Family Practice Advance Access published May 12, 2014

Family Practice, 2014, Vol. 00, No. 00, 1–5
doi:10.1093/fampra/cmu017

Refugees' advice to physicians: how to ask about mental health

Patricia J Shannon[a,b,*]

[a]School of Social Work, University of Minnesota and [b]The Center for Victims of Torture, St. Paul, MN, USA.

*Correspondence to Patricia J Shannon, School of Social Work, University of Minnesota, 1404 Gortner Avenue, St. Paul, MN 55108, USA; E-mail: pshannon@umn.edu

Received November 27 2013; revised March 23 2014; Accepted March 24 2014.

Downloaded from http://fampra.oxfordjournals.org/ at UQ Library on May 19, 2014

Abstract

Background. About 45.2 million people were displaced from their homes in 2012 due to persecution, political conflict, generalized violence and human rights violations. Refugees who endure violence are at increased risk of developing chronic psychiatric disorders such as posttraumatic stress disorder and major depression. The primary care visit may be the first opportunity to detect the devastating psychological effects of trauma. Physicians and refugees have identified communication barriers that inhibit discussions about mental health.
Objectives. In this study, refugees offer advice to physicians about how to assess the mental health effects of trauma.
Methods. Ethnocultural methodology informed 13 focus groups with 111 refugees from Burma, Bhutan, Somali and Ethiopia. Refugees responded to questions concerning how physicians should ask about mental health in acceptable ways. Focus groups were recorded, transcribed and analyzed using thematic categorization informed by Spradley's Developmental Research Sequence.
Results. Refugees recommended that physicians should take the time to make refugees comfortable, initiate direct conversations about mental health, inquire about the historical context of symptoms and provide psychoeducation about mental health and healing.
Conclusions. Physicians may require specialized training to learn how to initiate conversations about mental health and provide direct education and appropriate mental health referrals in a brief medical appointment. To assist with making appropriate referrals, physicians may also benefit from education about evidence-based practices for treating symptoms of refugee trauma.

Key words: Culture and disease/cross-cultural health issues, doctor-patient relationship, immigrant health, mental health, primary care, trauma.

Introduction

There were 45.2 million people displaced from their homes in 2012 due to persecution, political conflict, generalized violence and human rights violations (1). The largest groups of refugees resettled to the USA were fleeing political wars and conflicts in Burma, Bhutan, Iraq and Somalia (2). Refugees presenting in family practice clinics may be struggling with significant physical and mental health symptoms of war trauma and torture (3). The initial primary care visit is often the first opportunity for physicians to address the devastating effects of such traumatic experiences. However, several barriers to communication have been identified by physicians and refugees that may inhibit discussions about the effects of war trauma and torture (4,5). In this study, refugees describe culturally acceptable processes for assessing the mental health effects of trauma.

Historical estimates indicate that up to 35% of refugees are torture survivors (6). Recent studies indicate much higher torture prevalence rates for Iraqis (56%) (7), Somalis (36%) (8), Oromos (55%) (8) and Karen (30%) (9). Non-tortured refugees

© The Author 2014. Published by Oxford University Press. All rights reserved. For permissions, please e-mail: journals.permissions@oup.com.

are exposed to trauma at even higher rates with whole populations facing political oppression, forced displacement, war, detention, forced labour and violence in camps (10). Refugee trauma survivors may present with physical symptoms of chronic pain, traumatic brain injury, headaches, abdominal pains, sleep difficulties, burns and injuries to eyes, ears, mouth and feet (3,11,12). In their meta-analysis of 181 surveys with refugees, Steel *et al.* (13) reported prevalence rates of 30.6% for post-traumatic stress disorder and 30.8% for depression. Untreated mental health distress can be debilitating and lead to long-term illnesses including hypertension, coronary vascular disease, metabolic syndrome and diabetes mellitus (3,7). It is crucial that family physicians be aware of refugees in their practices, their exposure to trauma, and provide assessment of physical and mental health symptoms.

