Trauma-Informed Primary Care of Refugees

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ABSTRACT: Refugee patients experience high rates of trauma, from experiences that occurred before migration, events during the migration journey, continued stressors following resettlement and intergenerational trauma. There is a well-established, dose-dependent relationship between trauma and adverse health outcomes due to the physiologic and behavioral impacts of trauma. Addressing the impacts of trauma in primary care is vital to improving the health of refugee populations and trauma-informed care is a framework for helping patients heal from their trauma. Trauma-informed services are grounded in an understanding of the effects of trauma on the body and brain, in order to resist retraumatization of patients in the healthcare setting, recognize signs of trauma, and be able to respond in a way that promotes healing from trauma. This paper introduces the basic concepts of trauma-informed care with specific recommendations for caring for refugee patients in the primary care setting.

WHAT IS TRAUMA-INFORMED CARE?

"Trauma happens to us, our friends, our families and our neighbors." [1]

-- Bessel Van Der Kolk, MD, *The Body Keeps the Score*

Trauma-informed care (TIC) shifts the approach to care from "What's wrong with you?" to "What happened to you?" [2] TIC is grounded in a **realization** of the widespread prevalence of trauma and an understanding of the effects of trauma on the mind, body, and spirit. By understanding how we are affected by trauma, we can better **recognize** the signs of trauma, **respond** to trauma histories, and **resist retraumatization** in our patients, colleagues, and selves.[3] These are considered the "Four R's" of TIC and the following sections of this article will outline these concepts with specific considerations for working with refugee patients.

TIC can be implemented at many levels, as illustrated in Figure 1. Each ascending level is dependent on the support of the foundation.[4] For example, it would be unhelpful to screen for trauma if a provider could not engage in patient-centered communications or did not have the resources to provide treatment for the identified trauma. Each level of care is discussed briefly in this section to give a basic introduction to TIC.

Figure 1. Trauma-Informed Care Pyramid[4]

Patient-Centered Communication and Practices

At the most fundamental level, trauma-informed delivery of care emphasizes patient-centered practices to make the health care encounter feel safe for patients. For many patients, receiving medical care is inherently uncomfortable because of the perceived lack of control and power differential between providers and patients. Some patients may have also endured violence perpetrated by a healthcare provider and the clinical space is a reminder of that trauma. Either way, safety is a prerequisite for being able to discuss a history of trauma and its impacts. The healing process will take time

and is dependent on building trusting relationships with patients; it is more important to help patients feel comfortable enough to return for another visit than to fix their problems in any single visit.

Patient-centered practices emphasize "doing *with* and not doing *to*." [5] Patients are the experts of their own lives and there is much to be gained from engaging them in treatment planning, rather than telling the patient what we think is best for them. Occasionally, medical care is straightforward (e.g., antibiotics for an ear infection) and you can use directive communication. When treating conditions that can be related to trauma, however, it is important to collaborate with the patient to find a solution, offer choices, and be considerate of the patient's preferences. Sometimes a patient may not be ready to engage in a certain treatment modality, such as therapy, and allowing them to make that choice without passing judgement may be more therapeutic than trying to change their mind.

Understanding the Health Effects of Trauma

Knowledge on the impacts of trauma allows providers to recognize signs or symptoms that may be related to trauma. Patients may develop maladaptive coping strategies, such as substance use, to manage the symptoms of trauma. The emotional, social, and cognitive impairments from trauma also increase the likelihood that patients will have other risk factors for poor health, such as unemployment or living below the poverty line. This awareness can guide diagnosis and treatment planning to reduce suffering and improve health outcomes.

Trauma also changes the way someone perceives and interacts with their environment, leading to chronic stress, unhealthy coping strategies, and behaviors that may come across antagonistic or disengaged. Without an understanding of the impact of trauma, providers may misinterpret behaviors and act in a way that comes across as judgmental. This miscommunication can damage the trusting relationship and impair the process of healing from trauma.[5,6] As we learn how the brain responds to trauma, we can see these behaviors through a new lens and respond with compassion, breaking the cycle of conflict that patients may have experienced in previous medical encounters.

Interprofessional Collaboration

Primary care providers can offer the development of trusting and safe relationships with patients, even without understanding their full trauma history. For some patients, this may be enough to help them develop healthier coping skills and address their health risks. Many patients, however, will need professional support to process and heal from the effects of trauma.

It is not the responsibility of the PCP to help the patient process their trauma. In fact, without proper training, asking a patient to open up about the details of their trauma can be very damaging to their own well-being and to the patient-provider relationship. As a PCP, it is important to be able to compassionately respond to a patient who shares a history of trauma and offer appropriate, trusted referral options. It can also be helpful to make this information available to all patients (e.g., pamphlet in the waiting room), so they can seek support without needing to disclose their trauma to the provider.

Understanding Your Own History and Reactions

As providers, we are human, just like our patients and our own experiences affect the way we care for and respond to our patients. For example, if you had lost a loved one to cancer you might be more attuned to the needs of a patient with cancer. You might also be very sensitive to their grief and these encounters could bring up difficult emotions or memories of your loss.

