

## **WELCOME!**

*This webinar is presented by a collaboration of Minnesota health plans working to improve antidepressant medication management in Minnesota. Thank you to Blue Plus, HealthPartners, Hennepin Health, Metropolitan Health Plan, Medica and UCare for their commitment to this issue.*



## **Behavioral Health Care for Refugees:** *Surviving Loss and Having Hope*

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## New Americans:

*Ordinary people under extraordinary stress*



3

## Plan for the series

- **Part 1: How it happens**
  - *Who are our patients?: Definitions, Statistics*
  - *Refugee experience: Loss, Trauma and Resilience*
  - *Who are "Us"? People, Professionals, Systems, Society*
  - *How do we meet?*
- **Part 2: What do we see and what do we do - July 25, 2016**
  - *Manifestations of mental health problems*
  - *Explanatory models of mental health problems*
  - *Treatment options*
- **Part 3: How do we make it work well**
  - *Communication and decision making patterns among family-patient-helping professional*
  - *Acceptability of solutions*
  - *Compliance/Adherence to treatment*
- **Part 3.1 : Language barrier, interpreting MH**

4



## Culture, Experience and Everything Else That Matters

### What is the Purpose of the series?

- Our **Purpose** is to understand our in order to be effective partners in assisting them with their health/MH needs
- Studying culture/experience is studying **meaningful differences and similarities** with a goal of building effective collaboration towards commonly accepted goals

5



## Culture, Experience and Everything Else That Matters

### “Us” and “Them”

- It is just as much about “**Us**” as it is about “**Them**”
- Together with looking at **our patients** we will look at **ourselves** as individuals, members of our profession, of our society and our culture
- We will also look at the dynamics of our **relationship** in the process including participation in **Larger Systems**

6

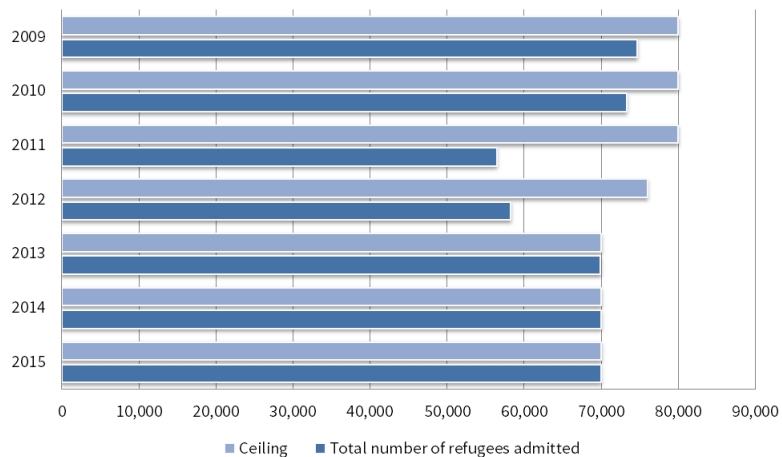
# Culture, Experience and Everything Else That Matters

## Today we will discuss:

- *Individual and shared experiences affecting Mental Health in refugees*
- *Mental Health problems and social/cultural context*
- *Refugees' understanding of mental health services in the US*
- *Refugees' relationship with larger social systems in the US and our role in it*

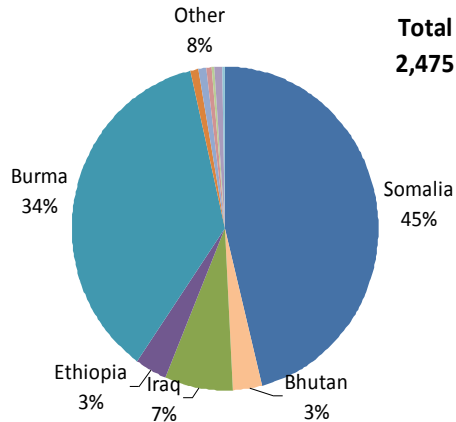
7

## US Refugee Arrivals by Nationality FY 2009 – FY 2015



8

## Top 5 Countries of MN Refugee Arrivals by Nationality FY 2014



9

## Population Statistics, 2014

(Census Bureau, Department of Human Services)

Population Measure	Minnesota
Population	5,453,218
Foreign born population	403,545
Foreign born share of total population (2008)	7.3%