Physicians, refugees and researchers have identified several barriers to communication about the symptoms of trauma. Physicians have described feeling uncomfortable asking refugees about their trauma histories, experiencing greater communication difficulties when interpreters are needed, and lacking time and culturally appropriate tools to initiate sensitive conversations (14,15). Physicians have further identified a reluctance to discuss mental health with refugees due to system barriers to obtaining mental health care (15). Refugees have identified a lack of understanding of mental health conditions, mental health stigma, a reluctance to initiate conversations about mental health and cultural barriers to accessing mental health care (4,5). Barriers to receiving care that have been identified through research include the lack of interpreters in mental health clinics, cultural differences in understanding mental health, lack of reliable transportation and difficulty navigating complex systems of care (16).

Primary care physicians who work with refugees successfully have described what is required to help refugees discuss past trauma and obtain the necessary care to begin healing. Crosby (3) asserted that refugees should be given an opportunity to tell their stories in a way that is comfortable and that physicians need to understand the full trauma story and its cultural and personal significance to provide an accurate diagnosis. Physicians who assess torture survivors have also recommended asking survivors directly about their past experiences of torture (12). In this study, refugees describe how physicians can ask about the psychological symptoms of torture and war trauma.

Methods

This data are part of a larger data set gathered to develop culturally grounded mental health screening processes for refugees. We used ethnocultural methods to conduct 13 focus groups with 111 total participants from four refugee groups between 2009 and 2011 (17). Table 1 reports brief demographic characteristics. Participants were recruited through cultural leaders who recognized the importance of the study. Following their guidance, the research team conducted interviews with separate groups for men and women in the Somali and Oromo communities and mixed-gender groups in the Karen and Bhutanese communities. We conducted separate mixed-gender young adult groups for participants between 18 and 25, who preferred to be interviewed separate from their elders.

This study was granted exempt status by the university institutional review board due to the community-based nature of the interviews. However, each participant completed an informed consent and received a $10 gift card. Focus groups lasted 2 hours and participants responded to questions concerning how they describe their problems, thoughts and feelings related to war and conflict and what are culturally acceptable ways to talk about these problems? Focus group interviews were conducted by myself and a faculty co-investigator through trained interpreters. Both faculty researchers have extensive experience working with refugee trauma survivors. Interviews were audio-recorded and transcribed by a member of the research team, which included two graduate assistants with refugee experience. We hired trained interpreters from health care organizations and provided additional training on the goals of the study, interpretation process and follow-up debriefing.

The data analysis procedure was informed by Spradley's Developmental Research Sequence as a method for discovering refugees' emic perspective on mental health (18). We explored taxonomies among and within domains, categories, themes and subthemes. Coding was conducted by a team composed of two co-investigators and four graduate assistants. Analysis

Table 1. Characteristics of focus group participants

Refugee group	Gender		Age		Years in USA	
	Male	Female	Mean	Standard deviation	Mean	Standard deviation
Bhutanese	20	14	37.2	17.3	1	0
Karen	11	12	38.3	14.9	2.17	2.0
Oromo	17	10	45.5	20.6	8.7	4.4
Somali	14	13	45.9	23.4	6.8	5
Total	62	49				

Downloaded from http://fampra.oxfordjournals.org/ at UQ Library on May 19, 2014

began immediately with transcription of the first focus group and proceeded with ongoing reading of transcripts, developing a list of codes, coding the data and meeting as a research team to review and reconcile emerging data. Cultural leaders were consulted for extensive peer debriefing of emerging domains and the interpretation of the data. To enhance trustworthiness of the data, credibility, transferability, dependability and confirmability were systematically tracked (19). Data trustworthiness was established through regular consultation with cultural leaders throughout the research and analysis process.