When caring for a patient with a history of trauma, it is important to reflect on our own histories. Hearing about another person's traumatic experience can trigger strong reactions related to our own trauma history that negatively impact our interaction with a patient. Over time, the recurrent stress of remembering our own experiences accumulates and becomes a heavy burden. Regardless of a provider's trauma history, it takes a lot of energy to listen to stories of trauma and respond compassionately to difficult interpersonal interactions. These stressors are expected and understandable, but left unaddressed they lead to vicarious, or

secondary, trauma and burnout. Just like trauma, burnout occurs when our coping mechanisms are overwhelmed and we enter survival mode. Our capacity to respond to others with compassion is diminished and we often turn to unhealthy coping strategies that impair recovery of functioning.

By fostering an awareness of our own experiences and needs, we can find ways to proactively balance the demands of work, engage in self-care practices to mitigate stress, and be able to recognize the signs of trauma in ourselves and others. TIC requires us to understand how trauma impacts ourselves and our colleagues so that we have the personal resources to care for our patients.

Bolton et al[5] suggests an "ABC approach" to managing secondary trauma as a provider:

- **A**wareness:
  - Be aware of your own history and how it impacts your interactions with patients.
  - Be aware of how you are feeling during and after a patient encounter.
  - Be aware of the well-being of your colleagues so you can offer support if needed.
- **B**alance:
  - Create a routine of self-care, knowing that caring for patients is hard work.
  - When stress levels are high, take the time needed to replenish your resources.
  - Develop workflows that allow for care team members to reduce their exposure to trauma during times of increased stress.
- **C**onnection:
  - Safe, genuine human connection is the antidote to trauma.
  - Develop your support system and don't be afraid to ask for help.
  - Check in with the members of the patient care team regularly.

Screening

The last tier of the TIC pyramid is screening, which depends on successful implementation of the previous four objectives. Screening can be beneficial in identifying patients that could benefit from support services, but is not without risk. Without adequate skills and systems in place to respond to a positive history of trauma, screening can retraumatize patients and make the clinical encounter feel unsafe. Any time we ask patients about their trauma, it is important to consider how to do this in the most supportive and safe way possible. The section *Respond: Help Patients Heal* will address ways to safely discuss trauma histories with patients. Also, when using screening tools, try to find culturally-relevant screening tools (see the attached handout "Resources for Working with Refugees").

REALIZE: WHAT IS TRAUMA?

i want to go home,
but home is the mouth of a shark
home is the barrel of the gun
and no one would leave home
unless home chased you to the shore
unless home tells you to
leave what you could not behind,
even if it was human[7]

-- *Home*, Warsan Shire, British-Somali Poet

The Substance Abuse and Mental Health Services of America[3] defines trauma as "an **event**, series of events, or set of circumstances that is **experienced** by an individual as physically or emotionally harmful or life threatening and that has lasting adverse **effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."

Event

When thinking about trauma, we often conjure examples of "Big T" traumatic events; these tend to be intense, acute events that threaten our sense of safety, such as a car accident or sexual assault. These are experiences that fit the DSM-5 Criterion A for diagnosing Post Traumatic Stress Disorder and therefore it is easy to understand their impact on a person's well-being.

"Small t" traumas are often subtler and more chronic, like experiencing neglect or growing up with an incarcerated parent. Each individual event may not acutely threaten the sense of safety, but cumulatively they contribute

to a harmful, unsafe environment. Importantly, both of these types of trauma can impact the brain's stress response and impair functioning.

Experience

What one person experiences as a traumatic event, another person may not be as affected by. Interestingly, the severity of a trauma does not reliably predict whether someone will continue to experience symptoms following trauma.[8] Whether someone continues to be affected by a potentially traumatic event depends on many different internal and external factors (see Table 1). Consideration of these factors can inform a clinician about an individual patient's risk for persistent symptoms. As providers, we have the ability to bolster a patient's ability to cope with stress and address factors after the event that can mitigate the effects of trauma.

Table 1. Risk Factors for Developing Post-Traumatic Symptoms[6,8,9]

Before Trauma	• Prior history of trauma • Adverse childhood environment • Pre-trauma life stress • Pre-existing psychopathology
During Trauma	• Not being able to do something to protect oneself
After Trauma	• Acute stress symptoms • Post-trauma life stress • Social isolation, lack of support system • Social constraint (i.e., cues that suggest talking about the event is not acceptable • Stigmatization (e.g., a person is seen as impure after being sexually assaulted)

Effect

Traumatic experiences leave lasting impacts on a person's physical and emotional well-being. The nature and duration of these effects can vary widely and are discussed in further detail in the section *Recognize: Effects of Trauma*.

Who experiences trauma?

