Chapter 3: Health Status of Karen Burmese

Health Statistics at a Glance

This chapter provides a broad overview of health topics that affect Karen people, particularly tuberculosis and related health needs. Unfortunately, there is a limitation on the availability of health data for Karen persons in Burma due to restrictions imposed by the SPDC on publications and reports, as well as constraints on health and humanitarian activities in Burma (Beyrer et al., 2006). These limitations have made it difficult to accurately assess the current health situation and to respond to health crises in Burma. Health statistics for Karen people or Burmese living in the United States are also limited as the diversity of Asians, Asian Americans, and Pacific Islanders are often obscured under this umbrella term and do not represent specific ethnicities or nationalities. Data that are specific to Karen or Burmese in the United States are reported when available in this chapter. The health statistics in this chapter are not specific to Karen, unless specifically stated.

Tuberculosis

In Burma

- In 2007, the estimated tuberculosis incidence was 171 per 100,000 (World Health Organization (WHO), 2009) and the estimated prevalence was 162 per 100,000 (WHO, 2009).
- Among new TB cases in 2007, 4.4% were estimated to be multidrug-resistant (WHO, 2009). Among previously treated TB cases in 2007, 16% were multidrug-resistant (WHO, 2009).
- In 2007, the estimated TB mortality rate was 13 per 100,000 (WHO, 2009).
- Bacille Calmette-Guerin (BCG) vaccine coverage at birth is 85% (WHO, 2007b). It is important to note that this statistic varies depending on access to health care in rural areas.

In the United States

- In 2006, there were 41 cases of TB among individuals from Burma. This number increased to 65 in 2007 and 112 in 2008, although the percentage of overall cases (1%) did not change (CDC, 2008a).
- Based on the past 5-year average number of TB cases, Burma is in the top 20 countries contributing to TB in the United States.
- In 2008, Burmese living in the United States for less than 1 year represented the majority of cases (66%), compared to those who lived here between 1-4 years (10%) and 5 years or more (20%) (CDC, 2008a).
- California has one of the largest Burmese immigrant populations; the state reported 19 TB cases among Burmese people in 2008 (California Department of Public Health, 2009).
HIV/AIDS

In Burma

- Estimates of adult HIV-prevalence in Burma vary between 0.7% - 2.0% among adults (USAID, 2008).
- The population living with HIV/AIDS is estimated to be between 200,000 - 570,000 (USAID, 2008).
- Prevalence rates among at-risk populations, particularly injection drug users and sex workers, remain high. According to UNAIDS (2005), 43% of IDUs and 32% of sex workers are HIV positive.
- The major mode of transmission is sexual (67%), followed by intravenous drug use (30%) (USAID, 2008).
- In 2007, approximately 7% of new TB cases were estimated to be co-infected with HIV (WHO, 2008b); 70% of those infected with HIV will eventually have active TB (USAID, 2008).

Malaria

In Burma

- Nearly half of all deaths (53.6%) from malaria in Asia occur in Burma (Beyrer et al., 2006).
- There were 411,494 lab-confirmed and 154,710 probable malaria cases in 2008 (WHO, 2010).
- The number of reported cases increased from 245,000 in 2000 to 566,000 in 2008 (WHO, 2010).

Substance Abuse

In Burma

- Among youths (13-15 years of age), 20.7% used some form of tobacco and 15.7% smoked cigarettes (WHO, 2007a).
- Boys aged 13-15 were more likely to smoke than their female counterparts, at 37.3% and 4.7% respectively (WHO, 2007a).
- According to the 2004 World Drug Report, the most commonly used drug among 15-64-year-olds was marijuana.
- In general, the prevalence of drug use is estimated to be 1% of the population (300,000) (United Nations Office on Drugs and Crime, 2005).
- Among registered drug abusers, opiate addicts make up approximately 90% (United Nations Office on Drugs and Crime, 2005).

Diabetes Mellitus

- In California, Asians were 1.5 times more likely to be diagnosed with diabetes than non-Hispanic whites (National Diabetes Education Program, 2007).
- In 2006 in the United States, Asians and non-Hispanic whites had the lowest rates of diabetes as compared to all other ethnic groups, with 8.4% and 7.1% respectively (CDC, 2007c).
- It is estimated that 3 million people in Burma have diabetes (Muecke, 2008).
End-Stage Renal Disease (ESRD)

- Asian Americans are nearly twice as likely to develop end-stage renal disease as non-Hispanic whites in the United States (National Diabetes Education Program, 2007).
- Rates of new ESRD cases are increasing at a rate of 11% per year for Asian/Pacific Islanders (APIs) compared with 6% per year for non-Hispanic whites in the United States (U.S. Department of Health and Human Services, 2000b).

