Pilot Study Examining the Impact of Acculturation on Refugees' Healthcare Satisfaction

Refugees are individuals who are forced to flee their country due to violence, persecution, human rights violations, and/or war.[1] Not surprisingly, some refugees who experienced pre-migratory trauma arrive in their resettled countries with adverse health conditions, such as posttraumatic stress disorder.[2] The United States federal government is aware of the health disparities that impact refugee communities and offers assistance to help refugee populations become self-sufficient. During the first ninety days, and sometimes the first five years, of arrival in the US, refugees receive employment, food, housing, counseling, and healthcare benefits (e.g., Medicaid Refugee Cash Assistance and Refugee Medical Assistance) to help foster independence and productivity in their new setting.[3] Despite receiving these supportive services, refugees are disproportionately impacted by poverty, negative health outcomes (e.g., poor healthcare satisfaction), and have limited access to healthcare in their resettled communities.[4]

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.[5] Although resources are provided to help refugees effectively adapt to their new environment, refugees often experience prejudice, discrimination, and exclusion while navigating in foreign social environments.[6] 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.[7] Acculturation can help refugees become familiar with a different and/or unfamiliar environment and overcome unexpected difficulties when they are resettled.[8]

Acculturation is a multidimensional phenomenon that focuses on the psychological changes that immigrant individuals experience when consistently interacting within new

environments with dissimilar host cultural norms and individuals.[9] This dynamic definition of acculturation accommodates the different narratives and experiences of immigrants, asylum seekers, and refugees.[10] Berry describes four styles of acculturation (assimilation, separation, marginalization, and integration) based on a person's relationship to their original culture and host culture.[11] Immigrants and refugees may experience marginalization when they choose to reject the host country's traditions while struggling to maintain their own cultural identity.[12] Maintaining a strong connection with one's heritage culture while pursuing the least amount of connection to their host society creates separation.[13] The inverse, assimilation, occurs when the immigrant maintains low levels of connection to their heritage and cultural identity and connect to their host society.[14] Whereas, integration occurs when one has a strong connection to both the host culture and their original heritage and customs.[15]

Literature in the field of acculturation is inconsistent about acculturation's impact on health outcomes. Some studies suggest that bicultural (or integrated) individuals, who possess and perform cultural behaviors from their heritage culture and host culture, have better health outcomes when compared to their non-integrated counterparts.[16] Researchers conclude that bicultural refugees have lower prevalence rates of major depressive episode and higher rates of preventive oral health.[17] In contrast, the Immigrant Health Paradox suggests that immigrants tend to have better overall health outcomes than native-born residents.[18] Particularly in the US, nonimmigrant populations tend to have lower rates of chronic diseases and mortality than white individuals, who tend to have the best health outcomes in comparison to other racial groups.[19] Despite being adversely impacted by these social determinants of health, they have lower mortality rates and higher rates of substance abuse and cigarette use when compared to US-born individuals.[20] One possible explanation for the observed trend is that immigrants maintain

cultural practices (e.g., mainly eating fresh produce) despite being in the US, which buffers against negative behaviors that are prevalent in their resettled community.[21] It is also important to note that maintaining cultural practices often diminishes as immigrants become more acculturated, obtain an education, and remain in the settled environment.[22]

Refugee Healthcare Satisfaction

Patient satisfaction is a type of health outcome that is often used to measure the quality of healthcare services a patient receives in a health system.[23] Patient satisfaction is impacted by patients' experiences, such as the quality of the interactions with doctors and specialists, which affects patients' retention rates.[24] The quality of the service that patients receive is often centered around the patient, doctor, and organization.[25] Patients tend to have greater healthcare satisfaction if health facilities/organizations offer effective and efficient services (e.g., human and electronic translators) and healthcare professionals listen and relate to patients' health concerns and provide high-quality care.[26] Patients' perceptions of quality healthcare services are related to their gender, age, severity of illness, and perceptions of the healthcare system in general.[27] However, refugee status is also a factor that impacts health satisfaction.[28]

