Acculturation: Refugees’ Health Care Satisfaction
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Abstract

In the United States, refugees are disproportionately impacted by negative health outcomes, such as health care satisfaction, in comparison to natural born Americans. The purpose of this pilot study was to investigate how acculturation shapes health care satisfaction. Three factors were used to examine acculturation in the study population: support systems (national, ethnic, and/or linguistic), English proficiency, and language preference. The primary researcher employed a qualitative study design by conducting semi-structured interviews with nine refugees who are residents in the City of Lancaster. There was a perceived relationship between English proficiency, social support, and health care satisfaction. This study’s results suggest that future studies should examine other factors, such as racial and ethnic differences, to further explore health care satisfaction in relation to refugee health and acculturation.

Keywords: refugees, acculturation, health satisfaction, English proficiency, language preference, social support
Acculturation: refugees’ health care satisfaction

According to the United Nations Higher Commission for Refugees (UNHCR), refugees are those who are forced to flee their country due to violence, persecution, and/or war (UNHCR, n.d.). Many refugees are temporarily placed in an asylum country and then permanently resettled in another country to remove this vulnerable population from being in the presence of immediate dangers (Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997; Steiner, Gibney, & Loescher, 2012; UNHCR, n.d.). Resettlement occurs when a country agrees to admit refugees into their territory (UNHCR, n.d.). States that accept refugees must also help them integrate through providing refugees with access to employment and affordable housing (Steiner et al., 2012; UNHCR, n.d.). Resettled refugees are guaranteed access to civil and economic rights and are protected from refoulement, the return of refugees to the country or territory that threatened their freedom and human rights (Eve, 2011; Steiner et al., 2012; UNHCR, n.d.). Although there are millions of refugees seeking asylum, every nation is not legally required to admit refugees. Thus, in 2015, there were only 37 resettlement countries (UNHCR, 2016).

According to the Department of State, in the fiscal year of 2018, the United States refugee resettlement program has admitted approximately 10,548 refugees into the US (Bureau of Population, 2016). Thousands of refugees came from various countries in Africa (3,957), Asia (4,551), Latin America and the Caribbean/Antillean Islands (302), and Europe (1,738) (Bureau of Population, 2016). Many refugees who experienced political exile and war crimes before they arrive in other countries have high rates of negative health conditions, such as posttraumatic stress disorder (Ellis et al., 2008; Bentley, et al., 2012; Li, Liddell, & Nickerson, 2016). The US federal government is aware of the negative health disparities that impact the refugee community.
and wants to help the refugee population become self-sufficient in their new environment. Therefore, within the first ninety days, and sometimes the first five years, of arrival in the US, refugees receive employment, food, housing, counseling, and medical care to help them live self-sufficient and productive lives (International Rescue Committee, n.d.). Temporary Assistance for Needy Families (TANF), Medicaid, Refugee Cash Assistance (RCA), and Refugee Medical Assistance (RMA) are some of the state and federally funded programs that are available to refugees who have a higher need (HHS, n.d.; International Rescue Committee, n.d.). However, even with the assistance of these programs refugees are disproportionately impacted by poverty, negative health outcomes, and have limited language access to health care in their resettled communities (Guerin et al., 2004; Bentley et al., 2012; Lunn, 2014).

Refugees and Acculturation

Unlike immigrants, resettled refugees receive resources to help them effectively adapt to their new environment (HHS, n.d.; International Rescue Committee, n.d.; UNHCR, n.d.). However, when refugees lack familiar support systems and experience extended periods of cultural shock, it can be difficult for them to quickly adjust to their resettled environment (US Refugee Admission, 2018). Many refugees are forced to leave their native country because of factors, such as war, persecution, and natural disasters (Kunz, 1981; Donà & Berry, 1992). When refugees leave their native country they cannot easily access and communication with members of their support systems, typically comprised of family and friends, and may be resettled in a country where the language and culture are unfamiliar (Weine, 2012). Although resources are provided to help refugees effectively adapt to their new environment, refugees also experience mistrust, prejudice, discrimination, and exclusion while navigating in American social
environments (Johnson-Agbakwu, Flynn, Asiedu, Hedberg, & Breitkopf, 2016). Differences in culture and misconstrued perceptions of refugees often cause refugees to yearn for their family members and friends who understand their customs and culture (Vega & Amaro, 1994; Johnson-Agbakwu et al., 2016). Acculturation can help refugees become familiar to a different and/or unfamiliar environment and overcome unexpected difficulties when they are resettled (Johnson-Angbakwu et al., 2016).

**Refugee Health**

The initial health assessment (IHA) that refugees undergo when they first arrive in America introduces and prepares refugees to enter the US health system (Mkanta et al., 2017). IHAs are commonly conducted by health professionals in local health systems who are mandated to follow the Centers for Disease Control and Prevention’s guidelines (CDC, 2011; Lee at al., 2013; Mkanta et al., 2017). Evidence-based data shaped the creation of these guidelines because refugee populations typically have underlying pre-migratory health conditions and are less likely to utilize the US health system (Tiong et al., 2006; CDC, 2016). During the IHA, refugees get general physical exams and are screened for diseases and disorders, such as diabetes and tuberculosis (Dicker et al., 2010; Lee at al., 2013; Mkanta et al., 2017).

Despite IHAs introducing refugees to the health care system in the US, refugees often have low rates of health care coverage and health care utilization (Uba, 1992; Ye, Fry-Johnson, & Parker, 2012). Refugees often have a difficult time navigating the US health care system because of limited English proficiency and culturally insensitive doctors (Thomas et al., 2011; Stillman, 2014; Taber & Levya, 2015). Previous literature highlights that within the refugee community, health care access, linguistic barriers, and economic hardships are common factors
that impact health care access and utilization (Woloshin, Schwartz, Katz, & Welch, 1997; Morris, Popper, Rodwell, Brodine & Brouwer, 2009). These issues disproportionately impact refugees’ utilization of preventive care and health outcomes in comparison to natural born American citizens (Woloshin et al., 1997; Morris et al., 2009).

**Refugee Health Satisfaction**

Health outcomes are commonly defined as changes in health status primarily due to medical interventions (Dewalt, Berkman, Sheridan, Lohr, & Pignone, 2004). Patient satisfaction is a type of health outcome (Holmes-Rovner et al., 1996; Manary et al., 2013). Patient satisfaction is a way to measure the quality of health care a patient receives in a health system (Cleary & McNeil, 1988; Jeffrey, Jackson, & Kroenke, 1997; Prakesh, 2010). Patient satisfaction is often impacted by the patient’s experiences, such as the quality of the interactions with doctors and specialists, which affects patients’ retention rates (Brown, Bronkesh, & Woods, 1993; Prakesh, 2010). The quality of the service that patients receive is often centered around the patient, doctor, and organization (Prakesh, 2010). Patients tend to have greater health care satisfaction if health facilities offer beneficial, effective, and efficient services, including: human and electronic translators, shorter waiting times, and acknowledging patients’ right to refuse care (Yucelt, 1994; Crow et al, 2002; Prakesh, 2010). Health professionals’ abilities to provide the best quality of care to their patients, listen and relate to their health concerns, and maintain confidentiality and privacy of patients’ information are a few ways to commonly improve patients’ health satisfaction (Baker et al. 2009; Zolnierek & Dimatteo, 2009, Fenton et al., 2012). Patients’ perceptions of quality health care services are related to their gender, age, severity of illness, and perceptions of the health care system in general (Brown et al., 1993; Prakesh, 2010).
However, refugee status is also a factor that impacts health satisfaction, but is often overlooked in the health care sector (Aspinall, 2014; Robertshaw, Dhesi, and Jones, 2017).

