Attitudes of West African Immigrants Towards Mental Health Problems and Substance Misuse: Recommendations for Treatment

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OBJECTIVES

- Objective 1: Participants will became aware of the attitudes of West African immigrants towards mental health problems and substance misuse, and how these can inform treatment for this population.
- Objective 2: Participants will enhance their understanding of West African immigrants' general perceptions of U.S. forms of mental health and substance misuse treatment, and how these perceptions can hinder their engagement in treatment.
- Objective 3: Participants will be able to identify key causal beliefs of West African immigrants regarding mental health and substance misuse problems, and how these can shape the help-seeking preferences of this population.
- Objective 4: Participants will gain insight into how to engage and provide culturally-informed mental health and substance misuse treatment services to West African immigrants.

Who are West Africans?

- West Africans are one of the fastest growing immigrant groups in the United States.

- 4% of foreign born in the US immigrated from Africa. This population has doubled every decade since the 1980s.

- The current workshop focuses on West African born immigrants in the United States.

West African Countries

574,000 West African born individuals live in the United States
Over half of West African immigrants are from Nigeria and Ghana.

Population of West Africans by State

1. New York 59,532
2. Maryland 58,440
3. Texas 52,528
4. Massachusetts 42,000
5. New Jersey 42,000
6. Georgia 35,625
7. California 30,895

(Gambino et al., 2014)

Characteristics of West African Immigrants

- Nigeria-born and Ghana-born immigrants have very high rates of college and graduate education; higher than that of the U.S. born population (Gambino et al., 2014; Immigration Policy Center, 2012).

- Lower rates of Nigeria-born and Ghana-born immigrants than U.S. born populations dropped out of high school (Gambino et al., 2014; Ryan & Siebens, 2012).

- West African-born Americans have a greater rate of labor force participation than native-born Americans and all other immigrant populations (McCabe, 2011).

- Paradoxically, poverty rates of Africa-born Americans are somewhat higher than native-born Americans (19% of all West African immigrants vs. 14% of native born Americans live in poverty, but 15% for Ghana and 11% for Nigeria). (McCabe, 2011).

Mental Health Services to West African Immigrants

- Are West African immigrants to the US at risk for mental disorders?
- How do West African immigrants deal with their mental health problems (e.g., formal or informal help seeking)?
- What are the barriers to West African immigrants' use of formal mental health services?
- Guidelines for the provision of culturally sensitive mental health services to immigrants.
- Conclusion.

Attitudes of West African Immigrants towards Mental Health Services in the Unites States

- West African immigrants have positive attitudes towards medical treatment, but only a few seek mental health treatment (Thomas, 2008).

- West Africans commonly use friends, family members, and clergy to deal with mental health problems.

- Most West Africans are not familiar with psychotherapy and often conceptualize mental health problems as spiritual disharmony (Nwokocha, 2010; Thomas, 2008).

Attitudes of West African Immigrants towards Mental Health Services in the Unites States

- Belief in supernatural causation is strong (e.g., Olusesi (2008) found although 87.5 of Nigerian immigrant participants of his study attributed psychosis to "a chemical imbalance in the brain," 72% agreed "magic spells, hexes, and voodoo" could cause psychosis and 71.6% attributed psychosis to "being possessed by evil spirits or the devil."
- Being mentally ill carries a burden of great shame and stigma for West African individuals and their families (Nwokocha, 2010).

Phases of Adaptation to New Environment

- Learning to adjust to a new environment can lead to demoralization and acculturative stress.

- Immigration as U shaped process –
  a. Initial euphoria
  b. Feelings of distress and dissatisfaction
  c. Adaptation

Kinzie, J., Boehnlein, J., Leung, P., Moor, L., Riley, C., & Smith, D. (1990). The prevalence of posttraumatic stress disorder and its clinical significance among Southeast Asian refugees. *American Journal of Psychiatry, 147*, 913-917.

Phases of Culture Shock

- The honeymoon phase,
- The disenchantment phase,
- The beginning resolution phase", and
- The effective function phase".