Results

Findings reported in this study describe a domain labelled, 'Recommendations for Assessing Mental Health'. There were seven categories describing recommendations for how physicians should ask refugees about the mental health effects of trauma: (i) make refugees comfortable, (ii) ask about the historical context of symptoms, (iii) ask direct questions about mental health distress, (iv) provide psychoeducation, (v) provide trained interpreters, (vi) interview some family members separately and (vii) use family as an ally. The first four categories were endorsed by all refugee groups. The last three were suggested by only a few refugee communities. Figure 1 provides a summary of these key points. Quotes identify participant number with 'P' and group number with 'G'

Make refugees comfortable

Refugees from all four cultural groups emphasized that physicians should take the time to make refugees feel comfortable. Doctors need to show refugees that they care. They need time to ask questions and refugees need time to speak about the pain they are suffering. Oromo refugees said, 'Don't cut us short, let us speak' (P1, G1). Providers need to work to build trust. Oromo youth suggested that providers take time to establish an ongoing relationship with refugees. Bhutanese refugees stated that physicians could make refugees comfortable by asking about their lives back home. Somali refugees stated, 'Doctors should be open and friendly and joke with them. If the doctor is not friendly and he is an uptight person, the refugee will not feel comfortable to talk to him' (P3, G4). They complained that short appointment times, changing interpreters and multiple providers contributed to lack of trust in physicians.

- Make refugees comfortable
- Initiate direct questions about mental health in historical context
- Provide psychoeducation
- Use trained interpreters
- Use family as ally
- Interview some children separately

Figure 1. Key advice for interviewing refugees.

Ask about the historical context of symptoms

Refugees want physicians to be interested in discussing the political and historical contexts of their symptoms. Oromo men stated, 'Don't just focus on pain. There are histories that are causing pain' (P7, G4), 'Connect pain to our problems back home' (P1, G1) and 'freedom back home, the political issues is one of the causes of depression' (P2, G1). Oromo youth asserted that it is politically important for physicians to recognize their identity as Oromos instead of Ethiopians. Somali refugees stated, 'Instead of saying. how is your mental state, if you could ask about the historical background and what they went through and then say how are you feeling right now?' (P4, G2).

Karen refugees explained their symptoms as being caused by political conflict including war, traumatic loss, displacement and violence in camps. They recommend getting political history from family members in the initial medical screening if necessary for understanding the symptoms of patients. Bhutanese refugees asserted that physicians should ask about traumatic histories at the first appointment. They said, 'Our people will not lie, they will tell you the name of the prison they were in and everything. They will tell you how their children were killed' (P2, G7).

Ask direct questions about mental health

Refugees uniformly stated that they will not discuss mental health unless the doctor asks directly. Deference to the physician's authority was common across all cultural groups. Oromo women asserted that doctors should ask directly about 'worrying too much'. They explained, 'We're used to worrying to ourselves. Day and night we are worrying and there is no place to go to get relief from our worry and our thinking' (P7, G9) and 'We are always thinking about those who are there. The problem is thinking about, worrying about them'. (P2, G9) Bhutanese stated, 'If you don't ask, I'm not going to answer' (P6, G7). They explained that if the doctor leads the question, 'they will be able to say but spontaneously, it will be difficult to say' (P8, G8). They recommended physicians ask very direct questions, 'What kind of life did you have in the refugee camp? Were you beaten? We will definitely tell' (P1, G7). They added that the first medical screening appointment is the best time to ask. Bhutanese youth suggested that physicians ask youth direct questions about their current fears. They suggested asking, 'Do you remember any events in the past that have affected you?' and 'Do you still have fear from the past?' (P8, G10).

Karen refugees stated that if they are asked about the impact of war at a medical screening, they will answer but they tend not to complain. One Karen man said, 'If the doctor asks something about pain, they will answer. But if the doctor doesn't ask about sleep, we won't answer that question. So you need to ask specific questions' (P1, G6). Karen youth stated that children should also be asked direct questions such as 'What problems did you have living in the camp?' (P1, G12). Somali refugees stated that if doctors ask

Downloaded from http://fampra.oxfordjournals.org/ at UQ Library on May 19, 2014

in the middle of the consultation, refugees might be most likely to tell you about their suffering. Somali's stated that it is okay to ask direct questions about mental health or drug and alcohol use; however, they suggest that doctors gain experience knowing how to ask mental health questions. It may be most helpful if a mental health professional works alongside the primary care doctor. Somali youth stated that it is okay to ask direct questions about mental health as most Somalis will tell you what is wrong; however, they emphasized that elders need to be questioned in respectful ways.

