Proposal for a Mental Health Intervention for Karen Refugees

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December 10, 2012

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SOWO 709

I have neither given nor received any unauthorized assistance on this paper.
Background

For the past fifty years, refugees from Burma have been forced to flee their country due to the oppressive military government that ruled the country until 2011 (Oleson, Chute, O’Fallon, & Sherwood, 2012). The Burmese majority, one of over a dozen ethnic groups that make up the country of Burma, has perpetrated ethnic, political, and religious persecution against the other groups (Shan 9%, Karen 7%, Rakhine 4%, Chinese 3%, Indian 2%, Mon 2%, and 5% “other”) (Cathcart, Decker, Ellenson, Schurmann, Schwartz, & Singh, 2007). Tension between the Burmese and Karen date back to Burma’s British rule, and it intensified during World War II when the Karen aligned themselves with the British and the Burmese with the Japanese (Neiman, Soh, & Sutan, 2008). During World War II, the Japanese invaded Burma, and both the Japanese and Burmese committed atrocities against the Karen people. Following the war, the Karen people wanted their independence from Burma, and they established the Karen National Union (KNU) in 1947. Despite promises to consider the Karen’s case for independence, the British did not advocate for them and so when Burma gained independence in 1948, the Karen people were part of the nation of Burma (Neiman, Soh, & Sutan, 2008).

In 1962, the Burmese military government, known as the Burmese State Peace and Development Council (SPDC), launched a war of pacification against the people of Burma (Skidmore, 2003). To this day, the Democratic Karen Buddhist Army (DKBA) has refused to succumb to the Burmese controlled army (Human Rights Watch [HRW], 2012), making them targets of violent attacks at the hands of the Burmese government. For example, the SPDC has made it difficult for the Karen to maintain their livelihoods in Burma. The Karen people have historically been farmers that cultivated “hill rice” (Neiman, Soh, & Sutan, 2008). Their lives involve seasonal patterns of planting and harvesting rice. Each year, the Burmese military exploits their livelihood by burning down Karen villages and destroying rice stocks and other supplies that enable their communities to survive (Neiman, Soh, & Sutan, 2008). During these attacks, those that are able to escape flee to the surrounding forests and become Internally Displaced People (IDPs). They often become malnourished and infected with malaria. Many Karen people are displaced several times in their lives, others flee to neighboring Thailand to seek refuge in refugee camps along the border.

In addition to attacks on Karen villages, the Burmese military government has been responsible for abuses such as forced labor, relocation, conscription, sexual violence, use of “human shields,” and indiscriminate attacks on civilians (HRW, 2012; Skidmore, 2003). It is estimated that as a result of the conflict, 10,000 people have died every year for the past fifty years (Skidmore, 2003). Additionally, about 500,000 people are internally displaced and 140,000 refugees reside in refugee camps in Thailand (HRW, 2012). Even though a constitutionally elected government now runs Burma, the Human Rights Watch reports that the Burmese military continues to violate international humanitarian law as evidenced through their use of anti-personnel landmines, forced labor, torture, beatings, and pillaging of property (HRW).

Due to the on-going conflict and resulting external displacement of so many of its people, the Thai-Burma border has become the world’s largest resettlement program (Harkins, 2012). As of September 2012, over 14,000 refugees from Burma had been resettled in the United States during the 2012 fiscal year (Refugee Processing Center [RPC], 2012). The third most common
language spoken by refugees between 2007 and September 2012 was Sgaw Karen. This highlights the trend that the majority of refugees from Burma are members of the Karen ethnic group.

According to the U.S. Office of Refugee Resettlement (2012), over 14,000 refugees have been resettled in North Carolina in the past ten years. In the fiscal year 2007, North Carolina resettled 544 refugees from Burma (Office of Refugee Resettlement). Out of the 1,810 refugees it resettled in that year, refugees from Burma were the largest group (Office of Refugee Resettlement). Orange County has been no exception. From 2005 to 2011, 630 (95%) of the 666 new arrivals in Orange County were from Burma (Community Health Assessment [CHA], 2011). Local agencies and interpreters from Burma estimate the population from Burma to be about 700-1,000, most of whom live in Chapel Hill and Carrboro (CHA, 2011).

