inSocialWork Podcast Series

Episode 76 - Dr. Patricia Shannon: Peeling the Fear from the Past: Building Community Capacities for Healing Refugee Trauma as a Human Rights Strategy

[00:00:08] Welcome to living proof A podcast series of the University at Buffalo School of Social Work at www.socialwork.buffalo.edu. Were glad you could join us today. The series Living Proof examines social work research and practice that makes a difference in people's lives. This is your host Adjoa Robinson and I'd like to tell you about a new feature we have at the Living Proof podcast series and that's for listener comment line. You can call us at 7 1 6 6 4 5 3 3 2 2 and leave a comment or suggestion. And who knows maybe in a future podcast we may feature your comment on the air. The number again is 7 1 6 6 4 5 3 3 2 2. Call us we love to hear from you. Hi from Buffalo where this summer folks are trying out our new beaches and waterfront bike trails. I'm Peter Sobota. As we all know simply coming to the U.S. does not end the challenges for refugees of oppressive and Persad Kotori countries. In this episode Dr. Patricia Shannon describes her practice experience and subsequent research that addresses the needs of traumatized refugees. She blends sensitivity to culturally specific expressions trauma human rights and trauma informed service delivery that provides a useful context for addressing their needs. Dr. Shannon in response to such questions as What traumas and mental health struggles do refugees bring with them from the camps how can we address these issues to help them resettle most successfully. And what are the gaps in the current service delivery system along the way. Dr. Shannon discusses the findings from her focus groups.

[00:02:00] Uncommon symptoms and a fascinating account of culturally specific descriptions of symptoms by the refugees. Dr. Shannon highlights the need to emphasize community and strength based responses to the mental health problems experienced by the refugee populations she concludes with her plan for future research and offers recommendations for practice. Patricia Shannon Ph.D. LP is assistant professor at the School of Social Work University of Minnesota where she conducts research on the mental health needs of Minnesota's newest refugee communities. Her previous experience includes 10 years of direct practice at the Center for Victims of Torture in Minneapolis. She is a specialist in the treatment of trauma survivors. Dr. Shannon is interviewed by our own Dr. Fhilomena Critelli assistant professor at the UB School of Social Work. Dr. Critelli interviewed Dr. Shannon by telephone Hello. This is Fhilomena Critelli and I'm here today interviewing Patricia Shannon from the University of Minnesota about her work on building community capacities for healing Refugee Trauma as a human rights strategy. I thought a nice place to start would be of you telling us a little bit about how you got into this work. OK well I have been working as a psychologist at the Center for Victims of Torture in Minneapolis for ten years. And part of my job there was not only working with torture survivors in psychotherapy but also doing community training and outreach and eventually community capacity building. So one of the things that I did during the Liberian war was to outreach to a very large community of refugees who were resettling in the northwest area of Minneapolis.

[00:03:52] This was a community that was largely suburban and in a matter of just a few years about 20 percent of their population became Liberian refugees who had experienced a whole lot of trauma related to the war. And I realized that although a small fraction of people can be seen at the Center for Victims of Torture for healing not the entire refugee community that had been tortured would have that opportunity. And how do we reach out to those communities and create a healing community. And that's how that work really got started was trying to reach out into the community to address the mental health needs of refugee trauma survivors refugee torture survivors. At that point what we did is we tried to reach into the community and create the multidisciplinary services

that we know torture survivors need at the clinic. So we tried to network the suburban community of providers meaning primary care the local mental health clinic school folks social services the food shelf and the county services into a monthly multidisciplinary meeting where they would talk about the needs of what we describe as new our newest neighbors meaning the library and refugees. And later it was expanded to the whole African community that was settling in those suburbs and it became sort of a place for folks to come for support whereas without that it was too easy for primary care folks to say we do primary care we don't do mental health and mental health folks to say these refugees have all sorts of medical and social services we can't address their mental health and social service folks to say we don't do primary and mental health. So by bringing them together they can start to think as more of a multidisciplinary team and be less overwhelmed by the needs of highly traumatized refugees survivors.