10



## Population Statistics, 2014

(Census Bureau, Department of Human Services)

- *Behind English, the most common languages spoken in the homes of Minnesotans 5 and older are Spanish (about 185,000 speakers) and Hmong (65,000 speakers). (Source for all: 2014 American Community Survey)*
- *In 1920, about 1 in 5 Minnesotans was foreign-born. In 2014, about 1 in 14 were (7.3%). Forty-five percent of Minnesota's foreign-born population are naturalized U.S. citizens.*
- *In 2014, the largest groups of foreign-born Minnesotans were born in Mexico (about 66,000); India (29,000); Laos, including Hmong (28,000); Somalia (26,000); Ethiopia (18,000); China, excluding Hong Kong and Taiwan (18,000); Thailand, including Hmong (17,000); and Vietnam (17,000). These estimates do not include U.S.-born children of these immigrants. They also likely underestimate the size of our immigrant populations because trust and language issues reduce response rates to Census surveys.*

11



## New Americans:

*Surviving Loss and Having Hope*

### Let's start with "Them"

- *Our patients: Individual and shared experiences affecting Mental Health in refugees*

12



## New Americans:

### *Surviving Loss and Having Hope*

- *Pull immigration*
- *Push immigration*
- *We mostly deal with the Push immigrants/refugees who experience stress on multiple levels*

13



## New Americans:

### *Surviving Loss and Having Hope*

- A **refugee** is a person who due to the “well-founded **fear** of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such **fear**, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such **fear**, unwilling to return to it.”

*UN High Commission for Refugees (2012)*

14



## Case Study

### PSYCHIATRIC EVALUATION

**IDENTIFICATION:** This is a 5X-year-old female apparently referred by her therapist, for psychiatric evaluation.

**SOURCE OF INFORMATION:** The patient appears to be a reliable informant, and the records which include notes from XXX.

**CHIEF COMPLAINT:** Depression.

**HISTORY OF PRESENT ILLNESS:** This is a 5X-year-old female who reports that she had no psychiatric problems until she came to this country in 2001.

She describes that she came here with a great deal of enthusiasm. However, this enthusiasm was completely unfulfilled by what later occurred. The patient describes that her disappointment with her life in this country has led to symptoms of depression. She also describes that she has had a great amount of losses associated with the war year in **Africa** and her exodus eventually resulting in her immigration to this country.

She describes that in **Africa** and then in the **Africa** where she fled to after leaving **Africa**, she had been doing well. In both places she worked as a registered nurse and had important positions. She was also married.

When she came here everything changed radically. Her husband came independently and then fled. Since about 200x, she has never found out where he went to and whether he is living in this country or perhaps Canada or somewhere else. Also, she cannot work as a nurse in this country. For a while, she worked as a nurse's aide, but this was menial and physically demanding work and after approximately three years, she stopped working in this capacity.

- She describes that she had an enormous loss of status and self-esteem when she came to this country and found American culture absolutely different and to a large extent not to her liking. She also felt completely displaced, ("You are cut from your root and you become a fly").

15



## Case Study

- As a result, the patient describes currently that she has anhedonia, low energy; sometimes she sleeps 10 or 11 hours a day. She feels distressed and demoralized. At times she feels that she has lost her reason for living although she denies any suicidal thoughts of any kind.

In addition, the patient experienced significant trauma during her war years in **Africa**. Perhaps the most tragic event the patient reports was that her niece whom she raised from 4 years old was abducted under complicated circumstances when she was approximately 16 years old and became, I guess, it could be described a sexual slave, and I believe had x children. Just recently she escaped and is now fleeing her abductor with her children.

- This niece has recently been in contact with Mrs. and Mrs. was quite preoccupied for her niece/daughter's well being.

**PAST PSYCHIATRIC HISTORY:** For the most part is as above. Patient has never taken the psychiatric medications before. She did not describe any hypomanic or manic symptoms in the past. She has never been hospitalized in the past, never made a suicide attempt. She does describe some recurrent nightmares related to her "daughter's" abduction and some intrusive memories of corpses that she saw during the civil war in Somalia.

**CHEMICAL DEPENDENCY:** Patient has no chemical dependency.

**MEDICAL HISTORY:** Patient has a history of migraine headaches. She has been treated with Depakote, which patient describes results in a partial response; otherwise, Mrs. had a positive PPD in the past and received INH therapy and she has had H. pylori infections in the past.