In the US, refugees often have poor health satisfaction (Mkanta et al., 2017). For example, refugees often have foreign accents when they speak English or do not speak English at all when accessing care in American health facilities (Yoo, Gee, & Takeuchi, 2009; Schwartz, Unger, Zamboanga, and Szapocznik, 2010). Thus, refugees are more likely to face discrimination at health facilities from health care providers than native-born Americans (Yoo, Gee, & Takeuchi, 2009; Schwartz et al., 2010). Due to factors such as perceived discrimination, lack of culturally competent doctors, and a lack of effective translation services, refugees often report low satisfaction (Asgary & Segar, 2011; Mkanta et al., 2017). Asgary & Segar (2011) conducted a qualitative study to evaluate health care barriers in refugee populations, mostly from African countries. They concluded that refugees tend to mistrust health care providers because they perceived doctors’ interactions as impersonal and focused on making money (Asgary & Segar, 2011). Even in studies where refugees reported satisfaction with the health care services they received, they were uncomfortable due to lack of access to interpreters and infrequent continuity of care (Odonnell, Higgins, Chauhan, & Mullen, 2007; Odonnell, Higgins, Chauhan, & Mullen, 2008; Mkanta et al., 2017). However, when refugees receive care from refugee treatment units they tend to be more satisfied with the care they received (Silove et al., 1997; Mkanta et al., 2017). Higher rates of health care satisfaction may be related to health professionals in these facilities receiving evidence-based cultural sensitivity training and having readily accessible interpreters (Silove et al., 1997).

Lancaster, Pennsylvania
Every year refugees from different countries around the world are resettled in Lancaster County (Dicklitch-Nelson, Reese, & Yoder, 2012). From October 2008 to September 2009 Bhutanese (256) and Burmese (133) refugees were two of the largest populations of refugees in Lancaster (Resettlement Program, 2007). Traditionally, more Bhutanese, Sudanese, Somali, and Iraqi refugees have been resettled by local resettlement organizations, such as Church World Service (Appendix A; CWS, n.d.; Pennsylvania Refugee Resettlement Program, 2007). Lancaster County is currently experiencing a shift in the demographics of refugees that are being resettled in this area. For example, Cuba and the Democratic Republic of the Congo make up the majority of refugees who are currently being resettled in Lancaster County (Pennsylvania Refugee Resettlement Program, 2017). From October 10th 2016 - September 9th 2017, Lancaster County resettled 614 refugees, with a majority of them from the Democratic Republic of the Congo (151) and Cuba (208) (Pennsylvania Refugee Resettlement Program, 2017). Regardless of what country they are from, refugees are mainly resettled in Lancaster because this country offers an abundance of affordable housing and a variety of employment opportunities in the agricultural, and maintenance sector (Lancasteronline, 2015). Local resettlement organizations, including Church World Service, in Lancaster work hard to integrate refugees into their resettled communities and provide them with resources to be self-sufficient (Dicklitch-Nelson et al., 2012). However, since Lancaster County and City have relatively small populations, compared to other major counties and cities in Pennsylvania, refugees’ housing, working, and health needs often exceed the supply of resources that Lancaster County can provide to this population (Dicklitch-Nelson et al., 2012).
According to the 2016 Census report, Lancaster County’s population is approximately 309,637 and the City of Lancaster’s population is 59,218 (Census, 2017). On average, for every 327 residents, one refugee is resettled in Lancaster (LNP, 2015). Four of the largest resettled refugee populations in Lancaster County come from Somalia, Burma, Bhutan and the Congo (Church World Service, 2015). In addition, since 2003, Lancaster has taken in 20 times per capita, which is one of the reasons why Lancaster is called the “Refugee Capital” (BBC, 2017). Due to the influx of refugees, the health care system in this area is actively trying to accommodate for needed services, including translators and culturally competent doctors, that help refugees adjust to this system. However, with local hospitals having limited resources, refugees’ need for diverse and inclusive services is often difficult to meet (Dicklitch-Nelson et al., 2012; Langlois, Haines, Tomson, & Ghaffar, 2016).

Significance

Understanding the experiences of refugees in Lancaster is vital to effectively provide health care services in this population. Refugees arrive in the US with chronic health issues and face significant socioeconomic and cultural barriers that limit them from accessing health care (Schweitzer et al., 2006; Wessels, 2014). It is crucial for health care providers to adequately provide culturally sensitive and adequate health services to refugees. Thus, quality and accessible health care services will be expanded to this vulnerable population.

This study contributes to the literature by speaking with refugees from various countries, whereas previous studies in the acculturation literature only explore the effects of acculturation on one refugee population (Ellis, 2010; Lincoln, et al., 2016). Given the magnitude and diversity of the refugee population in the US, this study attempts to understand
the impact of acculturation on refugees’ health satisfaction by examining refugees who come from many national and ethnic backgrounds. In addition, a plethora of research has investigated the impact that factors, such as health literacy programs and culturally competent workers, have on refugee health care satisfaction. However, this study focuses on exploring the relationship between acculturation in refugee populations and health care satisfaction.

Studying refugee health care satisfaction is important because this health outcome is often associated with negative health behaviors and low rates of health care access and utilization (Mkanta et al., 2017). Evaluating refugees’ health care satisfaction allows researchers to identify areas of concern. Ultimately, this study’s findings can reveal gaps within Lancaster’s health care system and offer policy recommendations to improve refugee health care satisfaction and outcomes.

Literature Review

For centuries, pseudo-scientists have developed and popularized theories and terms that promote White supremacy and glorify Western society. J.W. Powell coined the term “acculturation” in 1880 (Rudmin, 2003). This psychological phenomenon was defined as a process occurring when individuals from different cultures constantly interact and come into contact with a foreign culture (Redfield, Linton, & Herskovits, 1936; Gastro, 2007). In this model, acculturation and assimilation are synonymous processes, immigrants give up their traditional culture and completely assimilate to the dominant group’s traditions, customs, and culture (Gordon, 1964; Alegria, 2009). During the mid 1800s and early 1900s, the field of science was heavily influenced by Social Darwinism and scientific-racism that suggested non-White groups were biologically and mentally inferior to White Westerners (Denis, 1995;
White, 2002). The unidimensional, unidirectional, and discriminatory definition of acculturation suggested that aboriginal and immigrant groups were unintelligent, prone to disease, and barbaric in comparison to Anglo-Saxons (Gordon, 1964; Thielman, 1985; Escobar & Vega, 2000; Rudmin, 2003; 2009). According to these pseudo-scientists, the adoption of the dominant group’s customs and cultural practices would have allowed immigrants and aboriginal populations to become mentally superior and modernized (Gordon, 1964; Berry and Sam, 1997; Lara, Gamboa, Kahramanian, Morales, & Bautista, 2005; Hernandez, 2015). Therefore, acculturation strategies and perspectives were traditionally tools that prescribed superiority to White Western cultures.

Current definitions of acculturation are dynamic, multidimensional, and no longer impose white-supremacy ideologies (Unger et al., 2002; Rudmin, 2009; Jimenez et al., 2010; Schwartz et al., 2010). The definition of acculturation no longer categorizes immigrants as inferior and Western society as superior (Berry, 2006b; Rudmin, 2009; Schwartz et al., 2010). Instead the various definitions of acculturation focus on the psychological changes that impact immigrant groups or individuals and the social changes that host cultures endure as immigrant populations interact with dissimilar people and cultures in new environments (Gibson, 2001; Unger et al., 2002; Berry, 2006b). The shift in definition is partially caused by the decline in pseudoscience and cultural psychologists concluding that immigrant populations have the agency to decide whether they will completely or partially adapt to their host culture (Teske & Nelson, 1974; Gordon, 1984; Berry, 1980; Sam & Berry, 2006). A more dynamic definition of acculturation accommodates for the different narratives and experiences of immigrants, asylum seekers, and refugees (Unger et al., 2002; Rudmin, 2009; Jimenez et al., 2010; Schwartz et al., 2010). Thus,
current scholars tend to define acculturation as a process in which the host culture and the immigrating individuals experience psychological and cultural change (Lincoln et al., 2015).