- BRINK,P. J. & SAUNDERS,,J. M. (1976). Culture shock: theoretical and applied. In Transcultural Nursing. A *Book of Readings (edited P. J. Brink) p 126. New Jersey:* Prentice Hall Inc.

Major Mental Health Difficulties of West African Immigrants

- Anxiety
- Depression
- Schizophrenia and other psychotic disorders
- PTSD
- Culture bound syndromes (obeah, genital shrinking, brain fag, koro, 'Zar,' Dhat, Ode Ori, etc.).
- Pseudo-normal state/ psychic fragmentation
- Memory and concentration problems,
- Acculturation stress,,
- Social withdrawal

- Often West Africans only seek mental health help when a mental health crisis has occurred.

- Help more likely sought for psychotic illnesses (e.g., schizophrenia, bipolar disorder) than for depression and anxiety.

Beliefs, Attitudes, and Help-seeking Behaviors

Service use is a function of

- Predisposing factors (e.g., demographics, social status, and health beliefs);
- Enabling factors (family resources, community resources, availability of culturally sensitive services, health insurance); and
- Need factors (how people view their own health and functional state, as well as how they experience symptoms of illness).
- The help-seeking process involves the interplay of the **characteristics of the person** seeking help, the **type of help being sought**, **the context** in which help is being sought, and the **potential helper** (Wills & DePaulo, 1991).

Beliefs and Help-seeking

Beliefs that shape attitudes to problems, care, and cure come from:

- Direct observations;
- Information received from outside sources;
- Inferences drawn from various processes, including previous experiences (Fishbein & Ajzen, 1975) and supernatural or transcendental experiences (Iroegbu, 2005, 2006).

A person's health beliefs, as shaped by intelligence, socio-cultural understanding, and previous experience, will determine:

- Whether or not to seek help;
- The stage at which to seek help;
- The types of help to seek.

Pre-migration Experiences/Reasons for Migration

- Economic, social, and political instability
- War and displacement (Trauma)
- Military Dictatorship/Persecution/human rights violations
- Religious Persecution
- Medical Problems
- Direct suffering/vicarious suffering/ angst
- Spiritual problems
- Poor technology and poor infrastructure

- Concern for the future of children
- Luck (Diversity Visa Lottery)
- Educational Pursuits
- Curiosity

Post migration Experiences

- Disappointment/dissatisfaction/ demoralization with life in the US.
- Lack of social support.
- Discriminatory practices in the new environment, especially institutionalized racism and alienation.
- Family conflict (marital conflict and intergenerational conflict).
- Difficulties in areas of employment/underemployment , finance, and housing.
- Lack of social support.
- Separation from spouses and children and concomitant loneliness and sadness.
- Lack up upward mobility.
- Legalization battles. Mental Health Problems (e.g., anxiety and depression).
- Ego dystonic sociocultural dictates diametrically opposed to indigenous values.

Causes of Post-migration Problems West African Immigrants

- Lack of information/preparation prior to immigration to the US.
- Economic problems
- Undocumented status.
- Structural inequities in the US.
- Discrimination and Prejudice.
- Cultural barriers.
- Insularity and Social Isolation
- Lack of Active Participation in the Political Process.
- Wayfarer mentality.

West African's Pre-Migration Help-Seeking Behavior for Mental Illness

- Informal/Alternative services (pastor, imam, herbalist, traditional healer, internet support group, or self-help group.
- General Medical Care
- Specialty mental health care (e.g., psychiatrist, psychologist, clinical social worker, and other mental health professionals.
- Only 3% of Nigeria's health budget is devoted to mental health.
- Nigeria's 174 Million people rely on only 130 psychiatrists.
- Traditional healers fill the gap.

http://www.aljazeera.com/news/2015/06/traditional-healers-nigeria-mental-healthcare-psychiatric-150606161409127.html

Federal Neuropsychiatric Hospital, Aro, Abeokuta, Nigeria.