Resettlement in the Carrboro-Chapel Hill Community

Orange CHA (2011) reports that Orange County is a desirable place for immigrants and refugees to settle because of its opportunities for education and work, its generally peaceful environment, and the welcoming approach of the refugee resettlement agencies. Three local resettlement agencies provide case management services, immigration legal services, English classes, and assistance with employment. In Walker’s (2011) interviews with directors of refugee resettlement agencies, they noted that some employers in the area are helpful in alerting the resettlement agencies when positions become available and some even provide training to refugee workers. Additionally, there are many volunteers that work at resettlement agencies to assist with the resettlement process. The directors also acknowledged the strengths of the Karen refugee community, noting that those who have lived in the area often serve as interpreters for newcomers, take them grocery shopping, teach them to use public transportation, and help them enroll their children in school (Walker).

Despite these strengths, the Karen community faces many challenges upon resettlement into this area. One major challenge faced by the Karen refugee community is language. Directors of refugee resettlement agencies reported that refugees have difficulty accessing services and communicating outside their own communities without interpreters (Walker, 2011). Furthermore, the directors stressed a need for culturally appropriate interpretation in healthcare settings. Access to health and mental healthcare and an understanding of the US’s healthcare system is another challenge that Karen refugees experience. Walker’s (2011) research found that many Karen refugees in North Carolina were not accessing healthcare because they did not understand how and when to access services. Cathcart et al. (2007) noted that after their eight-month access to Medicaid, many Karen are left with little knowledge about health insurance. Another challenge that needs to be addressed is mental health. Although not specifically documented in the Chapel Hill-Carrboro community, other cities have researched the mental health needs of this population. In their chart review of Karen patients in a Minnesota clinic, Power et al. (2010) found that almost nine percent of their Karen patients had at least one mental health diagnosis. These included depressive disorders, anxiety, and post-traumatic stress disorder. A barrier to seeking help is the stigma attached to mental health issues in their culture as well as accessibility. The education director of the U.S. Committee for Refugees and Immigrants (USCRI) in Raleigh stated that developing mental health services was the greatest
need for the refugee community at this time (Carrie Cargile, personal communication, October 29, 2012). Research supports the need to address this issue among refugee populations and offers suggestions on how to implement culturally appropriate interventions.

**Mental Health of Refugees**

The experience of refugees puts them at great risk for mental health issues (Porter & Haslam, 2005). Research on clinical populations of refugees has found high prevalence rates of posttraumatic stress disorder (PTSD), depression, anxiety, and problems with somatization (Nicholson, 1997). For instance, research on Southeast Asian refugees has found a prevalence rate as high as 71 percent for PTSD and 81 percent for depression among clinic patients (Kinzie et al., 1990 as cited in Nicholson). In a study on seventy newly arrived refugees from Burma, Schweitzer, Brough, Vromans, and Asic-Kobe (2011) found that 9% had PTSD, 20% had anxiety, 36% had depression, and 37% showed significant symptoms of somatization. In a systematic review of the literature, Fazel, Wheeler, and Danesh (2005) found that 9% of adults and 11% of children resettled in Western countries reported symptoms of PTSD. The authors note that this is about ten times the prevalence rate for the general population.

