trauma care

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Trauma Care for Forced Migrants

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Abstract: Ever since World War II, forced migrations have increased exponentially, shaping our world, economies, and political discussions. When the United Nations formed the United Nations High Commissioner for Refugees (UNHCR) in 1950, it could not predict the escalation of forced migration from civil unrest, personal persecution, war, and recently, climate crises. As forced migrations increase, we must understand the emotional trauma involved, and how to mitigate it. This study examined how providers of refugee services understand, assess, and treat trauma in the forced migration population. This paper is based on qualitative data collected from social work providers who work with forced migrants. Transcribed interviews were analyzed through content analysis regarding assessment and treatment approaches. The findings show that the lack of trauma-informed care was prevalent among the participants. This was reflected in the participants' experiences. Three main themes emerged: (1) trauma was misdiagnosed; (2) few were trained in evidence-based practices to manage trauma; and (3) providers felt isolated in their work as if working in silos. These themes and their implications are discussed.

Keywords: trauma; forced migrants; DACA; refugee; immigration; resettlement

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1. Introduction

The United Nations understood the personal hardships and nation destabilizations that forced migrations due to war and civil unrest causes. In the aftermath of WWII, the United Nations developed a commission to address displaced Hungarians during civil unrest [1]. Originally, this commission believed their charge would end in three years, reasoning that they will have solved the problem by then. However, 72 years later, we are in a chronic situation where the nations may vary but the needs remain the same. How do those who work with forced migrants manage this ongoing crisis, and what can we learn from 72 years of reacting to displacements? Given its chronicity, continued civil disputes and wars, and most recently the acute needs of those fleeing climate crises and economic unsustainability, we must develop effective methods of helping those displaced and preparing for those who will be displaced.

1.1. Trauma and Forced Migrants

The International Organization for Migration (IOM) defines migration as encompassing all forms of movement of persons domestically and internationally [2]. Forced migration differs from immigration by notable elements. Typically, immigrants to a country come of their choosing and often have resources that they bring into the new country as well as connections, either family or work, that help them relocate their lives and work [3–5]. Forced migration is a term used for those who immigrate not by choice but for survival [6]. They often arrive in the new country without resources or connections [6]. They usually do not choose the country that they flee to, but rather are assigned (as is the case with United Nations designated refugees), or are seeking asylum in the nearest feasible country [7–9].

These are important distinctions between immigrants and forced migrants. Forced migrants in this paper include refugees, asylum seekers, and those who cross boundaries undocumented. Often, the forced migrant does not know the new country's language, has

no family already living in the country, and likely suffered violence and poverty. If the migrant is fleeing civil unrest, violence, or government persecution, there is an increased likelihood that they have suffered forms of violence, oppression, and torture [10–13].

Not only are the circumstances of their fleeing often traumatic, but so is the journey, which may include walking with anything they can carry for months at a time and/or years in a refugee camp [14,15]. Many experience trauma directly in the forms of physical and emotional abuse by others, imprisonment in subhuman conditions, and/or witnessing family members' torture and murder [16,17]. The effects of this trauma are long-lasting and impair their ability to resettle and integrate into the new country [18]. Trauma can make learning a new language nearly impossible later in life, or debilitate workers who were once competent and capable in their previous lives [19]. This trauma shapes and informs the forced migrant's experiences in their new home country. It directly affects how well they can integrate and remain in the country of their resettlement [20]. If we are to mitigate the harm of displacement, we must understand how to address the trauma in forced migrants in ways that enable them to function at the level hey functioned before the disruptions that caused their displacement.

Acute trauma and Post-Traumatic Stress disorders are prevalent among forced migrants [17,21–26]. Yet, screening for trauma is not universal; and even if the forced migrant is screened for trauma, there may not be a health or mental health provider trained in treating trauma. Trauma-informed care is not widely understood and practiced in health and behavioral health settings [27,28]. Trauma-informed care includes relational and trust-related awareness and interventions that are not necessarily included in cognitive behavioral therapy (CBT). There are five core tenets within trauma-informed care: bearing witness to the client's experience of trauma; providing a space that is physically and emotionally safe; including the client in therapeutic decisions by being transparent about the roles and abilities of the providers who work with the client, and welcoming the client to make treatment-related choices; working with the client's strengths rather than focusing on pathology; and understanding that the client's experience with trauma is influenced by culture, history of trauma, resources, and status [28–30]. Additionally, trauma and PTSD symptoms can be difficult to assess as the symptoms can vary depending on the age and cultural beliefs of the individual. Hinton has explored how culture shapes our experiences with, and understanding of, illness and health, making it more challenging for providers to assess trauma [27,28,31–33]. Even if the individual is assessed accurately, effective trauma treatment may not be available. While cognitive behavioral techniques are familiar to many providers in Europe and the United States, CBT may not be the most effective approach for treating PTSD [34–36]. Similarly, traditional meditation tends to not be effective in treating PTSD. Studies suggest that it may worsen PTSD if the individual cannot control their ruminations of the traumatic events [37].

