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A Helping Hand Out of the River: Refugee Perspectives for Provider Engagement

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Purpose	A growing number of refugee groups are seeking care within the U.S. health care system for medical, psychological, and social needs. Research is limited in understanding refugee-specific conceptualizations of helping relationships and provider characteristics that improve interactions in health systems. This study aimed to identify provider characteristics that facilitate engagement and helpfulness in a refugee-specific population from refugee participant voices to inform future practices of health care clinics.
Methods	Semi-structured interviews with refugee participants were conducted to assess 1) experiences moving on from difficult experiences, 2) engagement with the health system, and 3) provider characteristics that facilitated engagement and healing. Qualitative data were analyzed using a grounded theory approach.
Results	An emergent theory was revealed on refugee-defined provider characteristics that facilitated healing and engagement in the health system. Providers who support an individual's story to be told, show awareness of barriers to accessing resources and prioritization of addressing barriers, maintain cultural humility, and demonstrate compassion, empathy, warmth, and openness toward patient engagement were the primary characteristics that facilitated engagement and healing.
Conclusions	Utilization of engagement strategies by providers at the onset of treatment is critical to providing culturally sensitive health care. Nonspecific but essential provider characteristics are thought to improve relational dynamics, trust-building, and overall engagement in the U.S. health care system from the perspective of refugee participants. (<i>J Patient Cent Res Rev.</i> 2023;10:231-238.)
Keywords	refugee; health care utilization; integrated care; mental health; engagement

A refugee is defined as someone who has been forcibly displaced from their home due to a “well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion,” requiring international protection.¹ The number of individuals who constitute this population has increased since 2011, with a reported 94.7 million people worldwide in 2021.²

Refugee populations are exposed to numerous traumatic experiences, including war-torn environments; living in refugee camps for extended periods of time in which

sexual violence, theft, and unsafe living conditions are common; isolation; being “othered” and experiencing discrimination.³ In addition, they face many postmigration stressors when settled (eg, poverty, separation from loved ones, new culture, language, systemic racism).^{4,5} Presenting symptoms in this population are often related to posttraumatic stress — nightmares, somatic symptoms, flashbacks, hypervigilance, memory deficits,⁶ anxiety, depression — all of which can disrupt quality of life. Additionally, refugees often deal with chronic physical health problems (eg, diabetes, cardiovascular disease, musculoskeletal problems)⁷ at higher rates than the general population.^{8,9} To support refugees' needs, a community-focused lens can help identify appropriate services to enhance care, including preventive services, psychoeducation, and increased accessibility.

The American Psychological Association states that the ability to develop therapeutic relationships with refugees is an essential aspect of clinical expertise.¹⁰ Practitioners

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can help build such relationships by conveying positivity and consistency, creating an atmosphere of trust and safety, and adopting a culturally sensitive attitude.¹¹ It is necessary to explore the question of how people of various cultures view this “helping relationship”¹² to protect against only using Euro-North American definitions of help and instead ensuring that culturally specific definitions are being used.^{6,13} While some notable research speculates about the salient characteristics of a helper,¹⁴ there is a lack of research designated to defining the helping relationship from the perspective of the individual receiving help. Therefore, it is important to ask what characteristics providers might need to be effective to facilitate such a framework in treatment.

Study Objectives

The present study is a qualitative exploration of refugee-identified health care provider characteristics that facilitate a trusting, therapeutic relationship, create an environment for health improvement, and promote integration of refugees into community-based health and well-being programs.

Conceptual Framework

Community-based participatory research (CBPR) is a form of research that prioritizes partnership to better answer and address research questions via cooperation, sharing of resources, co-learning, and empowering disenfranchised voices.¹⁵ Through identifying community members’ needs and integrating their voices with available resources, localized change becomes more feasible. In this manner, qualitative research highlighting refugee voices has been a strong approach in understanding the gaps in treatment. Isakson and Jurkovic¹⁶ have identified a refugee-informed framework for conceptualizing and treating trauma. Specifically, in a study using grounded theory qualitative analysis, 11 refugee participants engaged in semi-structured interviews around their experience of “getting better” after torture and exposure to trauma. A theme from the participant voices revealed a uniform desire to “move on” and heal from these traumatic experiences by not dwelling on past events and feeling empowered to “take control of the healing process.”¹⁶ While it does not negate the exposure-based recommendations for trauma treatment often employed in Western cultures, it adds another layer that is culturally informed and refugee-specific around maximizing present functioning, empowering communities and individuals, and not fixating on past events to allow for healing.¹⁶