VIDEOS

- https://www.youtube.com/watch?v=4kKdU_Z2wDE

Lagos 2 mins

- https://www.youtube.com/watch?v=uKd9MxBzAUc
- The Chains of Mental Illness in West Africa NYT

- https://www.youtube.com/watch?v=e3zclECnYpY
- 5mins

Domains Affecting Service Utilization among West African Immigrants in the US

The four critical domains that affect service utilization as identified by Phan (2000):

- Acceptability,
- Accommodation,
- Accessibility, and
- Affordability.

The "macro-micro link"

- Social and structural features of the person's environment
- Availability of particular treatment resources,
- Physical proximity to services,
- Monetary and psychological costs of help-seeking.

SITUATIONAL CONSTRAINTS TO HELP-SEEKING

- The type of help one decides to seek, and where to seek help can be determined by:
- Lack of insurance
- Immigration status
- Service providers' ability (as impacted by their own beliefs, cultural knowledge, and tolerance as well as by situational constraints in service delivery like agency policy and availability of resources.
- The quality of help received in the end further shapes an individual's beliefs and attitudes towards future help-seeking from that source.

Barriers to utilization of Mental Health Related Services Among West Africans

- Failure to recognize mental illness or denial of its existence.
- Not seeing symptoms as being severe enough to warrant treatment.
- Thinking symptoms would remediate on their own.
- Patient's beliefs about etiology, nature, and treatment of mental illness (e.g., etic vs. emic).
- Self-esteem
- Use of religious or spiritual healing practices to address mental health problems

Barriers to utilization of Mental Health Related Services Among West Africans

- Use of medical services to treat mental health (e.g., affective) disorders
- Lack of faith in the efficacy of mental health services, especially psychotherapy
- Pre-migration help seeking patterns
- Refusal to use available health insurance for fear of being labeled a “public charge” and being placed at risk of deportation, or being denied of immigration benefits

Barriers to Utilization of Mental Health Related Services Among West Africans

- Lack/insufficiency of health insurance
- Absence or inadequacy of culturally tailored services
- Language barriers
- Attitude of formal service providers to immigrants
- Economic need/ Poverty
- Fear of losing confidentiality/ invasion of family privacy
- Fear of Stigma
- Mistrust of mental health system

Barriers to utilization of Mental Health Related Services

- Inability or unwillingness to take time off from work to seek treatment
- Institutional discrimination/racism /alienation
- Lack of culturally-competent services/ limited service availability
- Lack of easy access to service providers /Lack of proximity to services
- Lack of ethnically diverse providers or bilingual providers

Guidelines for the Treatment of the West African Immigrant Patient

- *Characteristics/attitudes of the clinician – Age, religion, ethnicity, and gender matter*
- *Multidimensional Assessment –*
- *Use of psychotropic medication and belief in the biomedical model*
- *Psychotherapeutic Intervention.-*
- *Cognitive-behavioral intervention.*

Professional Self Evaluation, Self-Awareness, and Cultural Competency: *Cultural Competency Continuum Scale*

- Professional self-evaluation
- Professional self-awareness

1. **CULTURAL DESTRUCTIVENESS**
2. **CULTURAL INCAPACITY**
3. **CULTURAL BLINDNESS**
4. **CULTURAL PRE-COMPETENCE**
5. **CULTURAL COMPETENCE**
6. **CULTURALLY PROFICIENCY**

Lecca, P., Quervala, I, Nunes, J. & Gonzales, H. (1998). *Cultural Competency in Health, Social and Human Services: Directions for the Twenty-First Century. New York: Garland Publishing*

Assessment

- Previous attempts to get help, types of help sought and obtained,
- Causal Beliefs *etic vs. emic models*
- Pre-migration history,
- Experience of migration,
- Level of acculturation,
- Degrees of loss and trauma,
- Work and financial history,
- Support systems,
- Medical history, and
- Family's concepts of illness.

Causal Beliefs about Mental Illness

- Intrapersonal,
- Interpersonal,
- Personal-circumstantial, and
- Supernatural

Assessment and Intervention

- Micro-intrapersonal;
- Meso-interpersonal,
- Macro-environmental, and
- Magna-spiritual.