Provide psychoeducation about mental health

Karen stated that it is important for physicians to provide education about mental health and common effects of war because Karen will take advice from educated people even more than their parents or family. Somali youth emphasized the importance of normalizing symptoms, making Somalis feel comfortable to talk and explaining that there is a cure for the problems. Otherwise, Somalis will not talk. They state that Somalis don't know what stress is, so there should be a lot of classes or education. One Somali refugee recommended explaining the symptoms of trauma before asking the questions,

> You have to show them it's curable otherwise they won't tell. There's no point of them telling you something personal if it can't be cured. And I think a way to approach this would be you saying the symptoms without telling them,' hey you have this' and let them tell you ' these are the same symptoms I've experienced'. (P10, G11)

Oromo youth stated that it is important to let people know that it is okay to talk and Bhutanese youth stated that they would definitely go to talk with a counsellor if the doctor referred them.

Provide trained interpreters

Oromo youth stated that refugees need someone who speaks the language and understands the culture. They explained that it takes time to build a relationship and get comfortable with interpreters and doctors. Interpreters also need to be regular. One Oromo youth stated, 'Just because you have an interpreter doesn't mean you are going to tell everything. It should be someone who you will see regularly instead of going from clinic to different clinic' (P8, G13). Oromo discussed their difficulty describing symptoms through interpreters. Sometimes they don't use the correct word or even speak the same dialect.

Interview some family members separately

Bhutanese youth stated that doctors should ask parents about children's mental health difficulties because they will know them best; however, teenagers should be interviewed separately. Karen refugees discussed the existence of domestic violence in their community and recommended that children be interviewed separately. They stated that some children will be very afraid to report domestic violence honestly because they fear either being beaten at home or that the police will take their parents away. Educating families is seen as one way to help break this pattern. Somali youth believe that children will not talk in front of their parents so they should be interviewed separately.

Use the family as an ally

Bhutanese refugees stated that convincing the family can be helpful when trying to engage refugees in mental health care. First they will seek out help through prayer or a Shaman, but if you can convince the family that mental health care is needed, the family will convince the patient. Somali refugees stated that it can be important to have a family member there when interviewing someone with mental health symptoms. Sometimes it may be better for the family to speak for the patient. Somalis in general suggested that it may be easier to trust the process if someone from their own cultural background is there helping to ask the questions.

Discussion

Refugees offer several concrete tips about how physicians can inquire about mental health in the context of a primary care visit. They also express frustration that there is often not enough time to have meaningful discussions about mental health with physicians who appear too busy. Refugees requested that physicians take the time to make them comfortable, initiate conversations about mental health and ask direct questions in the context of their histories, utilize trained interpreters, and provide psychoeducation about normal responses to trauma as well as available treatments. Although physicians may be hesitant to ask refugees about their trauma histories, refugees state that they are interested to discuss mental health symptoms resulting from traumatic histories; however, they assert that the physician needs to ask first. These findings are consistent with previous research with Liberian refugees who also indicated their willingness to talk about the impact of war to benefit their health (5). Liberians also stated that physicians need to ask about mental health before they will discuss it. Refugees tend to defer to authority figures and will not address issues that are not initiated by the physician. Physicians may require specialized training to learn how to initiate conversations about trauma and provide direct education and appropriate mental health referrals in a brief medical appointment. To assist with making appropriate referrals, physicians may also benefit from education about evidence-based practices for treating symptoms of refugee trauma.

Because stigma has been cited as a barrier to refugees receiving mental health services, physicians have a great opportunity

Downloaded from http://fampra.oxfordjournals.org/ at UQ Library on May 19, 2014

in the primary care visit to provide education that de-stigmatizes both the symptoms of war trauma and the mental health services needed to heal. Refugees may be relieved to know that symptoms of posttraumatic stress disorder and major depression are common and treatable responses to trauma. For torture survivors, recognizing the dehumanizing and violating nature of torture can be empowering and healing. The primary care visit may be the first time their stories are told and believed. Contrary to the popular belief that exploring traumatic histories may be re-traumatizing, the refugees in this study asserted that they want the historical causes of their symptoms acknowledged.

