Perceptions of German Healthcare Among Yazidi Refugees in Germany

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Perceptions of German Healthcare Among Yazidi Refugees in Germany

Scholarly Report submitted in partial fulfillment of the MD Degree at Harvard Medical School

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**Abstract:**

*Background:* At the height of the global refugee crisis, providing adequate and effective healthcare to these vulnerable populations has presented an enormous challenge. In 2014, in what is now called the “Forced Conversion Campaign,” the so-called Islamic State perpetrated an alleged genocide of the Yazidi people, abducting women and children and killing thousands of civilians. The Special Quota Project (SQP) is a German humanitarian assistance program that sought to resettle and rehabilitate 1100 Yazidi women and children. Survivors have endured one of modern day’s most brutal conflicts, yet little is known about their journey through recovery and experiences with healthcare in countries of resettlement.

*Objective:* Our aim is to assess healthcare as perceived by Yazidi refugees resettled in Germany and to identify potential factors influencing these physician-patient relationships.

*Methods:* Of the 1100 participants of SQP, we conducted in-depth semi-structured one-on-one interviews with 117 adult beneficiaries regarding their experiences with healthcare providers and perceptions of effectiveness of their treatments. Transcripts were analyzed using qualitative content analysis to systematically code and identify themes and patterns.

*Results:* A multitude of factors were identified as influencing patients’ perceptions of healthcare provided. Avoidance, feelings of hopelessness, and language barriers were identified as factors influencing the women’s negative perceptions of the care they received. Support, relief, and somatic symptom treatment were identified as prominent themes in positive healthcare interactions.

*Conclusion:* Interventions and therapy addressing themes of avoidance and helplessness may lead to improved healthcare utilization and retention. However, further research is needed in order to assess the efficacy of trauma-focused therapy and ideal duration of treatment in extremely traumatized refugee populations.
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**Glossary of Abbreviations:**

FSA = Future Suicide Attempt
IDP = Internal Displaced Persons
IRB = Institutional Review Board
IS = so-called Islamic State
ISTSS = International Society of Traumatic Stress Studies
MDD = Major Depressive Disorder
PTSD = Posttraumatic Stress Disorder
SQP = Special Quota Project
TMP = Trauma Memory Processing
Introduction:

Global Refugee Crisis and Refugee Health Literature:

The world is witnessing unprecedented numbers of forcibly displaced people, with 68.5 million internally displaced people, refugees, and asylum seekers in 2018 (United Nations High Commissioner for Refugees [UNHCR], 2018). By the end of 2017, the refugee population had increased in Germany by 45 percent (UNHCR Global Trends, 2018). At the height of this global refugee crisis, providing adequate medical and psychiatric care to this growing population has presented an enormous challenge. Although some studies suggest higher healthcare utilization by displaced peoples in countries of resettlement (Kiss et al, 2013; Norredam et al, 2007), existing literature demonstrates that refugees tend to have poorer health outcomes compared to local populations, even when given access to healthcare (Frantz, 2003; Refugee Council, 2005). Torun et al. (2018) identified cost of living, language barriers, and lack of knowledge of healthcare rights as main barriers to healthcare access among Syrian refugees living in Istanbul. Al-rousan et al. (2018) cited healthcare cost and perceived discrimination in and outside of healthcare settings as common obstacles to seeking care when examined from the perspective of Syrian refugees in Jordan (Al-rousan et al, 2018). Stephenson’s (1995) examination of Vietnamese refugees and healthcare providers in Victoria, British Columbia identified “problematic interpretation of patient symptoms and healthcare provider recommendations” and “lack of healthcare worker understanding of traditional remedies for common ailments” as barriers to healthcare utilization. Furthermore, a 2015 systematic review of literature exploring refugee experiences of primary care in their countries of resettlements found difficulties navigating primary care services, language barriers, poor provider-patient relationships, and cultural differences to be the most commonly cited limitations (Cheng and Schattner, 2015).

Having experienced significant violence and extreme poverty in their countries of origin or countries of displacement has negatively impacted the health of many women refugees (Costa, 2007). Female refugees and asylum seekers also have higher healthcare utilization compared to their male counterparts (Wetzke et al, 2015). A 2015 survey of Somali women refugees found patient-provider gender discordance, with female refugees preferring female providers and interpreters, to be a barrier to health seeking (Odunukan et al, 2015). In addition, providers
working with female refugees report lack of training, knowledge, and confidence in addressing the specific sexual and reproductive healthcare needs of this population (Mengesha et al, 2018). Still, little is known about the healthcare utilization and potential barriers experienced by Yazidi refugees.