Research has consistently explained these high prevalence rates as being due to the lasting psychological effects of the trauma many refugees experience during their pre-migration journey (Porter & Haslam, 2005). Their psychopathology was understood as a posttraumatic reaction to the acute stressors of war, torture, political violence, and other common traumatic experiences refugees encounter in their home countries before being forced to flee. However, more recently, researchers have highlighted the need to also understand the impact that post-migration stressors have on the mental health of refugees. For example, in Schweitzer et al.’s (2011) study on refugees from Burma, they found that exposure to traumatic events impacted their well-being, but more importantly, post-migration difficulties had a greater influence in predicting mental health outcomes. In Nicholson’s (1997) study of 447 Cambodian, Vietnamese, Laotian, and Hmong refugees, she found that current stress, measured by the degree of acculturative stress such as learning a new language, finding employment, rebuilding social supports, and redefining roles, was the strongest overall predictor of mental health.

One aspect of the Karen’s migration experience of particular salience is their protracted stay in refugee camps. Research has specifically documented that the Karen are in special need of assistance with their integration due to their protracted stay in refugee camps in Thailand (Harkins, 2012). Some people have lived in camps for over twenty years, creating a whole generation born and raised in asylum (Harkins). The conditions of the refugee camps are often unsafe and unsanitary, and research has shown that prolonged stays in the camps can exacerbate the trauma experienced by refugees (Nicholson, 1997). Beiser, Turner, and Ganesan (1989) conducted a study on 1,348 adult refugees from Southeast Asia and found that stressful camp conditions had a significant effect on the adjustment of refugees during resettlement and were a primary cause of depression. In a needs assessment conducted on resettled Karen refugees, interviewees reported that overcrowding in the camps is a major problem, and there is a lack of adequate food, shelter, medical care, and access to education (Mitschke, Mitschke, Slater, & Teboh, 2011). Furthermore, they have little or no freedom and are unable to work or farm, so they are forced to live on aid. Many of the Karen interviewed in Mitschke et al.’s study reported
that they applied for refugee status in the hopes of having a better life. This included wanting to be able to provide their children with better access to education and having employment to support their families. However, a major theme that arose in this study was the disillusionment many of the resettled Karen experienced once they were resettled in the United States. Some even reported that life in the camps was preferable to their resettled lives (Mitschke et al.).

The disillusionment highlighted in Mitschke et al.’s (2011) study points to the effect that post-migration stressors have on a refugee’s mental health. Not only do they have to deal with the acculturation stressors of learning a new language and finding employment, they also have to grieve the loss of their country, culture, and oftentimes, family. Researchers have found that grief over the loss of family members and social support is significantly correlated with negative mental health outcomes (Nicholson, 1997). Bennet and Detzner (1997) found that social isolation and loneliness was a common theme in the life histories of Southeast Asian women (as cited in Miller, 1999). Other post-migration challenges encountered by refugees are changes in their cultural values. Hsu, Davies, and Hansen (2004) document the role that changes in family structure have on Southeast Asian refugees. In traditional Asian families, roles and positions of hierarchy are important. Filial piety, or having utmost respect for elders such as parents and grandparents, is evident in Asian families, and can be challenged when the role of children is forced to change during resettlement. Often children learn the language faster than their parents and become the main communication facilitators. This can cause a shift of authority from elders to the young, disrupting cultural values and roles of the family structure (Hsu et al., 2004). Another cultural value that presents as a challenge is a change in traditional gender roles. In Southeast Asian cultures, men are the heads of the family and are expected to financially support the family while women are meant to be subservient, obedient, and quiet (Hsu et al., 2004). However, once refugees have been resettled, women are often required to find employment because their husbands cannot find enough work to support their families. Changes in gender roles can put pressure on traditional marriage and family relationships.

Recommendations

The pre- and post-migration stressors that many refugees experience highlight the need for mental health services for this population. However, before developing mental health interventions for refugees, it is important to consider their understanding of mental illness. For one, Southeast Asian refugees often experience and express stress in somatic symptoms (Nicholson, 1997). For example, people from Asian cultures often describe depression as problems with eating, sleeping, headaches, backaches, and digestive problems, whereas Western culture describes depression as feeling sad or down. Somatization seems to be a more culturally sanctioned way of expressing emotion. This also points to the stigma and shame associated with mental illness in Asian cultures. Among Asian cultures, a heavy emphasis is placed on the moral model of mental illness. This model asserts that poor morals, laziness, and selfishness cause mental health issues; and therefore, they can be cured once a person improves their moral deficiencies (Haque, 2010). The stigma and shame associated with mental illness often prevents Asian refugees from seeking out and utilizing mental health services (Miller, 1999).

