

CULTURAL ASSESSMENT AND PSYCHIATRIC CARE OF SOMALI REFUGEES

JEROME KROLL

COMMUNITY-UNIVERSITY HEALTH CARE CLINIC
UNIVERSITY OF MINNESOTA MEDICAL SCHOOL

AHMED YUSUF

COMMUNITY-UNIVERSITY HEALTH CARE CLINIC
MINNEAPOLIS MINNESOTA



Community-University Health Care
Center
Variety Children's Clinic

UNIVERSITY OF MINNESOTA

OUTLINE OF PRESENTATION

- History of Somalia; Clan structure; Islam
- Relations with neighboring countries
- Cultural shaping of mental illness
- Mental illness in the United States
- CUHCC study on MI in Minnesota
- Assessing Somali patients
- Therapeutic interventions



Map of Somalia



Community-University Health Care
Center
Variety Children's Clinic

UNIVERSITY OF MINNESOTA

HISTORICAL BACKGROUND

- European & Arab colonization since 16th Century
- Partitioned in 19th C into Italian, British, & French protectorates
- After WW II, UN divided Somalia into northern (British) & southern (Italian) protectorates



HISTORICAL BACKGROUND - 2

In 1948, Britain gives historically disputed land (Ogaden) between Somalia and Ethiopia to Ethiopia, and historically disputed land (Northern Frontier District) between Somalia and Kenya to Kenya.

These were rich pastoral lands inhabited by about two million ethnic Somalis.





BOUNDARY REPRESENTATION IS NOT NECESSARILY AUTHORITATIVE



THE HORN OF AFRICA OF MINNESOTA

HISTORICAL BACKGROUND-3

- Granted independence by UN 1960 – North and South vote to form a single nation and democratic elections are held
- Military coup establishes dictatorship (Gen Barre) 1969 as a “scientific socialist state”
- Somali invades Ethiopia (1977-78) to reclaim Ogaden - Somali forces defeated



HISTORICAL BACKGROUND - 4

- US supports Somalia under General Barre as USSR supports Ethiopia as client states
- January 1991, rebel clans force Barre into exile – violent Civil War ensues – no functioning govt
- UN peacekeeping mission unsuccessful –drought and widespread famine 1992-93
- Oct 3, 1993 Black Hawk Down - 18 US soldiers killed in Mogadishu– US withdraws its troops



HISTORICAL BACKGROUND - 5

- Various cease-fires and provisional coalitions fail -- clan violence continues
- June 2006 Islamic militias defeat warring clan-based militias and seize Mogadishu
- Ethiopian troops enter Somalia and support its weak provisional government in recapturing Mogadishu
- Ethiopian troops leave – fighting continues



AFTERMATH OF CIVIL WAR

- Internal Displacement of 500,000 Somali
- Famine and Starvation
- Breakdown of civil society and law
- Clan affiliation provides safety & survival
- Dispersion to Kenya, Ethiopia, Yemen
- Diaspora to Western Europe, US, Canada



CLAN STRUCTURE

- Somali society organized into clans
- Clan groupings are major social units
- Clans are patrilineal in their lineage
- Core of one's identity is as clan member
- Person owes life, loyalty, service to clan
- Clan provides stability and protection



CLAN STRUCTURE - 2

- In West, young adults leave family to establish their own autonomy & identity
- In Somalia and the Mideast, young adults remain interdependent with their family and blood line (clan) -- clan provides and expects loyalty in all spheres -- one learns the list of names of one's forebears
- **Import: involve family in psychiatric work**



ISLAMIC SOMALIA

- Somalis are overwhelmingly Sunni Muslim
- Somalis are overwhelmingly ethnic Somali
- Somalia has not been subjected to religious or ethnic sectarianism and violence
- General Barre (1969-1991) discouraged religious & clan affiliation – unsuccessfully
- Religious observances increased after 1991



RELATIONSHIPS WITH KENYA AND ETHIOPIA

- One to two million ethnic Somalis lived in each of the territories given to Ethiopia and Kenya in 1948
- Refugees fled to these countries after 1991, threatening the stability of the region from the host country perspective
- Kenya especially has felt the Somali Civil War intrude itself into Nairobi & environs
- Kenyan tribesmen may react with hostility
- Large refugee camps set up in both countries