Forced Conversion Campaign:

The Yazidis are an ethnic and religious minority group indigenous to northern Iraq, northern Syria, and southeastern Turkey with an estimated worldwide population of 800,000 to 1,000,000 (Centorelli et al, 2017). Beginning on August 3rd, 2014, in what has been called the “forced conversion campaign,” the so-called Islamic State (IS) has perpetrated an alleged genocide of Yazidis in Iraq, abducting Yazidi women and killing thousands of Yazidi civilians. Within a matter of days, an estimated 2.5% of the Yazidi population was murdered (Centorelli et al, 2017). This genocide has led to the essential exile and displacement of Yazidis from their ancestral lands in Northern Iraq. Women and children were abducted and experienced repeated sexual and gender-based violence over the course of months (Cetorelli et al, 2017; Whyte, 2016; Mohammadi, 2016). Even after their release, many spent time in Internal Displaced Persons (IDP) camps in the Kurdistan region of Iraq, without access to social and psychological resources.

Special Quota Project:

The Special Quota Project is a German humanitarian assistance program that sought to resettle 1100 women and children in the State of Baden-Wurttemberg (Whyte, 2016). Women and children were accepted to the program based on two main criteria: Having been victims of traumatizing experiences in the context of the violent conflict in Syria and Northern Iraq; Having spent a period of time as IDPs in the Kurdistan region of Iraq. The program provided women and children with temporary residence in secure and separate housing for up to two years as well as medical and psychological treatment to aid in their recovery (Whyte, 2016). The women maintained rights to leave the program on their own accord, at any time, to return to Iraq.
Purpose of Inquiry:

The purpose of this study is to identify perceptions of German healthcare services as experienced by Yazidi women refugees resettled in Germany. Specifically, this investigation aims (1) to understand how IS-traumatized women experienced and interpreted their interactions with healthcare professionals after resettlement in Germany and (2) to identify potential barriers to the IS-traumatized women accessing and utilizing healthcare services in Germany. By understanding these barriers, we hope to provide concrete recommendations to healthcare workers caring for this vulnerable population.

Student Role:

This paper details the results of a small part of a research study led by Dr. Phuong Pham. Dr. Pham’s study is entitled The Assessment of Mental Health and Attitudes towards Justice, Accountability, and Prospects for Peace Among Iraqi Refugees in Germany. As a student researcher on the study, my role was to take the lead on a smaller subset of research questions pertaining to my area of interest, including perceptions of healthcare professionals, their relationship to beneficiaries, and impact on resettlement efforts. I assisted in the production of interview items in the study questionnaire, collection of data, conduction of interviews with beneficiaries in Germany, data analysis of English transcripts, and writing of research.

Methods:

Institutional Review Board:

The study is a collaboration between the Harvard Humanitarian Initiative and the Psychosomatic Medicine and Psychotherapy Department at the Medical University of Tuebingen. The study was reviewed and approved by The Harvard Human Research Protection Program Institutional Review Board, Protocol # 17-0786 and the ethics board of the University of Tuebingen. The study fulfils the ethical principles of the Declaration of Helsinki.


Study Participant Selection:

Study participants were Yazidi women who lived in Northern Iraq prior to the genocide perpetrated by IS. The women are survivors of horrific sexual and gender-based violence and torture. Following escape, the women were relocated to Germany as beneficiaries of the Special Quota Project (SQP).

Inclusion criteria:
1. Iraqi refugee living in Germany
2. 18 years of age or older
3. Beneficiary of the Special Quota Project

Exclusion criteria:
1. 17 years of age or below
2. Not a beneficiary of the Special Quota Project
3. Inability to communicate or consent for study participation

Participant Enrollment:

Study participation was offered to beneficiaries of the Special Quota Project through the caregiver network (ie. social workers, physicians, psychologists, interpreters, and other therapists). A census approach was used to provide every beneficiaries aged 18 years or older with the opportunity to participate. Participation was voluntary and no sampling was conducted. Recruitment materials included written documents outlining the purpose of the trial, voluntary nature of participation, potential benefits (no monetary compensation was offered), and potential risks. Women were advised that participation is voluntary and whether or not the women chose to participate in the study had no impact on her ability to receive services through the Special Quota Project. To ensure participant privacy, all names and contact information was documented in KoBoToolbox, a secure, electronic data collection software developed by the study’s principal investigator, Dr. Phuong Pham.
**Study Design:**

The study team conducted semi-structured in-depth interviews, lasting about 2 hours long with Yazidi women refugees. Interviews were conducted from September 2017 to January 2018. A questionnaire was developed by a team of psychologists and doctors from Harvard University and the Medical University of Tuebingen. Interviews were conducted by members of the study team accompanied by interpreters who speak Kurmanji, a dialect of Kurdish spoken by study participants. The questionnaire was developed in English and German. It was then translated by Yazidi women living in Germany into Kurdish-Kurmanji to ensure coherency and cultural understanding. The interviews were conducted in the State of Baden-Wurttemberg, Germany where beneficiaries resided. Interviews were audio-recorded and directly transcribed into English.

