

# PSYCHIATRIC CARE OF SOMALI REFUGEES: MAKING USE OF HISTORY AND CULTURE

JEROME KROLL

COMMUNITY-UNIVERSITY HEALTH CARE CLINIC  
UNIVERSITY OF MINNESOTA MEDICAL SCHOOL

AHMED YUSUF

COMMUNITY-UNIVERSITY HEALTH CARE CLINIC  
MINNEAPOLIS MINNESOTA



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# OUTLINE OF PRESENTATION

- Hx Somalia; Clan structure; Role of Islam
- Relations with neighboring countries
- Cultural shaping of mental illness
- Mental illness in refugees in the US
- Cultural assessment of Somali patients
- Therapeutic interventions



# Map of Somalia



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# HISTORICAL BACKGROUND

- European & Arab colonization since 16<sup>th</sup> Century
- Partitioned in 19<sup>th</sup> 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.





**THE HORN OF AFRICA OF MINNESOTA**

- Approximate area inhabited by Somali people
- AFAR** Other ethnic group

# HISTORICAL BACKGROUND-3

- Granted independence by UN 1960 – North and South Somaliland vote to form a single nation -- 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 - USSR supports Ethiopia
- 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 and thereafter
- Oct 3, 1993 Black Hawk Down - 18 US soldiers killed in Mogadishu– US withdraws its troops
- Various cease-fires and provisional coalitions fail to form a stable govt -- clan violence 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



# DADAAB REFUGEE CAMP



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# 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

- CHILDHOOD MALNUTRITION
- HEAD TRAUMA
- SEXUAL ASSAULT EXPERIENCES
- PTSD & THE REFUGEE CAMP
- DEPRESSION, LOSS & DEMORALIZATION
- ACUTE PSYCHOSES IN YOUNG MEN
- KHAT IN GENERAL & IN ADOLESCENTS
- NO CULTURAL CONGRUENCE OF MI TERMS





# 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. A control group of 476 non-Somali male patients under age 30 showed only a 14% rate of psychosis**
- **The older male, and the majority of Somali female patients, show predominantly depressive and PTSD symptomatology.**



# KHAT PSYCHOSIS

- CLINICAL PICTURE
  - Manic psychosis vs schizophrenia spectrum disorder
  - Heavy use preceded the psychotic episode
  - Acute confusional, aggressive, excitatory presentation
  - Psychotic episodes tended to recur upon recommencement of khat use





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# 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



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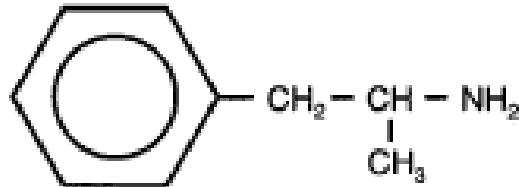


**Khat Wrapped in Banana Leaves and Smuggled in a Suitcase**

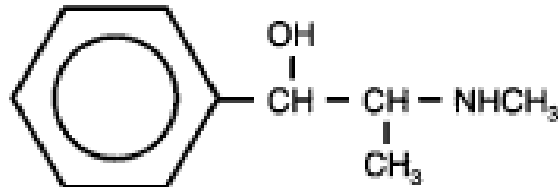


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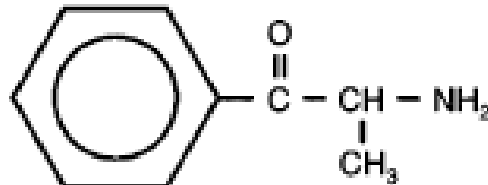
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Amphetamine



Ephedrine



Cathinone (Active Component in Khat)

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

JAMA 269, 12 (1993)

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# CULTURAL SENSITIVITY ISSUES

- It is helpful to know some history and cultural patterns, such as:
  - gender roles & rules
  - role of elders
  - views on mental illness
  - age of person when war started



# 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 accustomed to our expectation of finishing up in 20 minutes -- they tend to provide a long narrative to a complicated question



# INSUFFICIENCY OF MED MANAGEMENT MODEL IN CROSS-CULTURAL WORK

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



# TREATMENT WITH MEDICATIONS

- Intolerance of side-effects
- Pts & family 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



# 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
  - Role of MH professional poorly understood



# 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 – **this conflicts with our model of privacy & autonomy**
  - Family and clan needed for all levels of assistance (practical, identity, moral values)



# CULTURAL ASPECTS OF ASSESSMENT-4

- **Boundary Issues with Refugee Patients**
  - Physical space and role of touching
  - Privacy re personal disclosure
  - Gender considerations & role of interpreter
  - Is advocacy a boundary violation?
  - Unwelcome diagnoses
  - Power differential between physician & patient





# INTERVIEWING WITHOUT A CHECKLIST

## Experience in Africa

- WHEN DID YOU COME TO THE US?
- WHERE DID YOU COME FROM? CLAN?
- WHEN WAR STARTED, WHERE WERE YOU?
- WAS YOUR HOUSE ATTACKED?
- WHO WAS KILLED? WHO WAS INJURED?
- DID YOU DIRECTLY WITNESS VIOLENCE?
- WERE YOU INJURED? ASSAULTED?



# INTERVIEWING WITHOUT CHECKLISTS-2

## Experience in Africa

- WHERE DID YOU GO AFTER THE ATTACK?
- DID YOU HAVE CHANCE TO BURY DEAD?
- WERE YOU ATTACKED DURING ESCAPE?
- WHAT HAPPENED AT THE BORDER?
- DID YOU GO TO CITY OR REFUGEE CAMP?
- WAS IT SAFE – WAS IT DANGEROUS?
- HOW MANY YEARS IN REFUGEE CAMP?



# INTERVIEWING WITHOUT CHECKLISTS-3

## Experience in the US

- Where did you arrive in the US? When did you come to Minnesota? Who came with you? How many in your household now?
- What are your living arrangements?
- Do you have your own room?
- Who cooks, shops, cleans, does laundry?
- Do you take ESL or go to school?



# INTERVIEWING WITHOUT CHECKLISTS-3

## Experience in the US - 2

- What are your financial supports?
- What is your citizenship status?
- Are you married? Marital history?
- Have you been in any legal troubles?
- How can this clinic be of help to you?
- After all this, we can proceed with a Medical and Psychiatric History!



# Non-pharmacological therapeutic interventions for Somali patients.

- Disability benefits and income
- Health care coverage
- Housing vouchers; relief from homelessness
- PCA, childcare, & homemaking services
- Immigration status assistance; Green cards; deportation; help pts sponsor relatives
- Disability waiver (N-648) for citizenship



# 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



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