

COVID-19 and U.S.-Based Refugee Populations: Commentary

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The arrival of the pandemic known as COVID-19 has resulted in an emergency appraisal of the way mental health services are delivered to refugee and asylum-seeker populations at the Boston Medical Center in Massachusetts. The following commentary summarizes some of the main approaches used to address the unique needs of this vulnerable population under lockdown.

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These are unprecedented times not only for humanity in general but also for the mental health field as well. The arrival of the pandemic known as COVID-19 has thrust us into a rapid adjustment mode to try to regain some sense of control. As trauma often does, the pandemic has caused our lives to change on a dime. Partial or complete lockdowns have created a new reality for all of us in the United States and across the world. As scientists and practitioners, when it comes to working with our patients, with little preparation, we feel like we are building the plane as we are flying it. A lack of a united front vis-à-vis a disaster response from state and federal government officials has contributed to this feeling. However, we are reminded that the Chinese word for crisis is composed of two characters, one representing danger and the other opportunity. Though we are living through challenging times, they also represent a window of opportunity to observe and take note of the way humans behave in real-life situations and intervene.

In the field of psychological trauma, we have known for quite some time that isolation and lack of control over our circumstances can trigger or exacerbate posttraumatic stress disorder (PTSD). However, we are currently contending with factors that complicate the picture, such as a very real fear of impending death and the inability to comfort our sick loved ones. Likewise, these events are likely to trigger an existential angst highlighting our individual and collective vulnerability upon realizing that the whole planet is going through the same circumstances, and there is no place to escape this pandemic except for staying in place at our homes.

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As health care professionals, we have had to organize and adapt every single day since the mandate of social isolation took place in the United States. We work at Boston Medical Center, at the Boston Center for Refugee Health and Human Rights. Like most of our colleagues all over the world, we have had to face a new reality in which we have had to create new rules of engagement vis-à-vis the clinic's everyday operations. Most importantly, we have had to develop ways to ensure an ongoing provision of services to our patients, most of whom are asylum seekers/refugees with histories of torture originating from many developing countries. Just a few days into the mandate to socially isolate, we transferred our services to the vehicle of teletherapy. With the exception of a skeletal crew for walk-ins, clinicians were asked to leave the hospital and do therapy over the phone. A couple of weeks later, we added the option of video conferencing with patients. Also, some of our clinicians volunteered to provide psychological first aid to COVID-19 families whose loved ones have passed or are very ill.

From the psychology of trauma and resettlement's perspective, we have encountered very particular issues that are unique to the refugee and asylum-seeker populations. These include the following:

1. Teletherapy does work for patients that fear leaving the home due to COVID-19 and may also be isolating due to PTSD avoidance-related symptoms. For many, the hospital is viewed as a dangerous place beckoning the sick and asymptomatic others who may be spreading the illness.
2. Most of our patients come from Africa and work in high-risk occupations providing direct service in nursing and residential homes and to frail elderly in their homes. This pandemic brings up memories of Ebola and cholera and fears for their families back home in places that may be resource limited. They also fear losing their jobs and feel they do not have a choice to leave as in many cases they are also supporting family back home.
3. Due to the sensitive nature of the trauma/torture histories of our patients, teletherapy represents a challenge. Some patients are not willing to share their stories over the phone due to

several reasons, including the emotional toll of having to share severely painful histories.

4. When doing teletherapy with our population, one needs to be especially attuned to the fact that housing may be unstable and lack areas of privacy. Great care is needed to determine whether the living circumstances are suitable or if an alternative is needed.
5. For some, the emptiness of the streets conjures up memories of the past during times of conflict when one needed to hide. Other potential triggers include such things as the forced isolation, the extreme loss of human life, and being reminded of other epidemics like cholera.
6. We have found the following to be helpful tips and practices with this population. Consider asking questions such as
 - a. How is this pandemic affecting you?
 - b. Do you have fears about coming to the hospital?
 - c. How stable is your job at this time?
 - d. Are you fearful of being exposed, and what are you doing to protect yourself?
 - e. Do you have enough food in the home?
 - f. Are you safe where you are living (also with reference to domestic violence or exploitation in any way)?
7. Providers need to know about concrete resources in their areas, including food banks, shelters, unemployment options, etc.
8. Providers might need to consider having some allowances with patients that do not feel comfortable talking on the phone, including video conferencing or meeting in person.
9. When dealing with patients that dissociate, or new patients, it might be clinically advisable in order to better assess them to see patients by videoconferencing or in person.
10. Follow the patients' lead on the telehealth's session length. Time may need to be adjusted. Although some patients are able to handle up to 45 min, others may not be able to attend up to 30 min.
11. Assess for a resurgence in PTSD symptoms in those patients that have been in remission.
12. Patients seem confused as to the allocation of resources available for them. We have initiated a series of weekly e-mail blasts to our patients, clearly explaining what these are.

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