**Survey instruments:**

The survey instrument is a self-report questionnaire used to measure the women’s overall experiences with professional healthcare aids in Germany. The participants were asked to answer how helpful they found experiences with psychiatrists and medical physicians in aiding their recovery. Items were rated on a five-point Likert scale, from 0 (“not at all helpful”) to 4 (“extremely helpful”). The questionnaire was also developed to assess sociodemographic variables including age, marital status, number of household occupants, literacy, level of education, current enrollment in school system, employment status, religious affiliation, and ethnic identification.

**Data Analysis:**

Qualitative data from transcripts were analyzed using qualitative content analysis to systematically code text data. Themes and patterns were identified using Dedoose. Deductive and inductive approaches were applied. Sociodemographic variables and quantitative data were calculated using the mean ($M$) and standard deviation ($SD$).
Results:

Sociodemographic variables:

The study population included $N = 117$ adult participants of which $N = 116$ were included in data analysis. To ensure homogeneity of the study population, one male was excluded from data analysis.

The age range of women participants was from 18 to 51 years, with an average of 32 years and standard deviation of 8.1. The majority of participants were married (71.6%). Of the married women, 21% reported having partners living in Iraq, 15% reported having partners in Germany, and 30.1% reported not knowing the whereabouts of their partner (escaped, in captivity, or deceased). One-third of the respondents were illiterate, though the majority of the sample (82.9%) were attending school (including language classes and vocational school) during the period of data collection.

Of the 116 participants in the study, 115 reported belonging to the Yazidi faith and 103 identified as ethnic Yazidis. Twelve respondents identified as belonging to the Kurdish ethnic group. The women spent a mean of 6.78 months in captivity ($SD = 4.2$) and have lived in Germany a mean of 727.89 days ($SD = 90.0$). All 116 participants met criteria for a diagnosis of posttraumatic stress disorder (PTSD). More sociodemographic information regarding the participants could be found in Table A.

Ratings:

The women were asked to rate how helpful they perceived their interactions with doctors and psychiatrists on a scale of 0 to 4, 0 being “Not at all helpful” and 4 being “Extremely helpful.” Of the 116 participants, 97 reported having interacted with doctors. The experiences with medical doctors were rated with a mean of 3.2 and standard deviation of 1.3. Of the 116 participants, all 116 reported having interacted with psychologists. The experiences with psychologists were rated with a mean of 2.6 and standard deviation of 1.7. Not all respondents who responded “yes” to meeting with doctors and psychologists chose to answer questions
regarding effectiveness. For more specific information regarding the breakdown of responses, please refer to Table B and Table C.

Themes:

Negative Interactions of healthcare Professionals:

Participants were asked about the perceived effectiveness of their interactions with healthcare professionals, including psychologists, psychiatrists, and medical physicians. Factors identified as negatively influencing participants’ perceptions of these healthcare interactions include fear of having to disclose trauma stories (avoidance), hopelessness, and language barriers.

Avoidance:

The majority of the traumatized women who experienced negative interactions with healthcare professionals noted a fear of having to disclose their trauma histories to providers. Participants gave many reasons for not wanting to speak to providers about their trauma. Some felt that although providers are well-intentioned, they will never truly understand what the women experienced and how much they had suffered. These women chose to instead disclose their stories only to fellow survivors. Others experienced negative emotions, including anger, anxiety, and sadness when asked to speak about their time in Iraq. Some women even experienced somatic symptoms, such as headaches, when asked about their trauma history.