There is limited research that examines acculturation's impact on refugees' healthcare satisfaction. Refugees are more likely to face discrimination at health facilities from healthcare providers than native-born Americans.[29] Due to factors such as a lack of culturally competent doctors and a lack of effective translation services, refugees often report low rates of healthcare satisfaction.[30] In 2011, Ramin Asgary and Nora Segar conducted a qualitative study to evaluate healthcare barriers faced by refugee populations, most of which were from African countries.[31] They concluded that refugees tend to mistrust healthcare providers because they perceived doctors' interactions as impersonal and focused on making money without comprehensively

treating their health condition.[32] In studies where refugees report being satisfied with the healthcare services they receive, they also report feeling uncomfortable during visits due to the lack of access to interpreters and infrequent continuity of care.[33] However, when refugees receive care from refugee treatment units they tend to be more satisfied with the care they received.[34] Therefore, higher rates of healthcare satisfaction may be related to health professionals in these facilities receiving evidence-based cultural sensitivity training and having readily accessible interpreters.[35]

Study Purpose and Significance

In order to address the gap in literature, this study attempts to understand the impact of acculturation on refugees' health satisfaction by examining refugees who come from many national and ethnic backgrounds.[36] In addition, to better tailor healthcare services and expand high-quality and accessible healthcare services to this vulnerable population, it is crucial for healthcare providers to understand the complex psychological process that refugees experience and the barriers they face while in the healthcare sector. Ultimately, this study's findings can reveal gaps within Lancaster's healthcare system and the healthcare system as a whole and offer feasible policy recommendations to improve refugee healthcare satisfaction.

Methodology

The purpose of this study is to explore the potential relationship of acculturation on refugees' health outcomes and healthcare satisfaction. The primary researcher conducted semi-structured interviews to capture refugees' past and current experiences accessing healthcare services in Lancaster and gauged how acculturation influences refugees' daily experiences. A qualitative, as opposed to a quantitative approach, is used to understand the feelings, values, and perceptions that underlie and influence refugee health outcomes. The complex relationship

between acculturation and health satisfaction is explored when refugees elaborate about their experiences and how external factors affect their health outcomes. This study employs semi-structured face-to-face interviews with refugees living in the City of Lancaster in Pennsylvania. Lancaster's population is approximately 59,265, with 40 percent identifying as non-Hispanic White, 17 percent Black or African American, and 25 percent of the population living under the federal poverty level. On average, for every 327 residents, one refugee is resettled in Lancaster.[37] Four of the largest resettled refugee populations in Lancaster are from Somalia, Burma, Bhutan and the Congo.[38] In addition, since 2003, Lancaster has taken refugees at a rate of twenty times per capita, which is one of the reasons why Lancaster is called the "Refugee Capital."[39] All protocols for this study are approved by the Institutional Review Board (IRB) from Franklin and Marshall College (#R_3MnXAYBYPo1TTic).

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 identify as female and six as male. All participants are between 18-55 years old and have lived in Lancaster for at least two years.

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.[40] Only recruiting this specific type of participant allows the primary researcher to capture participants' process of acculturation as they live and adjust to life in Lancaster and experiences navigating this city's healthcare system while being a refugee. Snowball sampling is 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 refugee communities. Thus, snowball sampling allowed the researcher to recruit more participants through previous participants referring their friends and acquaintances.[41] Participants were also recruited through the research team collaborating with Church World Service.[42] After each participant completed their interview, they were compensated with a $10 gift card.

A semi-structured interview guide was used to ask core questions to all participants (Appendix A). The guide is based on previous literature that highlighted English proficiency and social support being factors that influence acculturation and health outcomes for immigrant and refugee populations.[43]

Interviews were conducted in private offices in participants' workplaces, in Lancaster's downtown library, and on Franklin and 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 asked study-related questions. 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; however, one participant brought her own translator who is 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 identification number to maintain confidentiality and saved the audio as password-protected computer files.

Two researchers 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 are from different racial, ethnic, socioeconomic, and geographic backgrounds, which meant people with diverse perspectives analyzed each transcript. The research team used analyst triangulation to review the findings and discuss the ways that they could comprehend the data and reduce bias that would have occurred with just one researcher coding. 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 healthcare, 7) language as a barrier to accessing healthcare services, 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 all disagreements in coding to ensure that interviews were being consistently coded. The research team also performed descriptive analyses to gauge health status and other measurable items on the interview guide.

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

Findings

Five major themes appeared during 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 healthcare satisfaction. Each of these themes will be explored more during the following sections.

