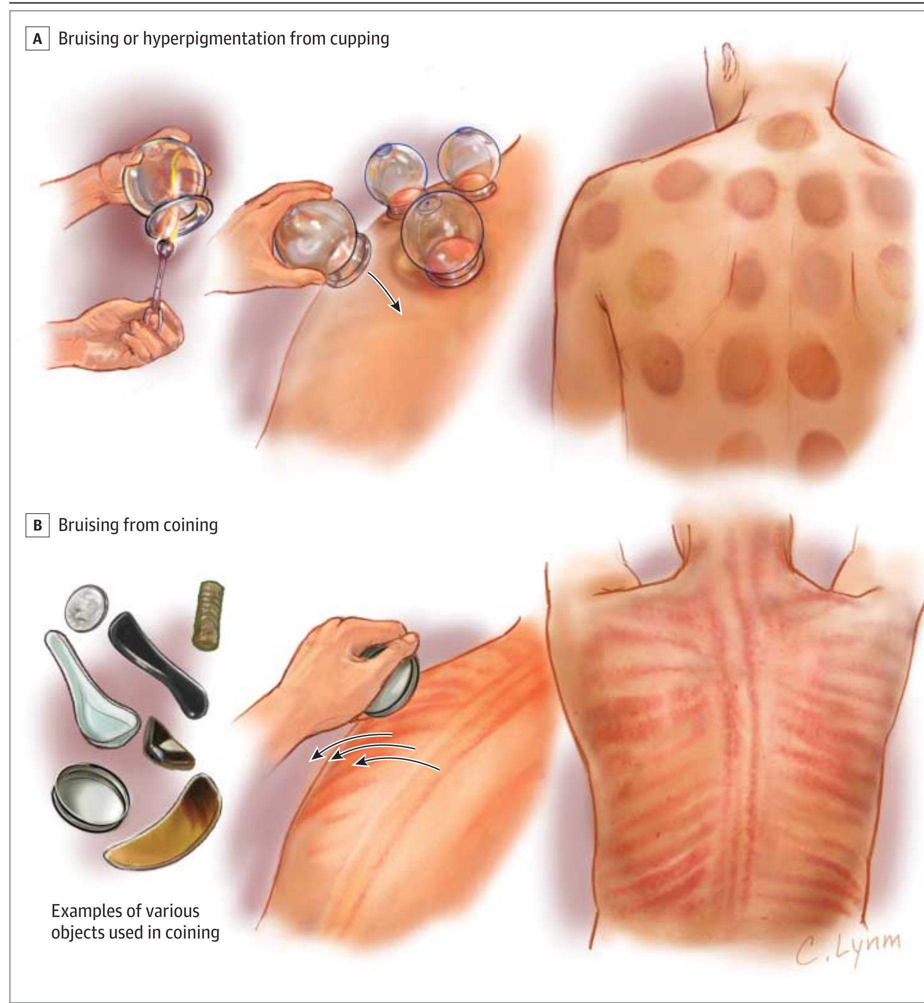
Chronic pain may have both physical and psychological components. Pain may have a specific etiology and refugees should be appropriately evaluated (ie, osteoarthritis from overuse and trauma, myofascial pain syndromes, postconcussive pain, and vitamin D deficiency). In addition, chronic pelvic inflammatory disease may result in chronic pelvic pain. Generalized musculoskeletal and body pain is common and may include headaches, abdominal pain, pelvic pain (especially in sexual assault victims), and chest pain.[62] Posttraumatic stress disorder, major depression, and somatization may contribute to chronic pain.[63-65]

The treatment of chronic pain is challenging, requiring a multidisciplinary approach and lacking an evidence-based literature supporting effective therapies in the refugee population. Standard treat-

Table. Medical Conditions Related to Torture and Ill Treatment[17-20,39-42]

