Newcomer Survivors of Trauma Guidance for Health Professionals

Background

Refugees, asylees and asylum seekers of all genders are at higher risk of having experienced trauma, including torture and sexual and gender-based violence (SGBV) as well as human trafficking (sex and labor). Survivors may be victims of physical and/or psychological torture and suffer both physical sequelae (e.g., head trauma, chronic pain, anatomic loss, limitation of movement or walking) and psychological sequelae (e.g., depression, anxiety, or post-traumatic stress disorder (PTSD)). Health professionals play a vital role in providing direct care to patients with physical and mental health needs as well as assisting with asylum claims by providing objective documentation of physical and psychological injuries.

Providers may be reluctant to ask patients about traumatic experiences for several reasons: fear of triggering or overwhelming a patient, concerns about time constraints, a lack of familiarity with (or unavailability of) referral resources such as behavioral health or mental health services, or due to their own experience of trauma, either primary or secondary. However, research has shown that patients **want** their providers to ask about their past trauma experiences if it would be beneficial to their overall health.[1]

Simply listening to a patient's story is often the first step towards healing.

Care team and assessment

Survivors should be offered the choice to work with a health care professional of their own gender identity (including interpreters, medical assistants, and nurses) and visits should be conducted in the survivor's preferred language. Interpreters should not be family members or friends, due to the need for privacy.

Simple questions that may be helpful in eliciting a trauma history include:

- "Tell me about why you left your country."
- "Have you ever been seriously hurt physically or emotionally by someone or something that happened in your country or after leaving?"
- "I understand that many individuals from your country *and/or* who traveled here on the route you took experienced or witnessed very terrifying things. Did this ever happen to you?"

If providers see or suspect sequelae of torture, they should ask the patient **directly** if they were subjected to violence or torture, including rape or sexual torture. Many survivors of torture and sexual and gender-based violence may be reluctant to discuss their experiences or may have difficulty recounting the specific details.

[1] Shannon P, O'Dougherty M, Mehta E. Refugees' perspectives on barriers to communication about trauma histories in primary care. Ment Health Fam Med. 2012 Jan;9(1):47-55. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3487607/

Examination

If torture is alleged to have occurred within the past the 6 weeks, it is especially important to carry out a thorough medical examination before acute signs fade. The examination should include assessment and documentation of physical findings, injuries, illnesses, and need for ongoing care, as well as a psychological appraisal for mental health needs.

Trauma symptoms

Experiencing trauma may be associated with a wide range of symptoms. Early intervention is important in preventing long-term disability and suffering. Patients should be assessed for symptoms of PTSD, depression, and substance use.

Examples of trauma symptoms include (adapted from Helping Refugee Trauma Survivors in the Primary Care Setting, 2012[2]):

- Difficulty sleeping or recurrent nightmares
- Appetite disturbance
- Difficulty concentrating or short-term memory problems
- Non-specific body pain
- Depressed mood or lack of interest or pleasure
- Feelings of hopelessness or suicidal thoughts
- Feeling emotionally numb or cut-off or distant from others
- Feeling watchful or on guard without reason
- Exaggerated startle response
- Recurrent intrusive daytime thoughts or images of the trauma
- Avoidance of thoughts or situations that serve as reminders of the trauma
- Severe emotional distress or physiological reactions at reminders of the trauma

Many patients may have chronic somatic complaints such as headaches, abdominal pain, body pain, fatigue, or dizziness that are physical manifestations of mental health conditions or cultural idioms of psychological distress (for example, “heavy heart” in Karen people from Burma, or “nerve attacks” in Latino/a cultures[3]).

- Providers should complete a diagnostic workup as indicated for the symptom(s) described but consider that patients may be describing distress related to an underlying trauma.
- Patients may be frustrated or disappointed if testing is negative and there is no physical explanation for their symptoms, especially if issues around mental health are stigmatized in their culture.

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[2] Johnson DR. Helping Refugee Trauma Survivors in the Primary Care Setting, 2012. https://healtorture.org/resources/helping-refugee-trauma-survivors-in-the-primary-care-setting/

[3] Chapter 3, Assessment and Symptom Presentation. The Center for Victims of Torture: Improving Well-Being for Refugees in Primary Care: A Toolkit for Providers. https://healtorture.org/resources/improving-well-being-for-refugees-in-primary-care-a-toolkit-for-providers/

- Providers should provide education on how trauma and depression can have physical manifestations and consider debriefing with an interpreter to understand how language and culture may influence patient's descriptions.