Models of Acculturation

Berry’s stages of acculturation provide a multi-dimensional analysis of the relationship between immigrants’ psychological and physical responses to acculturation. Berry’s theory relies on the degree of exposure, willingness of immigrants to change and adapt to their host culture, and measures the distance between two cultures to highlight the varying degrees of acculturation (Berry, 1997; Bhugra, 2004). Even though the term culture has many definitions, many scholars in the field of acculturation define culture as shared understandings, values, and/or referents by a specific group of people (Rudmin, 2003; Sam & Berry, 2010). According to Berry, acculturation requires different cultures and people to interact and as a result, some cultures may experience change (Berry, 1980). Berry describes four styles of acculturation (assimilation, separation, marginalization, and integration) based on a person’s relationship to their original culture and host culture (Berry, 2005; Berry 2014). Immigrants may experience marginalization when they choose to reject the host country's traditions while struggling to maintain their own cultural identity. (Berry, 1997; Berry, 2014; Lincoln et al, 2015). Maintaining a strong connection with one’s heritage culture while pursuing the least amount of connection to their host society creates separation (Berry, 1997; Berry, 2014; Lincoln et al., 2015). The inverse, assimilation, occurs when the immigrant maintains low levels of connection to their heritage culture/identity and high connection to their host society (Berry, 1997; Berry, 2014; Lincoln et al. 2015). Whereas, integration occurs when one has a strong connection to both the host culture and their original heritage and customs (Berry, 1997; Berry, 2014).
Studies suggest that integrated individuals or bicultural individuals often have good health behaviors and conditions (Szapocznik, Kurtines, & Fernandez, 1980; Berry, 1997; Berhe, 2005; Berry 2014). Individuals who are integrated are commonly viewed as bicultural individuals, who possess and perform cultural behaviors from their heritage culture and host culture (Suarez et al., 1997; Cabass, 2003; Benet-Martínez & Haritatos, 2005; Schwartz & Unger, 2010). Examples of cultural behaviors include: language preference (Cabass, 2003; Schwartz & Unger, 2010). Researchers have conducted studies that show a relationship between bicultural individuals and positive health conditions. For example, Hwang et al. (2005) conducted a study with 1,747 U.S. and foreign-born Chinese Americans to examine if acculturation impacts the risk of developing a major depressive episode. Hwang and colleagues (2005) concluded that bicultural identities and higher rates of acculturation (e.g. longer lengths of residence in the US and the age they arrived to the US) were associated with lower risks of having a depressive episode. Mak and Zane (2004) studied somatization’s relationship to the experiences of acculturation, stress, support, and distress amongst adult Chinese-Americans. They concluded that acculturation had no effect on somatization, but factors such as anxiety, age, education, and stressors were significantly associated with acculturation (Mak & Zane, 2004).

**Language & Acculturation**

Many scholars categorize language as a necessary medium of acculturation (Graham & Brown; 1996; Guinn, Vincent, Wang, & Villas, 2011; Salinas, Hilfinger, Morales-Campos, & Parra-Medina, 2014). Language is one of the most significant factors associated with national and ethnic identity because it is a cultural and, sometimes a regional, identity marker (Clement, 1986; Laroche, Kim, Hui, & Tomiuk, 1998; Laroche, Ponds, & Richards, 2009). Language and
group identity have a reciprocal relationship: language use shapes the patterns of group identity and group identity impacts the use of language (Pool, 1979; Fishman, 1999; László et al., 2013). Language is a common medium of acculturation because speaking the dominant language in a particular region allows people from different cultures to communicate with each other and experience the norms and customs of the host culture (Clement, 1986; Schwartz et al., 2010).

Language use and proficiency are often used as proxies to determine levels of acculturation in immigrant populations. Language use and proficiency are often associated with the amount of contact that an immigrant receives with the host culture and the educational (Clement, 1986). For example, immigrants who have a high English proficiency and frequently speak in English have better adjustment periods in new environments (Kang, 2006). Better adjustments often correlate to individuals being more acculturated than individuals who do not or slowly adjust to their host cultures. Ways to measure language use would be to ask a participant “How often do you speak English?” or “What language do you prefer to speak?” as opposed to “How well do you speak English” which is a measure of language proficiency (Wallen, Feldman, & Anliker, 2002; Zea, Asner-Self, Birman, & Buki, 2003).

**Social Support & Acculturation**

Studies have shown that social support is positively associated with acculturation (Bernal, 2014; Hyung-Chul, Ji-Young, Soon-Jeong, Harry, 2015). Social support is defined as the support granted to an individual or groups through social interactions and ties to other individuals, people, and the greater community (Lin, Dean, & Ensel, 1981; Thoits, 1982). Examples of social support include local community members educating an immigrant on where find affordable housing and local organizations helping refugees find local supermarkets (Angel & Angel, 1992;
Thus, social support helps immigrants, refugees, and multicultural families feel less anxious, which helps them to better adapt to the unfamiliar environments of their host countries (Poyrazli, Kavanaugh, Baker, & Al-Timimi, 2004; Noh, 2007; Ayers, Hofstetter, Usita, Irvin, Kang, & Hovell, 2009; Stewart, 2014; Hyung-Chul et al., 2015). Social support facilitates an individual's likelihood to form social ties to the people around them. Thus, groups, such as refugees and immigrants, are more likely to form group affiliations with the larger community (Tran & Wright, 1986; Hyung-Chul et al., 2015). Therefore, the strength and quality of immigrants and refugees’ social support is related to higher rates of acculturation (Bernal, 2014; Hyung-Chul et al., 2015).

The Impact of Acculturation on Immigrant Health

Acculturation affects immigrants’ health outcomes, behaviors, and conditions. Common challenges that immigrants face while experiencing acculturation include, learning a new language, social norms, and becoming familiar with the mainstream culture (Jiang, Green, & Henley, 2009). Integrated individuals, as opposed to migrants who are marginalized, assimilated, or separated, on average have better psychosocial outcomes because they are better able to adapt to and balance the different cultures that they are exposed to and immersed in (Benet-Martinez & Haritatos, 2005; Tadmor et al., 2009). Specifically, they tend to have lower rates of depression and higher self-esteem (Szapocznik, Kurtines, & Fernandez, 1980; Chen, Benet-Martinez, & Bond, 2008; Schwartz, Zamboanga, & Jarvis, 2007). Despite the stage of acculturation an individual is occupying, one factor that influences psychosocial outcomes is the degree that the migrant’s heritage and host culture are similar (Rudmin, 2003). When controlling for ethnicity, migrants who are proficient in English and/or come from English speaking countries typically
experiences less marginalization and stress when arriving to America, in comparison to migrants who do not speak and are not proficient in English (Schwartz et al., 2013).