Another barrier to treatment noted by the literature is the difference in therapeutic approaches between Western and Asian cultures. For example, Miller (1999) questions the
salience of individual psychotherapy in refugee populations. For one, given the role of post-migration stressors on a refugee’s mental health, Miller cautions against exclusively using trauma-focused individual therapy. Furthermore, many refugees are not accustomed to sharing their problems with others. For example, in the Karen culture, it is considered a cultural violation if you tell someone your problems, because they don’t want to burden their confidant with finding the solution (Beth Farmer, personal communication, November 24, 2012). Kinzie et al. (1988) also explains that there is not a similar practice done in Asian cultures like the practice of self-disclosure required in individual psychotherapy.

There is currently limited research on evidence-based treatments for mental health services for Southeast Asian refugees; however, researchers have made several recommendations. First, in order to lessen the stigma attached to mental health services, the literature suggests incorporating psychoeducation into mental health interventions to educate refugees about mental health in the United States (Haque, 2010). Miller (1999) also suggests providing services outside of mental health settings, so as to lessen the stigma attached to attending mental health services. George (2012) highlighted the need to recognize resiliency when developing interventions. By using a resiliency perspective, interventions can help give meaning to refugee suffering while also emphasizing the strengths that have enabled them to overcome their difficult migration experiences (George). Hsu et al. (2004) also analyzed resilience and protective factors to identify what may buffer a refugee from developing mental health issues and used these findings to make recommendations for treatment. For example, they found that refugees that focus on the future with optimism and hope are less likely to develop depressive symptoms. Therefore, it is important to help refugees focus on the future. Hsu et al. also found that social support from ethnic communities served as a protective factor during the resettlement process. Research has found that social support from one’s own ethnic community is important because it provides a sense of identity and belonging (Chung, Bemak, & Kagawa-Singer, 1998). Furthermore, refugees who have psychosocial problems often report dissatisfaction with their social support networks; therefore, interventions that enhance social supports, build natural helping networks, and create mutual assistance programs may be helpful in alleviating these problems (Nicholson, 1997; Hsu et al., 2004). One method recommended in the research to address this issue is group therapy (Nicholson).

Group treatment has been shown to have positive mental health benefits for traumatized and displaced populations (Akinsulure-Smith, Ghiglione, & Wollmershauser, 2008). Kinzie et al. (1988) note that group therapy may be effective with Southeast Asians because it promotes acceptance and cohesion in the group, has guidance by leaders, and promotes learning from others, which are all particularly relevant therapeutic factors to Asians. Asner-Seif and Feyissa (2002) state that group counseling is beneficial to refugees because it can lessen feelings of isolation and offers a support network within the group. Group therapy creates a safe place for refugees to explore their experiences, creates a sense of universality amongst them, and gives them a sense that they are not alone (Asner-Seif & Feyissa). Research also suggests that the relationships refugees build in group therapy help them to feel useful because they are able to help other group members. This aspect of group treatment can help refugees to regain a sense of purpose in their lives (Yalom, 1985).

Community Adjustment Support Group
Given the salience of addressing mental health issues in the Karen refugee population as well as the lack of resources available to address this need in the Carrboro-Chapel Hill community, I would like to propose a community adjustment support group. The curriculum I would like to use was designed by the *Pathways to Wellness: Integrating Refugee Health and Well-Being* project. The curriculum outlines eight, ninety-minute sessions. It was designed for resettlement agencies and community-based organizations that want to have a support group for refugees around emotional well-being and successful integration into the community.