Cancer

- Liver cancer is the third leading cause of mortality among Asians in the United States (Intercultural Cancer Council, 2004). Both API men and women have more than twice the incidence of liver cancer as the non-Hispanic white population (U.S. Department of Health and Human Services, 2009).
- Southeast Asians have a higher rate of lung cancer than non-Hispanic whites (Intercultural Cancer Council, 2004).
- Mortality rates for cervical cancer have increased among foreign-born women. Of particular concern is that 70% of the API population is foreign-born (Tsui et al., 2007).
- APIs have the highest incidence rates of stomach cancer (U.S. Department of Health and Human Services, Office on Women's Health, 2008). Asian/Pacific Islander men are twice as likely to die from stomach cancer, compared to the non-Hispanic white population, and API women are 2.6 times as likely to die from the same disease (U.S. Department of Health and Human Services, 2009).

Hepatitis B

- There is a 15% prevalence rate of chronic hepatitis B among the Burmese in the U.S. (U.S. Department of Health and Human Services, 2008).
- Southeast Asians are at a high risk for transmitting the hepatitis B virus from mother to child (U.S. Department of Health and Human Services, 2008).
Tuberculosis

In Burma

Although people in almost every country are infected with tuberculosis (TB), 22 countries account for 80 percent of the worldwide TB cases (WHO, 2009). Specifically, South and Southeast Asia have the highest burden of TB worldwide, as one in three cases of diagnosed TB is in this region (Beyrer et al., 2006). Burma is one of these 22 countries, with an estimated 97,000 new cases diagnosed each year (WHO, Regional Office for South-East Asia, 2008). In 2007, the incidence of tuberculosis was estimated to be 171 per 100,000, the prevalence was estimated to be 162 per 100,000, and the mortality rate was estimated to be 13 per 100,000 (WHO, 2009).

Non-Governmental Organizations (NGOs) have been crucial in reducing the incidence of TB. With support and assistance from the World Health Organization (WHO), the Burmese Ministry of Health (MOH) instituted a directly observed treatment short course (DOTS) program as a mechanism to control TB. Through DOTS, other improvements in the National Tuberculosis Programme (NTP), and increased surveillance and monitoring activities, the case detection rate increased over a 5-year period (1999-2004) (Stover et al., 2007). The Ministry of Health increased DOTS coverage to all of Burma's 324 townships (WHO Regional Office for South-East Asia, 2008). According to WHO, Burma had a case detection rate of 95% from 2003-2006.

As the majority of its funding comes from international donors, the MOH is unable to provide the support necessary to improve the public health infrastructure. According to a published report by researchers at the Johns Hopkins Center for Public Health and Human Rights, the actual burden of disease may be under-estimated because of the government's inability to fully operate surveillance, monitoring, and reporting activities (Beyrer et al., 2006).

Multidrug-resistant (MDR) TB in Burma was first reported in 2000. The estimated incidence of sputum smear positive MDR TB cases in 2007 was 2,331 (WHO, 2008a). Among new TB cases in Burma in 2007, 4.4% were MDR TB; and among previously treated TB cases in 2007, 16% were MDR TB (WHO, 2009). The rate of MDR TB was 5.3% on the Thai-Burmese border compared to the national average of 0.9% in Thailand (Stover et al., 2007).

One reason for the development of MDR TB is that TB drugs have become widely available on the black market, enabling people to take them without supervision (Stover et al., 2007). Another hindrance to the current TB control program is the military junta's reliance on sputum exams as the only means of TB confirmation and reporting (Stover et al., 2007).

In Tham Hin Refugee Camp, Thailand

Although there are few epidemiologic data on TB in the refugee camps along the Thai border, the information that is available paints a similar picture to the TB epidemic in Burma. In 2006, as many as 2,700 of Tham Hin's 9,500 refugees were scheduled to be resettled in the United States (McKinsey, 2006). In a 2007 evaluation study of the International Organization for Migration's (IOM) TB screening process, researchers found that 30% of 4,686 people screened at Tham Hin were classified as TB suspects, and 5% (or 252) were found to have TB (Nolan, Schecter, & Mase, 2007). Only one case of MDR TB was discovered among the refugees screened. Researchers concluded that the burden of TB among Burmese refugees was not much less than other refugee groups along the Thai border.