“Because I found difficulties talking about my violent experience with normal people. I knew when I confide to psychologists they would understand my story without being sad or affected by my sayings.” - Participant 056

“They tell us to visit (the psychologist), but my discomfort increases every time I talk about what happened… I’ve been there once, but I got uncomfortable speaking about my experiences” - Participant 029
“Here I went to someone three times, and do not go now, I do not know, I get frustrated; when I tell my story. I feel more frustrated...I feel anxious while speaking on them. I want to forget it.” -Participant 110

“Now I have a headache when I talk about it. I don't want to experience any headache, I have a terrible headache now, because I talked about it.” -Participant 019

“I asked to the translator. He said you need to do it is good for you. I said I don't want that. I said because if I tell my story to him I'm going to feel worse.” -Participant 015

“When you go and see a psychologist, they will ask to tell your story from the beginning and that makes sad and think again about what happened to me. In Iraq, I visited psychologists several times; they made my state even worse.” -Participant 098

“When we went to talk, we got even more upset. Doctors cannot cure what we experienced” -Participant 035

Furthermore, participants felt that speaking about their past triggered memories and worsened their psychological health. The women reported feeling re-traumatized by the experience. They mentioned wanting to forget these memories in order to create new lives for themselves in Germany but found it harder to do so when asked to speak about their experiences. They reported worsened mental health from having to disclose their trauma.

“It didn't help me [going to doctor]. He returned me and I felt as if I experienced violence.” -Participant 059

“No, they make me remember more. Yes, when I’m with them, I remember even more.”
-Participant 043
Interviewer: “Is it good when you see a psychiatrist?”
Participant: “Not really. Talking to them opens another wound.”
-Participant 082

“The day I talk to the psychologist, everything rushes back to my mind and I can’t forget. I feel more troubled when it happens.” -Participant 102

“Believe me, whenever she came, I was crying and shedding tears, I couldn’t hold my tears so I asked the social workers that I couldn’t come, I told them that whenever I would talk, I would think about it for the rest of the day...When I talked, I used to cry, I used to leave the group because it reminded me of what happened to me. I told them that I wanted to forget, and whenever I talk about it, I remember.” -Participant 081

**Hopelessness:**

Themes of hopelessness were also expressed as barriers to seeking care. Many participants felt the burden of their trauma experiences to be too great to overcome. The women mentioned good, trusting relationships with their doctors. However, they felt that no amount of support or counseling would ever help them forget what had happened in Iraq.

“We are hopeless case” - Participant 078

“The psychotherapist came here and I said no. I went twice to him but I don't feel like any human will be capable of healing me unless my heart feels fine.” -Participant 025

“They (the doctors) are good, when we have a problem, there are some doctors who you can trust, but you know they can’t do anything with man's heart or mind.”
-Participant 115
“I think it won’t help, because i’ve been living here for 3 years, nothing helped me to forget.” -Participant 065

“They asked questions, and I answer, but I don’t feel much better, nothing can help us out of this.” -Participant 079

Many of the participants witnessed the murders of their loved ones. While the women were able to escape captivity, many had family members who are still missing or remain in IS captivity. These women did not feel their interactions with healthcare professionals to be helpful because doctors have no ability to give them what they truly need, justice and their loved ones freed.

“The people who come to us to talk, it doesn’t change anything for our psychology. We want the captives to be helped. We want them to be rescued from the hands of those evil-doers.” -Participant 053

“No, no one can help me with this...No, nobody can bring my loved ones back to me.”
-Participant 041

**Language Barrier:**

Many participants expressed inability to communicate with healthcare providers as a main barrier to care and treatment effectiveness. Language barriers were present throughout the care cycle, with participants noting inability to communicate to social workers their need to schedule medical appointments, difficulty finding Kurdish interpreters, and inability to comprehend treatment instructions, such as the scheduling of medications.

“We do not really understand each other. We need to bring interpreters with us. They do not understand us.” -Participant 035
“We go when we have pain. But I have an infection for 1 year, and I am going to the doctors here. They are taking me there without an interpreter. I don’t understand any word they say. They cannot help me. I tell them that I have an infection and they understand nothing.” -Participant 028

“They were preparing training for me. I used to visit them, and they said to come too. They prescribed pills for me. But I don’t know what pills they were.” -Participant 055

“I don’t understand them when they come to me to help me. I have a problem with the language. I don’t have enough language skills to tell those women who come here to help me what to do. Even if they are Yazidi, I can't tell them what to do the way I want.” -Participant 115

**Positive Experiences with Healthcare Professionals:**

Of the respondents who reported their interactions with healthcare professionals effective in improving their health, a number of themes were identified. Factors identified as positively influencing participant’s perceptions of healthcare interactions include feelings of support, relief from conversations, help with future planning, and symptomatic treatment.