Trauma happens to people regardless of age, gender, race or socioeconomic status. However, we know that some groups, such as women, racial/ethnic minorities, persons with disabilities, and LGBTQIA+ individuals experience trauma at much higher rates.[10] There is also a high prevalence of trauma in refugee populations, and this trauma does not end with resettlement. Although a person may have left unsafe environments in their home country, they often face a multitude of systemic, personal, and social adversities in their host country that are difficult to escape. In fact, the chronicity of trauma experienced after resettlement often exacerbates the effects of pre-migration trauma

Table 2. Potential Sources of Trauma for Refugees[2,4,6,9,11,12]

Pre-Migration	During Migration	Post-Migration
• Violence • Witnessing violence • Destruction of belongings • Torture • Sexual and gender-based violence • Extreme poverty, malnourishment • Natural disasters • Limited access to education, health care	• Family separation • Extortion • Displacement • Discrimination • Unstable, unsafe living environments • Uncertainty	• Acculturation and assimilation • Cultural bereavement • Conflict of values • Loss of identity and meaningful social roles • Linguistic and/or cultural isolation • Lack of social support • Disillusionment • Discrimination • Difficulty navigating new systems • Intergenerational trauma • Adverse childhood events/environments • Concern for loved ones still living in country of origin

and acts as a barrier to healing. Table 2 lists some types of trauma refugee patients may experience.

RESIST RETRAUMATIZATION: UNIVERSAL TRAUMA PRECAUTIONS

"Because of complex interactions between traumatized clients, stressed staff, pressured organizations, and a social and economic environment that is frequently hostile to the aims of recovery, our systems frequently recapitulate the very experiences that have proven to be so toxic for the people we are supposed to treat." [13]

-- Sandra Bloom, M.D.

Universal Trauma Precautions (UTP) represent a trauma-informed, patient-centered approach to care that assumes any patient could have a trauma history and thus every interaction is conducted in a way that minimizes the risk of retraumatization. UTP is not a set of rules, instead it is an awareness of the impact your mannerisms can have on other people. Importantly, a provider does not need to know a patient's trauma history to practice UTP. To implement UTP, we have to reflect on the way patients may experience a healthcare encounter in your clinic, in order to make changes that are more patient-centered. One lens to view this experience through is power and control.

Power and Control

Very often, when a person experiences trauma, this involves a feeling of powerlessness and a loss of control. To begin thinking about our interactions with patients, we can examine the power differentials present in a healthcare encounter. For all of our patients, we ask for a level of intimacy that is not often shared between two strangers, such as divulging personal information or engaging in physical contact. This imbalance of power is even further exaggerated for refugee patients, who also experience language and cultural differences. Below are a few examples of power differentials that may be present in a healthcare visit. Please note that this is not an exhaustive list, but is instead meant to prompt an awareness of power dynamics.

Power differentials present in all clinic visits:

- **Medical knowledge** - patients come into the clinic with a health concern and the medical provider holds the knowledge that is key to treating the problem. A patient may feel that they have to do whatever the provider asks in order to get the treatment they need.
- **Personal information** - providers ask patients to divulge personal information and have access to patients' medical records, but often share very little information about themselves, leaving the patient feeling much more exposed.
- **Physical touch** - during the physical exam, providers touch the patient's body, but the provider is not enduring the same invasion of their personal space. Additionally, the provider knows what will happen during the exam or what exams are appropriate to perform, but the patient does not know this information.

Power differentials specific to working with refugee patients:

- **Language** - Even though an interpreter helps communicate with patients, the visit is often conducted in the terminology familiar to the provider. The provider also speaks the same language as other staff and clinicians, whereas the patient may not have someone else in the clinic that speaks their language without the use of an interpreter. A patient may not feel comfortable asking a staff member to go through the trouble of getting an interpreter if they have a question or concern.
- **Culture** - The clinic visit is conducted in the manner that the provider is used to, but this might be very different from the way that patients experienced health care before arriving in their host country. Patients may have different expectations about treatment options and outcomes (e.g., an injection works better than an oral medications).

When we are more aware of these interpersonal dynamics, we can consciously change the way we practice to return control to patients. The six key principles of TIC (see Table 3) can help us consider other ways to think about our interpersonal interactions.

Table 3. Key Principles of Trauma-Informed Care[3]
• Safety • Trustworthiness & Transparency • Peer Support & Mutual Self-help • Collaboration & Mutuality • Empowerment, Voice and Choice • Cultural, Historical & Gender Issues

UTP: General Principles

- Create a **safe environment** that is unlikely to startle a patient (e.g., avoid loud noises).
- Be aware of your **body language.**
- Be aware of your **position** in relation to the patient and the door.
- Pay attention to the patient's body language and look for signs of stress.
  - If you suspect the patient is distressed, validate this experience (*"I can understand how this could be stressful."*).
  - Do not provide blanket reassurance (*"There is no need to be anxious!"*).
- Use **clear, understandable language** and avoid the use of jargon.
- **Explain to patients** what you are doing and why, and that they have the choice to decline any part of the visit
  - Find the language that works for you to explain the visit and offer choice.
  - Work towards incorporating this language into every visit.
- Find ways to **offer choice** and **return control** to the patient:
  - Ask the patient what they like to be called.
  - Ask if the patient is comfortable with the interpreter.
    - Some patients prefer a gender-concordant interpreter.
    - Consider the ethnic or tribal affiliation of the interpreter.
  - Offer choices for how you carry out the visit or for treatment options (e.g., whether the patient would prefer to keep the door open or closed).
  - Ask patients whom they would like to involve when making medical decisions.[9]
- **Be aware of your personal reactions** and try to give everyone the benefit of the doubt.
  - Remember that **we are all doing the best we can** with the information we have and the coping skills we have learned.
    - Example: A patient provides an inconsistent, conflicting history → rather than assuming the patient is being dishonest, remember that trauma impacts our ability to retrieve autobiographical memory.[2,14]
  - This is especially important when working with someone of a different cultural background - we may misinterpret their behavior if we see it through our own cultural lens.
    - Example: A patient makes minimal eye contact → while this is considered atypical in Western culture, many cultures believe direct eye contact to be disrespectful.
- Focus on a **patient's strengths** instead of their problems.
- Get to know your **patients as people.**
- **Educate yourself** about the historical, cultural and gender issues relevant to your patient.
  - Learn how to say "hello" in the patient's language.
  - Be aware of non-verbal etiquette specific to the patient's culture.
  - Consider how a patient's culture may impact their healthcare preferences.
  - Understand what types of trauma are more common in the patient's country of origin, so you can be cognizant of potentially triggering situations and know what for specific signs of trauma you might look for.[9]
  - See the attached handout "Resources for Working with Refugees"