The data further analyzed in this paper are part of a larger study that followed up on the recommendations by Isakson and Jurkovic¹⁶ that discussing healing and “moving on” was a therapeutic experience and that

this type of discussion could be used as an engagement strategy for providers working with refugees. As described in the Methods section in more detail, participants were interviewed about factors that promoted healing and moving on after trauma. They participated in a follow-up interview to give feedback about the set of questions in the first interview and gave suggestions for clarity and cultural sensitivity, with the purpose of developing a semi-structured interview engagement strategy based on discussing factors that promoted their healing and moving on from trauma, given that refugees may be reluctant to discuss past trauma in initial clinical sessions.

In alignment with CBPR philosophies, gaining this information in collaboration with targeted community representatives — in this case, refugee populations and community liaisons on the research team — is a robust way to implement trauma and patient-informed frameworks. Regarding CBPR principles, this study aimed to highlight refugee voices in defining helpful provider characteristics for engagement in health care and healing. Lessons learned may offer ideas for providers to consider in their efforts to increase engagement with refugee patients.

METHODS

Grounded theory was selected as the methodology because it allows for the construction of a substantive theory and permits the development of this theory from the perspective of historically neglected voices, which is essential to improving practices to better meet the health care needs of the current study’s population.¹⁷ The institutional review board at the University of New Mexico approved and monitored this study.

Sampling Procedures and Participants

Refugee participants were recruited through local refugee service providers who had extensive experience working with this population, including behavioral health clinicians and refugees who were community liaisons and interpreters. Several of these community liaisons were part of the research team and provided feedback on making the study culturally appropriate, including discussions on how to interpret specific questions and findings. Participants who completed the interview were asked if they knew anyone interested in participating. A script was provided to them, along with inclusion criteria. Participants had to be adult refugees resettled in New Mexico, have resided in the United States for at least 1 year, had legal status, and who were determined to be emotionally stable by the mental health providers supporting recruitment as based on participant responses on the Patient Health Questionnaire-9 (PHQ-9).¹⁸ Participants also had to have stable housing and a history of torture or trauma related to being a refugee.

In all, 17 refugee participants were recruited to participate; 9 were African refugees (2 from Burundi, 5 from the Democratic Republic of Congo, and 2 from Rwanda) ranging from 27 to 55 years in age, with 5 identifying as male and 4 as female; 8 participants were Iraqi, ranging in age from 40 to 60, with 5 identifying as male and 3 as female. Two additional people consented to participate but did not complete the interviews: one because she denied having experienced trauma, and the other because he decided he did not wish to talk about his trauma experiences.

Interview Procedures

At the beginning of each interview, participants read and signed a consent form that described the interview, nature of the study, and confidentiality. The interviewer answered any questions the participant had. All participants were informed that they could refuse to answer any question, stop the interview, or take a break at any time. Each participant was assigned an identification number. Consent forms, hard copies of transcripts, and recordings of the interviews were stored in a locked filing cabinet in the office of the first author. The PHQ-9¹⁸ was used to assess depression and suicidal ideation and was administered prior to completing consent. The measure was included as an additional way to assess the emotional stability of potential participants before deciding to participate.

Interpreters were available to all participants who were not able or comfortable completing the interviews in English. The interpreters had received formal interpretation training and had several years' experience.

Interviews

All participants were asked a set of questions that were adapted from an existing interview designed to inquire about the moving on and healing process for refugees who experienced torture and/or trauma.¹⁶ All interviews were conducted by a licensed clinical psychologist or an advanced graduate student in clinical psychology. The initial semi-structured interview, which lasted between 1 and 1.5 hours, was conducted in a private room at a behavioral health research center or in a private room at the participants' residence when preferred.