**Support:**

Participants who had positive perceptions of healthcare professionals often mentioned the strength they were able to draw from patient-doctor relationships. They noted feeling support and less alone knowing someone else cared for their wellbeing. The women felt “weak” and “powerless” after the violence perpetrated against them in Iraq. Rather than focusing on their past trauma, these women appreciated the doctors who helped them believe in their own abilities.
“They helped me and my children to become better. They take us to doctors; they are always ready to help. It feels good when you know that there are some people who are ready to help you doing something that you can't do them alone.” -Participant 098

“By God, yes. They helped me a lot, they gave me strength. Because I was weak when I went there. I kept on going there for a year. They gave me a lot of strength.”
-Participant 051

“Like how I can look after myself, how I would not fear anything, like, another one, how I can believe in myself.” -Participant 109

“Yes, it was helpful. They give me strength. When they think of me, care for me, ask about me, it gives me support. It gives me strength.” -Participant 043

“Sometimes he talks to me when I feel down and uncomfortable and powerless, I become stronger, more comfortable and relaxed.” -Participant 024

Relief from Talking:

Women who had positive relationships with their doctors and felt the interactions effective in helping their recovery expressed relief from speaking to their providers. They felt they could entrust their providers with problems they have been experiencing. The conversations with providers helped them to forget about their problems.

“Well, we talk and it’s good for us. We forget our problems.” -Participant 047

“I pour my troubles out, and I get relieved. I tell them things that I can’t tell anyone else.”
-Participant 049
“Actually a lot. When I talk to them, I empty my heart and I feel calm and relaxed.” - Participant 101

“I feel my heart is full of pain, when i talk i feel like it’s bleeding the pains away and letting go, and the doctor gave me very good pieces of advice.” -Participant 87

The conversations not only helped the women forget their problems. Doctors provided the women with advice regarding how to cope with their issues, how to build stronger relationships with their loved ones, and how to build their new lives in Germany through work and education.

“I was going to a doctor, he helped me a lot. He helped on many issues I had like beating my kids, when we were with ISIS, I had never beaten them, and I had feared they would take them from me. I have never beaten them, but when we came here, I have grounded my kids, yet the doctor helped to give up this problem.” -Participant 115

“He gave me so much strength, so much encouragement. How I can continue my life, how I can build a relationship with my son. He was very helpful.” -Participant 051

“They support us in everything such as doctors, psychologists, social workers when they are finding jobs for us after school and pediatrician...When the psychologist speaks to us, says everything and we understand that it is for our life. We feel so comfortable.” - Participant 021

“Sometimes one does not know her situation and others say to her ‘You are in such a state. Do this thing because it may help you; and avoid that thing...When I tell my problems to her, she, for example, show me a path. This helps me the most.” -Participant 113
“By the medical treatment, and the psychologists show the right way to deal with everything, they tell me what is the good thing for me and what to do, the bad ones that get away from.” -Participant 76

“What because it feels like that person knows what I have been through and he knows what my treatment is...He advises me...He tells me to go and do sports, go to school, make yourself stronger, go out, be a good example for your children.” -Participant 024

**Symptomatic Treatment:**

Women who had positive interactions with their doctors also noted symptomatic relief from their treatments. Many women suffered from physical and emotional pain as a result of being in IS captivity. The women generally had positive experiences with psychological medications that were prescribed to them. Their doctors, in addition to support, provided them with treatment for these symptoms.

“Yes the doctor was helpful when I went, and also for the stomach problems I was put through a big equipment treatment, afforded by the government, the doctor did make me feel better” -Participant 068

“You gave me medicine to help me, I was really in a dark place but after seeing a therapist and taking medicine I have become better” -Participant 091

“They give medicines and help us.” -Participant 022

“I am mentally well balanced, thanks to the medication. I was harming my children. When I was in Iraq, I took a knife and tried to kill myself several times. I was running out on the streets at night, but now I'm fine thanks to the medications I use here.”

-Participant 034
“They prescribe pills which make me better. I get free from my fear, and I can forget it for the day. During the day I think about those killed by ISIS, I remember the times I was there, I remember dreadful things like this, but I don’t see any nightmares, and I don’t feel afraid when I use the pills.” -Participant 102

**Discussion:**

This study reveals a number of factors that positively and negatively influenced the participants’ perceptions of the German healthcare system and its role in their recovery. Although these findings are not novel to existing literature, they serve to confirm the findings in the Yazidi population. The results show that negative perceptions of healthcare encounters related to themes of avoidance, hopelessness, and language barriers while positive perceptions related to themes of support, relief, and symptomatic treatment.

