New Approaches to Health Care for Displaced Populations

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The United Nations defines a refugee—according to the 1951 Convention Relating to the Status of Refugees—as somebody who, "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country." Recent estimates suggest that there are approximately 50 million displaced persons worldwide, including internally displaced persons (who have not crossed international borders) and refugees.

Health care professionals engage with these populations in numerous ways, ranging from personal, clinical encounters with refugee patients to participation in international medical interventions. Good intentions and sound medical knowledge, however, are not sufficient to provide the health care required by this community of patients. With their history of displacement, persecution, fragmentation of cultural and familial structures, and violation of human rights, displaced persons have a more complicated biopsychosocial profile than most patients in the United States.

By becoming more aware of the various issues that affect members of displaced communities, health care providers may become better at confronting their acute and long-term health problems. Furthermore, the health care issues that apply to these populations may also apply to others who do not exactly fit the United Nations definition. Illegal residents or immigrants, those who have been internally displaced, and asylees who do not yet have official refugee status, for example, may benefit from the approaches and perspectives described for refugees.

This issue of MSJAMA examines the special problems faced by refugees and displaced persons. Richard Mollica provides a model for how to incorporate the patient's trauma story into the primary care medical interview, so that this essential part of this story is not missed. Health care professionals must take into account the complicated perspectives of culture, human rights, and the ethical problems of international intervention. Stevan Weine proposes a more active engagement with the ramifications of culture in health care interventions, particularly as it pertains to the patient's family and local physicians.

Alejandro Moreno and colleagues review the epidemiology of human rights violations in displaced populations and suggest how these might be addressed through the education of physicians and an awareness of human rights violations in the clinical encounter. Gina Jae interviews Philip Gourevitch, the author of We Wish to Inform You That Tomorrow We Will Be Killed With Our Families, a powerful and critical analysis of the genocide and refugee crises in Rwanda in 1994. Ferid Agani examines the mental health system of Kosovo after the war and NATO interventions of 1999, focusing on the importance of recognizing local institutions in the rebuilding that goes on after such crises.

REFERENCES
Assessment of Trauma in Primary Care

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Knowledge of the acute and chronic effects of mass violence and torture is accumulating.¹ The entry of millions of refugees and asylum seekers into the United States is bringing highly traumatized patients into the practices of primary care physicians. Therefore, the clinical assessment of trauma in primary care medicine has become a central issue. The primary care practitioner can assume neither that the health effects of violence will reveal themselves in the standard medical interview nor that they will be fully identified through an extensive evaluation similar to that for other organ systems. Efforts to train primary care physicians in this country and abroad have demonstrated the need for a new scientific method for assessing the clinical impact of traumatic life experiences.

In A Guide to the Physical Examination and History Taking² and the companion pamphlet A Guide to Clinical Thinking,³ Bates et al review the approach to history taking and diagnosis in a general medical setting. This approach can be adapted into a specialized approach for the assessment and management of the health care needs of traumatized patients. This adaptation begins with a recognition of “clinical thinking as an invisible process,” where “from the moment you see the patient and listen to the chief complaint, you develop ideas about what may explain the complaints and how you can determine their probable nature and cause with increasing certainty.”³ It is our experience working with traumatized patients that the traumatic life events of the patient must be a central focus of clinical thinking.⁴ This entails considering the effects of the patient’s trauma story on the medical history, physical examination, and laboratory studies.

For example, there are special considerations in evaluating the chief concern. The possibility of an organic basis to the chief complaint must be first ruled out, but the physician must also be attuned to how the patient’s trauma story is contributing to the patient’s physical and/or emotional distress. Very few patients can state directly that their story is contributing to the patient’s physical and/or emotional distress. However, in assessing the patient’s medical history, one can determine their probable nature and cause with increasing certainty.³ It is our experience working with traumatized patients that the traumatic life events of the patient must be a central focus of clinical thinking.⁴ This entails considering the effects of the patient’s trauma story on the medical history, physical examination, and laboratory studies.

Some physicians are reluctant to take a complete trauma history, particularly of sexual abuse, until a trusting relationship has been established. However, demonstrating to patients that their trauma story is an important component of their medical history is a significant step in establishing rapport. Private disclosure usually follows from the physician’s clinical interest in the patient’s life experience.