[00:05:44] So that's how I got into that work. And then there were some lessons learned from that project that we that I took then into the university to try to extend to my current work. Nice if you could tell us a little bit more now. You've made a shift from practitioner to researcher and academic setting ground with what you're doing now in terms of the work. I guess some of what happened after that project even while I was still at the Center for Victims of Torture was that we thought it was actually not so hard to network the providers as it was to reach out directly to the community of survivors that people who have been tortured in particular have often been tortured and traumatized into silence. They've been oppressed during war they've been oppressed during torture and silenced and they are not going to readily raise their hands and say I'm the torture trauma survivor you're looking for over here. So how to reach survivors when they comment to the country was really the problem. How do we outreach to them quicker. And so currently I came into the university partly to partner with the Minnesota Department of Health and the Center for Victims of Torture to identify and develop short a mental health screening tools that could be used in the public health screening process for refugees to identify trauma survivors earlier in the process. So what happens right now. Just to explain a little bit further is refugees who come into the country within the first three months are given a public health screening and this screening is largely focused on infectious disease and the resources are focused on infectious disease.

[00:07:24] They may or may not do a mental health screening at that time but that is a point where quite often there's very good compliance with the medical screening it's voluntary. But refugees are quite concerned about whether or not they have infectious disease or parasites so they tend to come to their screening and it's an opportunity in a place to address mental health early on. Well refugees have medical insurance as part of that work what we did to try and get a baseline. Most recently in the past year as we did a national survey of public health coordinators across the United States to find out they are doing and that survey told us that most of them actually are not addressing the mental health of refugees in any systematic way. And the ones who say they are are doing so through a very informal conversation. So there are not short screening tools they can use within the time constraints that they have and that kind of led us to trying to develop and culturally adapt tools to the current populations that are coming into the United States right now. One of the particular traumas and mental health struggles that refugees do bring with them from their countries of origin and refugee camps. The statistics that I saw from 2009 indicated that the United States admitted about 70000 refugees who are legally they have a right to resettle in this country when they have refugee status. And maybe I should back up and define what is a refugee. Refugees apply for refugee status abroad in their country of origin.

[00:09:00] And if someone is granted refugee status they have been found to have a well-founded fear of persecution based on one at least one of five categories of discrimination race religion nationality membership in a particular social group or political opinion. And so when they come they've already found to have a well-founded fear of persecution and so they have endured some sort of trauma or been thought to be at risk to endure trauma and have a legal right to resettle. That's

a refugee the current refugee groups the United States has resettled 70000 from over 20 different countries. So there are many different political and civil conflicts going on around the globe. That and natural disasters that bring refugees to our shores. Currently the largest groups of refugees are the Iraqis. Certainly the Qur'an. Refugees from Burma who have been living in camps in Thailand for decades. The boot needs who are in Nepal. The Somalis from the civil conflict in Somalia and Romo refugees from Ethiopia and those are the groups that in trying to develop screening tools. We conducted 13 focus groups with all four of the major groups. We did not conduct them with Iraqis because they weren't here in large enough numbers a couple of years ago. But we interviewed well over 100 refugees about experiences of the ways they would talk about and describe mental health to try and see how difficult it would be to adapt and develop culturally grounded screening tools.

[00:10:47] So to answer your question some of the things that people talked about were uniformly across these focus groups they described living through pretty extreme traumas both the Qur'an and the butties talked about living in camps where at first they were forced out of villages by soldiers and then they moved to camps where they endured either incursions military incursions into the camps or fires. It was not unusual for their camps to be burned down. So the booty's when they first came to Minnesota were all from one family and the entire family had lived in a camp that was completely burned down. So when they first heard the fire alarms and the sirens in Minnesota they had a they were terribly frightened because they thought there was a fire. And we're all going to perish and it just brought back the trauma that they brought with them from their camp experience. Now the Somalis have endured tremendous civil war for a long time and many of them talked about in their entire families being killed witnessing killings witnessing torture. The Oromos as well are an oppressed group in Ethiopia. Some of them talked about having you know you go to sleep at night and you wake up and you see people who you saw walking around yesterday dead in the middle of the street. I mean just extremely high levels of fear living under these threats for very long periods of time. And some more effective than others they did describe some common symptoms. After we interviewed these folks about their experiences we asked them to identify how they would know if someone was suffering from what they had been through historically because they all pretty much knew what the atrocities and the dangers were that they had all lived through.

[00:12:32] And we found across those four groups 18 common symptoms and they included things that are common to to our understanding of post-traumatic stress and depression and also culture specific words and problems that we tried to understand across these different cultures. So the common items included things like trouble sleeping having bad or scary dream having too many thoughts a lot of the refs she's talked of that they can't stop thinking about what they went through. They can't stop thinking about the past having bad memories that come back to them at different times worrying about family and friends was not unusual because although refugees come with their families many times they don't come with the entire extended family so they may have a sister and aunt or some of them even had children that had to stay back and they worried about them. They worried about more loss in the future more threats to people back home. They worried about what was happening in the culture here. So many refugees were facing discrimination here that they had never faced before and talked about worrying about that worrying about their children. Some used a phrase that I liked and it was feelings of fear from the past are still with me today. They understood that the fear was in the past. But the but the feeling is still here today they're still struggling with the symptom. I thought that was interesting. They talked about feeling hopeless about the future. Some losing parts of their memory certainly having trouble concentrating a good number talked about across all four groups struggling with feeling angry and sometimes easily getting into fights with others which we might describe in our culture a little bit as having kind of a short fuse just very easy to spark to anger.