Follow-up interviews, which lasted about 1 hour, were conducted approximately 1 month after the initial interview. The follow-up interviews allowed participants to add any comments or clarifications and to provide feedback about each of the questions from the initial interview. As the study progressed, the initial interview questions were revised based on feedback from the second interviews, refugee mental health experts, and research

team. Thus, the revised set of questions was presented to later participants during their first interview (Table 1). Revisions focused on clarifications and examples that participants suggested.

Content from the first interviews and any additions or clarifications the participants made in follow-up interviews about their moving on experiences is the focus of this manuscript.

Data Analysis

All interviews were audio-recorded and transcribed by the research team or by a confidential transcription service, Transcription Hub. The transcriptions were entered into NVivo 8 computer software (QSR International) for data analysis.¹⁹ Transcripts and notes were imported directly into NVivo, which allowed for categorizing, defining, editing, searching, and merging codes and categories. Using the grounded theory methodology of Corbin and Strauss,²⁰ transcripts were analyzed using several operational procedures, including open, axial, and selective coding. Open coding involves the identification of themes and categories. Throughout the interviewing phase and when reviewing the transcripts, researchers discussed themes that emerged during the initial interview, which were then organized into a coding scheme.

Two research assistants were trained to code the interviews: one an advanced doctoral graduate student in clinical psychology and the other a doctoral clinical psychology graduate student in her final year of clinical training. They were trained to verify the coding scheme and categories by locating and coding themes line by line in a transcript interview. They coded a transcript independently to test out the coding scheme, and the research team decided if the themes represented the content of the data and if the names of the categories were appropriate. The codebook was adjusted following recommendations from the coders.

Members of the research team formally coded each of the interviews independently. The coders achieved an acceptable level of interrater agreement (70% or greater). When disagreements occurred, the coders and other research team members discussed and decided which code was most appropriate. Throughout this process, the codebook was iteratively refined.

As similar themes emerged, with no significant information being added, researchers decided that saturation — the point at which new data fits into the current coding scheme²¹ — was achieved, which allowed the researchers to fully answer the research questions. In preparation for axial coding, the final codebook

Table 1. Original and Revised Interview Guides Used for Data Collection

Original version of “moving on” interview questions
1. What experiences in your home country led you to the United States?
2. How long did they [the experiences] last?
3. Have there been other big challenges for you since _____ (use their words regarding trauma/torture)?
4. A) What is different about you since then? B) What remains the same?
5. What were some of the most memorable experiences and challenges you had after _____ (use their words to name the experience)?
6. A) As you began moving on with your life, what were your goals or aims? B) Was “healing” or “getting better” one of your goals? C) What does “getting better” mean to you? D) How do people think about this in _____ (name of person’s home country)?
7. Were your goals for getting better different or similar to the traditional ones in your country?
8. Could you share an experience that helped you get better?
9. How would I know you are getting better?
10. What has been the most helpful in the process of getting better?
11. How have other people helped in the process of getting better?
12. Have there been any setbacks in the process of getting better?
13. What would you recommend to people who have recently been through similar experiences?
14. What can [others, treatment providers, etc] do to help you get better?