For refugees and survivors of mass violence, the physician should pay particular attention to psychosocial history, particularly bereavement, and to the traumatic loss or disability of family members, especially spouses and children. The unnatural death of a child or spouse should be added immediately to the patient’s problem list. Suffering after the loss of a loved one may manifest in many ways, including severe chronic depression and physical pain.

The physical exam and review of systems should be guided by information obtained during the medical interview, including the patient’s trauma story.¹ A mental status examination must be in the repertoire of all physicians because of the high prevalence of emotional distress in this population. Many traumatized patients cannot present their emotional distress to the physician in a coherent fashion without being emotionally retraumatized. Simple screening instruments that assess the traumatic life experiences and psychiatric symptoms of the patient in a question-and-answer format, such as the Hopkins Symptom Checklist-25 and the Harvard Trauma Questionnaire, can overcome this problem.² These instruments have high cultural validity and reliability and are readily accepted by patients from diverse backgrounds.

The physician concludes the clinical assessment by developing a problem list. The patient’s trauma history should be placed at the top of this list. The physician must specifically ask the patients if each of the listed medical and/or psychiatric problems have been exacerbated by their current economic or social situation. It is important to determine the negative effects of patients’ illnesses on their daily life. Overall therapeutic management will consider the impact of trauma on the patient’s health and functional status over time.

This new clinical assessment approach to trauma can lead to measured and realistic interventions within the context of the patient’s life history. Treatment priorities must be set because not all patient problems can be solved. A well-thought-out acute and long-term treatment plan can prevent physicians from being emotionally overwhelmed by the human cruelty that has damaged their patients.

REFERENCES
From War Zone to Contact Zone: Culture and Refugee Mental Health Services

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It is no longer appropriate to conceptualize a world in which the movement of refugees is one way and permanent, or where health care professionals can consider themselves naive outsiders. Contemporary habits of travel and communication have placed much of the world's population in "complex connectedness."1 Paradigms of cultural competence based only on recognizing cultural difference are not sufficient to take into account the subtleties and importance of the cross-cultural interactions between refugees and mental health services. Instead, paradigms from the "new ethnography"2 that reflect how cultures engage and influence one another must be incorporated into the delivery of mental health services.

Existing frameworks for understanding refugee mental health services have emphasized the idea of the "war zone." This framework prioritizes the result of exposure to war trauma and emphasizes concepts such as posttraumatic stress disorder, damaged self, and psychotherapy, while relegating issues concerning culture to the background. These are culture-based assumptions that influence the choices that mental health professionals make about refugee services. Traditionally, mental health services tend to focus on treatments for individuals who are willing to present themselves as "patients." Relatively few refugees, however, are willing to be patients, although many suffer.2 A leading scholar of the new ethnography, James Clifford proposes the "contact zone"3 as a place of exchange, interpenetration, and negotiation between 2 or more worlds. Health care services, from a contact zone perspective, are not universal receptors that any incoming refugee group can plug into, nor are they a plug that can fit in the socket of every post-war nation. Rather, each situation is a complicated interaction between refugees and professionals, shaped not only by the particulars of a given location, but also by persons, professionals, ideas, policies, or monies from far away.

I used a contact perspective to investigate historical memory in Bosnia-Herzegovina.4 I would like to provide several examples of ways in which new conceptualizations of culture can affect services for refugees. First, talking about trauma through interpreters does not necessarily make for culturally relevant care, nor does placing a mental health clinic in a community necessarily make the clinic inviting to that community. The "contact zone" perspective insists that providers take a closer look at how professional ideology, service organizations, and refugees' attitudes may result in a pattern of underutilization of refugee mental health services, and how this might be changed.

Second, the contact zone perspective shows that a crucial missing element in refugee services is a focus on the family and its strengths. The "CAFES" (Coffee and Family Education and Support) intervention was developed through a commitment to collaboration between mental health professionals and Bosnian families in Chicago. CAFES is a multigenerational family support and education program run by lay Bosnian refugees who are trained by an interdisciplinary professional team, based on the principles that the family is of central importance and that families are strong and good. This approach, itself a cross-cultural product, fits better with the needs and strengths of Bosnian refugee families.