16





## Case Study

- **FAMILY HISTORY:** Patient did not report any family history of psychiatric problems.

**SOCIAL HISTORY:** A complete social history was not done today. Patient grew up in **Africa**. Patient did tell me that she was a member of XXX tribe, which meant that during the civil war, people in her tribe were particularly targeted. For that reason, she had to flee with her family.

- Prior to that she was working as an RN in an extremely well known private hospital in the capital, XXX. She left with her husband and five of her children. She was told that two of her children, a daughter and the niece that I described above who she raised, were killed when a bomb was dropped on a school. She fled with her family to a city called XXX and then went across the Red Sea to Yemen where she lived for several years and once again found a job as a registered nurse.
- She then came to this country with her family in 200x. As described above, her husband came separately and then disappeared and she still does not know his whereabouts, perhaps he remarried. She later found out that both of her children, her niece and her daughter had survived that bombing and eventually her daughter came to live with her in this country but her niece has now in-flight from her abductor as described above in some place in Africa.
- Patient is currently living with her adult children in this country. She has not worked for approximately four years after eventually deciding that she was not capable of doing the physical labor that was available to her. She describes a great deal of culture shock and role reversal as described above in the history of present illness. She is volunteering her time in an African Women's Organization two times a week and enjoys that a great deal and feels very close to her children whom she lives with.

On mental status examination, patient is well groomed, traditionally dressed, extremely friendly and cooperative. For the most part, she speaks English well. A couple of times I had to ask my question in slightly different ways, a few times I had to ask her to elaborate, so I can understand her explanations. But she describes her mood as mildly to moderately depressed. Her affect is mostly restricted to the depressed range; a couple of times she cried. Thought processes are logical. She has no suicidal ideation. Sometimes she feels like "a useless person."

### **ASSESSMENT:**

Axis I: Major depression, moderate, rule out recurrent major depression, rule out posttraumatic stress disorder.

Axis II: Deferred.

Axis III: Look at medical history.

Axis IV: Moderate to severe cultural stress, financial stress. She has one son that she describes is doing poorly and his lack of success, she finds very stressful, is extremely preoccupied by her daughter/niece who may be in harm's way in Africa.

Axis V: 60 to 70.

**PLAN:** Discussed with the patient my impressions and options for treatment. At this point, patient says that she does not want medication for her depression; she would prefer talk therapy. I told her at this point because of my patient load, I cannot offer her frequent appointments and I referred her to my colleague, Dr. XXX. She will return to see Dr. XXX, and return to see this writer in approximately two months.

17



## New Americans:

### *Surviving Loss and Having Hope*

### **Opportunities**

- *Gain of basic civil rights, basic safety and security*
- *Freedom or communication/information*
- *Opportunities for cultural development for those who were denied their culture*
- *Freedom of Faith*
- *For some (seniors, handicapped people, women) more possibilities for independence and self-sufficiency*

18



## **New Americans:**

*Surviving Loss and Having Hope*

### **Internal Losses (individual)**

- *Loss of Ease of Communication*
- *Loss of Independence and Self-Sufficiency*
- *Loss of Security and Stability*

19



## **New Americans:**

*Surviving Loss and Having Hope*

### **Environmental losses (individual)**

- *Loss of Material Possessions*
- *Loss of Value of Education and Professional Experience*
- *Loss of Roots and Connection to Cultural and Social Traditions*
- *Loss of Connection to Family and Friends*

20



## **New Americans:**

*Surviving Loss and Having Hope*

### **Internal Losses (individual)**

- *Loss of Status*
- *Loss of Self-Esteem and Identity (including cultural)*

21



## **New Americans:**

*Surviving Loss and Having Hope*

### **Challenges in marital life**

- *Changes in the foundations of marriage*
- *Changes in influence of kin*
- *Changes in power structure*
- *Lifestyle changes*
- *Aging/retirement/health*

22



## New Americans:

### *Surviving Loss and Having Hope*

#### **Intergenerational conflict**

- *Rates of acculturation/role reversal*
- *Values/culture clash*
- *Parenting crisis*
- *Distancing b/w 1<sup>st</sup> and 2<sup>nd</sup> generations*
- *Distancing b/w 1<sup>st</sup> and 3d generations*