The Mae La Displaced Persons Camp near Mae Sot is the largest refugee camp in Thailand along the border with Burma. There are approximately 45,000 refugees in the camp, nearly all of whom are Karen. Many have been living there since the camp opened in 1984. BPRM offered resettlement to these refugees and aimed to resettle 15,000 refugees before September 30, 2007, (Nolan, Schecter,
Medical screening of U.S.-bound refugees from Mae La Camp by IOM began on April 9, 2007, following the new Technical Instructions for Tuberculosis Screening and Treatment. The IOM screening process begins with TST placement and reading for refugees from age 2 through age 14. All persons then undergo a medical exam and, for those 15 and older, those with a TST of 5 mm or more, and those under 2 with clinical signs or symptoms of TB, a chest x-ray (with lateral if less than 10 years of age). Refugees with any findings of suggestive of pulmonary TB (including for this purpose pleural or laryngeal) will then have three morning sputum specimens collected for AFB smear and culture. Any person found to have smear- or culture-positive TB is required to complete treatment for TB by ATS/CDC treatment guidelines under strict DOT management before being allowed to travel to the U.S. In the first 3 weeks of screening, during which 1,300 refugees were screened, three sputum specimens were obtained from each of 97 refugees because of abnormal x-ray findings and/or symptoms. Of these, two refugees had at least one positive AFB smear. This is an initial smear-positivity rate of about 150/100,000, which suggests that the burden of TB disease is likely to be very similar to that of Tham Hin. (from Nolan, Schecter, & Mase, 2007).

In the United States
In 2006, there were 41 cases of TB among individuals from Burma. Of the 41 cases of TB reported, it is unknown what percentage of the cases were Karen Burmese. This number increased to 65 in 2007 and 112 in 2008, although the percentage of overall cases (1%) did not change (CDC, 2008). Based on the past 5-year average number of TB cases, these cases place Burma in the top 20 countries contributing to TB in the United States. In 2008, the number of TB cases and percentages among Burmese in the United States varied according to the number of years since arrival in the United States. Individuals living in the United States for less than 1 year represented the majority of cases (64 cases, 66%) compared to those living between 1-4 years (10 cases, 10%) and 5 years or more (19 years, 20%) (CDC, 2008). With one of the largest Burmese immigrant populations, California had 19 reported cases of TB from persons born in Burma in 2008 (California Department of Public Health, 2009).

Bacille Calmette-Guérin Vaccine
Bacille Calmette-Guérin (BCG) is currently used in many parts of the world as a vaccine against TB; in Burma in 2006, BCG vaccine coverage at birth was 85% (WHO, 2007b). These statistics may vary based on access to health care, particularly in areas where there is ethnic conflict with the government. Reaction to a tuberculin skin test (TST) caused by BCG vaccination wanes rapidly in individuals who receive the vaccine in the neonatal period and more slowly in those vaccinated at an older age (Menzies, 2000). An Interferon-Gamma Release Assay (IGRA) is preferred for testing persons who have received BCG as it is expected to reduce the possibility of false-positive results and improve acceptance of treatment for LTBI (CDC 2010c). The current CDC TB testing guidelines state that a positive reaction to tuberculin in BCG-vaccinated persons indicates infection with M. tuberculosis when the person tested is at increased risk for recent infection or has medical conditions that increase the risk for disease. (Refer to Table 7 in the June 09, 2000 MMWR for criteria for tuberculin positivity, (CDC, 2000)). Therefore, a history of BCG vaccination should not influence the decision regarding whether to treat latent TB infection (LTBI) (CDC, 2000).
Malaria
Malaria is among the most important public health problems in Burma, and is a top priority in health planning (WHO, 2010). Nearly half of all deaths (53.6%) from malaria in Asia occur in Burma (Beyrer et al., 2006). There were 411,494 lab-confirmed malaria cases in 2008 (WHO, 2010).

In Southeast Asia, particularly what is defined as the Greater Mekong sub region (Burma, Thailand, Laos, Cambodia, Vietnam, and Yunnan Province, China), the areas at greatest risk of malaria are the forested regions, populated by ethnic minority groups (Beyrer et al., 2006; USAID, 2009). For example, the ethnic minority Kachin state on the Burma-Chinese border had mortality rates for malaria almost five times higher than the national average (WHO, 2003). In addition to these ethnic minority groups, there is often a significant migrant population, both domestic and international (USAID, 2009), and non-immune migrant workers involved in gem-mining in forests, logging, agriculture and construction, that is also at risk (WHO, 2009).