Third, the contact perspective can be useful in managing cultural issues concerning the relationship between international and local professionals. Too often, international professionals' investment in promoting ideas from outside exceeds their commitment to understanding the way that local professionals live and work. The epitome of this approach is "trauma training," where local professionals are plucked from their jobs and put in classes taught by "international experts." Such activities are bound to fail because they are detached from the actual delivery of services. A contact perspective encourages professionals to relinquish the role of colonizer (in the guise of international trauma mental health expert) and to encourage processes of dialogue and translation that increase the expertise and authority of local psychiatric and community leaders. For example, in Kosovo, the University of Illinois at Chicago and The University of Pristina formed a collaboration that supported the Kosovars in developing and implementing a plan for development of mental health services. A professional-to-professional initiative, the Kosovar Family Professional Education Collaborative, has been helping Kosovar professionals to develop professional identity and expertise that builds upon Kosovar cultural values concerning the family.

These are examples of how the contact zone and other new teachings in ethnography may open up vistas for refugee mental health services that move away from ineffective or exploitative practices and toward interventions that better fit the needs and strengths of refugee families and the professionals that serve them. These and other implications of the new ethnography are not limited to refugee mental health, and further deliberations on their usefulness to other refugee health services should be pursued.

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Human Rights Violations and Refugee Health

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THE UNITED STATES IS A NATION FORGED BY IMMIGRANTS, MOST of whom chose to leave their countries of origin for personal, economic, or social reasons.1 Refugees and asylees, on the other hand, are immigrants who are forced to leave their homes because of persecution or threat of persecution. Because of the unique circumstances surrounding refugee and asylee patients, special attention must be paid to human rights issues when they are evaluated in a health care setting.

Of the more than 3.2 million refugees and asylees who have resettled in the United States since 1975,2 a significant proportion has experienced some form of torture.3 Two US surveys found that 5% to 10% of all immigrant patients seen in tertiary care hospitals, for example, had suffered torture in their countries of origin.4,5 These statistics probably underestimate the prevalence of torture by not representing individuals who opt not to come forward with their history of persecution.

Refugees and asylees suffer other human rights violations despite international law. For example, in violation of the 4th Geneva Convention, civilians now represent more than 90% of all casualties during armed conflicts; most of these casualties are children and women.6 Less recognized are the violations of social, economic, and cultural rights that many refugees and asylees may endure, such as lack of access to employment, education, medical care, and basic public health measures.

There are early opportunities for health care workers to determine if their patients have been exposed to human rights violations and to assess the effect these may have had on their health. Prior to departing for the United States, refugees will have received a health assessment to detect conditions that may preclude their entrance, such as active tuberculosis, human immunodeficiency virus infection, or leprosy.7 Refugees receive a similar assessment after they arrive in the United States. Although asylees, unlike refugees, do not receive mandatory health assessments, their attorneys may request, as part of an asylum claim, a medical-psychological evaluation to document sequelae of torture or related refugee trauma.8

Inadequate training of health care workers is a major reason why refugees and asylees often receive incomplete health assessments and inadequate primary care follow-up. Two surveys of US medical and public health schools found that only a small percentage of them teach about human rights violations and their relation with health.9,10

There are several ways of confronting human rights violation issues in the primary care clinic. Ideally, obtaining a history about a refugee or an asylee starts before the actual visit takes place. Providers should obtain some basic information about the patient beforehand, including his or her country of origin, the country’s politicoeconomic conditions and prevalent health problems, and the population’s cultural values. In this way, health care providers demonstrate a genuine interest in the patient that may help to eliminate patient distrust, which is an important barrier to giving care. Providers also close cultural gaps, avoid misunderstanding symptoms, and become more aware of the types of human rights violations that the patient might have endured.

Health care providers caring for refugees and asylees should maintain a high index of suspicion for conditions that are considered “exotic” in the United States but common in other parts of the world, such as schistosomiasis.7 A thorough physical examination, however, is also essential to detect the subtle marks of torture, such as scarring or radiological findings of previous trauma.11

Health care professionals should also be willing to work in multidisciplinary teams, including attorneys and other non-health professionals, to provide effective care for these patients. Refugees and asylees often struggle for years with language and cultural barriers, family reunification issues, and legal status problems in addition to health problems; an integrated approach where advocates work together will ameliorate these problems for the patient.