As highlighted above, the literature supports group treatment for addressing the mental health needs of Southeast Asian refugees. The *Pathways to Wellness* curriculum was chosen because of its incorporation of recommendations from research. First, the group framework provides opportunities for members to connect and seek support from one another. It helps to normalize their experiences, so that refugees feel less alone. For example, the second session explores the common experiences of culture shock. The curriculum also provides psychoeducation about mental illness in the United States, so as to reduce the shame and stigma attached to it. As suggested by Hsu et al. (2004), the curriculum acknowledges the role of cultural values. It does so by helping refugees create connections between their traditional beliefs about mental health and those in the US. They discuss how their culture or belief systems guide how they’re supposed to act when they’re grieving, sad, happy, etc. As a follow up to this session, Week 5 is spent exploring how the mind and body are connected. During this session, participants learn relaxation and calming techniques. During Week 6, the curriculum focuses on helping group members understand that resettlement is a long-term process filled with small steps. Just as Hsu et al. found that refugees who focus on the future are more successful, the curriculum helps participants set goals for themselves and create realistic time frames for achieving them. The last session utilizes the resilience framework recommended by George (2012). Participants are reminded that because of the great difficulties in adjusting to life in the US, refugees can forget that they are strong survivors. Participants are asked to think about a time they have overcome a great obstacle and emerged victorious. They are reminded that every hero’s story has struggles, and the leaders of the group want participants to see themselves as the hero in their own story.

**Implementation**

I would like to propose this intervention to Refugee Health Initiative (RHI). RHI was started by a group of medical students at UNC to address the health needs of refugees living in the area. RHI partners with Church World Service (CWS), a refugee resettlement agency in Durham. RHI is also affiliated with Student Health Action Coalition (SHAC) and functions as one of their community outreach programs. RHI currently provides health literacy education to recently resettled refugees in Orange, Durham, and Wake counties. This is accomplished through a series of “healthcare orientation” home visits. During home visits, volunteers cover topics on nutrition, physical activity, health literacy, understanding the medical system, and mental health. In addition to providing home visits, RHI has also participated in health fairs and led several educational sessions on topics including substance abuse, domestic violence, safety, and first aid.
RHI is an ideal organization to implement the support group for a number of reasons. First, they are affiliated with Church World Service. This is helpful because CWS can refer refugees that they feel might benefit from the group. RHI also potentially has the financial means to implement the program. Due to RHI’s affiliation with SHAC, they receive money to provide interpreters. As most recently resettled Karen do not speak English, every session will need to have at least one interpreter. It is assumed that RHI will be able to recruit graduate student volunteers from the School of Social Work to run the group. They will need to have one faculty member to supervise their efforts. RHI has held educational sessions in Carolina Apartments, an apartment complex where many Karen refugees live, so it is hoped that the space used for those sessions will be available for the support group. Having the support group in this location eliminates transportation issues and will be easily accessible to refugees. Also, as Miller (1999) suggested, providing mental health services outside of mental health settings, like Carolina Apartments, removes the potential barrier of stigma.

Below is a list of steps that need to be taken in order to begin the implementation process:

1. Propose intervention to leaders of RHI and CWS to obtain their feedback. For example, do they have the funding available to provide an interpreter for eight sessions?
2. Recruit at least two social work students to run the group. Provide training to these students as well as a Karen interpreter.
3. Discuss with CWS the best way to refer Karen refugees to the group. Given that the RHS-15 has not been implemented yet, is there another way CWS can refer refugees they think might benefit from the group? The Community Adjustment Support Group Training Manual suggests having a group of 8-10 members and that they all be of the same gender.
4. Talk with Carolina Apartments and RHI to secure a room for the group.
5. Look into providing childcare during the meeting. One potential source of childcare is from the local high schools. Students from Carrboro and Chapel Hill High Schools are required to obtain a certain amount of community service hours in order to graduate. Speak with school social workers about recruiting students to provide childcare during the group sessions.
References