[00:14:23] Spending time alone keeping alone people being lost or staring was something they saw often in the camps people talking talking to myself having trouble eating and then stomach aches

and headaches are common across the board as sort of somatic symptoms of stress and these refugees endorse those symptoms as well. And those were the common ones. And then there were some culture specific symptoms that were still trying to understand and write about but they included specific words for crazy if that was a symptom that were culture specific. They talked about taking one's clothes off singing when people were sleeping feeling that my brain doesn't work having too much air in my brain having trouble recognizing people was something they talked about. They talked a lot about the hard things and the heart that bother you having we cards having tired hearts burning emotionally was a phrase used by some of the folks and feeling pain all over that can't be expressed. And we thought these elements are all symptoms of stress related to the refugee experience. And so we expect to find more as we look at these interviews and this data but that gives you an example of common and culture specific. It's really interesting and it sounds like it must have been really challenging to even get these focus groups together. And you know as we're talking I'm thinking about that. Did you do them you didn't have translators that didn't do them in groups of these countries or. Sure. I mean from the community work that we did we knew many of the cultural leaders and we've worked through the cultural leaders. And there are certain cultures where you can't get anything done unless you do work with the cultural leaders and the leaders.

[00:16:13] You know this particular focus group study was preceded by a community wide needs assessment that we did 50 interviews with service providers and cultural leaders. So we had really met the cultural leaders before then and they had identified mental health as a huge gap and service for their communities. And we're strongly in support of this project. So when we asked them to help us have conversations with the various new communities of refugees to understand the language of mental health the language of stress they were more than happy to help us. And they guided a sense of whether or not we should have men and women in the same group or separate. We followed some of their direction on those elements of group composition. Well that was very interesting that you did have people who were allies in sort of the need for mental health services because we were talking a little bit earlier I think some of the concepts of mental health may be kind of strange or alien to some of the some of the groups coming and even among I think people in the United States who sometimes have an idea that once people get hearing your problems are over you know they talk to the United States and it should just go forward. So interesting to hear a little bit about some of those challenges in getting people to think about mental health the mental health aspect of their resettlement process. Well that's interesting because I think for cultural leaders pulled together folks who they thought would be useful to us in this. And we ask pretty broad based questions so we didn't ask them to say what had happened to them.

[00:17:50] We knew the political situations they were coming from. Instead we asked them to talk about their thoughts and their feelings in response to what they had been through. How did they know someone is doing well. How did they know someone's not doing well. What is the difference between people who lived through the same thing some do well some don't. What's the difference between those people. We asked in a bunch of different ways how should doctors ask questions about mental health stress. And one of the more surprising findings from those focus groups actually was the fact that they really had not talked about this before we did the focus groups and they were extremely grateful. They knew the relevance and the importance and they said things like we just need someone to talk to. Thank you for pulling us together in this forum. There is a common belief that refugees have a mental health stigma that prevents them from talking. What we found instead is that they have a full range of understanding of mental distress from people who are mildly affected but they can still take care of their kids and they can still go about their business. But you don't want to burden them too much to people who seem crazy. They can no longer take care of their kids and they describe stigma in some of the refugee communities. It's not so much a negative towards that person but that person might be isolated because they want to protect them and not burden them with more bad news from home.

[00:19:17] So they talked about stigma in a very different way and it made me wonder and we'll find out as we analyze this data more if that concept of stigma is something that western mental health folks talk about because they know they have to talk to refugees in a little different way and then it becomes like a telephone game everyone's talking about stigma and nobody is actually really trying to reach into the newcomers world and find the way to talk about it that's going to be meaningful and helpful because we found that they were extremely grateful and very willing to talk about it and the ones for whom mental health stress is an issue. They know what you're asking about and they want to talk and they want to find some relief. So when it hits home it hits home. Sounds like a really important point because I know a lot of literature and lot of people talk about seem to suggest that you know they don't want to talk about it and that it's very hard to reach. So you're finding a way that can really help improve the services to this population. I like to just talk a little bit more and think about just some of the gaps in the current service system. You're kind of pointing to the fact that we're bringing together a wide range of service providers and if there were kind of holes and gaps and lack of understanding among them about some of the needs. Maybe you could talk a little bit about that for us.