As the role of language as a barrier to healthcare have been well-documented in the refugee population (Torun et al, 2018; Ballamy et al, 2019; McGarry et al, 2018; Borgschulte et al, 2018), our discussion will focus on addressing themes of avoidance and hopelessness. Existing literature exploring the prevalence of posttraumatic stress disorder (PTSD) in Yazidi women and beneficiaries of the Special Quota Project showed rates of 41% to 57% in women exposed to rape and gender-based violence (Kizilhan, 2018). PTSD prevalence of up to 80% was found in cohorts of Yazidi women and girls who survived enslavement and are living in internally displaced person camps in the Kurdistan Region of Iraq (Ibrahim et al, 2018). The Diagnostic and Statistical Manual of Mental Disorders: DSM-5 (2013) defines PTSD based on 8 criterions, including exposure to a stressor (Criterion A), intrusive symptoms (Criterion B), avoidance of trauma-related stimuli (Criterion C), negative changes in cognition and mood (Criterion D), alterations in arousal and reactivity (Criterion E), duration of more than 1 month (Criterion F), distress or functional impairment (Criterion G), and exclusion of other causes potential causes (Criterion H). Of the 116 participants in this study, all 116 met criteria for diagnosis of PTSD. A study of the gender differences in symptomatology of PTSD among Iraqi Yazidis displaced in Turkey found women were more likely than men to report flashbacks, hypervigilance, and psychological distress, whereas men were more likely to exhibit detachment...
or estrangement (Tekin et al, 2016). While there was no significant gender differences in stimulus avoidant behavior, the study found that Yazidi women were more likely than their male counterparts to represent an intrusive type of response to trauma, with predominance of re-experiencing and hyperarousal symptoms (Tekin et al, 2016). The intrusive response may serve as explanation for the women’s tendency to avoid interactions with healthcare professions in fear of having to retell their stories and re-experience their trauma.

According to the *International Society for Traumatic Stress Studies (ISTSS) Expert Consensus Treatment Guidelines for Complex PTSD in Adults*, the recommended treatment model involves three phases:

Phase 1 focuses on ensuring the individual’s safety, reducing symptoms, and increasing important emotional, social and psychological competencies. Phase 2 focuses on processing the unresolved aspects of the individual’s memories of traumatic experiences. This phase emphasizes the review and re-appraisal of traumatic memories so that they are integrated into an adaptive representation of self, relationships and the world. Phase 3, the final phase of treatment, involves consolidation of treatment gains to facilitate the transition from the end of the treatment to greater engagement in relationships, work or education, and community life. (Cloitre et al, 2012)

Trauma memory processing (TMP) is used in Phase 2 and thought to target intrusive re-experiencing, a central feature in PTSD. TMP’s goal is to activate neural networks in the brain responsible for two key functions that are thought to be disrupted by intrusive experiencing in PTSD: intentional memory retrieval and suppression of memory retrieval. Oftentimes, this phase involves re-experiencing the traumatic events in the context of a safe environment that is maintained by the therapist’s support, encouragement, and guidance (Cloitre et al, 2012). Although this triphasic approach has been supported by studies for treatment of PTSD in patients with childhood physical and/or sexual abuse (Cloitre et al, 2002; Cloitre et al, 2010; Steil et al, 2011), to the best of our knowledge, there are no published randomized controlled trials of phase-based treatments for adult-onset complex trauma populations. For instance, research regarding treatment for the trauma experienced by refugees, such as the Yazidi population, and
other populations exposed to torture and/or genocide is limited. A study of the sustainability of a five phase, trauma-focused group therapy in a small cohort of male Iranian and Afghan refugees did show sustainability of PTSD symptom reduction at 7 years post-treatment (Drožđek et al, 2013). However, the small sample was comprised of only health-seeking individuals who were willing to disclose their trauma histories (Drožđek et al, 2013). Patients who are reluctant to speak to providers and have a self-perceived inability to process traumatic events have been shown to have more severe PTSD symptoms and lower levels of social support (Köhler et al, 2018). Furthermore, no consensus exists regarding the ideal duration of treatment, including length of time in Phases 1 through 3. Decisions regarding transition from one phase to the next is often tailored to individual patients at the discretion of the clinician. According to ISTSS,

Phase 2 processing of trauma memories should be initiated when there is agreement between the clinician and patient that the patient has enough skills and life stability to safely engage in trauma-focused work. During this phase, relapses are expected and planned for, with the patient sometimes returning to Phase 1 tasks to re-learn or re-consolidate skills before continuing with trauma processing. (Cloitre et al, 2012)

Given the lack of specific indications for transition to more advanced phases like trauma memory processing, it is possible that women in the present study who struggled with avoidance were prematurely treated with TMP. Thus, leading to relapse and subsequent reluctance to continue therapy. Ideas of retraumatization or relapse from trauma-focused therapy also explains the women’s positive perceptions of interactions with healthcare professionals who provided other forms of support. Namely, the women felt interactions with healthcare professionals to be effective when conversations centered around coping mechanisms, how to rebuild existing relationships, and future planning. It is also important to note that the psychologists in this study did not start “treatment” or trauma-based therapy on all the women. Many women are still being evaluated for readiness to receive therapy.