23



## New Americans:

### *Surviving Loss and Having Hope*

- *Many refugees have experienced **irreversible loss***
- *Many also show incredible **resilience***
- *They may be able to learn how to live with loss and **still have hope***
- *Both our patients and us need to learn how to **tolerate ambiguity** and deal with balancing both parts at once*

24



## Culture, Experience and Everything Else That Matters

- *Individual and shared experiences affecting Mental Health in refugees*
- **Mental Health problems and social/cultural context**
- *Refugees' understanding of mental health services in the US*
- *Refugees' relationship with larger social systems in the US and our role in it*

25



## Mental Health problems and Social/Cultural context

### What is “culture” for our Purpose?

- *Culture is a combination of **beliefs and behaviors** that came into being in the process of **survival and adaptation** of communities of people*
- *Culture is experience accumulated over generations*
- *All elements of **culture are/were functional** at certain times in particular social/historical contexts*
- *What is important for us is set of **beliefs and behaviors** affecting patients' ability to effectively access and utilize healthcare services*
- **Everything Makes Sense!**

26



## ***Mental Health problems and Social/Cultural context***

### **Social/Cultural acceptance of mental health problems**

- *A combination of Stigma and Acceptance*

27



## Social/Cultural acceptance of mental health problems

Mentally ill people in several Africa nations - including Sudan, the Democratic Republic of Congo, Uganda, Kenya and oil rich Nigeria - are chained to hospital beds, put into prisons alongside dangerous criminals or chained up by their own families.

The Daily Mail, May 12, 2016



29

## Psychiatric Services: Comparative Statistics

World Atlas, WHO

	Somalia	Sudan	US
Psychiatrists per 100,000 population	.06	.09	13.7
Psychiatric Nurses per 100,000	.03	.2	6.5
No of mental health beds per 100,000 population	.4	.2	7.7



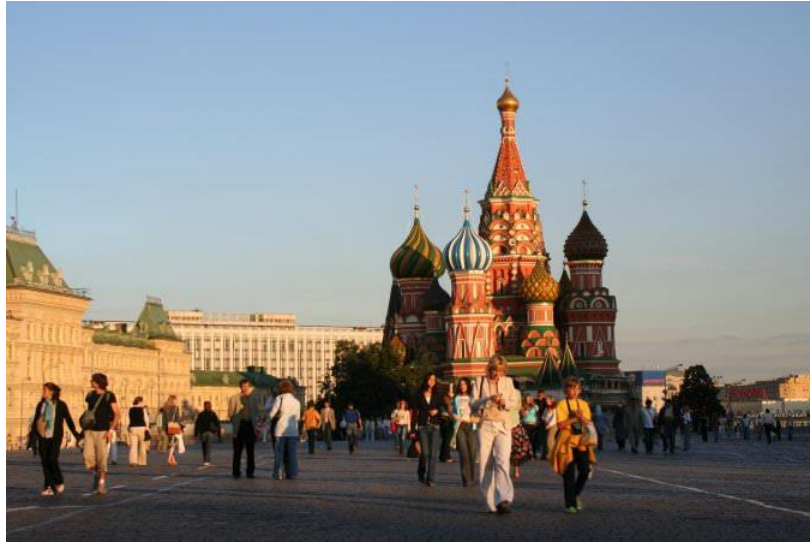
## Social/Cultural acceptance of mental health problems

### Stigma and Acceptance of MH problems:

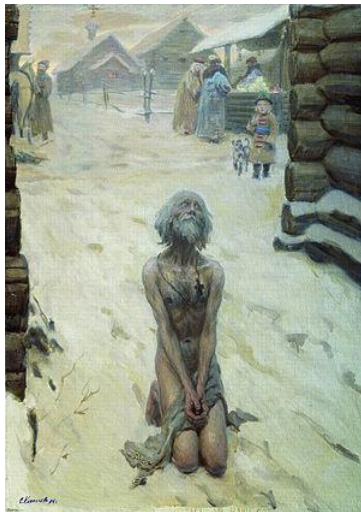
- *Mild to moderate Mental Health problems are absorbed by families and community and fit into the definition of "norm"*
- *Only extreme conditions that families or community can not manage are identified as "Mental/Crazy"*
- *Concern is **social function** and **safety**, not personal emotional "well-being"*



## Stigma and Acceptance of MH problems: St. Basil's Cathedral



## St. Basil, "Fool for Christ"



34



## Social/Cultural acceptance of mental health problems

### **Stigma and Acceptance of MH problems:**

**“Toska”** - Russian word roughly translated as sadness, melancholia.

“No single word in English renders all the shades of toska. At its deepest and most painful, it is a sensation of great spiritual anguish, often without any specific cause. At less morbid levels it is a dull ache of the soul, a longing with nothing to long for, a sick pining, a vague restlessness, mental throes, yearning. In particular cases it may be the desire for somebody or something specific, nostalgia, love-sickness. At the lowest level it grades into ennui, boredom.”