Culture shock was defined as the confusion and anxiety that refugees felt when having to resettle in Lancaster.[45] Participants state that they had negative experiences when initially adjusting and resettling in Lancaster. Participant no. 1 is an Asian Bhutanese man who resettled in Lancaster about ten years ago. The participant explains the challenges of integrating into his resettled community. Participant no. 1 states:

> 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 no. 1 also notes 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 no. 1 expected to be welcomed by the residents in his Lancaster neighborhood, but he did not get the welcome that he yearned for.

Participant no. 2's initial period in Lancaster resembled the harsh encounter that Participant no. 1 experienced; however, Participant no. 2 encountered culture shock that negatively impacted him and his family. Participant no. 2 is a Black man from the Democratic Republic of Congo. When speaking about his initial experiences in the US, he states that:

> 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.

Participant no. 2's family went without eating for a prolonged period because they did know where to buy cultural food and did not have many acquaintances**.** Participant no. 2 also adds that:

> 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 no. 2's experiences of being stereotyped at his workplace reveals his understanding of how other non-refugee people view refugees. Participant no. 2 feels disrespected because people at his job erroneously believe that he is an uneducated "jungle person," after only knowing that he was from the Congo. Participant no. 2 personally believes that aspects of US culture involve the misrepresentation of refugees as "nonsense" or less than. Thus, not only did Participant no. 2 have a difficult time adjusting to his neighborhood, but he also feels discriminated against at his job. Thus, Participants no. 1 and no. 2 express that cultural and societal differences prevented them from smoothly transitioning into Lancaster's workforce, social, and political spheres.

Language preference, English proficiency, and self-reported nationality are three factors used to categorize participants as bicultural. Language preference is coded based on participants' comfort using a language or languages while living in Lancaster. Language preference is coded

into three categories: native language, English, and both native and English languages. Five participants state that they prefer speaking their native language, which includes Nepali (3), Spanish (1), and Swahili (1). Three participants state that they prefer speaking both their native language and English. One participant only prefers speaking English. In addition, English proficiency is defined as a participant's ability to speak and comprehend English. Moreover, level of English proficiency is based on a participant's ability to speak English and the primary researcher's perception of participants' English proficiency. For example, two participants are coded as having low English proficiency because they either need a translator or stated that they "do not understand English very well." Seven participants 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. For instance, these participants are proud of their heritage and culture and also declared that they were American.

When asking participants to specify what language they prefer to speak and what nationality and racial category they identify with the most, five participants state that they are bilingual and/or have multiple national and ethnic identities that connect them to American culture. The team coded these responses as biculturation. Participant no. 7 states:

> 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 no. 7 feels comfortable using both languages in his resettlement community, despite English being widely spoken. Participant no. 7's inability to choose one language and nationality that he identifies with highlights that he perceives himself to be connected to US culture.

Participant no. 6 is a Black woman, born in Ethiopia, and currently attends university in Lancaster. Participant no. 6's responses to the questions about the language and nationality that she mostly identifies with resembles Participant no. 7's answers. Participant no. 6 states:

> 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.

She also notes that she is "both American and Ethiopian" when stating her nationality. Participant no. 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. Participants no. 6 and no. 4 are the only participants who state that English was their only preferred language, even though their first language is not English. Based on these results, bicultural individuals had differing language preferences, levels of English proficiency, and national/ethnic identities.

When talking to participants about their experiences when they moved to Lancaster, participants note that ethnic or national community and resettlement organizations played the biggest role in helping them overcome initial cultural differences. Participants state 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 no. 8 is a White-Hispanic Cuban man, who worked at a local refugee resettlement organization. He shares about the

comfort that he felt while interacting with his national, ethnic, and linguistic community in Lancaster. When speaking about his perceptions of his community, Participant no. 8 notes that:

> 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 no. 8 differentiates between the Spanish speaking community and the Cuban community. Even though Cubans predominantly speak Spanish, Participant no. 8's statement highlights that not all Spanish speakers in Lancaster come from the same country and share the same ethnicity. Therefore, Participant no. 8 shows that he feels comfortable interacting with people from his home country and other people that share his native language.