Final version of “moving on” interview questions
1. What experiences led you to leave your home country?
2. How many days/years did these experiences last?
3. What were some of the big problems or difficulties you had since leaving your country?
4. A) A lot of people act or feel differently after distressing events and trauma such as changes in how they feel about themselves, how they feel about the world, changes in relationships in their families and communities, and their faith in God. Can you describe some of the changes you have noticed in yourself after those distressing and traumatic events? B) Are there things about you that haven’t changed after these distressing and traumatic events? If so, what are they?
5. What are some of the good experiences you have had since leaving your country?
6. A) Now that you’re here in New Mexico, what would you like for yourself? B) Is “healing” “moving on” or “getting better” after your experiences of the distressing and traumatic events one of your hopes or aims? C) What does “healing, “getting better” or “moving on” after distressing and traumatic events mean to you?
7. People often have setbacks and problems or difficulties in the process of healing/moving on/getting better. What problems/difficulties did you face and how did you deal with them?
8. Could you share stories or events that helped you get better, heal, or move on after the distressful and traumatic events?
9. What were the signs or behaviors that helped you recognize that you were getting better/healing/moving on?
10. What has been the most helpful to you in the process of getting better/healing/moving on after the distressing and traumatic events?
11. Have other people helped you in the process of getting better/healing/moving on after the distressful and traumatic events? If so who and how? (Optional: ask if they have not already discussed)
12. What is it about who you are or the way you deal with problems that have helped you to get better/heal/move on after the distressful and traumatic events?
13. What gives you meaning or purpose in life? (Optional question if not discussed: Many people say that spiritual beliefs or practices are helpful in the process ... Has this helped you get better/heal/move on? How?)
14. Are there things in your life right now that you are grateful for? If so, what?
15. What advice or wisdom would you give to people who have recently been through similar experiences?
16. What can others do to help you to begin or continue to get better/heal/move on? (Give examples, if needed: doctors, family members, neighbors, friends, helping professionals) (Acknowledge what they have already said, if applicable.)
17. For anyone with whom you might work (like a doctor), who may have never been through similar distressing or traumatic experiences like you, what would you want them to know or understand about the process of getting better/healing/moving on?

was entered into NVivo and the agreed-on codes were organized according to analyses.¹⁹

Next, using axial coding through NVivo,¹⁹ the research team linked themes, categories, and subcategories and organized them systematically according to context, conditions, and strategies that aided or hindered the moving on and healing process. Specific to this manuscript, selective coding was used to develop a model in which refugee-identified provider behaviors were related to moving on and healing. Several core themes emerged as reflecting provider behaviors that were valuable to building trust, engagement, and a therapeutic alliance.

RESULTS

Refugee participants shared their perspectives on providers' behaviors that promote health, healing, and recovery. They shared personal stories about providers' behaviors and gave insights into what helped them move forward in restoring their health. Analysis of the interviews revealed 5 main themes, which are described, along with corresponding subthemes, in this section.

Theme 1: Importance of Listening to Refugees' Stories

Listening to refugees' stories was seen as one of the most important components of building trust and understanding. Knowing the story helps providers understand the problem and its impact on patients. One participant discussed how sharing stories acts as a teaching opportunity for providers. Understanding the depth of problems, as well as cultural and situational experiences in which these problems occur, enables providers to better understand future patients who have been through similar situations.

"The story I can provide can help the doctors to understand [similar accounts] from someone else who [had] the same experience as me. If they understand from me how [it] was and how the process was still going ... what I can say will help him to understand [those] who come after me [with] the same problem."

Participants also shared strategies that providers can use to facilitate the process of storytelling. Three subthemes emerged.

Subtheme 1.1: Believing in Patients' Stories. Due to the complexities of the situations they have been through, some refugees felt as though some providers did not believe their stories, whether due to nonverbal feedback or based off dismissal experienced in previous social interactions. One participant stated, "... you tell stuff about war, they may think that is not true." Acknowledging patients' stories despite the unbelievably horrific details

that they might carry was seen to be among the factors that encouraged participants to share.

Subtheme 1.2: Asking About Beloved Ones and Family Members. Participants expressed that some of their ongoing stressors are related to family members who they left behind or others who accompanied them but are going through struggles. Asking about family seems to help facilitate conversation and foster support and well-being. One participant noted:

"She [the doctor] listened to my story and asked me about my family and what they are doing and how they are, and she thinks I am doing good and that makes me believe in what I am doing and that makes me feel better."

One participant shared a story about being separated from his family members and wanting support from providers to reunite them. Although assistance with reunification is outside most providers' purview, understanding a patient's family situation may provide insight into the patient's experience of stress and health, as well as increase the provider's connection with the patient.

Subtheme 1.3: Avoid Making Assumptions. Participants reported that providers sometimes tend to interpret refugees' symptoms and experiences as trauma-related, when in fact, symptoms could be related to nontraumatic experiences.

Theme 2: Understanding Barriers to Care and Encouraging Help-Seeking Behaviors

Multiple barriers to seeking care were discussed by participants, including language, illiteracy, and difficulty in navigating the U.S. health care system. It is important for providers to recognize these barriers and give participants a safe space for expressing when and how they need help.