- Guadalupe, K.L., & Lum, D. (2005). *Multidimensional contextual practice: Diversity and*
- *transcendence*. Belmont, California: Brooks/Cole.

Intervention

- Person-centered, family- focused, and culturally sensitive intervention
- Explanation of the therapeutic process
- Acknowledge the difficulties of learning to adjust to a new environment
- Goals of treatment must take into cognizance clients' causal beliefs
- Active listening, empathy, respect and genuineness
- Use didactic, experiential, instructional, and metaphorical communication strategies (e.g. proverbs and anecdotes)
- Psychoeducation and advice giving may be necessary

Working with Interpreters

Quality of care dependent on verbal communication (language critical in developing therapeutic alliance, needs assessment, and intervention).

Mental health professionals are hardly ever prepared for the challenging and complex process of working with interpreters to serve immigrant populations.

Mental health professionals must learn how to:

- Initiate a therapeutic relationship with an interpreter;
- Set the therapeutic frame;
- Address boundaries;
- Acknowledge the role of culture, transference, counter transference, and vicarious trauma;

There is need for:

- Screening to assess interpreters' and mental health professionals' competence;
- Training to orient interpreters to clinical work with forced migrants;
- In vivo feedback; assessments; and an appropriate place for therapists and interpreters to process their experience.

Working with interpreters: tools for clinicians conducting psychotherapy with forced immigrants

Author: O'Hara, Maile; Akinsulure-Smith, Adeyinka M

Socio-economic Factors on Mental Health

Social and economic factors affecting the most vulnerable West African immigrants must be addressed to truly help them with their mental health difficulties.

Service Needs of West African Immigrants

- A culturally sensitive mental health service delivery system.
- Medical Health Services
- Domestic Violence Services
- Economic empowerment
- Multicultural Training
- Job training
- Youth Empowerment
- Child Care
- Translation and interpreter services
- Culturally sensitive elder care
- Immigration/citizenship preparation clinics
- English as a Second Language Classes
- Access to accurate information about the available services.
- Psychoeducation to change attitudes to reflect the current realities.
- Liaison services between the West African community and the schools.
- Inclusion in civic activities.
- Human rights and civil rights protections.
- Economic empowerment.
- Community Empowerment.
- Special courses on U.S. laws and customs.
- Vocational English.
- Accessible employment training opportunities .

Purpose of Presentation

1. To report the findings of a qualitative study regarding the attitudes of West African immigrants towards alcohol and drug misuse.

2. Discuss possible impacts of these attitudes on West African immigrants' help-seeking.

3. Explore effective culturally-informed substance abuse prevention and treatment strategies in working with this population.

Alcohol Use: West Africa Versus United States (Shield, 2013)

	UNITED STATES/CANADA	WEST AFRICA
Mean Annual Alcohol Consumption	9.5 liters	7.8 liters
Lifetime Abstinence from Alcohol (Men).	11%	45%
Lifetime Abstinence from Alcohol (Women)	22%	59%
Mean Annual Alcohol Consumption of Alcohol Users (Men)	20%	29%
Mean Annual Alcohol Consumption of Alcohol Users (Women)	14%	24%

Alcohol patterns vary widely between West African countries, often depending on the percentage of Muslim populations.

Drug Use: West Africa Versus United States (United Nations on Drugs and Crime, 2013)

	UNITED STATES/CANADA	WEST AFRICA
Annual % of Population Using Marijuana	10.7%	12.4%
Annual % of Population Using Cocaine	1.5%	0.7%
Annual % of Population Using Opiates	3.9%	0.4%

Cocaine and heroin use in West Africa has doubled since 2006, particularly affecting the younger population. West Africa has steadily grown as a major transit area for drug trafficking to Europe and the US, with use spilling over to teenagers and young adults.