Annotated Bibliography


Crawford analyzes the cultural, economic, and legal factors that lead to the sexual trafficking of women and girls from Burma. Thailand has long been notorious for its sex tourism, but recently the Thai government has implemented policies and programs that have worked to decrease the supply of Thai women in the sex industry. However, they have done little to combat the demand for sex tourism, and ultimately, an increasing number of women and girls from Burma are entering into the Thai sex industry. Crawford examines the push factors in Burma that force women out of Burma and place them at high risk for entering into the sex trade in Thailand. For one, the Burmese military has used rape and other forms of sexual violence as a weapon for decades. This has instilled fear in women who have experienced rape at the hands of the military as well as in communities where women might be raped. This fear has been a push factor to flee Burma, and has also led some to the conclusion that since sexual abuse is inevitable they may as well be paid for it. This mentality highlights the dire economic circumstances that many women have no other option but to engage in sex work in order to support their families. The dire economic circumstances are a result of the corruption and mismanagement of the economy as well as the militarization of the government. Crawford reports that 40% of Burma’s government spending is on the military where as only 1% of the GDP is spent on health and education. Thus, many of Burma’s people are forced to migrate into Thailand to find work. Once in Thailand, Crawford highlights how Thai refugee policies have impacted the sex industry. Thailand does not officially recognize refugees, as it did not sign the 1951 convention relating to the status of refugees. It only offers “person of concern” status, entitling only certain people to basic protection. For example, it has provided this status to the Karen ethnic group, but this protection has not been made available to the 350,000 Shan refugees who live in Thailand and are considered illegal. Thus, sex work is one of the few options available to women without
documented status, language, education, or other qualifications for non-sex work. Furthermore, girls often shoulder the economic responsibility of the family, despite being the least educated with few work opportunities. Although this article mostly talked about the Shan’s forced involvement in the sex trade in Thailand, it provided a great insight into the way refugee policies impact the life outcomes and choices for those fleeing persecution. I was also reminded of the sexual trauma that many Karen may have faced while still in Burma, even if the Karen ethnic group is not at as high a risk of sexual exploitation and trafficking as other ethnic groups from Burma.


This article reports on the case study of Karen refugees living in St. Paul, MN to better understand third country resettlement and the integration of Karen refugees into the St. Paul community. The Thai-Burma border is the largest resettlement program in the world, and due to the large-scale financial and human resource engagement that occurs along the border, more research is needed to see how successful the program has been. Harkins (2012) interviews members of the Karen refugee population in St. Paul as well as key informants to gather information about this process. Harkins argues that St. Paul is an important case study because it has the potential to provide other communities with the lessons it has learned about providing services to refugees, especially those coming from protracted refugee situations. This article also provides information about the process of becoming a refugee first in Thailand, and then the option for resettlement in another country, such as the USA. Harkins cites concerns refugees have applying for resettlement, such as a fear of moving to a distant foreign country to start a new life, the lack of choice for refugees as to which country they go to, and the hardships many have to go through to even apply for resettlement. There are many “push” factors for Karen refugees. For one, living in the camps restrict their ability to live self-sufficiently because there are limited employment and educational opportunities. Many also assume that it will never to be safe to return to Burma and that they will not be allowed to stay in Thailand indefinitely. “Pull” factors include better educational and employment opportunities, family reunification, and an overall better future. As there is such a high secondary migration to St. Paul, Harkins also includes the “pull” factors for St. Paul specifically, including the availability of interpretive services and informal networks that have been set up by the Karen in the community. I hope to use this article for my research to better understand what works in a successful resettlement community and to compare the resources that the Carrboro community has in comparison to the St. Paul community.