1.2. Impact of Trauma on Resettlement

For forced migrants to enter and resettle in a new country, they must be able-bodied to work in entry-level positions, many of which require physical exertion. They must be able to develop a functional language acquisition, and conform to the fundamental norms of the new country. This can be a challenge for any immigrant, but for forced migrants who have fled poverty, war, persecution, and violence, the challenge is even greater [38]. Social workers, medical professionals, and others who work with forced migrants can be helpful in the transition. To be helpful, these professionals need to recognize the signs of trauma, understand the questions that need to be asked, and know how to mitigate the stress of relocation and help the migrant manage their PTSD.

However, developing and implementing effective approaches to working with forced migrants is difficult. The difficulties are exasperated when each country has its process of working with forced migrants, and each migrant has their own experiences based on the country of origin, the culture of the individual, and the attitudes and resources of the hosting country [16,17,21–23]. These factors contribute to a gap in trauma-informed

care. This study examined how providers of refugee services understand, assess, and treat trauma in the forced migration population. This paper is based on qualitative data collected from providers of forced migrants.

2. Materials and Methods

This is a qualitative study of 12 medical professionals who work with forced migrants in community health settings, and 18 social workers who work with forced migrants in community health centers and social service agencies. Participants were recruited initially by contacting the directors of community health centers and social service agencies who work with forced migrants. Recruitment occurred in the Boston area of Massachusetts. The directors were provided with flyers with information about the study which they distributed among their staff. The flyers described the study, its purpose, and the rights and protections of the participants, including that their participation in the study is voluntary and confidential, and that their director will not know who participated. Each flyer contained the principal investigator's contact information. Potential participants were invited to contact the principal investigator directly if interested. At the end of the recruitment, there were 12 medical professionals and 18 social workers. The requirements for inclusion were current experience working with forced migrants.

2.1. Rights and Protections

Prior to the study recruitment, the study was reviewed and approved by the institution of the principal investigator through the Institutional Review Board (IRB), approval code 32098. In addition to the IRB approval, each participant read and signed an informed consent form. The informed consent described the study, the participant's right to confidentiality, the fact that no identifiable information would be published, the study's possible harm and benefits, and how any harm would be managed. For example, if the interview questions reminded participants of painful memories, the participant could decline to answer any question or stop the interview at any time. They were also informed that the principal investigator is a licensed clinical social worker who could help the participant during the interview as well as assist the participant to find additional help. The consent form also disclosed to the participant that the principal investigator (PI), as a licensed provider, is a mandated reporter who would need to report knowledge of specific forms of abuse or threat. These reportable events were detailed in the consent. All collected data were kept in the PI's password-protected computer.

2.2. Data Collection

Data were collected from the semi-structured qualitative interviews, allowing room for participants to speak more in-depth on issues they initiated. The literature directed the scope of the 10 questions which centered around the needs of the forced migrant and the experiences of the providers in working with forced migrants. For example, "What services do they [the forced migrants] need?" "What do you think is most helpful in providing care to this population?" Follow-up questions were asked for clarification and to explore the issue further. If the participant responded on a related matter, that would be further explored with the participant if it was relevant (i.e., "You mentioned something that I would like to explore further"). Interviews were conducted in a private location of the participant's choosing. The interviews were audio-recorded, with the participant's approval, for future transcription. Interviews lasted between 45 min and one hour.