Medical Conditions	Symptoms
Chronic pain (very common)	Somatization Musculoskeletal pain following beatings "Chest pain" Peripheral neuropathy
Head trauma (very common)	Chronic headaches Cognitive impairment, memory impairment Seizures Vertigo, dizziness Facial fractures, scarring Telefono—hard slap to ears resulting in rupture of tympanic membranes, hearing loss
Shaking	Retinal, subdural hemorrhages
Burn injuries	Extensive burns requiring surgery and skin grafting Painful contractures and scarring
Nerve injuries	Brachial plexus injuries resulting from suspension Peripheral neuropathy from beatings Handcuff neuropathy
Fractures	Fracture of bones (ribs, arm, leg, fingers) from blunt trauma (often without adequate treatment and requiring further surgical repair)
Amputation	Missing fingers, ears, or other appendages
Sexually transmitted diseases	Human immunodeficiency virus Chlamydia, gonorrhea Syphilis Hepatitis B and/or C
Chronic genital pain from trauma	Urethral strictures requiring surgical repair
Chronic pelvic inflammatory disease	Chronic pelvic pain after sexual assault
Infertility	
Sequelae from female genital mutilation	Infections, sexual dysfunction, pain, infertility
Sexual dysfunction	
Solar retinopathy from forced sun gazing	
Ocular trauma	Secondary glaucoma
Scars resulting from abrasions, lacerations, cutting wounds, and burns	May be nonspecific or have typical appearance (whip-mark lacerations, cigarette burns) May serve as reminders of trauma Often in unusual locations (ie, inner thighs), in large numbers
Sequelae from withholding necessary medications (ie, seizure from systemic lupus erythematosus vasculitis, stroke)	

Figure. Dermatologic Findings From Cultural Health Practices That May Be Incorrectly Identified as Signs of Torture or Physical Abuse



A, In cupping, circular lesions occur on the skin as a result of the application of cups in which a vacuum has been created by heating the cups prior to application or by mechanical suction. The cups are left in place (stationary) or moved about (gliding). Petechiae and round ecchymotic marks from cupping typically last up to 3 to 7 days but hyperpigmentation can last longer. B, In coining, a smooth object (eg, coin, bone, jade, metal lid) is repeatedly rubbed on a lubricated area of skin until petechiae appear. The resulting skin lesions are typically linear and oriented in a direction away from the heart. The areas most often treated are the chest, back, and torso. Marks readily fade to ecchymosis and generally resolve in several days.

ment using physical therapy and exercise is warranted, in addition to treatment of coexisting psychological disorders. One small randomized trial demonstrated pain improvement when exercise was added to psychological treatment.[66] Complementary and alternative medicine (eg, acupuncture, tai chi) is potentially useful in the management of chronic pain, although it is not well studied in refugee populations.[67]

The etiology of Ms P's chronic pain is likely multifactorial and has been resistant to various modes of treatment. Initially, Ms P brought a large bag with more than 60 bottles of pain medication that had been prescribed to her by different clinicians, creating the potential for dangerous polypharmacy. Ms P did not take any of the pills because the instructions were all in English, which she could not read. This highlights the importance of understanding her trauma history and considering all of the potential factors contributing to her symptoms. Subsequently, her chronic pain has been treated with physical therapy, pharmacological therapy with different classes of agents, psychiatric treatment and counseling, trigger-point injections, corticosteroid knee injections for osteoarthritis, and shoulder injections for bursitis, acupuncture, and cupping. Despite a coordinated multidisciplinary treatment approach, her symptoms have not been remediated, although she has had improvement. In Ms P's case, management also included acknowledging her losses, helping her cope with her pain, and assisting her to live independently. For Ms P, it is important to set realistic goals and provide ongoing empathy and support, even if her symptoms cannot be cured.

Recommendations for a Standardized Approach to Caring for Refugees Experiencing Trauma

The primary care visit is an opportunity to detect physical and psychological symptoms related to past traumatic experiences. Patients may present with complex pain syndromes, sleep disturbance, cognitive dysfunction related to traumatic brain injury, sequelae of physical and sexual trauma, and psychological disorders. Challenges to obtaining an appropriate history include lack of trust, inadequate communication (including language barriers), and cultural differences between the clinician and refugee.