Physical findings

Often, there may be no obvious physical findings of torture, if scars have healed or torture methods that do not leave marks were used.

Both acute and chronic skin lesions can represent sequelae of torture. For example:

- Beatings and blunt trauma may result in abrasions, bruises, scars, puncture wounds, missing or damaged teeth, and skeletal deformities.
- Burns from cigarettes or heated objects may leave sharply demarcated and atrophic scars.
- Linear zones of alopecia at the wrists or ankles may represent prolonged application of tight ligatures.
- Scars resulting from whipping typically appear depigmented and often hypertrophic, surrounded by narrow, hyperpigmented stripes.

Of note, it is important to consider common skin disorders and cultural practices such as cupping, scarification, piercings, and tattoos in the differential diagnosis when considering skin findings.

Skeletal or other anatomic deformities may result from torture. For example:

- Repeated application of blunt trauma to the feet, hands or hips may result in fractures, tendon rupture, atrophy of adipose tissue foot pads. Walking may be painful or difficult.
- Suspension may result in chronic shoulder injuries, muscle wasting, brachial plexus injuries, or 'winged scapula' due to nerve injury or dislocation of the scapula.
- If a nail has been pulled off, an overgrowth of tissue on the nail bed may result.

Harms related to labor trafficking and exploitation (specific to work in dangerous and unregulated conditions) may include deep and long cuts, bruising and tears, and scars from prior burns, including rashes and burns from chemical exposure. Victims of all forms of human trafficking may also have tattoos or brands.

Sexual and Gender-Based Violence

Forms of SGBV experienced by refugees and asylees may include sexual assault, sexual exploitation, forced pregnancy, forced abortion, rectal incontinence or tears, or female genital mutilation or cutting (FGM/c), and may be associated with intense stigma and social exclusion.

- FGM/c is defined by the World Health Organization (WHO) as all procedures involving partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.[4]
- FGM/c is typically carried out on young girls between infancy and adolescence, and occasionally on adult women.

[4] WHO. Eliminating female genital mutilation: an interagency statement. 2008. https://iris.who.int/handle/10665/43839

- Long-term health problems can include urinary or other infections, infertility, painful menstruation or sexual intercourse, difficulties during childbirth, need for later surgeries, and long-term psychological challenges including depression, anxiety, post-traumatic stress disorder, and low self-esteem.
- Referral to a (pediatric) gynecologist or urogynecologist should be considered.
- For additional information on FGM/c including the Minnesota FGM/c Prevention and Outreach Project, refer to the additional resources section.

Rape, sexual assault, and sexual humiliation are common forms of abuse and may be used as weapons of war.

- Patients should be screened for STIs including HIV, pregnancy, chronic gynecological or genitourinary problems, sexual dysfunction, and psychological symptoms as indicated.

Documentation

Documentation and photographs of physical findings of torture, SGBV, and human trafficking and exploitation can help support an individual's claim of asylum.

- Providers should place photographs and descriptions of skin findings, including their location, measurements, and other details, in a patient's medical record.
- If a skin examination is not performed during a visit, providers should ensure that skin findings are **not** erroneously documented as 'normal' or 'without lesions' in the visit record, as this can later affect the credibility of an asylum claim.
- Documentation of non-torture related scars may also be important as it indicates that patients are very specific about the description of torture-related scarring.
- Providers may be asked to write letters in support of a patient's asylum claim describing physical and psychological findings and whether they are consistent with described torture.
    - These typically include descriptions of the findings, with photographs where appropriate, with an accompanying statement stating whether the findings are consistent with the described torture.
    - The non-profit organization Physicians for Human Rights has online resources including sample affidavits and guidance for pediatrics (such as considerations for unaccompanied migrant children) available: Asylum Network Resources (https://phr.org/issues/asylum-and-persecution/asylum-network-resources-linked/).

Secondary Trauma

Secondary trauma refers to the effects on healthcare professionals of being exposed to trauma indirectly through working with trauma survivors and being witness to their past experiences and current life stressors.

- According to the Center for Victims of Torture (2005), "Among providers working routinely with extreme trauma such as torture, secondary trauma is considered to be an occupational hazard—something that can be reduced and managed, but not avoided completely."
- Providers may feel shock, outrage, and sadness in response to hearing about trauma, and may experience intrusive thoughts, images, or nightmares outside of work.
- Providers may feel overwhelmed and helpless, especially if they do not have anything immediate to offer to patients. In the longer term, secondary trauma can lead to loss of work satisfaction, burnout, and secondary stress.

