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Hypertension During Disasters

By Claire Hutkins Seda, Writer, Migrant Clinicians Network, Managing Editor, *Streamline*

One year ago, Hurricane Maria crumpled Puerto Rico's infrastructure for months to come. Many homes were without power for over six months. Water systems were devastated and residents turned to local springs for drinking water. Transportation came to a stand-still. Without passable roads, food deliveries didn't reach grocery stories. Workers in agriculture suddenly had no job, as the fields had blown away. With communication systems knocked out – even cell phones weren't working in many parts of the island – Puerto Rico was left in the dark.

Facing this terrifying post-Maria situation were thousands of Puerto Ricans in rural communities with chronic conditions like hypertension. Under typical conditions, hypertension can already be a challenging health concern to manage. After Maria, for many, it was almost untenable.

"Hurricane Maria affected patients with hypertension in different ways," explained Jose O. Rodriguez, MD, MCN's Senior Medical Advisor for Puerto Rico, and Family Medicine Specialist and Medical Director of Hospital General Castañer, a community health center located in the center of Puerto Rico. At this health center, 26 percent of all patients have been diagnosed with hypertension – and many of them struggled after Hurricane Maria because of overlapping barriers to maintain their treatment plans. Damaged medication was particularly dangerous. "Some lost their medications [in the storm] and there was no way to get cash because there was no electricity for ATMs, no passable roads, and no gasoline available for vehicles. Without cash, patients could not buy their medications or pay their deductibles. The pharmacy had no ability to bill the medical plan and consequently they did not send their medications."

To overcome these massive hurdles, Hospital General Castañer stepped into action. "On the fourth day after the hurricane, we began to visit the affected areas to evaluate patients and begin to deliver medication. In addition, our pharmacy opened its doors to patients and began to sell or advance medication to patients who had lost them [in the storm]." While supplies ran dangerously low, Dr. Rodriguez said that "no one was left without medication for not having money or a medical plan."

Photo courtesy of CSM

"A patient had a stroke due to uncontrolled hypertension because his hypertension was untreated for two weeks and he was in continual stress. In this case, the doctor documents the cause of death as a stroke. But, when we consider the hurricane as the cause of stress and the reason he was unable to take his medicines, then this death should be related to the storm." - Dr. Jose Rodriguez

Two weeks after the hurricane, medical supplies began to trickle in. For many, it was too late. The hurricanes resulted in thousands of deaths. According to a Harvard University study published in the *New England Journal of Medicine* an estimated 4,645 excess deaths occurred from September 20, 2017 to December 31, 2017.[1] Many of these deaths were the result of chronic health conditions turning deadly after the cut-off of access to food, water, electricity, and medicine, and coupled with toxic stress.

More than Medicine: Standard Approach to Hypertension Not Applicable After Maria

Hypertension is typically addressed through diet, exercise, the cessation of smoking and drinking, and vigilantly administered and regu-

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1 Kishore N, Marqués D, Mahmud A, et al. Mortality in Puerto Rico after Hurricane Maria. N Engl J Med. 2018;379(2):162-170.

Protecting Pregnant Agricultural Workers: Medical-Legal Partnership in California

By Claire Hutkins Seda, Writer, Migrant Clinicians Network, Managing Editor, *Streamline*

In the spring, the California Department of Pesticide Regulation announced that 209 million pounds of pesticide active ingredients were used in 2016 across the green fields of the Golden State, ranking 2016 as the third highest-use year on record. In Monterey County, in California's fog-defined Central Coast where lettuce and other greens grow year-round, nine million pounds of pesticide active ingredients were applied, an increase of four percent over 2015.[1] That same year, ten of the 30 zip codes with the heaviest pesticide use in California were located in Monterey County – and more than 18,000 students attend school next to fields that spray highly hazardous pesticides – the most of any county.[2] With such intensive and growing pesticide usage comes a myriad of health concerns.

"It's a huge issue in agricultural communities – not just in California, but all across the US," says Aaron Voit, Esq., the Equal Justice Works Fellow for California Rural Legal Assistance (CRLA) who has made pesticide exposure in Monterey County the focus of a new medical-legal partnership. CRLA and the Monterey County Health Department have teamed up to eventually provide legal services to pesticide-exposed patients at all of the county health department's nine community health center look-alike clinics, which serve roughly 170,000 people per year.