DADAAB REFUGEE CAMP



Community-University Health Care
Center
Variety Children's Clinic

UNIVERSITY OF MINNESOTA

DADAAB REFUGEE CAMP



Community-University Health Care
Center
Variety Children's Clinic

UNIVERSITY OF MINNESOTA

SOMALI MENTAL ILLNESS IN U.S

- CLINICAL PRESENTATIONS:

Depression, PTSD, Psychoses, Head Trauma

- SOMALI ATTITUDES/BELIEFS re MI

- Mental illness not on a continuum

- MI = incoherence, violence, nakedness

- Illnesses given by God, acted on by jinns

- NO CONGRUENCE OF MI TERMS

- STIGMA ATTACHES TO PT AND FAMILY



CULTURAL SHAPING OF MENTAL ILLNESS PRESENTATIONS

- CLAN VALUES OF HONOR
- SHAME AND PRIVACY
- CULTURE & RELIGION SHAPE PSYCHOTIC CONTENT
- RESISTANCE TO THINKING ONE HAS A MENTAL ILLNESS
- **IMPORT: MODIFY YOUR VOCABULARY**



SPECIAL ISSUES RE MENTAL ILLNESS

- KHAT IN GENERAL & IN ADOLESCENTS
- CHILDHOOD MALNUTRITION
- HEAD TRAUMA
- SEXUAL ASSAULT EXPERIENCES
- PTSD & THE REFUGEE CAMP
- DEPRESSION AND DEMORALIZATION
- ACUTE PSYCHOSES IN YOUNG MEN



CUHCC STUDY

- **Outpatient population of Somali refugees (N=600) seen consecutively in an inner city clinic in Minneapolis.**
- **Patients were diagnosed by DSM-IV-R criteria.**
- **Patterns of illness and adjustment varied significantly by age and gender cohorts, reflecting the relevance of chronological age and gender on different trauma and loss experiences**



CUHCC STUDY - 2

- **Half of the Somali male patients are under age 30, 80% of whom presented with acute psychoses. In a control group of 476 non-Somali male patients under age 30 seen at the clinic, the rate of psychosis was only 14 % in males.**
- **The older male, and the majority of Somali female patients, show predominantly depressive and PTSD symptomatology.**
- **War trauma, childhood malnutrition, Khat use and role expectations in male adolescents may provide partial explanations for the high rate of psychoses.**



RESULTS

- Under age 30: 82% Men vs 33% Women have psychotic disorders ($p < .001$)
- Ages 31-50: 47% Men vs 11% Women have psychotic disorder ($p < .002$)
- For all ages: Women have higher rates of Depr-PTSD than Men ($p < .007$)
- Ages 31-50: Women have higher rates of Depression alone than Men ($p < .02$)



KHAT PSYCHOSIS

- CLINICAL PICTURE
 - Manic psychosis vs schizophrenia spectrum disorder
- Becoming more common than previously thought
- Common findings
 - Heavy use preceded the psychotic episode
 - Psychotic episodes tended to recur upon recommencement of khat use
 - (Young immigrants in general most vulnerable to psychoses)





Community-University Health Care
Center
Variety Children's Clinic

UNIVERSITY OF MINNESOTA

WHAT IS KHAT?

- Leaves from the plant *Catha edulis*
 - Flowering evergreen tree or large shrub
 - Khat tree can live up to 75-100 years
 - Most favored part of the leaves is near the top
 - Fresh leaves needed for most desirable effect