UTP: History and Physical Exam[15]

- Give the patient **permission to decline** any part of the history or physical exam
- If a patient declines a part of the history/exam:
  - **Thank them** for communicating their needs (this takes a lot of courage!).
  - Offer **alternatives** (including skipping that part of the history/exam).

    - If needed, you can explain the risks of not performing a part of the history/exam, but respect a patient's wishes if they still decline it.
- **Obtain consent** for sensitive parts of the history.
    - Let the patient know that they can share **as much or as little** as they want.
    - See the section *Respond: Help Patients Heal* for more guidance on obtaining and responding to a trauma history
- Before the physical exam:
    - **Explain why** you are doing the exam and outline what the exam involves.
    - Give the patient permission *again* to stop the exam or decline any part of the exam.
    - **Ask the patient** about their comfort and offer a chaperone.
- During the exam:
    - **Tell the patient** what you are doing *before* you do it and always make sure the interpreter has finished interpreting what you say before you start!
    - Avoid stepping out of the patient's eyesight.
    - Use **professional touch** only and do not touch the patient except for the exam.
    - Respect a patient's **personal space** as much as possible.
- After the exam:
    - **Thank** the patient.
    - **Discuss** your findings and **ask** for questions.

RECOGNIZE: EFFECTS OF TRAUMA

"Traumatic experiences...leave traces on our minds and emotions, our capacity for joy and intimacy, and even on our biology and immune systems." [1]

-- Bessel Van Der Kolk, MD, *The Body Keeps the Score*

Trauma and the Brain

Our brains have evolved to function quickly in life-threatening situations. Most of the time, sensory stimuli from the spinal cord are relayed by the thalamus to higher-order processing centers in the frontal cortex to make sense of the world around us. This is a relatively slow process; in order to react rapidly in life-threatening situations, the limbic system can respond to environmental stimuli without conscious recognition. To do this, the amygdala monitors incoming stimuli and acts as a "danger detector," activating the autonomic nervous system through the hypothalamic-pituitary-adrenal (HPA) axis when a perceived threat is detected. The resulting surge of catecholamines and cortisol mobilize the energy to carry out the "fight, flight or freeze" instructions from the limbic system, while input from the higher cortical centers is attenuated. In life-threatening situations, this rapid response is beneficial, allowing for split-second, instinctual reactions. Once out of harm's way, stress hormones are metabolized, the brain resumes its regular functioning, and the body relaxes. No long-term damage results from this process because it resolves.

Changes in the brain occur with episodes of severe or recurrent danger, where the brain never gets the message that the danger has passed. With "Big T" traumas, a person is often unable to stop the events from occurring, resulting in repeated firing of the brain's alarm system and activation of the HPA axis. The amygdala remains on guard, the stress hormones remain elevated, and the person experiences inescapable shock.[1] Even after the event resolves and the person is objectively out of harm's way, the stress response continues because the brain never receives a signal to stop the response. "Small t" traumas may not cause such intense activation of the limbic system, but the repeated experiences strengthen the stress response pathways over time. As the saying goes, "neurons that fire together, wire together." Repeated firing of a neural circuit strengthens the pathways, making them easier to activate in the future; the brain learns to be on the lookout for any similar event.

The amygdala, with the help of the nearby hippocampus, remembers the sensory memories of the event and is primed to react the next time it recognizes a similar threat. The result is a hyperreactive alarm system that sets off even in situations that do not pose a true threat to safety. Any sensory experience - be it a sound, smell, or sight - that resembles the

original trauma can trigger the amygdala and start the cascade of stress responses in the body. Unfortunately, the amygdala is not able to distinguish between past and present, so it initiates a full response, as though the original threat was present.[1] The new neural pathways are so strong that even thinking about the traumatic event can precipitate a response.

A person may be able to logically recognize that they are not in an unsafe situation, yet input from the cortex is unable to override the amygdala and their body is sent into "fight, flight or freeze" all over again. They might startle at a sudden noise, respond to minor irritations with angry outbursts, or find themselves unable to move. In these cases, the person loses control over their own body.