Substance Abuse Treatment : West Africa Versus United States

(National Institute on Drug Abuse, 2012; Onifade et al., 2011)

Country	Population of Country	Number of Substance Abuse Programs
United States	319 Million	14, 500
Nigeria	177 Million	31

Substance Abuse Treatmentin West Africa

- 9 out of 14 West African countries have no dedicated budget for substance abuse services (Obot, 2013).
- Evidence-based practices in substance abuse treatment are scarce in West Africa, with almost no opioid substitution therapy.
- Many substance-abusing individuals in West Africa are treated in spiritual and religious healing sites.
- There have been reports of harsh treatment of substance users in treatment programs, as well as harsh prison sentences.

Methods

- Three different focus groups of West African immigrants were held in New York City, with a total of 34 respondents.
- Participants were at least 18 years of age, were born in West Africa, and immigrated to the United States at age 15 or older.
- The three groups were held from 2010-2011.
- All participants received a $20 gift card.

Three Focus Groups

- Focus Group 1 consisted of 13 members of a West African nurse's association. Nine were female, 4 male. They were mostly middle aged, mostly identified as Christian, and nearly all Nigerian.
- Focus Group 2 consisted of 9 students at a public community college. Five were female, 4 male. They were under 30 years of age and identified as either Muslim or Christian. They were from different West African countries.
- Focus Group 3 took place at a barbershop mostly frequented by men from Ghana. Twelve men of many different ages, mostly Muslim, participated in this group.

Focus Group Questions

1. What are the differences, if any, in drug and alcohol use between West Africa and the United States?
2. What are the effects of drug and alcohol abuse on the lives of West African individuals and families and on their community in the United States?
3. What do you think causes drug and alcohol abuse?
4. Does the experience of migrating from Africa and living in the United States relate to West African people using drugs and alcohol? How so?
5. How do you feel about people using drugs and alcohol?
6. What are the best ways to help a person abusing alcohol or drugs to get better?
7. What are the best ways to help a family of a person who is abusing alcohol or drugs?

RESULTS: Six Themes Identified

1) Greater prevalence of substance abuse in the United States than in West Africa
2) Social pressures to use substances in the United States
3) Post-migration stress enhancing substance use
4) West African families and community as protective factors against substance abuse
5) Religion and spirituality as a counterforce to substance abuse
6) Negative views of U.S. substance abuse treatment.

Theme 1: Greater Prevalence of Substance Abuse in the United States than West Africa

- Heavy alcohol use usually only occurs on important social occasions in West Africa.
- Drunkenness is shunned in West Africa.
- Drinking and drug use by women is very stigmatized in West Africa.
- There was a debate regarding prevalence of marijuana use in West Africa. Marijuana use in West Africa is viewed as only prevalent among certain populations.
- There is far less hard drug use in West Africa, and is associated with criminal behavior or cults.
- Several participants acknowledged increasing drug use in West Africa in the last decade.

Theme 2: Social Pressures to Use Substances in the United States

- Social pressure to use alcohol and drugs is particularly strong for young West Africans in the United States.
- Alcohol and drug use is glorified in U.S. culture. Young West Africans want to emulate U.S.-born Americans.
- It takes great strength to resist using substances with U.S.-born Americans.

Theme 3: Post-Migration Stress Enhancing Substance Use

- Fast pace of U.S. culture, with the need to take on multiple social, vocational, and educational roles, enhances need for substances to relieve stress.
- Economic pressure to support self and family enhances need to use substances.
- Drug-dealing as a way to make fast money leads to becoming dependent on the drugs one sells.
- Pressure from family members in West Africa on immigrants to demonstrate that they have achieved economic success in U.S. results in drug dealing and subsequent drug use .

Theme 4: West African Families and Community as Protective Factors Against Substance Abuse

- U.S. society was viewed as too individualistic, unlike the West African community, which was seen as more cohesive.
- Family life much more important for West African immigrants than for U.S.-born Americans.
- Those West African immigrants who socialize outside of West African community are more vulnerable to substance abuse problems.
- Substance abuse problems bring shame upon West African families.

Theme 5: Religion and Spirituality as a Counterforce to Substance Abuse

- Religious affiliation and spiritual practice was viewed as protective against substance abuse.
- Participants believed that the Christian and Muslim religions were both protective against substance abuse.
- Religious practice could inform treatment for substance abuse.
- Many West Africans believe that substance abuse could be caused by curses or other supernatural phenomena.