2.3. Data Analysis

Content analysis was used by the PI and a research assistant when coding the transcribed interviews. On initial reading, each coder highlighted passages that exemplified the participants' narrative for each question. The coders continued coding this way with each interview. The coders reread the interviews and assessed whether there were any missed passages. These passages were then read again and new codes were assigned. These

new codes reflected a more nuanced participant experience. For example, while the first coding might generate verbatim quotes that discussed an overall experience, the second coding strove to tease out shared or opposing experiences of the participants, or responses that provided a deeper understanding of the participants' experiences. The coders met and shared their codes, reviewing, comparing, and discussing the differences in codes. These discussions resulted in codes being dropped, combined, or renamed for clarity and inclusiveness. Codes were combined when appropriate to form large categories. Those categories were then examined, and combined if they provided more clarity. The final categories formed the foundation for emerging themes. These categories and themes were reviewed by three of the providers interviewed. These discussions did not result in major changes to the results. The following section is comprised of the main themes that emerged from the data.

3. Results

After recruitment, there were a total of 30 participants; 12 were from the medical field, and 18 were social workers. Of the medical field participants, 3 were Medical Doctors, 4 were Physician Assistants, and five were Nurse Family Practitioners (see Table 1). Three main themes wove through the interviews: Trauma was misdiagnosed; few were trained in evidence-based approaches to working with migrants' trauma, and participants often were unaware of supporting agencies in the community. Below are these findings. When quotes are used, they are noted with the gender, profession, and participant number.

Table 1. Participants.

Profession	Number in Study	Trauma Trained
Social Work	18	5
Medical Doctor	3	Physical trauma 2
Nurse Family Practitioner	5	1
Physician Assistant	4	1

3.1. Trauma Misdiagnosed

Many of the participants (n = 21), whether they were in the medical field or social work field, had not been trained in trauma care and were often unfamiliar with the symptoms of acute trauma or PTSD. Their lack of training was evident in their responses to questions regarding the behavior of their clients and patients. They tended to make assumptions about the forced migrants' behaviors. Instead of assessing the behavior as trauma, they perceived the behavior to be characterological. The following two quotes best capture this. "They (forced migrant clients) seem aloof. They repeatedly call me for things. Like they are owed help. Not sure about PTSD. They look pretty competent to me." (male, social work, #22). And, "I tell them to go to the language classes and they don't. I tell them to find a job, and they don't. I don't know if they are lazy or don't care. But it makes me feel like I am wasting my time trying to get them referrals." (female, social worker, #14). Some participants noticed similar behavior and attributed it to medical problems. As one medical provider explained, "I wonder if they are having a difficult time adjusting to our lifestyle, our food. I think what we are seeing is stress but also malnutrition and untreated chronic illness. Diabetes is pretty common." (female, physician assistant, #23).

Of the 21 participants who had not been trained in trauma care, 8 were medical professionals, and 13 were social workers. The participants had several types of responses regarding having had training in working with others who have acute psychological trauma. Participants with medical degrees (Medical Doctor, MD, Physician Assistant, PA, Nurse-Family Practice, NFP) reported having varying experiences with physical trauma, most often from prior work in Emergency Departments (EDs). The following quote captures that experience.

> I did a rotation in an ED and saw a lot of gunshot wounds and knife wounds. So, I know how the body responds to these kinds of traumatic injuries. And, sure, I imagine that they had emotional trauma too, but I didn't address any of that. And, sure, I know about PTSD, but it isn't on my mind when I see a patient. I guess I assumed someone else dealt with that at the hospital, like a social worker maybe. And truthfully, I don't know what I should look for. (Male MD, participant #3)

The social work participants (n = 13) who stated that they lacked trauma-care training tended toward one of two responses: "I think for my job (case management) I don't need to know that much about trauma care" (social worker, female, participant #27); "I assume every one of my clients has trauma. I mean, how could they not? I would love to be trained in trauma. But after graduation, where does one find the time? And where does one learn this?" (social worker, female, participant # 11).

It appears that those who had prior training in working with psychological trauma understood its importance. This was evidenced by the responses of the non-trained participants. Those participants who had some exposure to trauma-care practices were more articulate about its importance and how it can enhance their work with clients. For example, the following is from a social worker who reported extensive training in trauma care.