The Hispanic Paradox offers insight into the complex relationship between acculturation and health (Abraído-Lanza, Chao, and Flórez, 2005; Tahseen & Cheah, 2012). The Hispanic Paradox particularly refers to Latino and/or Hispanic immigrants having relatively good health outcomes when they arrive to America, despite their low education levels and high rates of poverty (Tahseen & Cheah, 2012; Camacho-Rivera, Kawachi, Bennett, and Subramanian, 2015). Most studies about the Hispanic Paradox focuses on Mexican immigrants when analyzing the Hispanic paradox (Tahseen & Cheah, 2012). Due to low educational attainments and socioeconomic status typically being determinants of poor health outcomes in native born Americans, Hispanic and Latino immigrants’ health defy their expected outcomes. Even though the majority of public health professionals associate low socioeconomic status with poor health, Latino and Hispanic immigrants often have rates of mortality, preterm births, and cardiovascular diseases that are the same, and in some cases even lower, than White Americans (Acevedo-Garcia, Soobader, & Berkman, 2007; Lara et al., 2005). Traditionally, non-White Hispanic men and women have had distinctly better health outcomes in mortality, disease burden, and infections when compared to other racial groups (Nazaroo, 2012). Possible explanations for this phenomenon are explained by non-White Hispanics, on average, having higher rates of socioeconomic status, accessibility to health care, and utilization of health services, than other racial and ethnic groups in America (Williams, 2001; Nazaroo, 2012). However, as Hispanic and Latino immigrants have more American born generations who are acculturated to American culture, this population has higher rates of negative health outcomes.
As Hispanic and Latino immigrants became more acculturated, they generally experience negative health outcomes (Varo & Amaro, 1994; Heilemann, Frutos, Lee, & Kury, 2004). Higher rates of acculturation in Hispanic immigrant populations are also associated with decreased fiber consumption, decreased breastfeeding, and increased use of cigarettes (Varo & Amaro, 1994; Heilemann et al., 2004). Abraido-Lanza et al. (2005) also stated that higher levels of acculturation corresponded with a greater likelihood of alcohol consumption, smoking habits, and a high body mass index. Studies also demonstrated that longer lengths of residency in the US are associated with higher risks of psychiatric disorders among some Latino immigrants, particularly those of Mexican origin (Vega et al., 2004; Algeria, 2009). Vega et al. (2004) found that rates of mood, anxiety, and substance disorders were higher for immigrants with 13 or more years of residency in the United States than those with less than 13 years in the US. Specifically, in Mexican Americans, longer residency in America was associated with increased risk of lifetime mood disorders and substance abuse/dependence (Alderete, Vega, Kolody, & Aguilar-Gaxiola, 2000).

Due to (1) acculturation playing a critical role in affecting health outcomes and (2) refugees having significantly lower rates of health care utilization and satisfaction this study is interested in how specific aspects of acculturation--support systems (national, ethnic, and/or linguistic), English proficiency, and language preference--influence health. The literature review suggests that strong social support systems, high/moderate English proficiency, and preferring to speak English may allow refugees to feel higher rates of health care satisfaction because these factors are associated with refugees feeling apart of and accepted in their resettled communities.

Methodology
**Study Design**

The purpose of this study is to explore the potential relationship of acculturation on refugees’ health outcomes and health care satisfaction. The primary researcher conducted semi-structured interviews to capture refugees’ past and current experiences accessing health care services in Lancaster and gauged how acculturation influences refugees’ daily experiences. A qualitative, as opposed to a quantitative approach, was used to understand the feelings, values, and perceptions that underlie and influence refugee health outcomes (Morse, 1999; Martyn, 2013). The complex relationship between acculturation and health satisfaction was highlighted when refugees elaborated about their experiences and how external factors affect their individual health outcomes. This study employed semi-structured face-to-face interviews with refugees living in the City of Lancaster in Pennsylvania. All protocols for this study were approved by the Institutional Review Board (IRB) from Franklin and Marshall College (#R_3MnXAYBYPoITTic).

**Participants**

The participants in this study included nine Lancaster refugees who racially and ethnically identify as Asian (3), non-Hispanic Black (3), White (1), and Hispanic-White (2). The participants countries of origin include: Bhutan (3), Ethiopia (2), Cuba (2), the Democratic Republic of the Congo (1), and Iraq (1). Three participants self-identified as female and six self-identified as male. All participants were between the ages of 18-52 and have lived in Lancaster for more than 24 months at the time they were interviewed.
Participants were recruited using purposive snowball sampling. The primary researcher used non-probability homogeneous purposive sampling because she only contacted and recruited participants who are refugees and were resettled in the City of Lancaster (Lund Research n.d.; Ragan, Nagel, White, 2004). Only recruiting this specific type of participant allowed the primary researcher to capture participants’ process of acculturation as they live and adjust to life in Lancaster and experiences navigating this city's health care system while being a refugee. Snowball sampling was also effective because it is difficult for non-refugees to access the refugee population if they do not speak one or more languages that are dominant in certain refugee communities. Thus, snowball sampling allowed the researcher to recruit more participants through previous participants referring their friends and acquaintances (Wright & Stein, 2005). Participants were also recruited through the research team collaborating with Church World Service (CWS). The primary researcher was given permission to contact staff members who are also refugees. After each participant finished the interview, they were compensated with a $10 gift card.

**Data Collection Tools**

A semi-structured interview guide was used to ask core questions to all participants (Appendix A). The guide was based on previous literature that highlighted English proficiency and social support being factors that influence acculturation and health outcomes for immigrant and refugee populations (Vega et al., 1994; Tricket, 2002; Lincoln et al. 2015; Johnson-Agbakwu et al., 2016).

**Procedures**
Interviews were conducted in private offices in participants’ workplaces in Lancaster’s downtown library and on Franklin & Marshall’s campus. The primary researcher scheduled interviews based on participants’ availability and convenience. Before each interview, participants were required to read through the informed consent form and ask any questions they had about the study (Appendix B). The primary researcher answered all questions that the participants had before the investigator and participant signed the original copy of the informed consent form. The primary researcher then asked and gained approval to record the interviews on a cell phone and recording device. The primary researcher recruited volunteer Swahili, Sheng, Nepali, and Spanish speaking interpreters in case a participant needed translation services. No participants asked the primary investigator for a translator from; however, one participant brought her own translator who was fluent in English and the participant’s first language.

After each interview was completed, the researcher verified that the audio was saved to the devices and then saved the name of the audio that corresponded with the number assigned to the respective participant. The primary investigator then wrote field notes highlighting any characteristics of the participants and/or their answers, such as body language and gestures and potential themes in responses, that could help the research team code. The primary researcher then transcribed interviews verbatim. The primary researcher read over each transcript, while listening to the respective audio to ensure that the audio was transcribed accurately. The primary researcher then assigned each participant a research ID to maintain confidentiality and saved the audio as password protected computer files.

Data Analysis
Two researchers (SG and HT) coded the transcripts in NVivo12, a qualitative data analysis software. The research team reviewed and coded each transcript based on major themes, including barriers to health and language as access, that each researcher perceived. The researchers were of a different race, ethnicity, socioeconomic class, and were born and raised in different regions of the US, which allowed for diverse perspectives to analyze each transcript. The research team used analyst triangulation to review the findings and discuss the various ways that they could comprehend the data and reduce bias that would have occurred with just one researcher coding (Patton, 1999; Patton, 2001). As the research team reviewed each transcript, they wrote down themes that emerged. The codes were based on the following themes: (1) cultural differences and cultural shock, (2) language preference, (3) level of English proficiency, (4) national, ethnic, and/or linguistic communities, (5) support systems, (6) language as access to health care, (7) language as barrier to health care, (8) translation services (9) education, and (10) lack of insurance. The researchers coded sentences or paragraphs because they wanted to fully capture participants experiences’ and not use snippets of sentences to infer themes. The research team thoroughly discussed any disagreements in coding to ensure that interviews were being consistently coded.

The primary researcher also wrote a researcher ID memo to be aware of the emic and etic perspectives that were present while conducting research in the refugee community. These memos allowed her to consciously consider her bias and attempt to mitigate its influence in coding and analyzing the interviews.

Limitations
Due to time constraints and limited funding, the primary researcher was unable to conduct follow up interviews with participants to clarify their responses to the questions they were asked during the initial interview. In addition, the research team only had three translators who spoke four languages available upon request. Due to financial constraints and inability to identify translators who spoke underrepresented languages, such as Amharic and Lingala, the research team was unable to interview many participants who did not speak English.