Furthermore, the women in this study who did not find their interactions with healthcare professionals to be effective in their recovery also endorsed feelings of hopelessness. Rather than questioning the therapeutic alliance, these women felt that their problems were incurable and
that no amount of therapy and medical care could help them recover. A study of the gender differences in symptomatology of major depressive disorder among Iraqi Yazidis displaced in Turkey found the prevalence of major depression to be 39.5% (Tekin et al, 2015). Of the participants who showed signs of depression, women were more likely than men to exhibit feelings of guilt and worthlessness (Tekin et al, 2015). The Diagnostic and Statistical Manual of Mental Disorders: DSM-5 (2013) sights the diagnostic criteria for MDD include: five or more of the following symptoms present for at least two weeks and represents a change from previous baseline functioning. At least one of the symptoms must be depressed mood or loss of interest or pleasure. (1) Depressed mood; (2) Markedly diminished interest or pleasure; (3) Significant weight change or significant change in appetite; (4) Psychomotor agitation or retardation; (5) Feelings of worthlessness or excessive or inappropriate guilt; (6) Concentration problems; (7) Suicidal Ideation. Depression severity, hopelessness, and self-esteem were shown to be significant predictors of long-term outcomes in patients with major depressive disorder (MDD) who had undergone acute phase therapies (von Bronswijk et al, 2018). These findings also support our finding in women with positive perceptions of the effectiveness of their interactions with healthcare professionals. These participants noted feeling supported and learning to believe in themselves through their interactions with their physicians and therapists.

Moreover, in a study exploring the role of hopelessness in relation to PTSD and suicidality, pre-treatment hopelessness was found to be a significant moderator of overall PTSD symptom severity and self-perceived likelihood of suicide attempts (Boffa et al, 2018). The investigation found that in individuals who reported elevated risk of future suicide attempts (FSA), reductions in self-reported hopelessness after treatment corresponded with reductions in overall PTSD symptoms and decreased FSA likelihood (Boffa et al, 2018). In a population of hospitalized patients with recent suicide attempts, a significant correlation was found among age, attempted suicide method, past suicide attempt, and psychiatric diagnosis in predicting levels of hopelessness (Efstathiou et al, 2018). These studies suggest using measures of hopelessness to identify trauma-exposed individuals who may benefit most from MDD and PTSD treatment and who appear most at risk of suicide. Still, little data exists regarding health seeking behavior in patients with hopelessness. In our study, hopelessness was found to be a major theme reported in those with negative perceptions of health treatment efficacy. Many women who exhibited
hopelessness reported refusing therapy and interactions with health professionals due to the belief that nothing could help them. Thus, hopelessness appears intimately tied with beliefs of ineffectiveness of therapy. Hopelessness, therefore, seems to be a major factor in hindering healthcare utilization in this targeted population.

**Limitations:**

The study is limited in its potential generalizability to other refugee groups. The Yazidis differ from other refugee populations not only in their experienced trauma, but also in the resources they had received in their countries of resettlement. As beneficiaries of the Special Quota Project, the participants in this study are afforded access to psychological and medical care as well as housing and educational opportunities that may not be available to the average refugee who has arrived in Germany on his/her own. In addition, there is a potential selection bias as the women were not randomly selected for participation. Because participation in the study was voluntary, women who were most traumatized and emotionally impacted may opt out of participation. Also, since enrollment materials were distributed through caregiver networks, women who underutilized their resources and were less connected to the caregiver network may have been underrepresented in the sample. Furthermore, the variability in spoken and written Kurmanji language presents an additional challenge.