Multidrug resistant (MDR) malaria is most problematic on the Thai-Burma border (WHO, 2010; Wongsrichanalai et al., 2001). As there is little regulatory oversight on the sale and importation of anti-malarials, 70% of anti-malarial pills sold in Burma contain substandard amounts of active ingredients, which increases the risk of MDR malaria (Beyrer et al., 2006).

Tuberculosis-Related Health Issues
Understanding other health issues affecting the lives of Karen Burmese patients provides critical information for TB care providers. Listed below are some conditions that increase the risk of latent TB infection progressing to TB disease (CDC, 2004).

- Human immunodeficiency virus (HIV) infection
- Previous TB (in a person who received inadequate or no treatment) indicated by chest radiograph findings
- Prolonged corticosteroid therapy and other immunosuppressive therapy
- Recent infection with *M. tuberculosis* (within the past 2 years)
- Substance abuse (especially intravenous drug use)
- Silicosis
- Diabetes mellitus
- End-stage renal disease
- Cancer of the head and neck
- Hematologic and reticuloendothelial diseases
- Intestinal bypass or gastrectomy
- Chronic malabsorption syndromes
- Low body weight (10% or more below ideal)

Among these conditions, those that are most relevant to Karen persons from Burma are further explored here. Information for these conditions is provided for both Burma and the United States when available.
HIV/AIDS

The HIV epidemic has posed major challenges to TB control efforts globally. HIV infection is the strongest predictive risk factor for developing TB disease once a person is infected with *M. tuberculosis*. While the average probability of progressing from TB infection to disease is less than 10% over the lifetime of an HIV-uninfected person, the risk ranges from 5% to 8% per year in those who are HIV-infected and not on Highly Active Anti-Retroviral Therapy (HAART) (Markowitz et al., 1997; Selwyn et al., 1989) – the combined use of several antiretroviral drugs that inhibit the ability of the virus to multiply in the body (National Cancer Institute, n.d.). Research suggests that active TB disease accelerates the course of untreated HIV infection, which may lead to more opportunistic infections and earlier death (Lopez-Gatell et al., 2007; Thomas, 2006; Whalen et al., 1995; Whalen et al., 2000; Zar et al., 2007). As such, TB is a leading cause of death worldwide among people who are HIV-positive, accounting for at least 11% of AIDS deaths and possibly as many as 50% (WHO, 2006b).

In Burma

Countries in the Southeast Asia region are beginning to witness increasing numbers of TB/HIV co-infected individuals. In the Southeast Asia region, 5 of the 11 countries are high- or moderate-TB/HIV burden countries: India, Indonesia, Burma, Nepal, and Thailand. Tuberculosis is the most common opportunistic disease in Asia among people living with HIV/AIDS. While the double stigma of HIV and TB leads to delays in both HIV and TB diagnosis and treatment, mortality in HIV-infected TB patients is also higher due to a worse prognosis or other opportunistic infections (WHO, 2006b). In Burma, TB/HIV surveillance data indicate that 11% of TB patients in Burma are coinfected with HIV (WHO, 2007b). In 2005, approximately 7% of new TB cases were co-infected with HIV (WHO, 2008b); 70% of those infected with HIV will eventually have active TB (USAID, 2008).

In Burma, HIV/AIDS is ranked as the nation’s third most pressing health challenge, after TB and malaria (USAID, 2008). The adult HIV-prevalence rate in Burma has been reported between 0.7% - 2.0%, an estimated 200,000 - 570,000 people (USAID, 2008). The major mode of transmission is sexual (67%) followed by intravenous drug use (30%) (USAID, 2008). From 2000-2004, infection levels among adults seeking treatment for other sexually transmitted infections dropped from 7% to 3% for men and 12% to 6% for women (USAID, 2008). Conversely, prevalence rates among at-risk populations, particularly injecting drug users and sex workers, remain high. According to UNAIDS (2005), 43% of IDUs and 32% of sex workers are HIV-positive.