> Oh, trauma (psychological) changes everything. When I first started working with folks with PTSD, I hadn't been trained. Believe me, I missed a lot in the assessment and intervention with these clients. I remember getting annoyed when a client couldn't remember the appointment or seemed quiet and distant. I remember thinking 'hey, I'm here to help. You should be more forthcoming.' Once I was trained, I could recognize the signs and knew better how to intervene. I am a much better social worker for it. (female, social worker, #17)

The participants who were trained and experienced in working with psychological trauma described the difficulty of recognizing the symptoms of trauma and PTSD. As this social worker explained,

> I work with Cambodians who were severely tortured. I know they have been because their file has the details of their torture. Sometimes there was a disconnect between what I knew about them through their file, and how they were in front of me. When I was first learning trauma care, I looked for the symptoms that the DSM outlined. But then, over time, I realized culture can change how someone manifests these symptoms. For a Westerner, and the trauma is fairly recent, the DSM helps in identifying it in clients. But if they come from a culture that has a whole different way of understanding stress and health the symptoms can look really different. (female, social worker, #19)

The medical professional participants who had trauma training and experience noticed how symptoms of PTSD change over the life course. Later in life, PTSD can appear as dizziness, weakness in arms and legs, insomnia, heightened fear response to common stressors, fainting, and compulsive behaviors (gambling, substance use, cleaning, compulsive rituals). Those who assessed for and recognized trauma remarked on how difficult it was to acutely diagnose. This was particularly true for medical professionals who saw patients for short sessions. The medical professionals focused on chronic illnesses and symptoms. As one physician assistant explained, "They have been in this country for longer than they were in their home country. Why would it be PTSD? It wasn't until a counselor on staff told me PTSD can resurface later in life that I understood." (male, physician assistant, #23).

3.2. Few Were Trained in Evidence-Based Practices to Manage Trauma

All the social work participants used cognitive and behavioral therapy (CBT) interventions to help clients manage their anxiety or depression symptoms. When asked why they chose that approach, a common response was, "I know CBT and it is effective with

depression". Some of the social work participants used mindfulness practices, such as teaching clients meditation and relaxation techniques. However, those who used mindful practices were not aware of how it affects long-term trauma such as PTSD. There were a few participants who had some level of previous clinical experience working with trauma, but none had professional training in trauma-informed care.

The medical provider participants had varying degrees of experience working with physical traumas. Those with the most experience had worked in emergency departments with patients who had injuries from violence or car accidents. Those who had this experience believed it helped them be more aware of emotional shock and diminished cognitive abilities. However, as one medical doctor stated, "There is knowing someone is reacting to trauma, and a whole other thing to know what to do or say." (female, medical doctor, #7). The medical providers described feeling powerless to help their patient's traumatic symptoms beyond giving them medications to help them sleep, lower their blood pressure, and manage their anxiety. One participant expressed his understanding of trauma-informed care this way,

> I've definitely heard about trauma care (trauma care and trauma-informed care are often used interchangeably to mean having knowledge about trauma and how to address it with clients). I worked briefly at a center that had made its waiting room with low lights and soothing colors, trained office staff to tell patients everything that was going to happen during the visit, lots of posters about trauma. We (medical staff) were coached on staying relaxed, uh, calm with the patients, and writing everything down for them in case they forgot or weren't able to take it in. I think that is trauma care. (male, medical provider, #11).

3.3. Working in Silos

The final major theme prevalent among the participants was feeling like they worked in silos, each member of the clinical team working independently from the others. The social work participants also felt cut off from other community providers and agencies. Even though the social workers offered referrals to other agencies, they rarely connected with the staff at these agencies. The medical providers felt isolated most with other colleagues at the same agency, while the social workers felt it with the medical staff at their agency but also with community partners.

As one social worker described,

> I can't speak to actual trauma care, but I do think we would be doing a better job for our clients if the pcp (primary care provider) and I could sit down and talk about our cases. I think they (pcps) focus on our clients' diabetes and stuff, but don't understand why the clients don't take the meds as prescribed. Sometimes I'll run into one in the hall and they look personally insulted if the client is not med compliant. What I want to say to them (pcps) is that there is a whole bunch that goes into a person being compliant. Now that we are talking about trauma, I bet that is a big reason they don't take the meds. There is also cultural stuff that makes it hard for folks to take drugs when they are feeling good. That happens a lot with blood pressure pills. 'Why should I take this? I feel okay.' But if me and the docs (doctors) sat down, we might come up with a better plan for our shared cases.