Theme 3: Treatment-Specific Provider Behaviors

Participants spoke about wanting holistic-oriented medical, physical, and therapeutic suggestions from their providers to help them heal. They desired general treatment support, including regular visits with a doctor or therapist, stress management suggestions, and appropriate psychiatric medications. Additionally, participants spoke about the importance of understanding the source of their problem, specifically trauma, rather than only focusing on their symptoms.

"Like, I'm not feeling well. They said that my blood pressure is going high. For them, they can just ask some questions to know why this blood pressure is going high, but they cannot know really what I faced in the past and they cannot go forward to know what

is going on. If you go forward, you can discover that there are so many problems [that] can cause this ailment. I said the doctor himself, he cannot himself know. He needs someone who can help him to know really what is going on with, like, a refugee or with someone who's faced, like, a trauma."

Participants suggested that providers highlight the patients' strengths to improve engagement, encouragement, and hope toward collaboratively arriving at solutions. One participant stated, "It's just like someone who needs help, who is in a river, and that hand really giving you that help." In addition, healing comes from preexisting strengths and helpful factors such as faith, resilience, and dedication. Providers who can bridge patient strengths with a collaborative approach to incorporating new strengths and skills through positivity were determined to be helpful.

Theme 4: Opening Communication Channels

Creating and maintaining effective communication was an expressed need by these participants. Specifically, the need for appropriate interpreters to help minimize language barriers as well as the need for providers to be patient and make time for patients to express themselves and to use simple, understandable language.

To create an environment which enhances communication, participants hope providers acknowledge the difficulties of sharing their story and are mindful of the patient's reaction to being asked questions. One participant suggested that providers "minimize questions" regarding past trauma reminders and "make questions easy and simple to understand," highlighting the importance of empathic listening and attention to cues from the patient to avoid re-traumatization when collecting information.

Theme 5: Positive Qualities of Providers

Subtheme 5.1: Patience. Participants pointed out that patience is one quality that promotes healing. Refugees need time to express their feelings, particularly with experienced trauma events and navigating trauma reminders. One participant shared that the "number one process is making ... people comfortable, to be able to express themselves ... so I would think just bring them comfortable first and then be able to make sure they can be able to express themselves before they can help them to their need."

Subtheme 5.2: Building Alliance. Another important quality is the ability to build alliance with refugees and act as partners in the recovery journey. Emphasizing the collaborative approach in a provider-patient relationship minimizes the impact of power differentials and reassures

agency to the patient, especially given that agency and autonomy have been compromised throughout the resettlement process.

Subtheme 5.3 Calm Demeanor. Providers with a calm demeanor was deemed an important quality, thought to facilitate the process of communication and allow patients to trust the provider, especially when talking about traumatic experiences.

Subtheme 5.4: Being Respectful. Respecting one's values was another important quality. Participants come from different cultural, religious, and value systems that need to be explored in a respectful way. One participant said simply, "Respect their values, be respectful, try to get to know them ... those are important."

DISCUSSION

The current study offers a unique and potent perspective via the voices of refugees on how providers can improve their process of engagement, promote health care utilization, address health concerns, and support patients in moving on from traumatic experiences. By understanding participant perspectives on how they define help and helping characteristics in providers, the study provides an inclusive definition of help defined by a refugee population as opposed to assuming a cross-cultural or Western definition of help.⁶ Additionally, the study offers a framework formulated by a refugee population for providers to engage in a holistic, culturally affirming, and helpful way such that religious, migration, psychosocial, and communal factors are embedded in the treatment dynamically. Refugees often interact with providers in an integrated care model where multidisciplinary care is accessible to address medical, psychological, and social needs.^{22,23} It is important to understand that the term provider extends beyond a single discipline or clinician but rather includes multiple health care professionals and the clinic itself. Integrated health care settings are ideal for engagement because they create opportunities for refugees to engage in the most pressing and relevant services that can then help them build the trust and understanding to engage in other services.