In an effort to find ways to address the HIV/AIDS epidemic, the Burmese government formed the National AIDS Committee (NAC) in 1989 within the Ministry of Health which centralized efforts into one single authority. While the multi-sectoral program targets high-risk populations (USAID, 2008), reduced funding has caused many AIDS programs to suffer. Health expenditures in Burma are among the lowest globally, as there is an annual budget of less than $22,000 for the prevention and treatment of HIV among a total population of 43 million people. Much of the country lacks basic laboratory facilities to carry out a CD4 blood test, the minimum standard for clinical monitoring of AIDS care (Beyrer et al., 2006). Additionally, there is much variation in HIV surveillance results across Burma.
In the United States

Although APIs represented less than 1% of all HIV/AIDS cases in the United States between 2001 and 2004, APIs had the highest estimated annual percentage increase in HIV/AIDS diagnosis rates of all races/ethnicities (8.1% for males and 14.3% for females) (CDC, 2006c). HIV transmission in API men occurs primarily among men who have sex with men (MSM), followed by men who have high-risk heterosexual contact or are injection drug users (IDUs). In 2005, MSM transmission accounted for 71% of all API AIDS diagnoses to date (CDC, 2006a). Among API women, HIV transmission occurs most often among women who have sex with men who are at increased risk, followed by women who are IDUs (CDC, 2006a).

Table 2 presents the estimated number of diagnosed AIDS cases in the United States in 2007 and cumulatively since the beginning of the epidemic. Asians comprised approximately 1.3 percent of the total HIV/AIDS cases in 2007 (CDC, 2009a).


### Substance Use

#### In Burma

The discussion of HIV/AIDS in Burma is intertwined with narcotics use and exportation. Burma is the world’s second-largest opium- and heroin-producing state and has also increased its production and export of methamphetamine (Beyrer, 2006).

Additionally, tobacco has been accepted as a social norm for many decades in Burma. Substantial literature, poems and songs present tobacco as positive for social life. There have been long traditions of serving tobacco to friends, and giving tobacco to guests at weddings and ceremonies (Kyaing et al., n.d.). The association between tobacco use and TB outcomes has long been suspected. More recent studies have provided evidence for causal association between active and passive tobacco smoking and a range of TB outcomes including infection, development of disease, treatment outcomes, relapse, and mortality (e.g., den Boon et al., 2005; Kolappan & Gopi, 2002; Lin et al., 2007). A case control study conducted in India between 1993 and 1996 showed a positive association between tobacco smoking and pulmonary tuberculosis (Kolappan & Gopi, 2002). More recently, both a population survey conducted in South Africa and a meta-analysis showed evidence that smoking is associated with an increased risk of contracting tuberculosis (den Boon et al., 2005; Lin et al., 2007).
Among youth in Burma (13-15 years of age), 20.7% used some form of tobacco and 15.7% smoked cigarettes (WHO, 2007a). Smoking and chewing betel quid among men are accepted as normal behaviors for adult men. Although smoking for women is not common in urban areas, about 20% of rural women, especially older age women, smoke cheroots and hand-rolled tobacco products (WHO, 2010).

According to the 2004 World Drug Report, the most commonly used drug among 15-64 year olds was marijuana. In general, the prevalence of drug use is rather low (estimated 1% of the population, or 300,000) (United Nations Office on Drugs and Crime, 2005). In 2002, national data reported that among new drug addicts, 4.9% were 15-19 years of age and 12% were 20-24 years of age (WHO, 2007a). Among registered drug abusers, opiate addicts make up approximately 90% of drug abusers (United Nations Office on Drugs and Crime, 2005).

Among Karen, the use of tobacco is quite common. As early as age 10 years, boys begin smoking (Neiman et al., 2008). Even though Burma is one of the world's largest opium producers, Karen villages are more likely to cultivate marijuana than opium. However, it is the use of betel nut that is most common among the Karen people. Betel nut, also known as Kunya in Burmese, is a stimulant that contains high levels of psychoactive alkaloids and produces a euphoric effect (Neiman et al., 2008).

In the United States

Both TB and substance use are prevalent in crowded, low-income areas in the United States. As a result, substance users are two to six times more likely to contract TB than nonusers (CDC, 2004). When compared to non-Hispanic whites, APIs generally have lower rates of substance use, including smoking. In 2004, only 11.3% of APIs smoked cigarettes compared to 22.2% of non-Hispanic whites (American Lung Association, 2006).

Despite a low overall prevalence of cigarette smoking among APIs in general, there are significant variations in smoking rates among different API groups. Cigarette smoking rates tend to be particularly high among individuals from Southeast Asian countries (American Lung Association, 2006).