The way that the brain prioritizes signaling during a life-threatening situation is beneficial to immediate survival. For example, the frontal cortex is inhibited in favor of more rapid limbic responses. The thalamus may augment pain signals to alert us to danger or dissociate from sensory input to facilitate functioning in spite of bodily injury. If the brain is on high alert all the time, however, this altered functioning changes how we are able to interact with the world, leading to symptoms such as difficulty concentrating, chronic pain, or feeling numb.

Symptoms of Trauma

In the aftermath of a "Big T" trauma, the brain continues to remain on high alert. It refuses to let its guard down and any signal suggesting danger causes a reactivation of the stress response.[1,5,16]

- Startling at loud noises
- Hypervigilance
- Flashbacks
- Nightmares
- Difficulty sleeping
- Irritability

Over time, the above symptoms may subside or may continue as in PTSD. Either way, the brain and body still have not experienced resolution. A person can push the trauma out of their conscious memory, but the limbic system does not forget so easily.[1,16] For many people with "little t" traumas, they do not experience the severe symptoms listed above, but rather experience the chronic distress mentioned here. The increased arousal and reactivity still remain on some level. In order to go about their day to day functioning, people find ways to manage these trauma symptoms, from denial to self-medication.[1,5,16]

- Anxiety / panic attacks
- Depression / low self-esteem
- Dissociation / numbing
- Anger / irritability
- Substance use
- High-risk behaviors (e.g., gambling, unsafe sex)
- Difficulty forming close relationships
- Avoiding situations that cause stress or are reminiscent of the trauma
- Difficulty concentrating

Health Impacts of Trauma

In 1998, Felitti et al[17] published a groundbreaking study on Adverse Childhood Experiences (ACEs). ACEs refer to various forms of emotional, physical, or sexual abuse, and household dysfunction and also includes Adverse Childhood Environments (see Figure 2). The study found that experiencing ACEs are extremely common with 64% of U.S. adults experiencing at least one ACE and 1 in 8 adults reported four or more ACEs. The data also demonstrated a strong, dose-dependent relationship between ACEs and health risk behaviors and disease later in life (see Table 4).

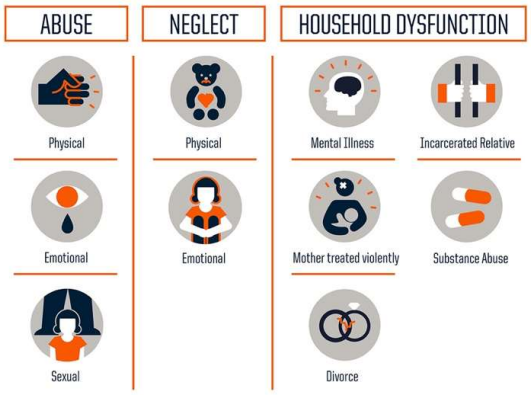

Figure 2. Adverse Childhood Experiences[18]

Study after study continues to show that trauma is bad for our health.[1,3] There are several reasons why trauma may lead to adverse health outcomes, including unhealthy coping strategies, impaired learning and functioning, and chronic inflammation. Research is still elucidating the causal relationships, but the impacts are clear. In order to help patients heal from trauma, we need to be able to recognize the signs of trauma. Have a high index of suspicion for trauma if you see the issues that are associated with ACEs (see Table 4).

Table 4. ACEs are associated with:[10,17]

Impaired Childhood Development	• Developmental delays • Cognitive / emotional difficulties • Academic challenges
Financial Well-being	• High school non-completion • Not having a college degree • Unemployment • Living below the poverty line • Experiencing homelessness
Health Risk Factors	• Smoking • Obesity • Anxiety / Depression • Suicide attempts
High Risk Behaviors	• Alcoholism • Use of illicit drugs • Injection of illicit drugs • Increased number of intercourse partners • History of a sexually transmitted disease
Violence	• Experiencing intimate partner violence (IPV) • Perpetrating IPV
Chronic Disease	• Ischemic heart disease • Stroke • Cancer • COPD • Diabetes

Other signs of trauma may include:[2,5,6,9,11,14,16]

- Psychological changes:
  - Difficulty concentrating
  - Impaired learning
  - Deficits in autobiographical memory retrieval
  - Emotional lability
- Impaired interpersonal skills
  - Decreased trust
  - Difficulty maintaining personal and professional relationships
  - Attachment difficulties
  - Conflictual relationships
- Impaired immune function / increased inflammation
  - High burden of chronic disease
  - Chronic pain, fibromyalgia, somatization
  - Chronic fatigue
  - Mental health disorders, especially anxiety and depression
  - Increased healthcare utilization (sick visits, ED visits)
  - Decreased preventive care

RESPOND: HELP PATIENTS HEAL

"If you do something to a patient that you would not do to your friend or children, consider whether you are unwittingly replicating a trauma from a patient's past." [1]

-- Bessel Van Der Kolk, MD, *The Body Keeps the Score*

The recommendations for care discussed up to this point can be implemented without the need to explicitly talk to a patient about their trauma history. If a clinic has implemented trauma-informed procedures and has the resources to support patients, it may be appropriate to ask about trauma. Screening for trauma can identify patients who may benefit from referrals to directly address the impacts of trauma. It is important to be conscientious of the way we ask about and respond to patients' trauma histories, in order to do this safely.