Findings

There were five major themes that appeared in the coding process. The themes included: cultural differences and culture shock, bicultural identity (language proficiency, language preference, and self-identified nationality), social support, health conditions, and language access as it pertains to health care satisfaction. Each of these themes will be explored more during the following sections.

Cultural Differences and Culture Shock

Culture shock was defined as the confusion and anxiety that refugees felt when having to resettle in Lancaster (Oberg, 1960). Participants stated that they had negative experiences when initially adjusting and resettling in Lancaster. Participant #1 was an Asian Bhutanese man who resettled in Lancaster about seven years ago. The participant explained the challenges of integrating into American society following his arrival to America. Participant 1 stated:

It’s totally different you know. A lot of challenges to navigate services around and to familiarize yourself with the community and the resources that are available here. So it was a, let me say it was a nightmare. You don’t know where you are and all of a sudden everything seems like different and you don’t know where you are.
Participant #1 later noted that “the culture was totally different...back in the home country the people in the neighborhood would come and knock” on a person’s door if they were new to the community, to check on them and welcome them. “But here I was placed into a home and.. there was none [of this].” Participant #1 expected to be welcomed by the residents in his neighborhood in Lancaster, but he did not get the welcome that he yearned for.

Participant #2’s initial period in Lancaster resembled the harsh encounter that Participant #1 experienced; however, Participant #2 reported encountering culture shock that negatively impacted him and his family. Participant #2 was a Black man who was born in the Democratic Republic of Congo. When he was asked to talk about his initial experiences being in the US stated:

I mean, when I first came I remember that we did seven days without eating, the whole family because we couldn't find anyone from Africa who could lead us to the store, African shops. You know what I mean? So, you know we have our own food, we don't eat American food, so it was a big challenge for me and my family.

Due to Participant #2 not having individuals in the Lancaster community to show him where to buy the food that his family culturally valued, his family went without eating for a prolonged period. When Participant #2 was asked “Is there anything else that you want to say about refugee and health?” he responded:

Yeah, especially the culture and you know some of the times people think differently some of the people think that if someone is a refugee it is nonsense. Nothing doesn't mean anything to the community to people and I remember when I first started doing my job because I'm working as a constructor people that I work with they were thinking that I am a jungle person...Someone who was used to animals who was from a jungle an uneducated person...It was a big challenge.

Participant #2’s experiences of being stereotyped at his workplace revealed his understanding of how other non-refugee people view refugees. Participant #2 felt challenged because people at his job erroneously believed that he was an educated “jungle person,” after only knowing that he
was from the Congo. Participant #2 personally believed that aspects of US culture involve the misrepresentation of refugees as “nonsense” or less than. Thus, not only did Participant #2 have a difficult time adjusting to his neighborhood, but he also felt discriminated against at his job.

Even though Participants #1 and #2 had a negative transitional period to Lancaster, they were not suggesting that this initial period of confusion and cultural shock made America a horrible country, in comparison to their home country. They were, however, stating that cultural and societal differences prevented them from smoothly transitioning into Lancaster’s workforce, social, and political spheres.

_Bicultural Identity: Language Preference, Language Proficiency, & Self-Identified Nationality_

Language preference, English proficiency, and self-reported nationality were 3 factors used to categorize participants as bicultural. Language preference was coded based on participants’ comfort using a language or languages while living in the City of Lancaster. Language preference was coded into three categories: native language, English, and both native and English languages. Five participants stated that they preferred speaking their native language, which included Nepali (3), Spanish (1), and Swahili (1). Three participants stated that they preferred speaking both their native language and English. One participant preferred speaking English. In addition, English proficiency was defined as participants’ ability to speak and comprehend English. Moreover, the level of English proficiency was determined based on participants’ self-reported ability to speak English and the primary researcher’s perception of participants’ English proficiency. For example, two participants were coded as having low English proficiency because they either needed a translator or stated that they “do not understand
English very well.” Seven people were coded as having high or moderate English proficiency because they either stated that they can read and speak in English and/or they easily comprehended and responded to all of the questions that were being asked. Out of the seven participants who had moderate/high English proficiency, only two participants identified as being from their country of origin and being American.

When participants were asked to specify what language they preferred to speak and what nationality and racial category they identify with the most, five participants stated that they were bilingual and/or had multiple national and ethnic identities that connected them to American culture. The team coded these responses as biculturation. Participant #7 stated:

English and Arabic. Arabic is the language of my people. It is the language that I first learned. I use it when I speak to friends and family from back home. But English is also good because it helps me express myself. Like it may sound weird, but in Arabic we can’t express emotions, because this language is based around emotions, unlike English. If I tried to express my emotions in Arabic people would look at me funny. It’s not our way...Yeah, I have never had any problem with speaking Arabic here in Lancaster.

Participant #7 feels comfortable using both languages in his resettlement community, despite English being widely spoken. Participant #7’s inability to choose one language and nationality that he identifies with highlights the fact that he perceives himself to be connected to US culture.

Participant #6 was a Black woman who was born in Ethiopia and currently attends a university in Lancaster County. Participant #6’s responses to the questions about the language and nationality that she mostly identifies with resembles Participant #7’s answers. Participant #6 stated:

English. I mean I knew Amharic from my mom and stuff, but I started learning English when I was in Kenya. So then when I came here obviously to learn better so I could fit in to school better I only spoke English for the longest time. So, to me it’s the most, I know it way better, like I can experience or express what I want better in English. But I still know Amharic.
She later responded, “Both American and Ethiopian” when she was asked about the nationality that she affiliates with. Participant #6’s responses highlight that she genuinely feels apart of both her Ethiopian and American culture because her Ethiopian nationality allows her to connect to her heritage and family, while English allows her to adapt to educational institutions and express herself. Participants’ inability to choose identifies that they feel connected to their culture in their resettlement communities and American nationality. Participant #6 and #4 were the only participants who stated that English was their only preferred language, even though their first language was not English. Based on these results, bicultural individuals had differing language preferences, levels of English proficiency, and national/ethnic identities.

**Social Support**

When talking to participants about their experiences when they moved to Lancaster, participants stated that ethnic or national community and resettlement organizations played the biggest role in helping them overcome initial cultural differences.

*National, Ethnic, Linguistic Community*

Participants stated that having support systems that consist of Lancaster residents who share the same national, ethnic, and/or language helped them overcome the initial cultural shock. Participant #8 was a White-Hispanic Cuban man, who worked at a local refugee resettlement organization. Participant #8 talked about the comfort that he felt while interacting with his national, ethnic, and linguistic community while in Lancaster. When the primary investigator asked Participant #8 to discuss his perceptions of his community he said:

> There are a bunch of people who speak Spanish here in Lancaster...There’s a big community of like Hispanic people here in Lancaster. I say good morning to certain people who are from Latino descent. So specifically, the community for Cubans is very large right now. So, I feel comfortable.
Participant #8 differentiated between the Spanish speaking community and the Cuban community. Even though Cuban people predominantly speak Spanish, Participant #8’s statement highlights that not all Spanish speakers in Lancaster come from the same country and share the same ethnicity. Therefore, Participant #8 showed that he feels comfortable interacting with people from his home country and other people that share his native language.

Participant #1 was very engaged with the Nepali community in Lancaster, which helped him overcome the culture shock that he experienced when he first arrived to Lancaster. Participant #1 was asked to define his community and speak about the ways that his community supported him when he was first resettling in Lancaster and he said:

They would of helped me financially if they were in a better position, they would. But they were like me, yeah, they were here for a couple of years and they were still struggling. They would come and talk...You know they would help me emotionally. You know accessing things where I need to go to get my groceries and that was a big, big, big thing. You know because we never grew up eating sandwiches and burgers and stuff. So, we have our own kind of food. So, it’s just really really scary in the beginning so these folks actually helped me you know getting those things into place. You know telling me where to go and how to get. Telling me a little bit about the culture um because they were there for a couple of years like I said, and they had information and knowledge.