Vladimir Nabokov

35



## Social/Cultural acceptance of mental health problems

### **Rwandan talking about Western MH practitioners:**

- *“Their practice did not involve being outside in the sun where you begin to feel better. There was no music or drumming to get your blood flowing again. There was no sense that everyone had taken the day off so that the entire community could come together to try to lift you up and bring you back to joy. Instead they would take people one at a time into these dingy little rooms and have them sit around for an hour or so and talk about bad things that had happened to them. We had to ask them to leave.”*

The Guardian, 02/05/2015

36



## Social/Cultural acceptance of mental health problems

### Stigma and Acceptance of MH problems:

- *In multiple WHO studies the course and the outcome of Schizophrenia was found significantly better for patients from developing countries then for those from developed countries*
- *Many people who would get a diagnosis of Mental Illness in US and live isolated life are integrated in society in their countries and are in many meaningful ways members of their communities*
- *Developed countries can offer medications, providers and facilities that developing countries don't have*
- *Just like developing countries are short on medications and hospitals, we are short on meaningful communities and family resources. **We also don't have what our patients need!***

37



## Culture, Experience and Everything Else That Matters

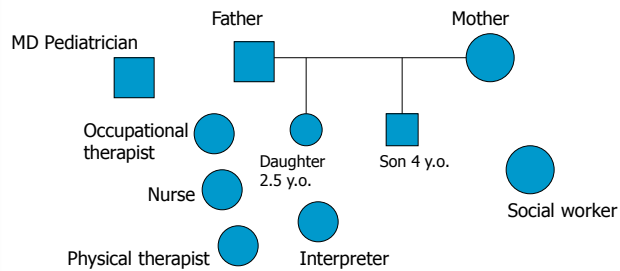
- *Individual and shared experiences affecting Mental Health*
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- **Refugees' relationship with larger social systems in the US**

38

## New Americans:

*Surviving Loss and Having Hope*

### Refugee family with a sick child: *Angry father*



39

## A FAMILY – LARGER SYSTEM PERSPECTIVE

- *Many refugee families are intensely involved with larger systems. **Larger systems** include work, school, religious institutions, health-care systems, public welfare, foster care, courts, mental health clinics, etc.*

*(Imber-Black, 1992)*

40



## A FAMILY – LARGER SYSTEM PERSPECTIVE

- *Harbin (1985): in the interaction between the **informal** (family) and **formal** system neither system need be inherently dysfunctional for problems to arise in their interaction*

41



## A FAMILY – LARGER SYSTEM PERSPECTIVE

- **Dyads:** *one may see a pattern of escalating complementarity in which the more help is offered, the more helpless the family appears, which leads to the entry of more helpers*
- **Triads emerge:** *family – school – child. These triads might involve such problems as mutual blame and mistrust*

*(Imber-Black, 1992)*

42



## A FAMILY – LARGER SYSTEM PERSPECTIVE

### Myths and Beliefs

- They may define family interactions with larger systems. They often originate from **other generations or family interactions with larger systems** at critical points
- Many cultures are based on **personal connection** and trust and mistrust towards “**the System**”

43



## A FAMILY – LARGER SYSTEM PERSPECTIVE

### *Definition of the problem*

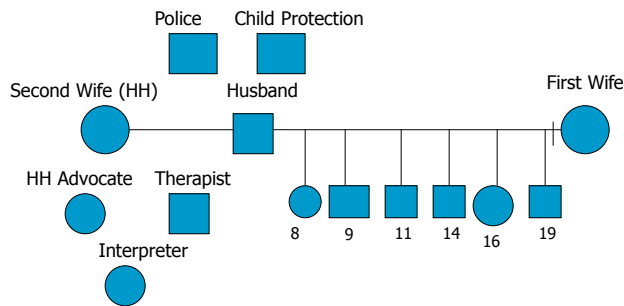
- How the family and the involved systems define the problem?
- Important for the helper to see his or **her own definitions** and preferred solution **as one more point of view** rather than as the “truth”
- **The problem of the referring person** – an overinvolved professional becomes a “family member”