And concerning feeling isolated from other agencies and community partners, this same participant stated,

> I make a lot of referrals. Sometimes I talk to social workers from other agencies on the phone, but most times I give the client the contact information and hope they follow through. Either way, I don't think this is great. How many actually follow through? It would be great if we all met monthly, like at some county-wide meeting where we could share our collective experience (of working with forced migrants)

(female, social worker, #29)

The participants described time shortage as the main reason for not meeting with other providers. The following was a common response, "You need to understand, I have 15 min to see a patient, write up my notes, submit orders. Meeting with other providers, even in this same building, feels like a luxury of time I just don't have." (female, Nurse Practitioner, #26).

4. Discussion

The findings of this study suggest that health and behavioral health providers are required to attend to the needs of forced migrants without training on trauma and trauma-informed care. Without this training, forced migrants seeking assistance can be misdiagnosed and perceived negatively. Agencies are faced with daunting issues yet are limited in their ability to be effective. Administrators and policymakers who are trauma-informed can create better connected systems of care.

4.1. Trauma Misdiagnosed

The findings reflect factors that have been shown in other studies, such as staff reporting not feeling well-trained to work with forced migrants, especially those migrants who have experienced trauma [39,40]. This was true even for those participants who have had some experience working with clients and patients who had been diagnosed with PTSD. When working with forced migrants, the standard definition of PTSD and its symptomatic characteristics may not appear in clients from varying cultures and ages.

As evidenced in this study, providers can misinterpret trauma behavior as indifference, or arrogance or feeling entitled. Some of the participants in this study expressed judgments toward the forced migrants when their behavior did not appear grateful for the services. Instead of seeing the client's hesitations, demanding requests for services, and lack of motivation as signs of trauma, they perceived them as ungrateful or lazy. This perspective can create discriminatory practices that the provider is unaware of. One misunderstanding might not be an issue, but all the misunderstandings combined can lead to systematic inequity in health services.

4.2. Few Were Trained in Evidence-Based Practices to Manage Trauma

The social work participants lacked training in providing trauma-informed care. Cognitive behavioral therapy was used by the participants without fully understanding if it was addressing the trauma. While CBT was used to address the symptoms of recognizable trauma, it did not address the overarching needs of the clients dealing with long-term PTSD. One participant was able to discuss the elements of trauma-informed care from having worked briefly in a health center that seems to practice it. This account was the closest the participants came to understanding the scope of this practice.

Trauma-informed care can extend effective treatment outside of the therapy office when providers of health and behavioral health, teachers, and others who work with vulnerable populations are trained to recognize the multiple ways in which trauma can manifest, engage with the individual in ways that acknowledge that those who experience trauma may be afraid, anxious, and mistrustful. They may also need accommodations if learning a new language later in life is difficult, or the pacing of work tasks is too stressful. Age and culture can further modify the signs and symptoms of trauma, making it challenging for providers to assess for trauma. When trauma is not recognized, misdiagnoses and misunderstandings are likely. Additionally, when trauma and PTSD are overlooked, the individual can internalize the stress and blame themselves for any limitations.

Trauma-informed care in its widest application would inform how waiting rooms are designed, information is displayed, and how trauma is discussed with staff and clients. Supporting staff need to be trained in trauma so that their interactions with clients/patients are congruent with the approach and understanding of the providers. Providers need the training to help them work relationally, meaning that the trust of the client needs to be

paramount. This may translate to the choices given to the client regarding their treatment, no-show policies that are not punitive, the ability to have trusted friends and family with them during the visits, and transparency on all client-related tasks (what tests are needed and why, what diagnosis is the provider assuming, why are the medications prescribed and which symptoms are they to address). Clients who use an interpreter may need to know more about the interpreters to know if they can trust them. For example, if a clinic hires an interpreter, is that someone from the forced migration population? Will this cause tension if the client and the interpreter had different statuses or political beliefs in their home country? Will the interpreter know other family members in the community? Can confidentiality be honored?

Medical providers can learn brief trauma interventions that can strengthen the work of the other providers working with the client. While brief, the exam room interventions can support and deepen the trauma care they are receiving from other providers. For example, a medical provider can focus on the client's diabetes and ask about trauma-related symptoms (insomnia, etc.). They can normalize some of the concerns the client has by educating the client that these are normal symptoms of trauma. The providers can ask permission before touching patients, and discuss with the patient the importance of self-care, especially for those who have PTSD. Providers who are mindful of trauma in their work cases can develop calming behaviors and gentle communication to help the patient feel safe. All providers need to be aware of their positionality (ethnicity, primary language, class, gender) when engaging with patients who have chronic trauma, such as PTSD.