Participant no. 1 frequently engages with the Nepali community in Lancaster, which helped him overcome the culture shock that he experienced when he first arrived in Lancaster. After reflecting on how he define his community and the ways that his community supported him when he was first resettled in Lancaster, Participant no. 1 states that:

> 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 no. 1's statement reflects the different types of social support that he received from the members of the Nepali Lancaster community. Participant no. 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 no. 2, who did not have any Congolese or African community members to show him around Lancaster. Thus, the difference between Participant no. 1's ability to persevere through the cultural differences, in comparison to Participant no. 2, was related to the amount of social support he had.

Participant no. 4 is an Asian woman who was born in Bhutan, sought asylum in Nepal for decades, and resettled to Lancaster over two years ago. Participant no. 4 previously stated that she had a rough time resettling in Lancaster due to cultural differences. However, while discussing her relationship with the Bhutanese and Nepali community in Lancaster, Participant no. 4 declares that:

> 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 no. 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 no. 9's relationship with 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 no. 9 is a Hispanic-White man, born in Cuba, and who is currently working as a construction worker. Participant no. 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 no. 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 in Lancaster, the Cuban residents, both refugees, immigrants, and second-generation Cuban-Americans, helped him adjust to living in a city. Participant no. 9 states:

> 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 car and something like that so it was easy.

Participant no. 9 affirms 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 state that they experienced cultural differences/cultural shock, but partially due to their affiliation with individuals from similar ethnic, national, and linguistic communities they are better able to acculturate to their resettled communities.

Participants rated their health on a five-point scale, including: Excellent, Very Good, Good, Fair, or Poor. Participants tend to rate their health positively, yet many participants have negative health conditions. Out of the three participants who report having excellent health, all of the participants state that they do not get sick or are only impacted by common colds. Out of the three participants who have very good health, participants state 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 have hypertension, gastric problems, high cholesterol, and/or diabetes. Out of the participants that have negative health conditions, five participants report that they are currently taking prescription medication or using over the counter medicine to treat their health conditions. Two

participants state that they actively try to avoid using the healthcare system and prefer home remedies or over the counter medicine.

Furthermore, seven participants state that they are satisfied with the healthcare they have received in Lancaster. A common theme in the data was that language access via speaking English or Spanish and translation services often allows patients to feel satisfied with the healthcare services they receive.

Participants note that speaking English was a way to successfully navigate the healthcare system in Lancaster. Participant no. 7 is a White man who identifies as Iraqi-American, and was categorized as bicultural. He works for a local refugee resettlement organization. During his interview, he states that he was not satisfied with the care he received in the Western healthcare system:

> This is a comparison in general, since I had access to healthcare 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 no. 7's frustrations with the healthcare system is due to him experiencing impersonal and business-like interactions with doctors. Participant no. 7's dissatisfying experiences with the healthcare 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 healthcare system, he also states that knowing English gives him an advantage. He notes:

> 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 no. 7's comparison between him and people who do not know English, demonstrates that his English skills allowed him to circumnavigate confusion and access care, despite it being less personal.

When asked what language he prefers to speak, Participant no. 9 states that "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 no. 9 highlights that English is important to know in order for him to have a better future because most people in America speak English. About his experiences routinely visiting his primary care provider, Participant no. 9 states:

> 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 no. 9 being motivated to learn English to gain access to financial and social opportunities, he utilizes the limited amount of English that he knows to communicate with doctors, even when words are lost in translation.

Like Participant no. 9, Participant no. 5 does not speak English and is unable to directly communicate with doctors. When Participant no. 5 was asked to talk about the reason why she is satisfied with the healthcare that she has received in Lancaster her translator declares 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 no. 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 help

Participant no. 5 have satisfying experiences at the doctor's office because they personalize her care by knowing her and her family's name.

Participant no. 4 reiterates Participant no. 5's views on the impact of translation services. When Participant no. 4 discusses speaking English in Lancaster she notes that:

> 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.

Since Participant no. 4 speaks English with an accent, it is difficult for her to communicate with US citizens and other English speakers in her community. However, her frustrations with being misunderstood do not occur when she visits her primary care provider. She also states that a translator helps her during doctors visits because she "asks me if I am good" and "she understands me." Therefore, in addition to English, knowing other common or dominant languages in Lancaster gives participants the opportunity to adequately access and utilize healthcare services.