Like many medical-legal partnerships, Voit aims to address systems-wide issues while also providing legal assistance to individual patients. CRLA has a long history of agricultural worker advocacy, Voit says, "so when it came time to think about how we could deepen our efforts to work on pesticide exposure, it became clear that one of the pieces that was missing was direct intervention for victims of pesticide exposure." Migrant Clinicians Network, which has worked directly with frontline providers to help them better recognize, manage, treat, and report pesticide exposure in the primary care setting for over 15 years, applauds CRLA's efforts.

"It's important for primary care clinicians in farming communities to rapidly recognize and treat pesticide exposure and prevent delays in diagnosis, which may help victims avoid long-term disability or other harm," noted Laszlo Madaras, MD, MPH, MCN's Co-Chief Medical Officer and a clinician in a large farming community in south-central Pennsylvania. "A good first step is being aware enough to ask the right questions during the initial taking of history. MCN has been collaborating with community health centers on the training of these efforts – and it's great to see CRLA taking up the charge as well."

The partnership's first priority is for the most vulnerable in the fields: agricultural worker women who are pregnant. The Center for the Health Assessment of Mothers and Children of Salinas (CHAMACOS), which has been studying the health impacts of pesticides in Salinas Valley for years, has put out a longitudinal study that found that seven-year-olds whose mothers experienced pesticide exposure while pregnant had impairment in cognitive functions and verbal comprehension, among other health complications like decreased lung function.[3,4]

Under California's state disability insurance law, pregnant women can typically receive replacement income for missed work for up to four weeks prior to the due date, but exposure earlier in pregnancy can have significant and lasting impacts on the child's health and development.

"Doctors are allowed to certify pregnant women for disability benefits if they think it's a high-risk pregnancy," he said, and there's now literature out there to make the case that working in the fields while pregnant presents an undue health risk to women and their babies, thanks to the CHAMACOS studies. Voit is using the CHAMACOS study results to help protect the children of the very community that CHAMACOS is studying. "Many of the doctors I work with [obtained] the blood and urine samples for that study," Voit said.

Voit has provided trainings with these same clinicians to identify who is at risk and help shepherd those patients through the process to help each patient determine what path – with a mix of paid and unpaid leave, for example – works best for her. The first step is identifying agricultural worker women of reproductive age. (For that, Voit used MCN's agricultural worker identification resource; see "Resources" below.) After the women are identified, clinicians must take an exposure history to determine their risk level. If their risk is high, they can be referred to Voit, who can provide information on what potential leave options they have, which can get complicated. "It's not a one-size-fits-all," explained Voit. As long as a woman qualifies for state disability insurance – meaning that she has at some point paid into the system – she can receive her weekly benefit amount for up to 52 weeks, regardless of how much she's paid into the system. "Even so, we still do individual assessments so that women can understand how much paid and unpaid

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Why Medical-Legal Partnership?

Today, community health centers largely recognize that improvement of health outcomes necessitates the recognition and mitigation (and, if possible, the elimination) of social determinants of health. Social workers on staff, community health workers reaching out in underserved neighborhoods, and partnerships with community-based organizations help reduce health disparities stemming from social determinants of health. Indeed, for many health centers, such outreach has been woven into the standard of care. Medical-legal partnerships bring attorneys into the health center as specialists. Clinicians can refer their patients to a lawyer for services related to their health just as clinicians refer patients to a mental health counselor or nutritionist. Medical-legal partnerships are yet another avenue through which health centers can address structural disparities that harm the health of vulnerable patients.

PCMH for Mobile Patients:
New Interactive Tool Helps You Find Resources

By Claire Hutkins Seda, Writer, Migrant Clinicians Network, Managing Editor, *Streamline*

Patient Centered Medical Home has become the preeminent model for primary care delivery across the US. The model, however, is predicated on a patient's geographic stability, wherein she or he works with a care team in one location over the course of treatment, for months or years. Among mobile patients like agricultural workers, such a model's weaknesses are exposed. But there are several key ways that community health centers can build or reshape their PCMH model to assure that mobile patients aren't left out.