44

## New Americans:

*Surviving Loss and Having Hope*

### Refugee family with a HH wife: *Family Split*



45

## A FAMILY – LARGER SYSTEM PERSPECTIVE

### Boundaries

- *Systems with a problematic member often experience their **boundaries altered***
- *Intrusiveness of some larger system leads to **diffuse boundaries***
- ***Overly rigid boundaries** (class, ethnic, cultural) may lead to denial of appropriate access to services. One family member may be “appointed” to span the boundary*

46



## A FAMILY – LARGER SYSTEM PERSPECTIVE

### Problems with larger systems:

- *Feeling powerless, unable to control or even predict future*
- *Lack of trust in the system*
- *Isolation and Confusion*
- *Overuse and Pressure*

47



## A FAMILY – LARGER SYSTEM PERSPECTIVE

### Problems with larger systems:

- *This lack of influence over one's life reproduce the state of **helplessness/hopelessness** refugees experienced due to trauma and loss*
- *For many this combination results in major mental health problems and the resulting severe general **functioning and adjustment difficulties***

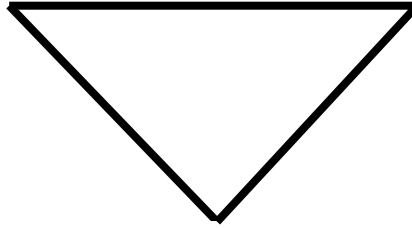
48



## A FAMILY – LARGER SYSTEM PERSPECTIVE: *Triangulation*

Refugee Family

Helping professional



**STRESS**

49

## What to do?



50



## Behavioral Health Care for Refugees: *Surviving Loss and Having Hope*

- *Our patients are dealing with **Trauma and Loss***
- *They are **Survivors***
- *What we are dealing with is their **efforts to cope***
- *Their coping is shaped by their **Culture and Experience***
- ***Everything makes sense***
- *It helps when we see our patients' **behavior as meaningful***

51



## Behavioral Health Care for Refugees: *Surviving Loss and Having Hope*

- *We are part of this process with **our culture and experience***
- *We are **more similar** than we are different*
- *Some problems are created on a level of **Larger Systems***
- *We can help better when we look closer at **ourselves** and our **Larger Systems***

52



## New Americans:

### *Surviving Loss and Having Hope*

#### **Exercise I:**

#### Your identity

- Write down 10 statements starting with "I am...."
- How many of the things you wrote are taken away from your patients?

53



## New Americans:

### *Surviving Loss and Having Hope*

#### **Exercise II:**

#### Dealing with loss

- Think of a loss you experienced (as a child)
- What did you lose?
- Think of those who helped you
  - Who was not useful and why?
  - Who was useful and why?
- What helped you to survive?
- How did it make you stronger?

54



## Your culture and Mental Health?

### **Exercise III:**

#### “Mental Health” in your culture

1. What identity groups do I belong to/identify myself with now and in the past/future?
2. What I like best about each of those identity groups' cultures \_\_\_\_\_
3. Stereotypes about people in my identity groups that I dislike are \_\_\_\_\_
4. What are the attitude towards Mental Health problems in my culture?
5. What are the accepted ways of dealing with life struggles, with “mental health issues”?
6. How members of each group that I identify with would react to working with mental health services?
7. What kind of approach would work with them?

55



## Behavioral Health Care for Refugees Part II: Diagnosis and Treatment

- *Most common MH problems in Refugees*
- *Cultural Manifestations of MH problems*
- *Screening, Diagnostics and Referral Process*
- *Applicability of DSM V, biological vs. psychosocial models*
- *Establishing Rapport*
- *Effective Treatment Approaches*

56

# Improving Antidepressant Medication Management Provider Toolkit

## Antidepressant Medication Management



### Provider Toolkit

Tools to increase antidepressant medication adherence and reduce racial and ethnic disparities in depression management.



<http://www.stratishealth.org/pip/antidepressant.html> 57