General Points:

- Talking about traumatic experiences can be very stressful for patients.
- **Frame all conversations** by explaining why you are asking about trauma.
  - *"I think it would be helpful to talk about some of your past experiences, because we know that past events can still affect our health in the present.*
- Always **give the patient permission** to tell you if they are feeling overwhelmed.
  - *"Sometimes these discussions can bring up difficult feelings, and if at any point you are feeling overwhelmed, please let me know and we will stop."*
- Pay attention to **non-verbal cues** that suggest emotional arousal (gaze aversion, restlessness, spacing out).
- **Check in** with the patient often, especially if you think they may be overwhelmed.
- Consider the **power differential** and recognize that a patient may not feel that they can say no. Sometimes it might be appropriate to end the conversation, even if the patient does not ask for this.
- Focus on the **present moment**. More important than what happened in the past is how the trauma is impacting the patient now.
- **Details are not essential**. We can learn about a patient's trauma history without asking for specific details. Allow the patient to share **as much or as little** as they want.
- **Mirror the patient's language** and consider how your language may reveal underlying assumptions.
  - If they label the event as an "attack," don't call it a "rape."
  - Avoid labels, especially when discussing violence perpetrated by people close to the patient (e.g., "the perpetrator," "the abuser"). Instead, label the behavior ("the person who hurt you").
  - Don't assume that the person who behaved violently is a "he."
- How we describe our distress varies by culture; it is appropriate to clarify language and **ask what a patient means**.[14,19]
- **Use the interpreter as a resource**. You can meet with the interpreter before seeing the patient to discuss goals and identify ways that they can serve as cultural broker.
- **Thank the patient** for their bravery and vulnerability.

Asking about trauma

- With most patients, there are few times when it is appropriate to ask directly about trauma. With refugee patients, however, asking about trauma at the first clinic visit can be beneficial for several reasons:
  - Develops trust and establishes rapport. Refugees have reported that they want to be able to talk about their experiences.[20]
  - Communicates that the clinic is an appropriate place to talk about trauma:
    - *"Thank you so much for being willing to share that with me. I want you to know that this is a safe place to talk about these experiences."*
  - Offers the opportunity to provide brief psychoeducation about trauma:
    - *"If these experiences are still affecting you, please let me know. This is very common after someone goes through something stressful and there are ways we can help you feel better."*
- Do not ask about a history of trauma if the patient is already in a state of high emotional arousal; bringing up traumatic memories usually causes distress.
- See the attached handout "Talking About Trauma" for a list of helpful questions.

Responding to trauma histories

- When a patient shares their trauma history, the most important thing to do is validate their vulnerability and bravery.
  - This can be as simple as, *"Wow, that sounds really difficult. Thank you for sharing that with me."*
  - Find language that feels comfortable to you, so you come across as genuine.
- Do not be afraid of silence after you acknowledge what a patient has told you. Often times, giving the patient space to respond provides an indication of their needs.

    - "Well, it was a long time ago and does not affect me anymore." → Might indicate that the patient does not feel comfortable
    - "The memories sometimes keep me up at night" → Lets you know how the trauma is impacting the patient in the present moment.
- Do not ask for details unless absolutely necessary. Showing the patient that they can safely share their story is more important than getting them to share all the details.
    - Focus on the impact of the trauma now → *"How do you think that might be related to what is going on now?"*
    - Ever wondering if you should ask something? → Ask yourself, *"Who benefits from knowing the answer to this question?"*
- This can be another time to provide brief psychoeducation about trauma, especially if the patient endorses ongoing effects from the trauma.
    - *"We know that many people who have experienced similar things as what you described still feel affected by them. That is a normal response to the stress you have gone through, and this is a safe space to talk about how these experiences affect you now."*
- What NOT to do:
    - Dismiss the patient's experiences:
        - *"That was difficult, but think about how much stronger you are now!"*
    - Say you understand their experience or situation:
        - *"I completely understand what you are going through."*
        - It is okay to say, *"I understand how that could be difficult."*
    - Make assumptions:
        - *"That sounds really horrible, aren't you glad you moved here?"*
    - Shut down the conversation:
        - *"I don't think I'm the right person to talk to about this, you should see a counselor."*

Bringing up the impact of trauma

When patients experience chronic health impacts from trauma, the treatment will likely be multifaceted. In addition to medications to improve symptoms, patients may need psychological and/or psychiatric therapy to adequately treat their condition.

Although you may make a connection between a patient's symptoms and their (potential) history of trauma, it can be difficult to communicate this with patients. Patients can interpret this as dismissing their suffering, suggesting that their symptoms are "all in their head" or implying that they are "crazy." This is especially true for refugee patients, who may fear stigmatization with a mental health disorder. They might also have concerns that they are being discriminated against due to their refugee status.

With any patient, the goal is to allow the patient to feel heard and eventually connect them with appropriate resources, which may take time. Until they are ready to consider trauma as a contributor to their symptoms, it is important to be consistent about the treatment plan while fostering a therapeutic alliance. Remember that the trauma a patient has endured and their continued suffering may contribute to their hesitation to open up those memories again. By continuing to support the patient, you develop a trusting relationship that will facilitate healing.