Participant #1’s statement reflects the different types of social support that he received from the members of the Nepali Lancaster community. Participant #1 had people in his community that were willing to emotionally check in with him, familiarize him with the Nepali stores, and help him culturally navigate American culture. As opposed to Participant #2, who did not have any Congolese or African community members show him around Lancaster. Thus, the difference between Participant #1’s ability to persevere through the cultural differences, in comparison to Participant #2, was related to the amount of social support he had.
Participant #4 is an Asian woman who was born in Bhutan, sought asylum in Nepal for decades, and resettled to Lancaster over 2 years ago. Participant #4 previously stated that she had a rough time resettling in Lancaster due to cultural differences. However, when Participant #4 was asked to speak about her relationship to the Bhutanese and Nepali community in Lancaster she declared:

Mainly. We came from Bhutan and then we stayed there as a refugee. See (a friend) and I are different like she born in Nepal, but I born in Bhutan so I came to Nepal and stayed there refugee like 20 years. So yeah...they helped us. They help us now. They help us fill out citizen forms and green cards...and then after that it's like I just little bit know, little bit know, you know it’s little bit better now.

Participant #4’s response highlights the integral role that established Nepali community members played in socially supporting her and other Bhutanese refugees. Not only did these allies help her culturally navigate Lancaster’s environment, but they also helped her participate and access civic engagement, which combatted her initial period of social isolation and confusion.

Participant #9’s relationship to Cuban community members who have lived in Lancaster for an extended period of time also played a role in helping him adjust to living in Lancaster. Participant #9 is a Hispanic-White man who was born in Cuba and is currently working as a construction worker. Participant #9 initially stated that “I was born again when I arrived you know to the [United] States because it was a new life and a better life.” Participant #9 is not ashamed or angry about his life in Cuba, rather he is choosing to acknowledge that resettling in America gave him a chance to have more opportunities to have “money in your pocket for something.” When he arrived to Lancaster, the Cuban residents, both refugees, immigrants, and second-generation Cuban-Americans, helped him adjust to living in a city. Participant #9 stated:

We Cubans shared the rent you know a big house a lot of room and we share the room...There's also other Cubans who lived here in Lancaster for more than 10 years and we know that people. They help you to with driver license and find a care and something like that so it was easy.
Participant #9 affirmed that Lancaster residents who shared the same nationality, ethnicity, and/or language as him not only socialized with resettled refugees, but provided them with the information and resources needed to become productive citizens in Lancaster. A majority of participants stated that they experienced cultural differences/cultural shock, but partially due to their affiliation with individuals from similar ethnic, national, and linguistic communities they were better able to acculturate to their resettled communities.

**Health Conditions & Health Satisfaction**

Participants were asked to rate their health on a five-point scale, including: Excellent, Very Good, Good, Fair, or Poor. Participants tended to rate their health positively, yet many participants had negative health conditions. Out of the three participants who reported having excellent health, all of the participants stated that they did not get sick or were only impacted by common colds. Out of the three participants who had very good health, participants stated that they occasionally catch the flu and common cold, have physical complications related to work, or they do not have any major complications. Out of the three participants who have good health, participants hypertension, gastric problems, high cholesterol, and/or diabetes. Out of the participants that have negative health conditions, 5 participants reported that they are currently taking prescribed medication or using over the counter medicine to treat their health conditions. Two participants stated that they actively try to avoid using the health care system and preferred home remedies or over the counter medicine.

**Language as Access to Health Care**

Seven participants stated that they were satisfied with the health care they have received in Lancaster. A common theme that emerged in the data was that language access via speaking
English or Spanish and translation services often allowed patients to feel satisfied with the health care services they received.

Participants noted that speaking English was a way to successfully navigate the health care system in Lancaster. Participant #7 is a White man who identifies as Iraqi-American, and was categorized as bicultural, who works at a local refugee resettlement organization. During his interview, he stated that he was not satisfied with the care he received in the Western health care system:

This is a comparison in general, since I had access to health care in the Middle East. This system is built differently. Here it is more like a business. Here people are in and out. The doctors look at a screen and then you are out. Back home it’s like the doctors get to know you. They ask questions. Here it’s like 10 minutes and that’s its. So personally, I feel like they do not have time for me. I go in, I do what I have to do, and leave.

Participant #7’s frustrations with the health care system is due to him experiencing impersonal and business-like interactions with doctors. Participant #7’s dissatisfied experiences with the health care system directly contradicts theories of acculturation that suggest bicultural individuals tend to have positive health outcomes, when compared to individuals who are not bicultural. When asked about his experiences navigating the health care system, he also stated that knowing English gave him an advantage. He stated:

I mean definitely everyone’s experiences are different. But it is known that the less English you speak, the less advantage you have. Thus, the less knowledge you have the less accessibility you have to the medical system. Yeah, I know people who told me ‘when I call the clinic I don't know how to get past the press 1 for English and 2 for Spanish.’ Or when they walk to the clinic they have to wait hours for people to help them make an appointment in their own language, so it’s a little bit challenging for people when they speak limited English.

Thus, Participant #7’s comparison between him and people who do not know English, highlights that his English skills allowed him to circumnavigate confusion and access care, despite it being less personal.
When Participant #9 was asked what language he prefers to speak he stated, “Spanish...It's my first language. But I am trying to learn English because it is important for my future. Yeah, we are in an English country.” Participant #9 highlighted that English is important to know in order for him to have a better future because most people in America speak English.

When Participant #9 routinely visits his primary care provider he stated:

Yeah, they asked me if I needed translation, but I said no because I'm trying to learn and understand English. If it's something that I don't understand or something like that the doctors tried to explain to me in many ways, like drawing something, moving their hands to spell words and I'll be able to understand. Yeah it is pretty good.

In addition to Participant #9 being motivated to learn English to gain access to financial and social opportunities, he utilized the limited amount of English that he knew to communicate with doctors, even when words were lost in translation.

Translation Services

Unlike Participant #9, Participant #5 does not speak English and is unable to directly communicate with doctors. When Participant #5 was asked to talk about the reason why she is satisfied with the health care that she has received in Lancaster her translator declared that:

She said she had an amazing experience because whenever she went they would actually find someone who can speak Amharic through the phone and stuff, and had them translate. It was a three-way call kind of thing, so she had an amazing experience, like they always were responsive. Like they knew her and everybody in her family’s name.

Participant #5’s experiences demonstrate the ways that translation services can bridge the gap between patients who do not speak English and their health providers. The translators also helped Participant #5 have a good experience at the doctor's office because they personalized her care by knowing her and her family’s name.
Participant #4 also supported Participant #5’s views on the impact of translations services. When Participant #4 spoke about speaking English in Lancaster she said:

We are from different countries our tongue is a little bit different and I don’t go to school here. Because of that, also like my language is a little bit. Like if I talk or say something else people don’t understand and I feel like very bad, like “Oh my God” and it takes me two or three times to repeat that so that time I feel bad...Like our tongue and like you speak really good. My tongue and your tongue is little bit different so is very hard for me to explain and then make them like clear.

When Participant #4 referenced the word “tongue” she means the way people “speak the same language,” which is English. Since Participant #4 speaks English with an accent it is difficult for her to communicate with natural born citizens and other English speakers in her community. However, her frustrations with being misunderstood does not happen when she visits her primary care provider. When asked about translation services she stated that a translator helps her during doctors visit because she “asks me if I am good” and “she understands me.” Participant #4’s response highlighted the impact that translation services has in reducing the language barriers between patients and doctors. Therefore, in addition to English, knowing other common or dominant languages in Lancaster gives participants the opportunity to adequately access and utilize health care services.