Migrant Clinicians Network's new interactive tool provides targeted resources to community health centers to re-envision PCMH for mobile patients, no matter where in the PCMH process those health centers are, from a clinic first considering a PCMH approach, to a health center with a well-established and integrated PCMH. Following the prompts, users can click through to find the most relevant resources for their stage in the process. Visit MCN's PCMH page to access the interactive tool: https://www.migrantclinician.org/pcmh.

Photo courtesy of CSM

For mobile patients, PCMH is most efficient when linked with MCN's Health Network, our bridge case management program for mobile patients with any ongoing health concern. Health Network assures continuity of care and treatment completion by providing comprehensive case management, medical records transfer, and follow-up services for mobile patients. The no-cost service is available for patients with any health concern. Recent Health Network patients include a pregnant agricultural worker who moves every three weeks; a person with TB who is moving back to his country of origin in the midst of treatment; an immigrant traveling internationally and struggling to keep his diabetes under control; a person who recently underwent a cancer screening but is moving to a new state before the results can be shared. Learn more about Health Network at https://www.migrantclinician.org/services/network.html.

Medical-Legal Partnership in California continued from page 2

leave are available to them, and to make sure that their paid leave is available to them when they most need it," Voit said. Few families can take much unpaid leave due to economic pressures, and each state varies in how much unpaid family leave is permitted – additional factors to consider.

"It's important to sit down individually with women and see what's available to them and come up with a paid and unpaid leave plan for their pregnancy," Voit noted. In addition to exploring potential leave plans, women must be given full information on the risks of pesticide exposure, particularly to children in the womb. The medical-legal partnership, Voit says, ultimately aims to "inform women of their risks and equip them with the information and the financial opportunity to make the best decisions that they can."

The medical-legal partnership has big plans. While he's currently stationed on-site in one of Monterey County's health centers, Voit has the ultimate goal to "firmly establish this practice here in Monterey County, and then to spread it to other farmworker communities in California."

In addition to individually assisting hundreds of agricultural pregnant women over the course of his fellowship, Voit is also developing tools and resources to help any patient who has been acutely exposed to pesticides to navigate the legal avenues toward reparation. He also hopes to eventually expand into other contamination concerns, including water contamination. In Monterey County, agricultural worker housing has routinely been in the spotlight for high levels of nitrates coming out of agricultural worker housing spigots, and Voit recognizes that many in the community have legal needs around the continuing harm that such contaminants present to agricultural worker health. Voit, for one, is enthusiastic for the work to come.

"We're looking at a model to open up doors in a different way, so that we can both reach people who are exposed and come up with new remedies that aren't currently available," Voit shared. "Because the ones that are available now aren't working well."

Resources

Here are a few resources that Voit recommends.

The American College of Obstetricians and Gynecologists committee opinion on Employment Considerations During Pregnancy calls out legal means as a way to address pesticide exposure. Available at: https://bit.ly/2NNLLLZ.

A recent Slate article, "Why Some Doctor's Offices Double as Legal Clinics," covered medical-legal partnerships for pregnant women: https://slate.com/human-interest/2018/04/why-some-doctors-offices-double-as-legal-clinics.html.

Pregnant@Work is "a resource that can help providers write effective notes for pregnancy accomodation on behalf of their patients," Voit said. Available at: https://www.pregnantatwork.org/healthcare-professionals/pregnancy/.

MCN's mobile and seasonal agricultural worker identification resource is available at: https://bit.ly/2JXXUvu.

Visit Equal Justice Works at http://www.equaljusticeworks.org/.

Visit California Rural Legal Assistance at http://www.crla.org/.

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3 University of California, Berkeley. "CHAMACOS Study." Accessed 7/24/18. Available at: https://cerch.berkeley.edu/research-programs/chamacos-study .

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larly adjusted medication. Most of these approaches were compromised after Hurricane Maria, Dr. Rodriguez noted. Fresh food quickly ran out in stores, as transportation slowed food deliveries and farms were wiped out, so patients with hypertension turned, like the rest of the island, to canned foods and emergency foods provided by the Federal Emergency Management Agency (FEMA), or food still available in markets, most of which were high in salt and sugar. Directly after the storm, with houses lacking roofs and electricity and roads swept away, few had exercise on their minds, or the infrastructure to even go safely on a walk around the neighborhood. Most critically, noted Dr. Rodriguez, toxic stress played a significant factor in increasing the health risks associated with hypertension.