Refugees and asylees will continue to grow as a population as long as armed conflicts continue worldwide, and their complex needs are far from over once they have been resettled. Health care providers should receive adequate training to provide care for this vulnerable population and be willing to respond to their unique needs as victims of human rights abuses.

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Interview With Philip Gourevitch: International Responses to Genocide in Rwanda

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The assassination of Rwandan President Habyarimana on April 6, 1994, marked the beginning of a systematic decimation of Rwanda’s Tutsi population. After more than 800,000 Tutsis were killed in a 3-month period, more than 200 humanitarian organizations responded to the displacement of an overwhelmingly Hutu refugee community, including fugitive leaders of the genocidal regime.

Philip Gourevitch spent several months in Rwanda between 1995 and 1998 where, as a staff writer for The New Yorker, he had the opportunity to examine the special problems faced by medical relief workers. His subsequent book on the Rwandan genocide won numerous prizes, including the National Book Critics Circle Award for nonfiction.

GJ: What were your initial impressions of the killings that were taking place in 1994?
PG: I first went to Rwanda in 1995, a year after the genocide. The story had faded almost immediately from the American newspapers or press. We had been told that there had been a collapsed state, anarchy, chaos—that something unspeakable, something unthinkable, something unimaginable had taken place. The one thing I felt sure of was that the killing of 800,000 people in 100 days was not “a collapsed state.” This was not anarchy or chaos, but must have required great organization and tremendous effort. Also, I didn’t like these words “unthinkable, unspeakable, unimaginable.” I thought, “The very least we can do is think, speak, and imagine what had taken place there.”

GJ: What was it like to elicit the stories of genocide survivors?
PG: The important thing was to take one’s time: talking to people and going back, never just leaving it at 1 conversation. That created a sense of familiarity and trust. Some people even sought me out because it was easier for them to talk to an outsider who would listen than to fellow Rwandans who were implicated. Other Rwandans had their own burden, their own stories, their own family dead.

GJ: How soon after entering into Rwanda did you start to get a sense of what had actually come to pass?
PG: It is a slow process getting to know things in Rwanda. Originally, I gave myself 3 months to write a single long article for The New Yorker. In 3 months, you have the advantage of not having to immediately respond in writing, not having to speak before you have listened.

The difference between what I am able to do as a journalist and the work of a diplomat or an aid worker is that I do not have to arrive with a framework of understanding. Many of the humanitarian relief organizations I encountered had made insufficient effort to inform their workers about the history of Rwanda. When I asked aid workers what their organization did to prepare them, the most common answer was “Nothing.” I became concerned that the organizations did not want their people to know, but only wanted for them to serve as technicians.

GJ: How would you characterize the role of humanitarians and humanitarian aid in the refugee camps established outside Rwanda’s borders?
PJ: The humanitarian aid and relief industry consists of multi-billion dollar organizations run by the United Nations and private nongovernmental organizations, whose business is to rush into crisis situations and dispense aid and medical relief automatically. I was quickly struck by how often the genocide was called a “humanitarian crisis.” The phrase itself began to operate as a way of divorcing the political reality from the human suffering. It is like calling a sucking chest wound a respiratory problem after somebody has just been shot in the chest.

During the genocide, the United Nations and the major western powers did nothing to stop the killing of Tutsis. Afterwards, the Hutu extremist government organized the mass flight of Rwandan Hutus across the border, taking the population that had supported them during the genocide with them into exile. This network of refugee camps, containing somewhere in the vicinity of 1 to 1.5 million people, was full of military and political leaders of the genocidal regime, who were exploiting humanitarian aid with the aim of returning to Rwanda to continue the genocide. Thus, the humanitarian relief effort became a catering service for the largest genocidal movement on the planet at the time.

At that time, it was controversial to say this, because the aid agencies had a vested interest in their own moral and economic well-being and were not drawing attention to this. In attempting to divorce the political reality from the humanitarian response, a great deal of harm was done in the name of doing good.