Discussion

This study aimed to explore the relationship between acculturation and health care satisfaction within the City of Lancaster’s refugee populations. My results suggest that English proficiency and social support systems are related to health care satisfaction. Previous literature suggests that English preference and proficiency are associated with acculturation because language is often a distinct indicator that non-native English speakers are adjusting or have adjusted to American culture (Clement, 1986; Laroche et al., 1998; Laroche et al., 2009;
Salgado, Castañeda, Talavera, & Lindsay, 2014). With English speakers typically having better health outcomes than non-native English speakers and people who do not speak English, one would have assumed that there would be a clear relationship between English preference and level of English proficiency in this study. English proficiency, however, was the most common factor that related to health care satisfaction because the health care system structurally privileges English speakers. For example, despite the large and diverse population of immigrants and refugees in the US, many hospitals administer health information solely in English and/or sometimes in Spanish (O’Donnell et al. 2007; O’Donnell et al., 2008). Many health providers are conscious of the need to effectively treat the large Spanish speaking population of health care patients (Moreno, Walker, & Grumbach, 2010). Nonetheless, there is still a majority of health professionals who only speak English and cannot cater to the health needs of their patients who have limited English proficiency (Moreno et al., 2010). Therefore, individuals who speak and understand English tend to comprehend what care they are receiving and are more satisfied with the care they receive in comparison to non-English speakers (Chamberlain, 2005; Hahn, Burns, Ganschow, Garcia, Rutsohn, & Baker, 2015).

A majority of participants in this study preferred to speak their native language as opposed to English. This pattern of language preference suggests that most people can express themselves and comprehend better in their native language or language that they feel most comfortable speaking. For instance, Participants #6 and #7 mentioned that English allows them to express exactly how they feel and to better communicate with others. On the other hand, for these participants their native language prevented them from effectively communicating for many reasons, such as languages being informed by cultural values that do not have words to
express many complex feelings. Participant #7 stated that Arabic, unlike English, was “not based around emotions.” Participant #7 is signaling to the idea that speaking English may lead to better health outcomes because patients are able to equally participate in making recommendations and decisions regarding their health. With high/moderate English speaking proficiency, patients are more likely to be health literate, and appropriately question doctors’ health recommendations, which may lead to better patient satisfaction. Therefore, further studies should operationalize and measure English language preference and proficiency and the capacity for English and non-English language expression to further examine the relationship between these factors in relation to acculturation and health care satisfaction.

This study also highlighted that, in addition to English preference, the most common languages spoken in a region dictate how a majority of health services are offered. For example, in Lancaster and across America, Spanish is typically the second most spoken language. In the City of Lancaster hospitals have staff members and translators who are fluent in many languages and offer Video Remote Interpreting (VRI) services that electronically translate over 150 languages (LGH, n.d.). However, in Lancaster, more services are available to people who speak popular languages, such as Spanish (LGH, n.d). Thus, one explanation for the reason why Spanish speakers in this study did not face many problems with adjusting to the health care system is because it is more common to find doctors who comprehend Spanish and have adequate translation services. In Lancaster, there are also established Bhutanese and Nepali populations, which may highlight why the participants who had low proficiency in English were able to access effective Nepali translators while in hospitals. The problem with providing health services based on the languages that are mainly spoken is that populations who are
underrepresented do not have the same access and quality of care. For example, Participant #2 stated that Swahili translation services are not effective because they misinterpret what he says and his words often get lost in translation. Thus, patients who do not have access to adequate and effective health services do not have the option to speak in their native language, which is often the language that they can best express themselves in.

There is a perceived positive relationship between social support and health satisfaction. When a majority of participants first arrived in Lancaster they experienced culture shock because they did not know how to navigate in an unfamiliar environment and find necessities, such as food from their culture. Refugees’ perceptions of cultural shock are related to poor health behaviors and outcomes (Buttaro, 2014). The more refugees feel isolated from their resettled environment, the more likely they will have low satisfaction with health professionals who may offer them suboptimal care due to their implicit biases related to their refugee status (Berry and Sam, 1997; Moreno et al., 2010; Folkman, 2013; Berry, 2014; Hunt et al., 2014). However, in this study, all participants stated that they had one or more forms of national, ethnic, and/or linguistic communities that provided them with initial social support upon their arrival to Lancaster. Some established refugees, those who have been living in Lancaster for a longer period of time, and communities helped the participants fill out papers to file for citizenship, buy a car and/or connect them to communities that aligned with their national and/or ethnic identity. Participants reported that this assistance and feeling of community helped them have a smoother transition in Lancaster. Thus, one explanation why only two participants reported dissatisfaction with Lancaster’s health care is because participants had the social support needed to acculturate in Lancaster and have positive perceptions of the health care sector. Many health facilities in
Lancaster specifically cater to refugees’ needs. Thus, there are resources available to improve the accessibility of the health care sector to refugees, contributing to their positive views of their care, despite having a stressful initial adjustment period following their arrival.

These findings also offer a critique to Berry’s stages of acculturation and the way integration is defined. Many refugees individualized their bicultural identity. Some refugees self-identified as both American and their national identity, while others chose to simply identify with their own culture, ethnicity, and nationality. Despite these differences in expression of their linguistics, national, and ethnic identities, they all reported that they enjoyed living in Lancaster. Most participants stated that they found it easy to make friends and work with individuals who were from different backgrounds, even though their ethnicity was underrepresented. However, Berry’s stage of integration does not allow for the multi-faceted and flexible ways that refugees perceive and choose their core identities. Berry’s stage of integration states that individuals will maintain their original and host culture when having first-hand contact with a different environment (Berry, 2003). However, Berry does not address integration that results in a complete or unbalanced merge of both heritage and host cultures. In this model of integration, immigrants, including refugees can use their agency and personalize their integration to fit their psychological and sociocultural needs. It is important to suggest a modification to Berry’s model of acculturation because Berry’s theory has historically been the most influential in shaping acculturation literature and studies. Thus, with more comprehensive measures of acculturation and the interplay between agency and personalized experiences, the field will be able to capture a diverse pool of refugee experiences.

**Limitations**
This study had several limitations. The research team was unable to recruit a large sample of refugees living in the City of Lancaster due to it being difficult to access this community without speaking multiple languages or knowing people of contact in the refugee community. Due to the research team not being members of the refugee community and having little access to the refugee population, they utilized snowball sampling, which may have produced a homogeneous sample. Furthermore, the research team did not examine the role that intersectionality, gender dynamics, class inequality, and racial differences play within refugee populations. Thus, further studies are warranted to draw definitive conclusions about the relationship between acculturation and health satisfaction among refugee populations.

Recommendations

Even though this study has several limitations, the findings offer insight into ways to improve refugee health care. Language preference and language use are limited to refugees in many areas of the health care system, such as patient-doctor interactions and reading prescription labels and directions. However, there are other overlooked areas of the health care system that can be improved to ensure equitable access to health services and health care satisfaction. Participants in this study mentioned that it is extremely difficult for refugees who speak underrepresented languages to call a health facility and schedule an appointment. The automated machines only offer English and Spanish translations as options to continue the call. Refugees who do not speak English or Spanish may have to physically travel to the health facility just to schedule an appointment; however, issues related to work and child care may prevent refugees from even getting to a health facility, which further perpetuates the low rates of health care access and utilization among refugees. Thus, one possible structural change that could be made in local and state hospitals is offering more languages on the automated voice calling system.
Offering more languages would increase health care access, utilization for groups of refugees that have historically been excluded from these types of services (Teixeira, & Li, 2009; Langlois et al., 2016).