[00:20:38] I think that takes us back to the public health system again and about when is the right time to ask refugees about mental distress and then there may not be one right time there might be a time and a time again and many different points of accessing the system. But I think that one of the reasons that came out in our survey nationally for not screening had to do with the lack of culturally appropriate screening tools as well as the lack of referral resources. So there is a common practice of it that we don't have a way to treat or a place to refer for treatment. We don't ask about the problem. The interesting thing about that is we surveyed all of the states and we receive responses from 44 states and we found that although that's a general belief among practitioners the lack of referral resources are culturally appropriate instruments was not significantly related to whether or not the states were screening for mental health. Rather it had more to do with whether or not they decided to screen for mental health or thought it was important. So that said that's interesting nonetheless they are highlighting a serious problem which is there are a few culturally appropriate mental health referral resources for refugees in the community and this is something that mental health practitioners and cultural leaders can work to develop in collaboration with the public health referral systems with the local community mental health resources. It involves learning how to work with interpreters learning how to build for interpreters. It involves outreach and psycho education in the community about mental health so that people who are suffering from PTSD can know that there are treatments available and they don't need to suffer forever. Some folks like you mentioned are going to come and resettle and do just fine. Some folks will find that their symptoms of stress dissipate over time.

[00:22:33] We know that about PTSD but there is going to be another significant group 30 percent or so who have diagnosable PTSD is what the literature says. And those folks could access treatment if it were available and get help that will improve their resettlement. And in that way I think we do see this as a human rights podcast we're doing but we do healing for these communities as a human rights intervention because it restores folks to their pre trauma levels of living and restores their life and their sense of community and their sense of trust and family and hopefully employability back to them and that is a way that I see healing as a human rights. I think all of us do as a human rights intervention for that portion of the community. But those resources communities need to find ways with limited budgets and under-resourced communities in particular to pull together the way we did with the Liberians and create sort of multidisciplinary teams to help each other because there is usually at least one resource however over strapped and folks can work with and community leaders can learn to outreach and work with them. Can you describe a little bit more because I think that a lot of times when we think about mental health treatment we think strictly of just you know a patient going to a clinic and it sounds like you're talking about some other ways of approaching it those are more community oriented. Yes. Well that was really emphasized to us

when we presented the interview data to the community and the cultural leaders.

[00:24:14] You know it was some of the service providers in the refugee resettlement community who said you really need to emphasize strength based wellness based community based approaches that are destigmatizing to educate the community about healing and what happens in the refugee resettlement system is a good deal. There is an initial service that there are initial services provided by the voluntary refugee resettlement organizations and then quite often refugees are referred to community based organizations that are immigrant led and the immigrant led organizations are overwhelmed with a whole number in over tasked with a whole number of resettlement tasks such as helping people with English and employment. And they are not trained or skilled in mental health. Nonetheless they are the place that their community is coming for healing. So one of the things the resettlement services so one of the things that we are trying to do in Minnesota is create a model where they're screened at public health and then we provide or we're teaching the community based organizations how to provide psycho education to their own folks in developing culturally adapted curriculum for them. And we're testing that out right now in a randomized trial of psycho add in the Korean community and humbling in the other communities as well. And these are simple six session curriculums that are focused on normalizing trauma symptoms talking educating survivors about the healing process the health care system the impact of trauma on relationships. And we hope that at that point they'll be educated. They'll have a sense of community and group and be able to think about whether or not they would want a further referral. But we also hope that the psycho education groups in general improves mental health stigma because they will be held at those community based organizations and they can learn how to educate their own communities.

[00:26:10] So in terms of evidence based practice one of the key components of evidence based practice for PTSD starts out all PTSD treatments with psycho education. This is a very simple thing we can do in the community and then hopefully the community can recognize their own folks that need further referral for mental health treatment. But right now it's a big change to try to task them with understanding and educating their own folks. And I'm hoping it will be helpful but that's an example of community based groups. Another place where we've done that kind of general destigmatizing education has been through religious institutions churches temples other places where they already have support groups going on for alcohol for grief and loss. You know they can have a refugee trauma group and talk a little bit and come together as a community. One of the nice things about group for survivors is it does restore a sense of community that has been destroyed intentionally by these oppressive governments and political situations. So that's a small example of community based work. But there are many other places where communities come together to do natural things like gardening and other kinds of group projects where one could insert these kind of ideas. Well it sounds to me like it's kind of addressing things on multiple levels because you're really are building community capacity in that a lot of times these mental health services aren't really accessible to such families because of language barriers and cultural barriers. But there's also that isolation.