Earning the trust of a refugee patient requires attentive listening, communication, empathy, and respect. Communication styles of refugees may be unfamiliar to Western clinicians (eg, lack of direct eye contact, inappropriateness of shaking hands with opposite sex). There may be a perceived power differential whereby refugees do not feel comfortable initiating conversation topics. Refugees may perceive discrimination based on their immigration status.[68] Refugees may have had previous negative experiences with the health care system or may be afraid of getting bills (refugees have revealed fear of arrest when receiving hospital bills they are unable to pay). They may view the clinician or hospital as agents of the government, and they may be reluctant to disclose information if they do not understand the confidential nature of the patient-physician relationship. Refugees may also have a fear of arrest and deportation if they are in the asylum process. Another potential reason for mistrust is the possibility that physicians may have participated in the system of oppression or torture in their home country.[69] It is important to discuss these issues directly.

Some refugees may have different ways of understanding illness and health care compared with Western physicians. For example, Ms P attributed her symptoms to fate, or Allah's will, and not to the effects of trauma or musculoskeletal conditions that were potentially treatable. Injections might be perceived to be more effective than pills, and by not being prescribed an injection, the refugee may feel that he or she is not getting the best treatment.

Limited English proficiency (LEP) can present a barrier to caring for refugee populations. Patients with LEP are more likely to report problems with care and are more at risk of medical errors.[70-72] One systematic review suggests that optimal communication, increased patient satisfaction, best outcomes, and fewest errors occurred when patients with LEP have access to trained professional interpreters.[73] To maximize the quality of the clinical encounter and to minimize the risk of errors, bilingual clinicians or certified professional interpreters should be involved in all encounters with patients with LEP. In Ms P's history of not understanding, she consented to a major surgical procedure (nephrectomy), compounding her existing trauma and illustrating the adverse consequences of inadequate interpretation.

Consideration should be given to offering use of an anonymous phone interpreter when sensitive topics are discussed. An in-person interpreter may be a member of the local community, and patients may be reluctant to discuss sensitive topics such as torture/trauma or sexual and reproductive health because of fear of disclosure or stigma. Gender concordance of the interpreter may be important in some cultural groups.[74,75] Ethnicity or tribal affiliation of the interpreter should be considered (eg, there have been instances where the interpreter is from the tribe or ethnic group that was associated with persecution of the patient or patient's ethnic group).

It is important for the clinician to develop a relationship with the interpreter. Clinicians should conduct a brief preinterview meeting with the interpreter to discuss goals of the visit, including how to obtain sensitive information in a culturally appropriate manner, and then a postinterview to confirm whether goals were met and to obtain feedback. It is important for clinicians to understand that federal law obligates physicians to use a professional interpreter under Title VI of the Civil Rights Act.[76] Resources for clinicians are available.[77-79]

Traditional Medicines

Clinicians should have an awareness of how traditional medicine and religious fasting might affect the health of refugee patients. A clinician should respectfully inquire about traditional medicines, determine the potential for any adverse effects and drug interactions, and be flexible about incorporating traditional treatments into the therapeutic plan. Black seed, for example, is commonly used in the Somali community, and Ms P used black seed as part of the therapeutic regimen for treatment of her pain.[80]

The concept of personal autonomy and private medical decision making valued in Western countries is not always the norm in other cultures, and family members or others in the community are sometimes very involved in medical decisions for individual refugees. As an example, family members may attend clinic appointments to assist in decision making as to whether the patient should undergo a procedure or accept psychiatric treatment. Similarly, in some cultures, delivery of bad news, such as a cancer diagnosis, is communicated to the family and not directly to the patient.[81] It is important to ask patients whom they would like involved in decisions.