Diabetes Mellitus

People with medical conditions such as diabetes mellitus are at a higher risk of progressing from LTBI to TB disease. Tuberculosis occurs more frequently in diabetics and causes greater mortality (Guptan & Shah, 2000). The risk of developing diabetes increases significantly when Asians immigrate to the United States, owing to changes in lifestyle, diet, and physical activity (Fushimoto, 1995). Diabetes is the 5th leading cause of death for APIs, who have higher rates of impaired glucose tolerance than non-Hispanic Whites (Cornell University, 2010). Data concerning diabetes prevalence for API is limited. A national survey (2004-2006) for people aged 20 years and older indicates that 7.5 percent of Asian Americans were diagnosed with diabetes (National Diabetes Information Clearinghouse, 2008).

End-Stage Renal Disease

End-stage renal disease (ESRD) occurs when the kidneys are no longer able to function at a level necessary to sustain life. Asians in the United States are almost twice as likely to develop ESRD as non-Hispanic whites (Karter et al., 2002). In addition, annual increases in ESRD rates are greater in APIs than in non-Hispanic whites. New ESRD cases are increasing at a rate of 11% per year for APIs compared to 6% per year for non-Hispanic whites (U.S. Department of Health and Human Services, 2000a).
Cancer

People who are diagnosed with cancer of the head or neck are at an increased risk of developing TB disease. In the U.S., nasopharyngeal cancer is most common among Chinese Americans, followed by other API groups (American Cancer Society, 2010). In 2002, APIs showed a higher incidence (4.1 per 100,000) of nasopharyngeal cancer than all other racial groups (CDC, 2002).

Hepatitis B

Although having hepatitis B does not increase the risk of progression to TB disease like the conditions noted above, it may have an impact on TB and LTBI treatment because TB drugs are potentially hepatotoxic. Persons from Southeast Asia are also at high risk of prenatal transmission of hepatitis B. While the majority of people infected with hepatitis B eliminate the virus within 6 months, roughly 10% of those infected develop a chronic, life-long infection. Having chronic hepatitis B increases the chance of permanent liver damage or cancer (Office of Global Health Affairs, 2004).

Special Issues

Mental Health

Among refugees, trauma associated with war, torture, rape, mass violence, and severe poverty has been long associated with mental illness. There is very limited information regarding the Karen refugees and post-traumatic stress disorder (PTSD). In the case of Southeast Asia, the literature primarily focuses on Vietnamese and Cambodian refugees. General information, however, regarding refugees and their experiences is well documented.

Research has found that refugees are prone to developing some type of PTSD as a result of trauma experienced pre- and post-arrival to the United States. This is due in part to the method in which they left their countries. Post-traumatic stress disorder was diagnosed in 70% of Southeast Asian refugees receiving mental health care. Post-traumatic stress disorder among Southeast Asian refugees is associated with trauma experienced before and after immigration to the United States (The Office of Minority Health, 2008). For Asian Americans, suicide was the 8th leading cause of death as compared to the 10th leading cause of death for white Americans in 2004 (The Office of Minority Health, 2008). Specifically, the highest suicide rate is among Asian American women who are 65 years of age and older. Older Asian women are 1.6 times more likely to commit suicide than their white counterparts (The Office of Minority Health, 2008). Once refugees have relocated to the United States, social isolation, feeling a lack of control over one's life, and lowered social status may compound the risk for depression and anxiety.

Refugees, unlike immigrants, do not choose to leave their countries of origin. Instead they are forced out. This forced migration leaves refugees with a sense of little control over their lives. It may also leave a sense of unpreparedness for the journey ahead (Southeast Asian Subcommittee of the Asian American/Pacific Islander Work Group, 2006). Long-term trauma such as forced displacements and torture are examples of the types of stressors that refugees can experience. These stressors place refugees at higher risk for developing mental disorders. The most reported mental health disorders include depression and anxiety disorders (Pumariega et al., 2005).

With regard to mental health care in the United States, the Karen immigrants are likely to be referred to non-Karen professionals for mental health counseling services. Mental health issues can be extremely complex, particularly in light of cultural differences in beliefs concerning psychological well-being and illness. Although the Karen people have words that describe what Americans would call depression and anxiety, their manifestations are not necessarily recognized as medical or mental illnesses by Karen people (Kemp & Rasbridge, 2004). Consequently, Karen persons may be less inclined to seek assistance from counselors openly offering “mental health services” than from counselors in settings such as schools, medical centers or job placement and employment centers (Kemp & Rasbridge, 2004).