"The emotional destabilization caused by the hurricane resulted in [patients'] inability to have control over their hypertension," Dr. Rodriguez emphasized. The stress produced by the loss of relatives, in addition to electricity, houses, medicines, and communication "placed all patients with chronic conditions – those with hypertension and those without — at risk of losing control of those conditions due to their emotionally compromised state. The lack of communication (no radio, no television, no newspapers, no cell phones) caused an additional increase in stress," Dr. Rodriguez added.

A New Approach

After Maria, Dr. Rodriguez and his crew — both in the hospital and among the outreach workers going directly to patients in the community — had to reevaluate the needs of patients with hypertension, and retool their approach. Their main strategy was to educate patients, emphasizing the importance of stabilizing their blood pressure.

"After the hurricane, our approach to patients with hypertension became more aggressive around education on diet, hydration, pressure monitoring, and the use of medications to control blood pressure and chronic conditions overall," he said. "Most patients even with uncontrolled hypertension may not have acute symptoms, but chronic uncontrolled hypertension causes damage to the cardiovascular system. In many patients, the first sign is a stroke, heart attack, brain hemorrhage, or heart failure. The patient must be shown how important it is to control their blood pressure to avoid these complications." (Read some of Dr. Rodriguez's solutions in the accompanying text box.)

Immediately after the hurricane and regularly since then, mental health has been a foremost concern. Dr. Rodriguez recognizes that his patients are still reeling from Maria. "The effects of Hurricane Maria are still lasting in the minds of patients. This hurricane season, any news of changes in the weather induces stress in patients, and many go into despair," he noted.

Looking Ahead: Preparing the Team for the Next Disaster

The changing climate weighs heavily on Dr. Rodriguez, who recognizes that long-term strategies must take into account the increasing risk and regularity of such major weather events. Education continues to be essential. "We are improving our education on monitoring at home, on alternative diets, and on the use of medication depending on their blood pressure readings," Dr. Rodriguez stated. His team is instructing all patients to store their medication in sealed Ziplock bags, and spreading the word that pharmacies typically only have two weeks' supply on hand.

To get the word out, Hospital General Castañer has engaged staff from all levels to take part in the educational effort. Doctors, pharmacists, and *promotores de salud* provide patients with education after their appointments, while they wait in the waiting room, and at health fairs in popular community locations. The outreach program has expanded its coverage area, and the health center has expanded the available hours of its psychologist, social workers, and rehabilitation counselor in three clinics. A new monthly program has been launched to bring patients with hypertension together for further support, collaboration, and education. And new partnerships are forming, including a partnership between the local supermarket and the nutritionist. The hospital is also running regular educational announcements on local radio.