This study conducted a needs assessment on Karen refugees that had been resettled in a southwestern city in the United States. The researchers interviewed twenty-one Karen refugees, ages twenty to seventy-one, to assess the biopsychosocial needs of the Karen. The authors recognized that although research has been conducted on the needs of other Asian populations
that have been resettled in the US, there is a gap in the research on the specific issues that the Karen encounter. The article opens with information on the experiences of the Karen in refugee camps in Thailand. They report that they have little or no freedom and are unable to work or farm, so they are forced to live on aid. Overcrowding is a major problem, and there is a lack of adequate food, shelter, medical care, and access to education. Many of the Karen that the researchers interviewed noted that they applied for refugee status in the hopes of having a better life. This included providing their children with better access to education and having employment to support their families. However, one major theme that arose in their interviews was the disillusionment many of the resettled Karen experience. There is an incongruence between the expectations of how their lives would be once there were resettled as compared to the reality of their resettled lives. Some even said that they thought life in refugee camps was preferable to resettlement. The interviewees spoke of a lack of financial resources to support their families. In looking toward the future, many of them discussed the importance of being able to care for their families without government assistance. However, at the same time, the lack of job opportunities was a primary issue raised and an ongoing concern. They expressed interest in job training programs to learn skills that would help them gain higher paying jobs. They saw language as a primary barrier to getting better paying jobs. In general, they felt like language was the key to unlocking opportunities. Participants in the study appeared motivated to learn English, but barriers such as cost and availability of classes prevented them from accessing classes. The authors also suggest the expansion of creative and nontraditional strategies for employment, such as micro-lending programs, fair trade handicrafts, and micro-gardening projects. These nontraditional strategies may provide additional opportunities for refugees who are unable to obtain more traditional employment. This is an especially important issue for my research this semester because research has shown that prolonged periods of under- and unemployment leading to an inability to meet the basic needs of one’s family can lead to decreased mental health in Southeast Asian refugees.


This study examined the beliefs, attitudes, and health-seeking behaviors of Karen refugees in regards to traditional and Western medicine. The researchers collected this information by interviewing key-informants and conducting focus groups with Karen refugees living in Minnesota. They also observed Karen refugees at a popular traditional medicine vendor as well as an international market that had multiple vendors of traditional medicine. The researchers were specifically interested in Karen refugees’ perspective on Western and traditional medicine because many have had exposure to Western medicine in Thai refugee camps, but they still use home remedies, medicinal foods, and medicines prescribed by traditional doctors. Despite this knowledge, there is a gap in the research about what role traditional medicine has once Karen refugees relocate to the United States. The authors found five major themes in their research. The first is that Karen refugees have a holistic view of health. “Good health” does not mean the absence of disease but rather a good balance between physical, mental, and spiritual health. The second theme that arose was that faith and spirituality are at the forefront of Karen healing beliefs. Therefore, Karen in the US seek out traditional healers to receive treatment and to get advice on how to make medicine. Another theme they found was that many Karen view Western medicine as “chemicals” and would prefer the natural
medicine prescribed by traditional healers. The fourth theme documented in this study was that accessibility plays a major role in what type of treatment Karen refugees get. Accessibility is more important than whether a Karen prefers Western or traditional medicine. Lastly, the authors report that Karens’ experiences as refugees play a major role in their perspectives about healthcare. Certain health issues are viewed as more dangerous based on what they witnessed during their experience as a refugee fleeing from Burma or living in the Thai refugee camps. The authors close with a discussion about the implications of their research. They note that it is important for practitioners to discuss with their Karen clients their use of traditional medicine, as their research shows the importance many Karen place on traditional medicine.