Discussing the impact of trauma with patients

- Use open-ended questions to assess for the patient's understanding of what is causing their symptoms.
- Explain that trauma symptoms occur because the patient has worked so hard to survive. The coping mechanisms (both conscious and unconscious) that were useful in an unsafe environment now have negative impacts on well-being when the patient is in a safer environment.
- Develop language to be able to explain what treatment options might look like and ask which options they would feel most comfortable with.
- Offer to let the patient meet briefly with a behavioral health team member to learn more about treatment options.

- It can be helpful to frame treatment as a chance to help them feel better; avoid talking about it as the only way they will feel better (comes across as punitive).
- Identify whether family members could be a resource or if their presence makes a patient hesitant to discuss mental health concerns.

Listening is therapeutic
- Take time for the patient to share their symptoms and concerns.
- Use reflective listening to understand how the patient interprets their symptoms.
- Identify additional symptoms that may be related to trauma (e.g., anxiety, insomnia).
- Validate the patient's suffering and develop a therapeutic alliance.
  - *"What you are dealing with sounds exhausting. We are going to work together to try to understand what is causing this and find a way to help you feel better."*

Rule out other causes
- Perform appropriate testing for other potential causes for the patient's symptoms.
- Think about your own biases to consider whether you may be misattributing their condition to trauma.
- Explain the thought process behind the tests you order.

If a patient requests further testing or treatment
- Reinforce the reasoning for what testing/treatment has been done already and review the results.
- Express concern for the potential harms of further testing/treatment.
- Validate the patient's suffering and frustration.
- Reassure the patient that you will continue to monitor their symptoms and pursue further testing as appropriate.
- Ask the patient about their concerns.
  - This helps create shared goals for moving forward.
  - You might be able to address them in other ways. For example, some patients are more worried about missing dangerous conditions than actually finding a diagnosis. In this case, reassurance could avoid an unnecessary workup.
- It can be helpful to explain the limitations of medicine:
  - *"Many people experience abdominal pain and we can do tests to try to understand what might be causing the pain. For some patients, we find a reason for the pain and can treat it. However, there is a group of patients that we are not able to find a reason for their abdominal pain, even with all the tests in the world. I wish I could tell you what exactly is causing your pain, but there is a lot we are still learning about the human body."*

Partner with the patient
- Reinforce that you will continue to work together, especially if you decline a patient's request for testing or treatment.
  - *"Even though I don't think it would be helpful to do X, I am here to support you and figure out ways to help you feel better."*
- Help set reasonable expectations:
  - *"Some patients have pain that we do not have a good cure for. Right now, our goal is to find ways to improve your pain and help you be as functional as possible, but we might not be able to make the pain go away completely."*
  - *"As we find ways to help you feel better, we might try things that won't work which can be really frustrating because it means you are still in pain. If something doesn't work, then we can try something else."*
- Schedule regular follow ups to monitor progress and assess for changes in condition.

Fostering Resilience
- Help the patient identify their own strengths and ways that they have coped in the past.
  - Identify areas of competence, even if they are unrelated to their mental health coping (example: learning how to use the bus system).
  - Emphasize the steps they have taken already and the progress they are making.
- Ask and learn about the patient's goals and aspirations.

- Use family as a resource to encourage new coping skills, such as incorporating more physical activity or developing healthy sleep routines.
- Be careful not to undermine a patient's current struggles with statements such as:
  - *"Well, you have survived so much already, you will easily make it through this, too."*
- As a provider, try to see the best in the patients rather than focusing on their mistakes.
- Even if a patient is not ready for mental health treatment, you can introduce techniques to help them tolerate the difficult emotions they are experiencing (i.e., breathing exercises).

CONCLUSION

"Trauma is not what happens to us, but what we hold inside in the absence of an empathetic witness." [21]

-- Peter Levine, PhD

Caring for refugees is at the same time a very challenging and deeply rewarding experience. In hearing the difficulties that refugee families have endured, the resilience of the human spirit shines. Trauma-informed practices provide a framework for providers to create a safe environment where patients can begin to heal from the impacts of trauma. The foundation of trauma-informed care is the formation of safe, trusting relationships. With an awareness of trauma's impacts on physical, mental, emotional, social and spiritual well-being, providers can begin to assess for signs of trauma and offer resources for healing. This understanding of trauma also offers a more forgiving lens through which to see our patients, colleagues, loved ones, and ourselves.

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Universal Trauma Precautions

Create a safe environment.

Avoid doing anything that might **startle** the patient, such as loud noises or sudden movements.

Be aware of your **body language** and **position** relative to the door.

Watch for body language that suggests the **patient is uncomfortable** and check in.

Offer your patient choices and ask about their preferences.

Focus on the **patient's strengths**, instead of their problems.

Obtain informed consent

Briefly explain **what** you are going to do and **why** you are doing it, before you do it.

Remind the patient know **they can decline** any part of the history or exam, and **it won't affect** your ability to take care of them.

Using an interpreter? Always **let the interpreter finish talking** before doing the next part of the exam!