To mitigate secondary trauma, it is important to first be aware that it is happening.

- One recommended tool for providers is the ProQOL Mesaure (https://proqol.org/proqol-measure) or Professional Quality of Life Elements Theory Measurement survey (Hudnall Stamm, 2009), which measures an individual's level of compassion satisfaction and compassion fatigue.
- Providers who regularly care for trauma survivors can take the survey every few months as a way to stay aware of how they may be impacted by secondary trauma.

Research on secondary trauma highlights the importance of self-care outside of the workplace, including a focus on personal health (e.g., sleep, exercise, relaxation, etc.) as well as activities or experiences that bring joy or peace.

- A useful strategy for those working with torture survivors is to develop relationships with colleagues and peers who can offer support and empathy.
- Organizations and administrators **must** recognize and address the potential for secondary trauma on their providers in ways that do not place all of the onus for mitigation on the one provider.
- Organizations should understand the specific needs of clinics serving refugees and asylees and provide training and support for staff including adequate time off and access to medical and mental health services.

Additional resources

The Center for Victims of Torture: Improving Well-Being for Refugees in Primary Care: A Toolkit for Providers (https://healtorture.org/resources/improving-well-being-for-refugees-in-primary-care-a-toolkit-for-providers/)
Manual for providers to improve the care of patients who have lived through traumatic experiences (applicable to newcomers without official refugee status as well as refugees).

The Center for Victims of Torture (https://www.cvt.org/)
Online resources and torture survivor rehabilitation services. Note: due to high demand, the waiting list for intensive services is currently closed, but may re-open later in 2024.

Heal Torture (https://healtorture.org/)
Website of the National Capacity Building Project of The Center for Victims of Torture, with extensive clinical resources on the medical and psychological care of survivors of torture.

U.S. Department of Health and Human Services (HHS) Office on Women's Health: Female genital mutilation or cutting (https://www.womenshealth.gov/a-z-topics/female-genital-cutting)
Information and frequently asked questions on FGM/c in the United States.

Young J, Nour NM, Macauley RC, et al. Clinical Report: Diagnosis, Management, and Treatment of Female Genital Mutilation or Cutting in Girls (https://publications.aap.org/pediatrics/article/146/2/e20201012/36886/Diagnosis-Management-and-Treatment-of-Female). Pediatrics. 2020;145(6): e20201012
Comprehensive review article from the American Academy of Pediatrics on FGM/c, including illustrations of types of FGM/c in children and adults and review of culturally sensitive history taking and documentation, acute and long-term health complications, and ethical and legal analysis including reporting of child abuse and the right to asylum.

Minnesota Female Genital Cutting Prevention and Outreach Project (https://www.health.state.mn.us/communities/rih/about/fgc.html)
Working group of diverse stakeholders to recommend, inform and coordinate FGC prevention and community engagement efforts in Minnesota.

Physcians for Human Rights: The Istanbul Protocol (https://phr.org/issues/torture/setting-anti-torture-norms/istanbul-protocol/)
Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Office of the United Nations High Commissioner for Human Rights. Includes international guidelines for the medical documentation of torture and its consequences.

CUES Intervention (https://ipvhealth.org/health-professionals/educate-providers/)
Evidence-based intervention for providers to support survivors of intimate partner violence.

Minnesota Coalition Against Sexual Assault (https://mncasa.org/)
Statewide coalition of organizations and individuals committed to ending sexual violence, with online tools and resources for health care providers, advocates, and survivors.

McKenzie, K. C. Asylum Medicine: A Clinician's Guide (https://link.springer.com/book/10.1007/978-3-030-81580-6). Springer, 2022. https://doi.org/10.1007/978-3-030-81580-6.
Comprehensive overview of asylum medicine, with emphasis on the historical and legal background of asylum law, best practices for performing asylum examinations, challenges of examining detained asylum seekers, education of trainees and advocacy.

MDH Domestic Refugee Health Screening Guidance: Mental Health Screening (https://www.health.state.mn.us/communities/rih/guide/10mentalhealth.html)

MDH Human Trafficking and Exploitation Prevention and Response (https://www.health.state.mn.us/communities/humantrafficking/index.html)

MDH Sexual Violence Prevention Program (https://www.health.state.mn.us/communities/svp/index.html)

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