Hospital General Castañer Strategies

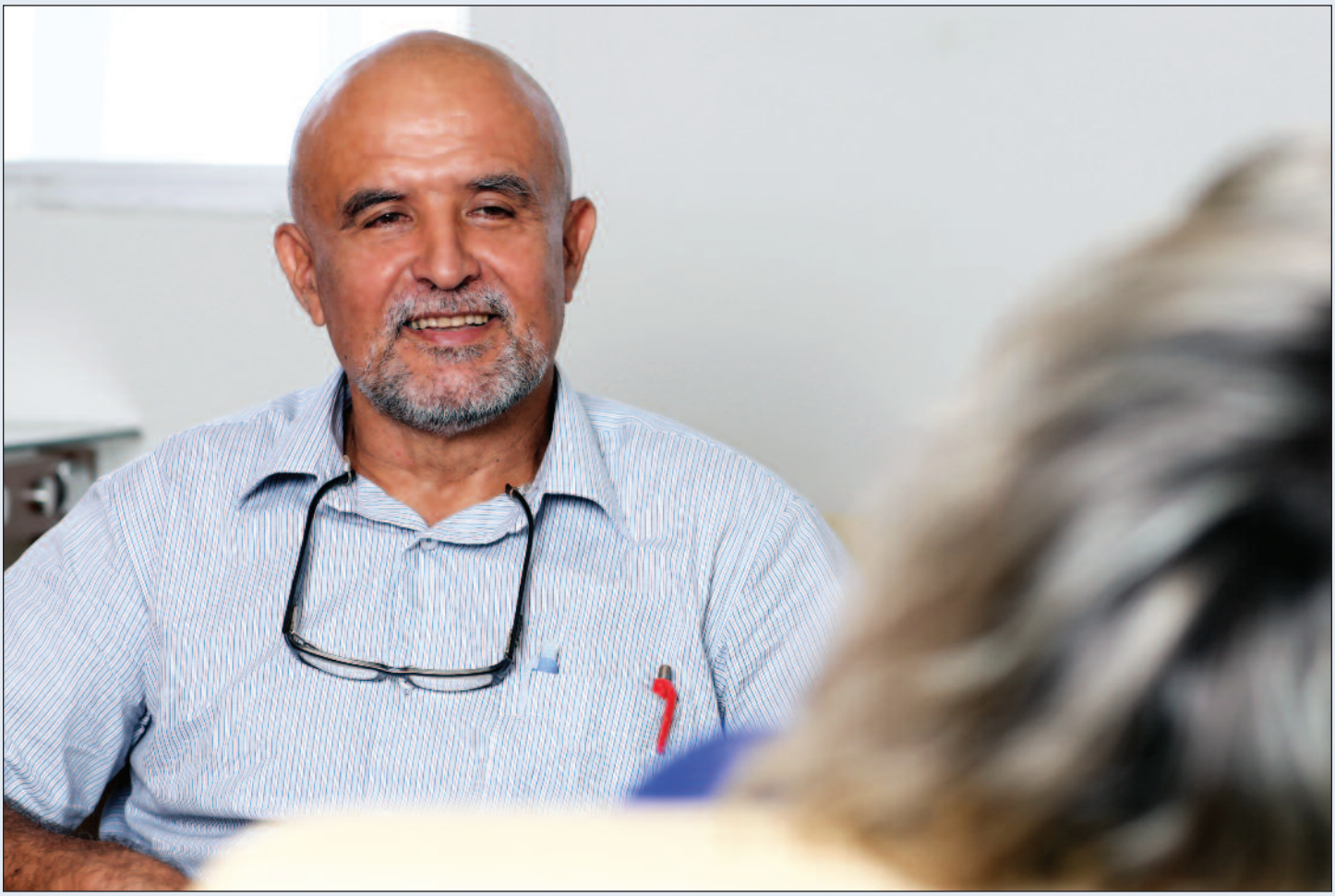
A summary of the approach that Dr. Rodriguez and his team have implemented to best serve patients with hypertension.

Health center staff can help patients manage chronic stress and other mental health concerns after a disaster:

- Help patients attempt to return to a level of normalcy in their lives.
- Encourage them to reactivate their social circles.
- Provide guidance on resources to address their mental state, including therapy.
- Prescribe appropriate medications for those struggling with stress, anxiety, and depression as needed.
- Keep the community informed. Make communication a key part of the outreach team's job. Rumors and misinformation spread fast, especially when official avenues of communication like radio and the internet are down, and the outreach team has a unique and important role to combat misinformation.
- Continue to make available and promote mental health resources, even after the community has begun to rebuild; mental health concerns may not be uncovered until months after the disaster.

Patient education is key. Remind patients that:

- A healthy lifestyle is their best bet to combating hypertension.
  - Drink sufficient water.
  - Limit your salt intake by paying attention to available foods and choosing your best options.
  - Exercise daily, despite the disruption in day-to-day life.
  - Do your best to eat within the confines of the recommended DASH diet (the Dietary Approach to Stop Hypertension, which emphasizes whole grains, fruits, vegetables and low-fat dairy products), even when foods are less available like after a disaster. Emphasize low-carb and plant-based foods.
- Know your rights. The Rehabilitation Act of 1973, section 504 notes that federal organizations providing financial and other assistance must make reasonable accommodation for those with disabilities.
- Take care of wounds and scrapes to avoid infection.
- Learn about and take care of co-infections and concurrent disease. For people with hypertension, this is particularly critical with those who also suffer from diabetes or dyslipidemia.
- Prepare for the next disaster:
  - Make sure you always have a month's worth of medications on hand.
  - Store your medicines in a waterproof plastic bag.
  - Make sure you know your medical history and your course of treatment.
  - If you require dialysis, keep an emergency food kit ready that suits your dietary needs.
  - Ensure that your medical devices are always charged.
  - Many patients are unable to pay for even the current month's supply of medications; others struggle to have enough food on the table. Consider providing samples, collaborating with a local organization to raise money for emergency medicine costs, and connecting with local food pantries to help low-income patients actualize this preparation list.