Use **professional touch**, respect personal **space** and stay within the patient's **eyesight**.

After the exam, **express** thanks, **discuss** your findings and **ask** for questions.

Take care of yourself

- Be **aware** of your history, your reactions and your colleagues.
- Find **balance** in your own life with regular self-care and taking time to rejuvenate as needed.
- **Connect** with your support system and check in on your colleagues.

Be aware of your personal reactions

Remember that **we are all doing the best we can** with the information we have and the coping skills we have learned.

Check in with the patient in a non-confrontational way if something seems off.

Working with refugees?

See the handout "Resources for Working with Refugees" for more info!

- Ask if the patient is **comfortable with the interpreter** (in person vs. virtual, gender concordance and ethnic/tribal affiliation).
- Learn how to **say "hello"** in the patient's language.
- Be aware of **non-verbal etiquette** specific to the patient's culture.
- Consider how a patient's **culture** may impact **behavior** and **healthcare preferences.**
- Understand **what types of trauma** are more common in the patient's country of origin, to be aware of signs/symptoms/triggers.

TALKING ABOUT TRAUMA

REMEMBER:

- **Let the patient control how much or how little they share**
- **Focus on the impact in the present moment, not the past details**
- **Be aware of the patient's distress level and check in often**
- **Mirror the patient's language and don't make assumptions**
- **Use the interpreter as a resource and cultural broker**
- **Ask yourself: "*Who benefits from this question?*"**
- **Thank the patient for their bravery and vulnerability**

IF YOU THINK THE PATIENT'S CONDITION MIGHT BE RELATED TO TRAUMA:

- "What do you think these feelings might be connected to?"[1]
- "Could you say more about that so I can understand how to be helpful?"[1]
- "How long have you felt this way?"[1]
- Do NOT make assumptions: "You must have been abused."[1]

OBTAINING A TRAUMA HISTORY AT THE REFUGEE INITIAL VISIT:

- "What was life like in your home country?"[2]
- "Were you or your family involved in dangerous situations?"[2]
- "I know many people from ___ whose families were hurt or killed in the war. Did anything like that ever happen to you or your family?"[2]
- "Have you ever had problems because of your culture or tribe /
- political beliefs / religion / gender?"[2]
- "Tell me about how you left your country."[2]
- "What happened the day before you left your country?"[3]
- "What things stands out about your journey to the U.S.?"[3]
- "What do you remember about the exact moment you arrived in the U.S.?"[3]
- "How do these experiences affect you now?"

MAKE THE CONVERSATION FEEL SAFE:

- "It's important and okay to go slow and take the time you need"[1]
- "How can I help you now?"[1]
- "What can we do to help you feel more under control now?"[1]
- Assess for safety when appropriate[1]

HOW TO RESPOND:

- Genuinely validate their vulnerability and bravery
- Do not be afraid of silence
- Do not ask for details unless absolutely necessary
- What NOT to do:
  - Dismiss their experience
  - Say you understand
  - Make assumptions
  - Dismiss the conversation

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RESOURCES FOR WORKING WITH REFUGEES

- **American Academy of Pediatric's Immigrant Child Health Page**
  https://www.aap.org/en/patient-care/immigrant-child-health/
    - Offers recommendations and tip sheets for caring for refugee children
- **Centers for Disease Control - Refugee Health Profiles**
  https://www.cdc.gov/immigrantrefugeehealth/profiles/index.html
    - Each profile contains information such as background on culture/beliefs, political history, healthcare prior to arrival and recommendations for post-arrival exams
    - Profiles available for Bhutanese, Congolese, Somali, Burmese, Iraqi, Syrian, and Central American (minors only) refugees
- **EthnoMed** https://ethnomed.org/
    - Provides a tool to learn common introductory phrases
    - Profiles available for Cambodian, Chin, Chinese, Eritrean, Ethiopian, Hispanic/Latino, Hmong, Iraqi, Karen, Nepali-speaking Bhutanese, Oromo, Somali, Vietnamese refugees
    - Limited information for Burmese, Congolese, Marshallese refugees
    - List of other helpful sites https://ethnomed.org/culture/other-cultures/
- **Massachusetts Department of Public Health Refugee and Immigrant Health Information**
  https://www.mass.gov/service-details/refugee-health-information-for-health-care-and-public-health-professionals
    - Resources about medical examinations and refugee health assessment
- **Minnesota Department of Public Health Refugee Health Provider Resources**
  https://www.health.state.mn.us/communities/rih/hcp/index.html
    - Includes forms for health screening, population-specific medical information, and an online refugee health CME module
- **Harvard Program in Refugee Trauma** http://hprt-cambridge.org/
    - Tool kit for primary care clinicians caring for traumatized refugees
    - Offers culturally-relevant screening tools and provider education materials
- **Immigrant, Refugee, and Migrant Health Resources**
  https://www.cdc.gov/immigrantrefugeehealth/resources/index.html
    - Patient education materials for topics such as COVID-19, seasonal flu, etc.
    - Available in Amharic, Arabic, Burmese, Dzongkha, Farsi, Karen, Kirundi, Nepali, Oromo, Somali an Spanish