GJ: What is the relationship between the media and some of these drives for humanitarian relief in crisis situations?
PG: Public perception stimulates both governmental policy and humanitarian response. What troubles me most is what happens when the story reaches the professional public. When the pervading response is to “just do something” there is a presumption that we will do the right thing. But in fact, as we saw in Rwanda, the world, having done nothing during the genocide, rushed into its aftermath in a manner that was often harmful, prolonging the situation and exacerbating and sustaining the worst elements within it. There is no such thing as too much information in these situations. Recognizing that humanitarian action during a political crisis has political consequences is a crucial step toward preventing this sort of situation from happening again.
Mental Health Challenges in Postwar Kosova

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The humanitarian crisis in Kosova in 1999 has exposed the strengths and weaknesses of Kosova’s mental health system. In this article I examine existing professional and social structures in Kosova, show how these structures reflect the needs of the population, and suggest ways of meeting those needs.

Twenty thousand patients with chronic psychiatric conditions and approximately 500,000 people with signs and symptoms of posttraumatic stress disorder present an extraordinary burden for the fragile, antiquated, and overly centralized mental health services of Kosova.1 Currently, there is 1 psychiatrist per 100,000 inhabitants, 1 psychiatric nurse per 35,000 inhabitants, 1 psychologist per 400,000 inhabitants, and 1 psychiatric social worker per 2,000,000 inhabitants.2 These dramatic conditions are exacerbated by insufficient long-term institutional resources, community-based mental health structures, and other support services for people with chronic mental illness.

The mental health system in Kosova continues to rely on extremely motivated mental health professionals, the strong Kosovar family unit, traditional healers in the society, and the qualified international mental health community. These are the cornerstones of the future mental health system and the resources that concerned health professionals must draw upon to work for the future of the Kosovar mental health system.

With these strengths and weaknesses in mind, members of the Kosovar mental health community started a Task Force for a Strategic Plan for Mental Health Reform in Kosova, under the auspices of the World Health Organization (WHO) Mental Health Unit and with support from mental health professionals from the University of Illinois at Chicago. Inspired by US practices and the WHO encouragement of mental health reforms, the role of the Task Force has been to implement a plan that will be grounded in evidence-based medicine while remaining culturally rooted in Kosovar society. The Task Force recognizes that the core of the future mental health system in Kosova must be community-based and family-oriented, with measures to ensure the dignity, integrity, and autonomy of the mentally ill person.

Acknowledging that the mental health system has historically been overly centralized and almost entirely based in the city of Prishtina, Task Force professionals are working toward providing locally based services, particularly by cooperating with local family physicians, traditional healers, and other community resources. Not only does this relieve some of the burden on limited medical resources, but it also encourages patients to develop support structures that will most benefit them and enlist local resources to identify the patients who most require treatment.

The Task Force has especially focused on integrating the family unit into treatment programs, including programs that are based on individual therapy. When coming to the clinics, patients usually arrive with several family members; the family provides a social support structure that practitioners must not ignore in the development of programs and interventions.

Reforms to the infrastructure, especially in education, legal and medical institutions, and human resources, are also essential. The immediate challenge is to respond to the very acute mental health needs of the population in the short term, while making nonlimiting decisions that will contribute to a positive direction for the future. Two collaborative projects between international and Kosovar organizations demonstrate how this challenge might be met. One is “Healing the Wounds of the War,” a project developed by the Institute for Mental Health Recovery of Kosova (IMHRK) in cooperation with the Mind and Body Center, Washington, DC. The second is an interuniversity project, Kosovar Family Professional Educational Collaborative, that includes the University of Prishtina, IMHRK, the University of Illinois at Chicago, the University of Chicago-affiliated Chicago Center for Family Health, the American Family Therapy Academy, and the International Trauma Studies Program of New York University.

The collaboration between Kosovar and US mental health professionals in these partner organizations has been successful for 2 reasons. First, these projects recognize the potential of local professionals, as well as local social structures, to bring about improvements in mental health; second, these projects attempt to combine short-term training programs with the enhancement of long-term professional skills. As a result, these projects have focused on the capacities of Kosovar mental health professionals as the future leaders and implementers of the mental health system in Kosova. In turn, the local professionals have been able to focus on the creation of community-based mental health services, operating under the auspices of the emerging state mental health system.

This is a historic opportunity to establish a modern system of mental health services after the crisis of 1999 and decades of oppression in Kosova.3 The results so far have been encouraging, especially with regard to the restitution of the morale of the Kosovar mental health community. The effects on the everyday work in the clinic are also becoming apparent, as mental health providers begin to see more efficient work and better clinical results.

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