**Conclusions and Suggestions for Future Work:**

The participants in this study are Yazidi women and survivors of extreme violence and torture. This study is one of the first to document their perceptions of healthcare professionals and the efficacy of their interactions. Our study results have certain impact on how to approach clinical encounters with this refugee population. Namely, the importance of assessing a patient’s perceived ability to disclose trauma information and take part in trauma memory processing in order to address healthcare avoidance. Furthermore, efforts should be made to address ideas of hopelessness and perceived effectiveness of therapy. Addressing these barriers while providing support for patients, with conversations focused on strengthening self-esteem, coping
mechanisms, and personal relationships may lead to better healthcare utilization, retention, and outcomes. However, as a result of this study’s inherent methodological design, these conclusions remain tentative. Still, further research is needed to explore the efficacy of phase-based, trauma-focused therapy in refugee populations, identify clinical predictors of patient readiness to disclose trauma histories, and determine the ideal duration of treatment.
Acknowledgements:

First and foremost, I owe my deepest gratitude to the Yazidi women who participated in this study, who welcomed us into their lives and allowed us to learn from their stories. This thesis would not have been possible without their bravery in speaking their truth. I owe the greatest thanks to my incredible research mentor, Dr. Phuong Pham, who offered invaluable insights and guidance. Thank you for your patience and support in answering my multitude of questions along the way. Many thanks to the researchers, interpreters, social workers, therapists, and physicians at the Medical University of Tuebingen and The Harvard Humanitarian Initiative for innumerable hours of dedication to this project. To Jana, Niamh, and Dr. Florian Junne, thank you for your expertise, friendship, warm welcome, and logistical guidance during my time in Germany. Most importantly, this work would never have been possible without the endless support of my family, especially my parents, Toan and Anna, whose life experiences and determination inspired my own passion for advocating for and improving the health of people worldwide.
List of References:


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van Bronswijk SC, Lemmens LHJM, Keefe JR, Huibers MJH, Derubeis RJ, Peeters FPML. A prognostic index for long-term outcome after successful acute phase cognitive therapy and interpersonal psychotherapy for major depressive disorder. Depress Anxiety. 2018;


**Tables:**

**Table A. Sociodemographic Variables of Participants**

Sample Description (N - 116)

<table>
<thead>
<tr>
<th>Mean</th>
<th>SD</th>
<th>Range</th>
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<tbody>
<tr>
<td>Age (Years)</td>
<td>32</td>
<td>8.1</td>
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<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
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<tbody>
<tr>
<td>Gender</td>
<td>Female</td>
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<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Frequency</th>
<th>Percent</th>
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<tr>
<td>Married</td>
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<td>71.6</td>
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<tr>
<td>Single</td>
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<td>28.4</td>
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<table>
<thead>
<tr>
<th>Knowledge of Partner's whereabouts</th>
<th>Frequency</th>
<th>Percent</th>
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<tr>
<td>Living or Deceased</td>
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<td>69.9</td>
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<td>Unknown</td>
<td>25</td>
<td>30.1</td>
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<table>
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<th>Residence of Partner</th>
<th>Frequency</th>
<th>Percent</th>
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<tbody>
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<td>Iraq</td>
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<td>21</td>
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<tr>
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<td>21.4</td>
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<td>15</td>
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<tr>
<td>Other Country</td>
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<tr>
<td>Deceased</td>
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<tr>
<td>Unknown</td>
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<td>3</td>
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**Literacy**

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**Highest level of education**

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<td>Some Primary</td>
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<td>Finished Primary</td>
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<td>Intermediate</td>
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<td>3.4</td>
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<th>Currently attending school</th>
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<table>
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<th>Currently employed</th>
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**Religion**

<table>
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<tr>
<th>Yazidi</th>
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<th>99.1</th>
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<tr>
<td>Other</td>
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<td>0.9</td>
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</table>

**Ethnic Group**

<table>
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<tr>
<th>Yazidi</th>
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<th>89.6</th>
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<tr>
<td>Kurdish</td>
<td>12</td>
<td>10.4</td>
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Table B. If you have interacted with doctors, how much did it help?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
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</thead>
<tbody>
<tr>
<td>Not at all (0)</td>
<td>10</td>
</tr>
<tr>
<td>A little bit (1)</td>
<td>5</td>
</tr>
<tr>
<td>Moderately (2)</td>
<td>4</td>
</tr>
<tr>
<td>Quite a bit (3)</td>
<td>15</td>
</tr>
<tr>
<td>Extremely (4)</td>
<td>63</td>
</tr>
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</table>

Table C. If you have interacted with psychologists, how much did it help?

<table>
<thead>
<tr>
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<th>Percent</th>
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</thead>
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<td>19</td>
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<tr>
<td>A little bit (1)</td>
<td>4</td>
</tr>
<tr>
<td>Moderately (2)</td>
<td>8</td>
</tr>
<tr>
<td>Quite a bit (3)</td>
<td>7</td>
</tr>
<tr>
<td>Extremely (4)</td>
<td>43</td>
</tr>
</tbody>
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