Priorities

Despite challenges, a physician's office is often where new refugees feel most comfortable asking for help. Attention to their basic needs should be the first priority. They may, for example, be most concerned with safety, food, and clothing appropriate to the weather, not with the clinician's agenda for their medical care. Other concerns of refugee and asylum-seeking patients may include lack of housing or utilities, their family's safety in the home country, legal representation if seeking asylum, lack of employment, or access to English language classes. By addressing the refugee's priorities, trust will be fostered such that over time a relationship develops and medical goals can be achieved.[82] When Ms P arrived at her physician's office, she had no housing, she was in severe distress, and she met criteria for severe PTSD. She was unemployed and had limited literacy and English proficiency, which adversely affected her ability to comprehend and interact within the medical system. She required assistance applying for disability and housing. Addressing all of these needs required case management support and liaison with resettlement agencies and local refugee community organizations.

Developing a Management Plan

An integrated, culturally appropriate approach to mental health care that considers the interrelationship of individual, family, and community; the interconnection of physical, psychological, and social problems; and the influence of trauma is important.[83,84] In the appropriate setting, simple mental health screening instruments are useful in the primary care setting. These may include the Hopkins Symptom Checklist 25 and the Harvard Trauma Questionnaire, which

have been validated cross-culturally.[85] Mental illness is equated to being "crazy" in some cultures, and new refugees initially may be reluctant to accept diagnoses and treatment for mental health conditions.

In fact, Ms P recently revealed she was not taking the selective serotonin reuptake inhibitor prescribed by her psychiatrist because she is "not crazy" and a friend in her community suggested to her that she should not take it. Ms P did not reveal to the psychiatrist that she stopped taking her medication.

Incorporating mental health services into primary care clinics may decrease stigma and normalize mental health care as part of routine services, although there is a lack of evidence to inform best practices. One systematic review demonstrated the benefit of community-based mental health services in improving mental health outcomes of refugees, although longitudinal data are lacking.[86]

Development of a treatment plan for Ms P required consideration of all of the above factors, including use of a trusted interpreter. Her requests for same-sex physicians and an identified location for her to pray when she is at the hospital during her prayer time were granted. She has a multidisciplinary treatment team that includes primary care, mental health, social work, physical therapy, rehabilitation medicine, complementary and alternative medicine, and a gynecologist experienced with refugees. Having liaisons with local immigrant community organizations is also essential. These include refugee resettlement organizations and, in Ms P's case, specific local Somali organizations.

Update on Ms P

Ms P's pain has improved. She initially had total body pain that was debilitating (requiring inpatient hospitalization). She now has pain mostly limited to her shoulders and knees, which is controlled with medications, occasional corticosteroid injections, physical therapy, and acupuncture. Her mental health has improved and she continues to see a psychiatrist experienced in treating refugee trauma. She no longer has nightmares and her anxiety is lessened. She is still grieving for (and has flashbacks to) her lost children, but "no doctor can help this."

Questions and Discussion

QUESTION I have an 85-year-old Somali patient. She has chronic pain and requested trigger-point injections. How do you approach a patient who is asking for a mode of Western medicine that you believe is not appropriate?

DR CROSBY Chronic pain in refugees is often multifactorial, with both physical and psychological components. A comprehensive evaluation is indicated, which includes taking psychosocial and traumatic histories in addition to a physical examination. The results provide an individually tailored therapeutic plan. In this case, if trigger-point injections are not indicated based on the clinical assessment, an alternative might be to offer acupuncture as one element of a comprehensive therapeutic plan. Our practice has found acupuncture to be effective for chronic pain in refugees, although randomized clinical trials in this population are lacking. Additionally, the patient should be screened for depression.

QUESTION What advice can you give regarding the inpatient care of this patient population?

DR CROSBY Depending on the patient, acute care can be very challenging. The physical environment can be frightening, and procedures and staff may be unfamiliar. For elective surgical hospitalizations, I have patients receive an orientation and even walk through the operating suite and recovery room in advance. For patients who have experienced trauma, alerting the anesthesia team and nurses to the possibility of emergence flashbacks might be appropriate.[87] It is important to communicate with the inpatient clinicians about any particular concerns for individual patients.

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