These findings are limited by the focus group nature of the interviews. It is possible that in-depth interviews would provide a more complete understanding of what may be helpful to refugees in conversation with physicians. It would also be helpful to better understand communication challenges from the perspective of physicians. Despite these limitations, refugees clearly indicate that they welcome more direct conversations with physicians about their histories and symptoms of trauma.

Declaration

Funding: Blue Cross and Blue Shield Foundation of Minnesota.
Ethical approval: Institutional review board of the University of Minnesota.
Conflict of interest: none.

References

1. United Nations High Commission for Refugees. *Fact Sheet: Displacement The New 21st Century Challenge, 2013*. The UN Refugee Agency Web site. http://www.unhcr.org/51bacb0f9.html (accessed on April 25, 2014).
2. Office of Refugee Resettlement 2013. *Fiscal Year 2012 Refugee Arrivals*. http://www.acf.hhs.gov/programs/orr/resource/fiscal-year-2012-refugee-arrivals (accessed on April 25, 2014).
3. Crosby SS. Primary care management of non-English-speaking refugees who have experienced trauma: a clinical review. *JAMA* 2013; 310: 519–28.
4. Saechao F, Sharrock S, Reicherter D *et al.* Stressors and barriers to using mental health services among diverse groups of first-generation immigrants to the United States. *Community Ment Health J* 2012; 48: 98–106.
5. Shannon P, O'Dougherty M, Mehta E. Refugees' perspectives on barriers to communication about trauma histories in primary care. *Ment Health Fam Med* 2012; 9: 47–55.
6. Baker R. Psychosocial consequences for tortured refugees seeking asylum and refugee status in Europe. In: Basoglo M (ed). *Torture and its Consequences: Current Treatment Approaches*. Cambridge, UK: Cambridge University Press, 1992, pp. 83–106.
7. Willard CL, Rabin M, Lawless M. The prevalence of torture and associated symptoms in United States Iraqi refugees. *J Immigr Minor Health* 2013: 1–8.
8. Jaranson JM, Butcher J, Halcon L *et al.* Somali and Oromo refugees: correlates of torture and trauma history. *Am J Public Health* 2004; 94: 591–8.
9. Schweitzer RD, Brough M, Vromans L, Asic-Kobe M. Mental health of newly arrived Burmese refugees in Australia: contributions of pre-migration and post-migration experience. *Aust N Z J Psychiatry* 2011; 45: 299–307.
10. Porter M, Hasla N. Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons. *JAMA* 2005; 294: 602–12.
11. Crosby SS, Norredam M, Paasche-Orlow MK *et al.* Prevalence of torture survivors among foreign-born patients presenting to an urban ambulatory care practice. *J Gen Intern Med* 2006; 21: 764–8.
12. Miles SH, Garcia-Peltoniemi RE. Torture survivors: what to ask, how to document. *J Fam Pract* 2012; 61: E1–E5.
13. Steel Z, Chey T, Silove D *et al.* Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. *JAMA* 2009; 302: 537–49.
14. Rosenberg E, Leanza Y, Seller R. Doctor-patient communication in primary care with an interpreter: physician perceptions of professional and family interpreters. *Patient Educ Couns* 2007; 67: 286–92.
15. Centers for Disease Control. Guidelines for Mental Health Screening *During the Domestic Medical Examination for Newly Arrived Refugees*. www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/mental-health-screening-guidelines.html (accessed on November, 2013).
16. Morris MD, Popper ST, Rodwell TC, Brodine SK, Brouwer KC. Healthcare barriers of refugees post-resettlement. *J Community Health* 2009; 34: 529–38.
17. Wendt DC, Gone JP. Decolonizing psychological inquiry in American Indian communities: the promise of qualitative methods. In: Nagata DK, Kohn-Wood L, Suzuki LA (eds). *Qualitative Strategies for Ethnocultural Research*. Washington, DC: American Psychological Association, 2012, pp. 161–178. doi:10.1037/13742-000
18. Spradley J. 1979. *The Ethnographic Interview*. Belmont CA: Wadsworth Cengage Learning.
19. Lincoln YS, Guba EG. 1985 *Naturalistic Inquiry*. Beverly Hills, CA: Sage.

Downloaded from http://fampra.oxfordjournals.org/ at UQ Library on May 19, 2014