Witnessing: How Clinicians Can Move From Traumatic Stress to Empowerment While Serving Their Immigrant Patients

[Editor's note: This article was first published on MCN's active news blog, Clinician to Clinician. Read the blog at: http://www.migrantclinician.org/blog and sign up to receive notifications of new blog articles by emailing: chutkins-seda@migrantclinician.org.]

When Kaethe Weingarten, PhD, first entered clinical practice as a psychologist and family therapist in 1970s Boston, she began to notice a common theme among her work with children: traumatized parents. At a local children's hospital, parents were overwhelmed while observing their children undergo treatments and procedures. In a very different setting at a mental health clinic for children who experienced sexual abuse, she saw non-offending parents struggling to observe what their children were going through. Despite the very different settings, the parents had similar strong and intense reactions. "Obviously, the parents weren't the victims – they weren't in

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Pilot Witness-to-Witness Project at MCN

In the summer of 2018, the American Family Therapy Academy gathered for their annual retreat in Austin, Texas. "The situation for families crossing the border and seeking asylum was getting increasingly dire, and we wanted to do something about it," recalled Dr. Weingarten, who is a member of AFTA's executive committee. Migrant Clinicians Network's Deliana Garcia, Director of International Projects and Emerging Issues, was one of several Austin-based nonprofit leaders invited to participate in a workshop during the AFTA retreat about the work being done on the border to assist with immigrant family needs. "The workshop was engaging, mobilizing, and stirring," recalled Dr. Weingarten, and inspired AFTA members to further discuss ways to support those who are working with immigrant families on the border: "It's essential that people who are directly witnessing the families have their own support," she said. In the months following, MCN and AFTA joined forces for a pilot program wherein members of AFTA provide witnessing support to MCN staff members over the phone or through video conferencing, over two or three sessions. The project is still in its piloting phase, but participating MCN staff members have already found value in the effort. "I've spent the last 30-plus years working alongside frontline providers who are encountering enormous stress and frustration and barriers to helping the people they've dedicated their lives to help. Just to be able to talk about those things is very comforting," noted MCN's CEO, Karen Mountain, MBA, MSN, RN. Mountain has met with an AFTA member several times over video chat. She sees the witnessing tools as an important resource for health centers, and hopes that new collaboratives based off of the MCN/AFTA pilot can support frontline clinicians in the future. "Health centers have spent a lot of effort growing their behavioral health [services]-- but for their patients, not for the staff," Mountain noted. "Why shouldn't there be some recognition of the fact that this is a tough job that we're doing?"

This section has been paid for by donations to Migrant Clinicians Network.

Recommendations for Clinicians

In the following excerpt from *Common Shock*, Dr. Weingarten outlines some recommendations that may be useful for clinicians who are experiencing trauma as a result of their position as witness. They are broken down by biological, psychological, interpersonal, and societal. These recommendations assume that you are currently safe.

A The Biological Consequences of Common Shock:

1. Learn to recognize how your body feels when it is experiencing stress. For instance, do you notice your heart beating faster, your breath feeling tight, a knot or butterflies in your stomach, your thoughts racing or slowed down, difficulty swallowing?
2. Use your breath as an anchor to feel calmer. Inhale slowly to a count of three, hold your breath to a count of three, and exhale to a count of three. Repeat this sequence until you notice you are breathing more easily.
3. Sometimes as a person releases pent up stress from a common shock experience, the body trembles involuntarily. This is a natural and healthy response.
4. Make a list of 10 activities that comfort you, for instance listening to a particular piece of music or taking a hot shower. Keep the list in your wallet or someplace where it is always handy and do one activity each day.
5. Avoid overusing stimulants like caffeine, alcohol, sugar or drugs, but do drink plenty of fluids and eat comforting, nutritious foods in moderation.
6. Balance vigorous exercise with relaxing exercise, e.g. running with stretching.
7. Take a warm shower or bath.
8. Try sitting on the ground. Many people find placing their bodies on the ground is comforting. If this is not possible, sit in a chair and feel the sensation of your buttocks and the backs of your legs on the chair.
9. Look at some object of natural beauty. Even one will do. Study a leaf, notice the way the light looks, look at a rock. Take a walk in a park or in an area where grass, plants or trees grow.
10. Light a candle and dedicate the light to something or someone whose presence near you will be comforting.