[00:27:46] I think that a lot of even without the torture without the trauma of just being a refugee being in a new society there are so many the stresses so many new things that have to be learned as you said building a new community for them. I don't know if there's anything you want to add to that. Well to your point of isolation that is often an issue especially for seniors who really wouldn't leave their new apartment especially in these cold climates you know if they didn't have a group to go to often it's the seniors who are charged with taking care of children while their parents are at English or they're working. And that's very isolating and it's very different from camp life and village life where older folks would get her get together and share a meal and they share the childcare and there would be much more of a sense of connection. Now when I visit refugees in apartments they are in one refugee and one apartment with little children and they would literally not talk to anyone unless I went to visit them. And transportation isn't easy. That's the other

challenge major challenge for folks in many of these metropolitan areas is learning transportation. If there is a community based organization how do they get to it. There's tremendous barriers to re-establishing community in a resettlement place like this and do anything else that you would like and about the work that you're doing your research. Well we are hoping to learn something we're hoping that we can see the benefit of earlier screening and that that will have benefits to the overall resettlement outcomes for this group of refugees who are struggling.

[00:29:24] That said in March of this year the CDC did come out with some mental health screening guidelines for the public health system and they offer a number of instruments and I think we don't know yet what the system can bear in terms of what it costs to do screening and to meet the multiple objectives of the public health system. But at least those guidelines that exist. And I think there is there is progress on it. So I am hopeful about that. I'm also hopeful that we are seeing special training programs for people from affected communities. So we have some refugee students in our social work school and other folks coming up who will be the next generation of leaders and know how to navigate the system and create services for their own folks. And that's really important to fund and encourage as well. Thanks. And are you any other future directions for this research that you want to share with us. Well there's a lot that we've learned a little bit in the focus group. So for example things we don't know enough about are not only mental health but across the board that refugee groups talked about high incidences of domestic violence and substance use in their communities. And I have a graduate student right now who is looking into substance use in the Korean community but I would say this there are whole areas of knowledge that we need to learn about and it's not at all clear how much living in a refugee camp for decades has contributed both to domestic violence and substance use. But also I think we don't know effective culturally sensitive or appropriate acceptable ways to intervene in those situations.

[00:31:06] And that takes a lot of study and I think both mental health and and these other problems are worth getting on top of early because we've seen the devastating effect with some older groups of refugees in this country that Cambodians among of letting generations of problems go unaddressed. It does end up in incertain long term problems related to gang violence and domestic violence. And these are newer groups of refugees who we could intervene. I think a lot earlier with so I would say yes there are a lot of research projects that could be fueled to try to help these communities thrive and resettle successfully and be productive which we know we need them to do in this economy. We want to thank you so much for sharing this incredible and intense research that you're doing. They just thought of one last little piece and that this must be incredibly I mean the risk of working with such traumatized people. It really can have an impact on people who are working with them and it must be quite difficult to really tap into some of this material. Some wanted just a little bit about that. It's a practitioner and a researcher that's managed well I think it's an important topic to talk about because I've thought about it for decades. It's hard to work with torture and not talk to people about secondary trauma or vicarious trauma. And since I teach trauma at the university I certainly teach students how to begin addressing self care at the same time that they're learning about the various approaches to trauma treatment. But this also is I think an area where there needs to be a lot of research because it's fairly clear after 9 11 that emergency responders and doctors and nurses and people in firefighters.

[00:33:03] They all get affected and they get saturated with trauma to a point where they can no longer respond effectively. And I would really like to see training programs for all these professionals integrate evidence based approaches to self care in their training programs and working with refugees is the same same way. I mean one of the things that I did for ten years and CBT was to train the United States asylum officers and asylum officers get stressed by listening to these stories just as refugee interviewers do. And I don't think there's a clear systemic way of addressing this but there are a number of people interested in working on it. Certainly in the child welfare system as well. So it's a really good question and it's something we have to keep working on

in our professional training. I think almost more than anyplace else. Well thank you so much Patricia. This is really so interesting and really appreciate you taking the time to speak with us today. Glad to be here. Thank you. You've been listening to Dr. Patricia Shannon describe her research with traumatized refugees on Living Proof. Hi I'm Nancy Smith Professor Endean at the University of Buffalo School of Social Work. Thanks for listening to our podcast. For more information about who we are our history our programs and what we do. We invite you to visit our website at W W W social work dot Buffalo dot edu. We are living proof that social work makes a difference in people's lives.