Discussion

This study aims to explore the relationship between acculturation and healthcare satisfaction within the City of Lancaster's refugee populations. The results suggest that English proficiency and social support systems are related to healthcare 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.[46] With English speakers typically having better health outcomes than non-native English speakers and people who do not speak English, one would assume 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 related to healthcare satisfaction because the healthcare 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. 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. 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.[47]

A majority of participants in this study prefer 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 no. 6 and no. 7 mention that English allows them to express exactly how they feel and to better communicate with others. For these participants, their native language prevents 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 no. 7 states that Arabic, unlike English, was "not based around emotions." Participant no. 7 is signaling to the idea that speaking English may lead to better health outcomes because patients can 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 healthcare satisfaction.

This study also highlights 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. Hospitals in the City of Lancaster have staff members and translators who are fluent in many languages and offer Video Remote Interpreting (VRI) services that electronically translate over 150 languages.[47] However, in Lancaster, more services are available to people who speak popular languages, such as Spanish.[48] Thus, one explanation for the reason why Spanish speakers in this study do not face many issues when adjusting to the healthcare 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 participants who had low proficiency in English were able to access effective Nepali translators while in hospitals. The issue with providing health services based on the languages that are mainly spoken is that populations who are underrepresented do not have the same access to care. For example, Participant no. 2 states 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.[49] 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.[50] However, in this study, all participants state that they have 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, 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.

Furthermore, participants report that this assistance and sense of community helped them have a smoother transition in Lancaster. One explanation of why only two participants report dissatisfaction with Lancaster's healthcare is because participants had the social support needed to acculturate in Lancaster and have positive perceptions of the healthcare sector. Many health facilities in Lancaster specifically cater to refugees' needs. Thus, there are resources available to improve the accessibility of the healthcare 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 of Berry's stages of acculturation and the way integration is defined. Many refugees individualize 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 report that they enjoy living in Lancaster. Most participants state that they find it easy to make friends and work with individuals who are from different backgrounds, even though their ethnicity is underrepresented. However, Berry's stage of integration does not allow for the multifaceted 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. 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 has several limitations**.** The research team was unable to recruit a large sample of refugees living in Lancaster as it was difficult to access this community without speaking multiple languages or having contacts 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. The results of this study cannot be generalized to the larger refugee population. Furthermore, the research team did not examine the role that intersectionality, gender dynamics, class inequality, and racial differences play within refugee populations. Thus, further comprehensive 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 healthcare. Language preference and language use are limited to refugees in

many areas of the healthcare system, such as patient-doctor interactions and reading prescription labels and directions. However, there are other overlooked areas of the healthcare system that can be improved to ensure equitable access to health services and healthcare satisfaction. Participants in this study mention that it is extremely difficult for refugees who speak underrepresented languages to call a health facility and schedule an appointment. 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 healthcare 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 is an affordable option that would increase healthcare access and utilization for groups of refugees that have historically been excluded from these types of services.[51]

Another suggestion is that refugees should be given comprehensive healthcare 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.[52] During these periods 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 and lack of familiarity with the US healthcare sector.[53] Not having access for prolonged periods further exacerbates feelings of exclusion and prevents refugees who need healthcare services from utilizing care.[54] Resettlement organizations should hold comprehensive health education classes for refugees, which would be especially helpful in the absence of strong social support systems. To assess the effectiveness of

these classes, tailored pre and post-surveys could be used to measure changes in refugees' health literacy scores and gauge understanding of their healthcare needs as program participants. Currently, in the US, many philanthropic and private organizations are strategically funding equity initiatives that mitigate health disparities in Black, Latino, immigrant, and refugee populations, which were disproportionately impacted by COVID-19.[55] Therefore, in addition to receiving government and state funding, organizations, such as Church World Service, should also apply for philanthropic grants and other external funding.

Conclusion

This study concludes that aspects of acculturation influenced participants' healthcare satisfaction. English proficiency and social support systems, consisting of national, ethnic, and/or linguistic communities are factors that were commonly connected to healthcare satisfaction. High or 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 complain about the quality of healthcare services that are offered in the City of Lancaster. However, it is important to note the problems that they express, such as poor physician-client interactions and inadequate translation services, when exploring ways to improve refugee health outcomes across the US. Expanding the number of languages offered when scheduling doctors' appointments over the phone is a feasible 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 healthcare insurance when they are resettled is another practical change within the healthcare system that can produce healthcare satisfaction among refugee populations.

Appendix: Interview Guide and 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?

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