Theme 6: Negative Views of U.S. Substance Abuse Treatment

- Many participants believed that U.S. substance abuse treatment programs are highly ineffective revolving door modalities, often in existence as business ventures. Methadone maintenance was particularly viewed negatively.

- Some participants endorsed U.S. models of substance abuse treatment. However, many others endorsed other methods of dealing with substance abusers such as:
  - A) Sending the individual back to Africa
  - B) Religious or spiritual immersion through use of religious/spiritual centers
  - C) Using herbalists with traditional healing methods
  - D) Harsh prison experiences

Discussion of Findings/Implications

- Incongruence between extant empirical evidence and participants' perceptions of rates of incidence and prevalence of substance abuse in West Africa versus United States. There is evidence that:
  1. Even though abstinence rates for alcohol are higher in West Africa than in the United States, higher quantities of alcohol consumed by drinkers in the former than in the latter (Shield et al., 2013).
  2. Rates of marijuana use in West Africa greater than rates in North America (UNODC, 2013).
  3. Rates of cocaine and opiates use increasing in West Africa (WACD, 2013).
  4. Prescription medications abuse is prevalent in West Africa (Ebigbo et al., 2012).

Possible Reasons for participants' perceptions:

1. Long absence from West Africa of some of study participants
2. Minimization of scope of substance abuse prevalence due to associated stigma.

Recommendations

1. Explore and utilize West African professional, community, and spiritual resources (e.g., physicians, social workers, churches, mosques, socio-cultural groups, African stores) to educate and inform West Africans about substance abuse prevention and treatment.
2. Create specialized substance abuse groups and "call centers" for those who identify as African.
3. Be well-informed about West African immigrants' causal beliefs about substance abuse and patterns of their help-seeking before starting to work with them.
4. Recognize the roles of stigma and secrecy as barriers to substance abuse treatment.

Recommendations

1. Adopt a strong family-oriented perspective, and include family members in treatment, if appropriate and feasible.
2. Carefully explore the suitability and feasibility of sending clients back to West Africa to seek treatment for substance abuse.
3. Encourage the discussion of religious and spiritual beliefs about causation and treatment of substance abuse.
4. Consider the uniqueness of individual clients, and base treatment decisions on individualized bio-psychosocial assessments.

VIDEO

- https://www.youtube.com/watch?v=ExLB_jt6z-A
- SUBSTANCE ABUSE TREATMENT IN NIGERIA 4 MINUTES

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Videos

- https://www.youtube.com/watch?v=uKd9MxBzAUc
- The Chains of Mental Illness in West Africa NYT

- https://www.youtube.com/watch?v=e3zclECnYpY
- 5mins

- https://www.youtube.com/watch?v=Jw_meN_060Q
- 5mins

- https://www.youtube.com/watch?v=Goc6FIUbnZM
- 42 mins first 2 minutes

- https://www.youtube.com/watch?v=2JmzOSuu12w
- Mental health treatment in Somalia

- https://www.youtube.com/watch?v=mw_raksSi9Q
- Views of traditional healers on how to treat mental health in Nigeria 10 mins

- https://www.youtube.com/watch?v=ExLB_jt6z-A
- SUBSTANCE ABUSE TREATMENT IN NIGERIA 4 MINUTES

- https://www.youtube.com/watch?v=XHqdTUlcD4U
- **Report Decries Treatment of Mentally Ill in Ghana**
- 4 MINUTES

PRESENTATION ORDER

- Intro – 5 minutes
- Mental Health with 30 minutes with Video
- Substance abuse 25
- Treatment issues 15
- Case 15 minutes

- How will they conceptualize working with Kofi and his family?

Klein, A. (2001). "Have a piss, drink *ogogoro*, smoke *igbo*, but don't take *ghana*"–Hard and soft drugs in Nigeria: A critical comparison of official policies and the view on the street. *Journal of Psychoactive Drugs, 33,* 111-119.

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