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Providers face cultural challenges when evaluating refugee children

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Numerous challenges face providers who are administering developmental screenings for refugee children, including differences in cultural and religious beliefs, language barriers, and disparate education levels, according to new research from the University of Rochester Medical Center (URMC) published in the journal *Pediatrics*.

The United States takes in approximately 70,000 refugees annually, of which 30 percent are children, and refugee resettlement experiences are known to impact critical stages of a child's intellectual, social, emotional, and physical development. But the developmental screenings recommended by the American Academy of Pediatrics don't always translate perfectly to other cultures, which can lead to a missed diagnosis of a potentially serious developmental disability. The research is the first known attempt to study the obstacles surrounding refugee developmental screening.

"For several of the languages spoken in these refugees' home countries, there isn't even a word for 'development' that is used in the way pediatricians use it in the United States," said Abigail Kroening, M.D., assistant professor of neurodevelopmental and behavior pediatrics at URMC and the study's lead researcher. "We hope this study will help providers to bridge some of these gaps and help refugee parents engage more with their child's development."

Working with the Center for Refugee Health in Rochester, the researchers interviewed 29 refugee parents, community collaborators

and providers, and turned up a number of cultural differences that may create barriers when identifying developmental milestones.

For example, those from cultures with multi-deity belief systems were more likely to attribute a child's disability to a generational curse or as a karmic retribution for a past transgression. Meanwhile, those with Christian or Islamic backgrounds were more likely to see a disabled child as a "gift from God." In either case, a parent may be less likely to report or engage as strongly with their child's disability.

"Here, we are inundated with baby books and milestone charts, and parents often proactively reach out to their pediatricians to say 'My child isn't talking quite as much as his peers—is that something to worry about?'" said Kroening. "That's not always the case in other cultures."

Families said that meeting with both a physician and an in-person interpreter (as opposed to a telephone interpretation) was the most ideal scenario for developmental screening. Additionally, researchers found that establishing trust between parent and provider was extremely vital to increasing a parent's engagement in terms of identifying behavioral milestones.

Kroening and her collaborators—Jessica Moore, Ph.D., senior instructor of Psychiatry and Psychology at URMC, and Therese Welch, Ph.D., associate professor of Neurodevelopmental and Behavioral Pediatrics at URMC—are continuing her research in the hopes of establishing a more concrete set of guidelines and resources for providers who treat refugee families and children.

"These children and their families have been through so much already just to get to the United States," said Kroening. "We, as pediatric providers caring for refugee children, are invested in doing all that we can to recognize their developmental needs, partner with parents, and

promote these kids' long term health and success."

As a refugee resettlement city, Rochester takes in 750 refugees annually, of which approximately one third are children. In recent years, refugees have come to Rochester from Bhutan, Cuba, Myanmar, Somalia, Congo, Iraq, and elsewhere.

More information: A. L. H. Kroening et al, Developmental Screening of Refugees: A Qualitative Study, *PEDIATRICS* (2016). DOI: 10.1542/peds.2016-0234

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