B. The Psychological Consequences of Common Shock

1. Tell your experience to someone you trust. Don't worry if you are getting the details right; convey your overall sense of your experience.
2. Let yourself release the feelings you have. If you feel sadness, cry; if anger, yell.
3. Create an image for yourself that makes you feel part of a larger group. For instance, imagine that you are one animal in a large herd of animals or imagine that your hands are linked in a human chain that spans the globe. Use this image several times a day, perhaps before you do your breathing exercise.
4. Think of one small action that you can take, symbolic or actual, that makes you feel less helpless.
5. If you are feeling afraid in the present when you know you are actually safe, ask yourself the following questions: Am I safe now? How is the present moment different from the time when I was in danger? What can I do now to comfort myself?
6. Express yourself in an artistic medium: sing, draw, bang on plastic container "drums," dance, make a collage, etc.
7. If you feel shame, consider whether it is appropriate or not. This is a very hard idea to consider, but well worth it. If you feel ashamed of something you have done, think of a way you can make amends. Consider asking someone to help you figure this out, if it is too overwhelming to imagine what you might do to make amends. If you feel shame, but you don't believe that you have really done anything to deserve it, consider that someone may have "dumped" – transferred – his or her unbearable feelings of shame on to you. You may want to confront the person or, again, create a ritual. For a ritual, you might want to cleanse yourself of your undeserved shame by burning or burying a symbolic representation of it.
8. Do not expect a lot of yourself. Cut yourself slack.
9. Spend time with people who care about you.
10. Let others comfort you. If others need comfort, comfort them.
11. Hug friends and family members.
12. Give yourself time to heal.

C. Interpersonal Consequences of Common Shock

1. Silence: It is important to feel safe and to share your experience with at least one other person whom you trust to listen carefully and to decide with you what, if any, next steps you might take to feel better and/ or to act in relation to the situation you have witnessed. In many situations it may seem impossible both to tell someone and maintain your own and/or others' safety. However, ultimately silence or secrecy seldom keeps people safe. These are difficult choices, but speaking out has a better chance of leading to improvement than silence.
2. Shattered Assumptions: Assumptions are not like glass; they are built out of experiences in the world with others and these experiences can change. When "shattered," with time, with support from others and with distance from the experiences that produced the collapse of core beliefs, related ones will form. These will form in new ways to accommodate both prior and new experience. It is unlikely that you will emerge the same, which may produce its own interpersonal challenges. But the changes can usually be placed in a context that makes them understandable to others.

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the child's position of having something traumatic happening to them – and they weren't the perpetrators. They were bystanders. But 'bystanders' didn't cover it, because the parents were traumatized," Dr. Weingarten recalled. "The experience of parents watching their children are in a witness position." She began to write on the idea of "witness," a combination of bystander theory and the newly emerging trauma theory.

"Far and away the vast majority of violence or violation that anyone experiences is from the witnessing position," Dr. Weingarten noted, and the type of traumatic experiences that people witness are widely varied. "The more I delved into it, the more I believed that there wasn't any one position [of witnessing] but there was a wide range of context; not just a medical context or a domestic violence context, but other forms of violence, and all the way up to [witnessing] genocide." Dr. Weingarten has expanded on witnessing theory, seeking to help people in the witnessing position to step into a position of empowerment over helplessness, thereby guarding them from the negative effects of witnessing trauma and potentially helping them find a way to take effective action from their position as witness. "Depending on the setting and the problem they're facing, there are all kinds of ways that people can move up into an aware and empowered witness position, which really is the only one that has any long-term staying power."