Another suggestion is that refugees should be given comprehensive health care education classes as soon as they arrive in the US. Even though refugees have access to state and federally sponsored health insurance, depending on the state and local community, there are often waiting periods that prolong refugees’ utilization of care (Langlois et al., 2016). During this period refugees may need check-ups and medical advice, but do not seek help because of multiple reasons, including not being able to afford health services without insurance (Caulford, & Vali, 2006; Langlois et al., 2016). Not having access for prolonged periods exacerbates feelings of exclusion and prevents refugees who need health care services from utilizing care (Langlois et al., 2016). Therefore, resettlement organizations should hold comprehensive health care education classes for refugees, which would be especially helpful in the absence of strong social support systems.

Conclusion

This study found that aspects of acculturation influenced participants’ health care satisfaction. English proficiency and social support systems, consisting of national, ethnic, and/or linguistic communities, were two factors that were commonly connected to health care satisfaction. High/moderate English proficiency and strong social support systems helped participants combat the initial cultural shock that they experienced, which allowed the participants to more readily adjust to their resettled environments. Overall, participants did not have complaints about the quality of health care services that are offered in the City of Lancaster.
However, it is important to note the problems that were reported, poor physician-client interactions and inadequate translation services, when thinking of ways to improve refugee health outcomes across America. Expanding the number of languages offered when scheduling doctors’ appointments over the phone is a step that local health facilities can take to improve refugees’ quality and access to care. The government and/or state officials enacting a law that allows refugees to immediately use their health care insurance when they are resettled is another practical change to the health care system that can produce health care satisfaction among refugee populations.
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Appendix

A)

Figure 1: Bar graph showing the majority of resettled refugees in Lancaster County in 2015 (CWS, n.d.). The three largest groups of resettled refugees were from Somalia, Burma, and Bhutan.
B) Demographics of participants

Table 1: Table showing the demographics of participants enrolled in this study.

<table>
<thead>
<tr>
<th>Participant #</th>
<th>Country (Birth)</th>
<th>Race</th>
<th>Hispanic or Latino</th>
<th>Self-identified Sex</th>
<th>Lived in Lancaster (months)</th>
<th>Age Range</th>
<th>Health Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Bhutan</td>
<td>Asian</td>
<td>No</td>
<td>Male</td>
<td>&gt;24</td>
<td>35-44</td>
<td>Very Good</td>
</tr>
<tr>
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<td>No</td>
<td>Male</td>
<td>&gt;24</td>
<td>35-44</td>
<td>Good</td>
</tr>
<tr>
<td>3</td>
<td>Bhutan</td>
<td>Asian</td>
<td>No</td>
<td>Male</td>
<td>&gt;24</td>
<td>35-44</td>
<td>Good</td>
</tr>
<tr>
<td>4</td>
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<td>No</td>
<td>Female</td>
<td>&gt;24</td>
<td>25-34</td>
<td>Excellent</td>
</tr>
<tr>
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<td>Female</td>
<td>&gt;24</td>
<td>35-44</td>
<td>Excellent</td>
</tr>
<tr>
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<td>Male</td>
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<td>18-24</td>
<td>Excellent</td>
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<td>35-44</td>
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</tr>
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<td>Male</td>
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<td>9</td>
<td>Cuba</td>
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<td>Male</td>
<td>&gt;24</td>
<td>35-44</td>
<td>Very Good</td>
</tr>
</tbody>
</table>
C) Interview Questions

1. What is your age?
   _ 18-24
   _25-34
   _35-44
   _45-54
   _55-64
   _65-74
   _75 or older

2. Do you identify as
   _Male
   _Female
   _Other (specify)
   _Rather not say

3. Are you of Hispanic or Latino origin or descent?
   _Yes, Hispanic or Latino
   _No, Not Hispanic or Latino

4. What is your race?
   _Black
   _White
   _Asian
   _Native Hawaiian or other Pacific Islander
   _American Indian or Alaska Native
   _Other

5. Where were you born (country)?
   __________

6. How long have you lived in Lancaster?
   _less than 1 month
   _less than 6 months
   _less than 12 months
   _13-24 months
   _more than 24 months

7. Tell me about the language that you feel most comfortable speaking?

8. What nationality do you identify with the most? Why?

9. Tell me about how you felt when you first moved to Lancaster.
10. Tell me about your community (family, friends, organizations, etc) and what makes you feel that you belong?

11. In general, how would you rate your overall health?

   - Excellent
   - Very good
   - Good
   - Fair
   - Poor

A personal health provider is the doctor or nurse who knows you best. This can be a general doctor, a specialist doctor, a nurse practitioner, or a physician assistant. Your personal health provider is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Please think about the health provider you usually see when you are sick or need advice about your health when you answer the following questions.

12. Tell me about your experiences getting health care in Lancaster.

13. In general, how would you describe your interactions with your health care provider?

14. Please describe any challenges that have prevented you from seeking medical care from a health care provider while living in Lancaster?
D - Informed Consent Form

The Impact of Acculturation on Refugee Health Satisfaction

You are being asked to participate in a research study about the impact of acculturation on refugee health outcomes in Lancaster, PA. The purpose of the study is to understand the factors that impact refugees’ health with hopes of developing interventions to better serve this population. Please read this form carefully and ask any questions you may have before agreeing to take part in this study.

This study is being conducted by Saliyah J. George through the Public Health Program at Franklin and Marshall College.

What will I do if I choose to be in this study?
If you agree to participate in this study, you will be interviewed and asked about your thoughts and perceptions of your refugee identity and your health behaviors. The questionnaire consists of 14 questions and will take approximately 15 minutes to complete. Your responses will be recorded and a transcript will be produced. All recordings will be deleted after the recordings are transcribed verbatim.

What are the possible risks or discomforts?
The questions that you will be answering were not intended to cause any emotional distress or embarrassment. However, some questions may require you to reflect on past memories that may have caused you discomfort. If you feel uncomfortable when answering any questions, please tell the interviewer at any time if you wish to take a break, stop the interview.

What are the possible benefits for me or others?
This study is designed to learn more about factors that influence refugees’ health behaviors and outcomes. Therefore, this study’s results may be used to help other people in the future.

How will my information be protected and how will that information be shared?
All questionnaires will be completed anonymously, meaning that no identifying information, such as your name or address, will be collected. The results of this study may be used in publications and presentations.
**Study Compensation**
Participants in this study will receive a $10 gift card for participating. This is a one-time compensation.

**What are my rights as a research participant?**
Participation in this study is voluntary. You do not have to answer any question you do not want to answer. If at any time and for any reason, you would prefer not to participate in this study, please feel free not to. If at any time you would like to stop participating, please tell me. We can take a break, stop and continue at a later date, or stop altogether. You may withdraw from this study at any time, and you will not be penalized in any way for deciding to stop participation. If you decide to withdraw from this study, the researchers will ask you if the information already collected from you can be used strictly for research purposes.

**Who can I contact if I have questions or concerns about this research study?**
The researchers will answer any further questions about the research, now or during the course of the project. If you have questions later, you are encouraged to contact Saliyah George at sgeorge1@fandm.edu. If you have any questions or concerns regarding your rights as a participant in this study, you are encouraged to contact the Daniel Ardia, dardia@fandm.edu and Hollie Tripp, htripp@fandm.edu.

This project has been reviewed and approved by the Franklin & Marshall College Institutional Review Board. Questions concerning your rights as a participant in this research may also be addressed to Marcus Thomsen, Ph.D., Office of the Provost, 102C, Old Main, mthomsen@fandm.edu, (717) 358-4283.

**A copy of this consent form will be provided to you at the end of the interview.**

**Consent**
I have read the information above. I have asked questions and received answers to all of my questions. I consent to participate in this study.

________________________________________                      __________________________
Signature of Subject                      Date

_________________________________________                      __________________________
Person Obtaining Informed Consent                      Date