KHAT



Community-University Health Care
Center
Variety Children's Clinic



Community-University Health Care
Center
Variety Children's Clinic

UNIVERSITY OF MINNESOTA



Khat Rolled in Newspaper for Transport



Community-University Health Care
Center
Variety Children's Clinic

UNIVERSITY OF MINNESOTA

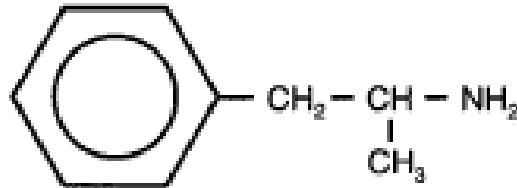


Khat Wrapped in Banana Leaves and Smuggled in a Suitcase

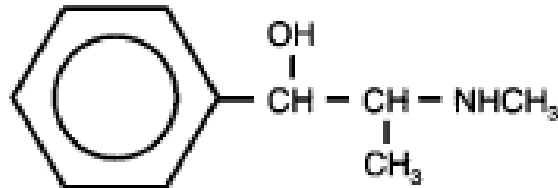


Community-University Health Care
Center
Variety Children's Clinic

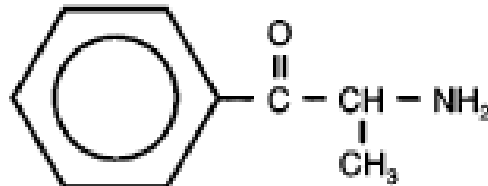
UNIVERSITY OF MINNESOTA



Amphetamine



Ephedrine



Cathinone (Active Component in Khat)

Cathinone, (S)-2-aminopropiophenone, the active component in khat, closely resembles amphetamine and ephedrine in chemical structure.

JAMA 269, 12 (1993)

UNIVERSITY OF MINNESOTA



Community-University Health Care
Center
Variety Children's Clinic

CULTURAL SENSITIVITY ISSUES

- It helps to know some history and cultural patterns, such as:

gender roles

role of elders

age of person when war started

clan identity and status

centrality of religious beliefs



CULTURAL SENSITIVITY ISSUES

- Respect for patient and patient's culture
- Sensitivity to role of religion in daily life
- Pursue discrepancies -- there is always a story behind them (do not play 'Gottcha')
- Patients of other cultures are not used to our expectation of finishing up in 20 minutes -- they tend to provide a long narrative to a complicated question



INSUFFICIENCY OF MEDICAL MANAGEMENT MODEL

- CULTURALLY INSENSITIVE
- PATIENTS' MISTRUST OF MEDICATIONS
- NO MODEL OF CHRONIC ILLNESSES
- PROVIDES NO GUIDANCE IN TREATMENT
PLANNING



CULTURAL ASPECTS OF ASSESSMENT

- Resistance to designation of mentally ill
- Mental illness attributed to djinns, spirits
- Resentment that strong responses to trauma and loss are reframed as mental illness
- Need for medical and social benefits conflicts with cultural patterns of privacy within family and clan



CULTURAL ASPECTS OF ASSESSMENT-2

- MISTRUST OF USE OF INFORMATION
 - Fears of government's response
 - Experience provides no basis to trust
 - Survival has depended on deception
 - Psychiatry asks personal & non-medical questions about self and family



CULTURAL ASPECTS OF ASSESSMENT-3

- PATIENTS ARE PART OF A FAMILY & CLAN UNIT
 - Pts identify self within their clan
 - Include family and clan elders in assessment
 - Family and clan needed for all levels of assistance (practical, identity, moral values)



TYPES OF INTERVENTIONS

- Diagnostic testing & referral to med clinic
- Psychiatric medications
- Cognitive & Behavioral Therapies
- Supportive therapies
 - Task-oriented and shared experience group work
- Religious Therapies: reading of the Koran



TREATMENT WITH MEDICATIONS

- Intolerance of side-effects
- Usually push for lower doses
- Poor med compliance that is denied
- Problems with gelatin capsules
- Need family support for med acceptance
- This holds for all classes of meds



Non-pharmacological therapeutic interventions for Somali patients.

- Disability status and income
- Health care coverage
- Housing vouchers; relief from homelessness
- Immigration status assistance; deportation; sponsoring relatives
- PCA, childcare, & homemaking services
- Disability waiver (N-648) for naturalization



CULTURAL ASPECTS OF TREATMENT

- Religious prayer and interpretation are first lines of approach
- Reading from appropriate verse of Koran
- Medications are acceptable but compliance especially for chronic illnesses is poor
- Psychiatric medications are acceptable when illness linked to loss and trauma



SUMMARY

- THOSE NOT DOING WELL HIGHLIGHT THE PROBLEMS ALL REFUGEES FACE
- PTSD IS A SANITIZED TERM FOR ALL THAT REFUGEES LOST: HOMELAND, HOME, SAFETY, FAMILY, STATUS
- DEPRESSION IS THE CONSTANT COMPANION OF PTSD



Taking the Oath of Citizenship: More effective than Prozac



Community-University Health Care
Center
Variety Children's Clinic

UNIVERSITY OF MINNESOTA