The importance that participants expressed around telling their story and being viewed holistically, and not as a set of symptoms, was vital to their healing trajectory. This included highlighting the impact their stories have had on their lives and an opportunity to teach the provider about their cultures, situations, and experiences. It is thought that this facilitates a collaborative approach to engagement as well as agency-building, elements that have been repeatedly emphasized as fruitful in helping relationships.^{11,24} Providers also should use culturally

sensitive scales of distress that have been developed with specific populations to better understand culturally defined stress and not assume Western models of distress and symptomatology capture a person's experience.^{24,25} The more providers believed in their stories, attuned to the potential impact those stories had on the patients' loved ones, and avoided making assumptions, the more encouraged participants felt to share. Being validated for strengths provided a sense of hope and a sense of direction for a better future and for healing.

Participants appreciated several provider characteristics, including an awareness of barriers to participation, such as transportation issues, acculturation challenges to the U.S. health care culture, language barriers, and cultural differences in engaging with health care providers. This supports previous findings that culturally affirming care targeting barriers as well as resiliency factors in refugee patients increases health care utilization.²⁶⁻²⁸ Participants highlighted that patience around these factors was notably helpful, so as not to feel pressure or shame for not understanding something or needing to go slowly particularly when discussing traumatic experiences. Patience, prioritization of building alliance, maintaining respect, and engaging in a calm demeanor were particularly helpful traits for providers to hold.

While research has positioned health care providers well in understanding evidence-based treatment practices for engagement for a select demographic, it is important to recall that in addition to a dearth of research assessing the needs of refugee populations in the health system, human dynamics are inherently ambiguous, undefined, and nuanced. Research suggests that nonspecific factors such as cultural humility, curiosity, and warmth are salient contributors to helpful engagements with others, including refugee populations.^{11,29} In fact, studies show that a greater proportion of the variance for positive therapeutic outcomes is accounted by these nonspecific factors.^{11,29}

Limitations

Several limitations should be addressed. First, due to the nature in which the data were collected, it is unclear how to differentiate length of stay in the United States and conceptualization of the helping relationship. It may be that the longer an individual has been in the United States, the more acculturated they have become to the health care norms and may have adapted their conceptualization of help and how to be helped. Additionally, these results are not generalizable to all refugee groups, as they are specific to one hospital system and U.S. state and because of the small sample size due to the qualitative nature of the study.

Future Directions

Future studies should explore countrywide or global perspectives on what defines the helping relationship and the characteristics most prevalent in providers for facilitating the healing and moving on process to increase generalizability of the current findings. Future research should also consider incorporating a measure of time in the host country to assess for differences based on exposure to the host country's health care culture, language barriers, and general settlement. In turn, findings from this additional research may provide a focus for the development of a survey that refugee patients can complete upon arrival and periodically throughout their engagement in the health system to have an opportunity to express their needs, definitions of helping relations and helpful provider characteristics, and gain autonomy in expressing these. Future studies could increase the sample size and include refugees from other countries to determine if results can be generalized.

CONCLUSIONS

This research emphasizes how fruitful nonspecific factors are in patient-provider engagement by offering a refugee-based perspective on what factors are most helpful for moving on, or healing, from trauma and other health problems. Future studies should focus on training modalities for providers in embracing nonspecific factors for healing and moving on for those with experienced trauma. This may be a cultural shift within certain health care settings and professionals, though one that has repeatedly been noted and exemplified as important and helpful. Spending time on cultivating a training to highlight these humanistic traits may be beneficial to maintain a framework that is culturally affirming and informed.

Patient-Friendly Recap

- The number of refugees worldwide has increased to nearly 100 million. Many of these individuals have experienced trauma, which can impact the type of care provided by clinicians in the resettled country.
- Authors twice interviewed 17 refugees residing in New Mexico to assess their thoughts on moving on from difficult experiences as well as which provider characteristics they felt helped healing and facilitated health system engagement.
- Providers who listen closely to a refugee's story, show awareness of resource barriers, and maintain cultural humility and openness contributed to improved relational dynamics and trust-building. The stories shared by study participants should be considered by those seeking to increase engagement with their refugee patients.

Author Contributions

Study design: Isakson. Data acquisition or analysis: all authors. Manuscript drafting: Isakson, Stein, Olson, Waggoner, Holtz, Ali. Critical revision: Isakson, Olson.

Conflicts of Interest

None.

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