4.3. Working in Silos

The findings also highlight the barriers to trauma-informed care. In addition to the lack of trauma-informed training, agencies may act as a silo, separate from other community resources. Even providers in the same agency can operate separately from one another. The doctor might be treating a symptom in the client, and the social worker might be working on the client's trauma, but the two providers are not sharing notes. Their work is separate even though the client's symptoms may have the same cause. Without trauma information about the individual seeking help, the health providers do not have the whole picture of the person. When medical professionals give discharge plans and outpatient instructions to the patient, the providers may not be cognizant that the patient and caregiver may not be equipped to follow the instructions. This is true for providers and clients who come from different cultural and economic backgrounds as well, but for trauma sufferers, much of their limitations in follow-through are hidden, often from the client/patient too.

This study highlighted trauma within the forced migration population. Since the forced migrant population is very diverse in countries of origin, cultures, languages, beliefs, and experiences, it is challenging to find one effective approach. However, what we know about trauma can guide the care we provide. Importantly, these trauma-informed practices go beyond the office setting and include the environment of the center and each staff member who interacts with the patients/clients. Even though these changes can feel wide in their scope, once implemented by trained professionals, the patient's positive outcomes should be evident.

5. Limitations of the Study

This study took place in the United States, in one region of the country. Its sample is exploratory and not sufficient to make universal declarations on its findings. This is an excellent place to start a more inclusive, international study that can test the effectiveness of trauma-informed care with forced migrants. If such future studies occur, it is recommended that an encompassing model of trauma-informed care be examined, one that begins that informed care before the individual ever enters the agency. Does the agency integrate itself into the community? Does it make getting an appointment free from confusion and hurdles? Is the agency's appearance soothing and informative? Is there ongoing training for all staff and providers?

Our ever-changing world requires more from those who work with vulnerable populations. With a greater understanding and expertise in trauma-informed care, currently forced migrants can make an easier transition to this country. With a less stressful relocation, forced migrants will be better prepared to create their new lives and move through their current disruptions.

6. Conclusions

Forced migration continues to increase throughout the world. The causes of these migrations are not resolving but growing. Globalization is making our world more interconnected and interdependent; the pandemic and the global supply chain issues revealed how connected we are, and how we must work together to meet the challenges facing our world. Nations that have not had large movements of forced migrants seeking safety may feel that this is not their problem. However, it is everyone's problem, now or soon. In the United States, the western states have had an unprecedented number of devastating wildfires. The wildfires gave many in these states their first experience of being forced migrants. Forced from their homes, they sought safety in other towns and states. We are faced with a question that most of the world is grappling with, who will take care of us when civil unrest and the climate crisis make our home, our country, and our world uninhabitable? These are concerns of our age and we must address them to reduce human suffering.

The field of trauma and post-traumatic stress disorders has evolved since it was first acknowledged in victims of fire and war. The field is learning more about the causes of long-term trauma, and how it manifests in different cultures and across the lifespan. Recently, elementary schools have sued in hopes of bringing awareness and resources to children living in violent and/or poor neighborhoods. Specifically, they requested trauma-informed approaches in the classroom [41]. Professionals from a wide swath of disciplines are identifying trauma in areas once not considered, poor neighborhoods, schools, child neglect and abuse, and pandemics.

Providers and policymakers who work with forced migrants need to be equipped with efficient and culturally effective tools and skills to mediate the trauma that often accompanies forced migrations. The health and behavioral health professions are familiar with cognitive and behavioral therapy interventions. More research is needed to assess if this is the most culturally effective approach with varying populations and cultures. Resilience-enhancing approaches should be studied, and if effective, used in combination with CBT or other culturally flexible techniques. Forced migration appears to be a chronic global crisis that needs a globally effective solution. Treating those amid migration requires immediate attention.

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Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki and approved by the Institutional Review Board of Wheelock College (protocol code 32098).

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study. No identifying information about the participants will appear in published forms.

Data Availability Statement: The data in this study, transcribed interviews, contain personally sensitive information that could compromise the confidentiality of the participants. The PI can be contacted regarding inquiries about the data.

Conflicts of Interest: The author declares no conflict of interest.

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