Previous research has found that Asian American populations have fewer chronic health conditions, fewer functional limitations, less disability, and lower mortality rates than non-Asian populations. However, the authors of this study note that broad generalizations about all Asian populations cannot be made. This study examined Southeast Asian refugees (Hmong, Cambodian, Vietnamese, and Laotian) to see if their health profiles were as positive as previous research on Asian Americans has found them to be. There has been research on Vietnamese Americans, which has found that they have poorer health profiles than other Asian groups and Whites. Very little research has been done on the differences between groups of Southeast Asian refugees. The researchers aimed to describe the prevalence of sensory deficits, functional impairments, and disability among older refugees within the four Southeast Asian groups. They also investigated risk factors that contribute to the health patterns of these groups. The results of this study show that the four Southeast Asian refugee populations differ significantly from each other. Specifically, they found that the Vietnamese group had better health outcomes than the Hmong and Cambodian groups, and were similar to the Laotians. This is striking considering that previous research has found that the Vietnamese population has the poorest health profiles compared to larger, more established Asian populations. The authors hypothesized as to why Southeast Asian refugee populations tend to be less healthy and more disabled than other immigrant groups. For instance, the difficult migration experience, wartime conflict prior to escaping, and long durations in refugee camps may all negatively impact their long-term health. They also noted that some researchers have suggested that the Hmong have poorer health profiles because they were more resistant to immigrating and resettlement. The researchers also highlighted the role that extended stays in refugee camps have on health. Many Hmong and Cambodians had protracted stays in refugee camps, exposing them to poor nutrition, less access to health care, and crowded living conditions.
Appendix

I met with Beth Farmer on November 24, 2012 to discuss the Refugee Health Screener-15 (RHS-15). Below are some key points she mentioned during our meeting.

1. RHS-15 was validated in 2011, n = 251
2. The process of creating the screener in different languages included getting community groups together and having them discuss the meaning of the words used in their language. Basically they translated it as a group and debated the meaning until they felt like the meaning was exactly right. Then their translated documented was given to a person that was not involved in the process who then read it to see if they agreed. This process continued until everyone was in agreement.
3. In addition to the languages listed on the Utilization Agreement, they are in the process of translating it into Swahili, African French, Farsi, Tagrinya, and Ethiopian.
4. She says other screeners are good too, like the Hopkins Symptoms Checklist for Depression and the Harvard Trauma Questionnaire for PTSD; however, they wanted to create a screener like RHS-15 because it can be done in less than 15 minutes. It also doesn't require refugees to tell their stories, which could be troublesome for the people administering the questionnaires (crying people in their office, longer process, etc.) People were looking for something quick. It's also culturally proficient (unlike other screeners).
5. Drawbacks of the screener: Doesn't assess for Domestic Violence, Substance Abuse, and it's not diagnostic.
6. Beth thinks it's effective and it gets people to treatment. She called it a "router." They wanted to find a screener that would get refugees help while they still had Medicaid. They didn't want people falling through the cracks. Also, depending on the diagnosis, they could qualify for disability or increased Medicaid.
7. Who should implement it? She says they decided that the volags weren't the best places to do it. She says they have a high turnover and wear so many different hats- it could get awkward if the person who is setting up your apartment is also asking you personal mental health questions. I think primary care physicians and public health nurses use it in WA.
8. In order to implement this tool, she said you need to know where you're going to send people. She said Wilmington is doing it and referring people to support groups at the Volags or pro-bono therapists in the area
9. RHS-15 is currently in Phase 2 validation. They are doing a cost-function analysis to figure out the best cut-off score. Right now the score may be too low, in that people are being "caught" who maybe don't need to be "caught." But at least it's catching the people who definitely need help.
10. She said people are using it differently all over depending on their needs. Examples: Boise, ID psych residents are using it. She also said it could be used for advocacy purposes to show there's a disparity for the people we're serving.
11. There are scripts for the RHS-15 that are used to explain what's happening, that it's used for referrals, etc.
12. 38 agencies have utilization agreements. ORR publicizes it through SCORE. The funding source for the initial development was the Robert Wood Johnson and Gates Foundation. They said that if they invest in it, then it had to be free to everyone else. So all of their tools are free, but everyone needs to sign the utilization agreement.