For clinicians serving migrants and immigrants, the witnessing model and Dr. Weingarten's efforts to help witnesses out of helplessness and into empowerment have substantial and relevant applications. "The situation for families crossing the border and people seeking asylum [has been] increasingly dire," Dr. Weingarten notes. Clinicians are struggling to provide accurate advice to their patients as the immigration landscape rapidly shifts on issues like public charge and fear continues to be used as a tool to uproot immigrant families from their communities.[1,2] A recent MCN poll of clinicians found that 65 percent of respondents had seen a change in the previous year in immigrant or migrant patients' attitudes toward health care access; most poll respondents named an increase in fear and anxiety around immigration policy as the primary change.[3] Witnessing the fear, anxiety, and uncertainty of their patients, and watching as more patients opt out of accessing health care as a result, many clinicians feel stuck and unable to do their jobs effectively. A common result is an empathic stress reaction.

In Dr. Weingarten's witnessing model, which she lays out in her book *Common Shock: Witnessing Violence Every Day: How We Are Harmed, How We Can Heal*, Dr. Weingarten identifies three manifestations of such an empathic stress reaction that a clinician working with migrants or refugees may experience. The first, burnout, is already widely associated with clinical work: a long-term work situation wherein the mounting stress inhibits a clinician's ability to work effectively. The second type of stress reaction, secondary traumatic stress, can arise suddenly after a clinician learns about a patient's traumatic experience. Fear, horror, and helplessness may plague the clinician and disrupt the clinicians' ability to be effective. A third manifestation is vicarious traumatization, wherein a clinician's repeated work with traumatized patients reshapes a clinician's worldview around the clinician's personal safety and the potential for harm. In essence, it changes the way we perceive our and our family's safety. Dr. Weingarten's work now, she says, is to help those witnesses cope with their stress and trauma

"What is it that helps the helpers continue to be able to help? My view is that it's essential that people who are directly witnessing the families have [their own] support," Dr. Weingarten emphasized. "There are all kinds of ways that people can move up into the aware and empowered witness position, which really is the only one that is effective long-term." Talking through the witness's experiences and reactions with an empathetic listener is just one method; read the text box for extensive recommendations from Dr. Weingarten on addressing clinician trauma and becoming an "empowered witness." ■

Resources:

Access resources on witnessing provided by Dr. Weingarten on our resources page: https://www.migrantclinician.org/toolsource/resource/witnessing-resources.html.

Learn more about witnessing at Dr. Weingarten's webpage: www.witnessingproject.org.

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Recommendations for Clinicians continued from page 6

3. Inhibition of Self-Disclosure: There are often times when a person needs to talk, but others cannot bear the story he has to tell. This invariably creates a sense of isolation and may deepen grief and loss. As sad as this circumstance is, it is rarely total. You may have to manage your disappointment that the person you most want to talk to is unavailable, but there will usually be someone available. If no one you know is willing to listen to you, look in your area for support groups led by trained professionals. Group discussion can be very beneficial when your own support networks are depleted. Or, you can seek professional help. You can contact your state's professional organizations of psychology, social work, marriage and family counseling, or psychiatry for referral information.
4. Problems of Fit: It is highly unlikely that any two people, even or especially life partners, will manage common shock identically, initially or over time. As painful as this can be, it is helpful to accept this as fact. Both parties should try to be clear and direct about their needs to their partner, friend or family member and both should be candid in return about what they can and cannot provide. Try not to turn to people for something you know they cannot provide. Look for other sources of support. Trust that when the situation is more stable, the discoveries you have made regarding problems of fit can be discussed and that incremental changes in preferred directions can be made.

D. Societal Consequences of Common Shock

In a calm moment of reflection, ask yourself the following question: Has violence, retaliation or revenge ever produced lasting peace and harmony in families, communities or nations at any time or in any place in history?

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calendar

November 10-14, 2018
"Creating the Healthiest Nation: Health Equity Now"
American Public Health Association Annual Meeting
San Diego, CA
https://bit.ly/1zGEO5z

November 11-14, 2018
National Network for Oral Health Access Conference
New Orleans, LA
http://www.nnoha.org/

November 14-16, 2018
PCA & HCCN Conference
New Orleans, LA
https://bit.ly/2CwGkzo

December 4-6, 2018
National COSH Conference
Baltimore, MD
https://bit.ly/2NwpYry

December 9-12, 2018
IHI National Forum on Quality Improvement in Health Care
Orlando, FL, USA
http://www.ihi.org/

February 20-22
Western Forum for Migrant and Community Health
Portland, OR
https://bit.ly/2PnQmWj