

Barriers to Mental Health Treatment within the Congolese Population

October 2016

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Recent Crises

The Democratic Republic of the Congo (DRC) has been in crisis as a result of the First Congo War from 1996-1997, the Second Congo War from 1998-2003 and the Kivu Conflicts in eastern DRC from 2004-present (1). The First Congo war was started after the Rwandan genocide in 1994, and millions of Rwandan refugees entered the eastern DRC. In 1996, Rwanda and Uganda entered the eastern DRC to find the remaining perpetrators of the genocide. The Ugandan army, Rwandan army and Congolese opposition leader Laurent Kabila defeated the Congolese dictator Mobutu Sese Seko. With the end of the First Congo War, Laurent Kabila became president. The Second Congo War ended after President Kabila ordered Rwandan and Ugandan forces to leave the eastern DRC. Despite the end of the war, rebel groups consisting of the Congolese army continue to cause unrest and harm in eastern DRC, specifically the provinces of North and South Kivu, Orientale, and Katanga. The continued crisis in the DRC has been described by the United Nations as one of the world's worse humanitarian crises. It has caused hundreds of thousands of victims to seek refuge in other countries.

Congolese Background

Language

The official language of the DRC is French, but Lingala, Kiswahili, Kikongo and Tshiluba are considered primary languages as well. While the majority of refugees speak different languages, the most common spoken in those resettling in the United States is Kinyarwanda. Their proficiency for English is minimal.

Education

According to the Centers of Disease Control and Prevention and the International Organization of Migration, 14% of the refugees have no formal education, 54% have primary schooling, 31% have earned a high school diploma, and 1% have a university degree. Women are less likely to attend school.

Religion

While 70% of the DRC population is Christian, 95% of the refugees resettling in the United States are Christian. The large majority consist of Pentecostal and Seventh Day Adventists. Few have indigenous beliefs exclusively.

Family

A Congolese household consists of the immediate family, extended family, and can include those not blood-related. Children are a sign of prosperity. The average woman has 5 children and their upbringing is shared by the entire family. Due to the conflict, women have become the primary source of financial support for the family.

Risk and Prevalence of Mental Health Illness

Refugees in general are at great risk to develop mental illness. Their risk factors include exposure to war, torture, refugee camps, human trafficking, physical displacement from one's country of origin, loss of family members and prolonged separation, stress of the adapting to a new culture, low socioeconomic status, and unemployment (2).

Over the past two decades, the Congolese population has undergone a tremendous amount of trauma and violence, especially sexual violence (3). One survey reported that in the Congo the "prevalence of sexual violence is significantly higher than previously reported in other conflict and post-conflict settings" (3). In the aforementioned survey, results were collected from a representative group from the Congo. Results included that 39.7% of women and 23.6% of men have been exposed to sexual violence during their lifetime. A large majority of these victims were exposed to conflict-associated sexual violence while other sexual violence was reported as interpartner violence. Sexual violence included molestation, forced to undress, stripped of clothing, rape including gang rape, forced marriage, abduction, sexual slavery, and forced to perform sexual acts with another civilian. Rape was the most common type of violence reported by both male and female victims. While violence was committed by mostly men, there were also woman perpetrators. Specifically, about 41% of women as perpetrators were reported among female survivors and 10% among male survivors.

While sexual violence was the most common violence reported by victims, other sources of violence included human rights abuses and the trauma of serving as a combatant. Human rights abuses included being beaten, shot, or stabbed, amputation, capture, abduction, forced displacement, property theft, property destruction, destruction of home and forced work. The survey reports that 67% of the population studied experienced some type of human rights abuse. The proportion of households experiencing abuse against a child included 6.8%. Concerning those serving as combatants, 20% of

the surveyed population reported serving as a combatant. They were either abducted or kidnapped and their most common reason for staying was because of threats to themselves or to family. In summary of these results, the survey found widespread sexual violence and human rights abuses in North and South Kivu since the start of the conflict.

After collecting the reports of violence among the study group, the researchers also assessed the prevalence of mental illness using the standard symptomatic criteria for major depressive disorder (MDD) and posttraumatic syndrome disorder (PTSD). Results concluded that 40.5% of the study group met symptomatic criteria for major depressive disorder after a 1-year recall period. A proportion of 50.1% of the population met symptomatic criteria for PTSD after a 1-year recall period. During the prior year, 25.9% reported suicidal ideation, and 16% reported attempted suicide at some point during their lives. This study found that a significant proportion of those surveyed were affected by mental illness including major depressive disorder and post-traumatic disorder, which is a reflection of the greater Congolese population. With the prevalence of trauma, it is likely that the Congolese refugees arriving to the United States have experienced significant trauma and violence in their own lives and also have mental health needs.

Barriers to Mental Health Treatment

Caring for the mental health of refugees is a challenge due to a variety of barriers. These barriers include language, culture, religion, stigma, lack of transportation, work conflicts, and lack of childcare. While the language, lack of transportation, work conflicts and lack of childcare are some common barriers in refugees, there are several aspects that are specific to the Congolese population and affect their mental health care.

Different Perception of Mental Illness

A study interviewed groups from four different locations, including a group in Butembo within the northern part of the North Kivu Province in the DRC (4). Within all four areas, including Butembo, there was some understanding of mental illness. The population described syndromes that consisted of several symptoms or presentations. One syndrome was described as a severe behavioral disturbance and another as sadness and social withdrawal. The study emphasized that although these syndromes bear resemblance to our own diagnostic categories, it would be incorrect to label them as such.

The syndrome of severe behavioral disturbances was referred to by the people of Butembo as *musire*, or a person with *erisire*. This description resembles psychotic disorders including a person thought to be verbally and

physically aggressive such as throwing stones and beating people. The behavior was considered uncoordinated. It included taking their clothes off, walking naked, eating inedible things such as leaves, walking aimlessly and sitting down in dirty places. People with *erisire* spoke of things that are not relevant or were unable to logically follow the course of a discussion. Other symptoms included singing all the time, laughing or crying at inappropriate moments, talking to people when no one is there, stealing things, and not realizing they are mentally ill. A subtype of *erisire* was called *erisire ry'emaumu* or silent *erisire*, which was characterized by social isolation, not speaking, absence of movement and profound sadness. Another type of *erisire* was characterized by too much activity, talking, dancing, singing excessively and inappropriate, exalted mood.

Another syndrome consisted of sadness and social withdrawal as its core features and bore similarities with nonpsychotic mental disorders such as depression or anxiety disorders. This was called *Amutwe alluhire* or tired head. This term was used to indicate someone who is sad, irritable or nervous and often cries without reason. The person is considered to be confused, easily angered or irritated and feels neglected by family and friends. They are often forgetful and socially withdrawn. Although these characterizations are associated with symptoms of major depression, in their culture it is rather an expression of someone not doing well and being overwhelmed by the tasks of life. For the people of Butembo it is understood as an adaptive reaction to a situation of distress rather than as a medical illness.

Dependence on Treatment within their own Community

Treatment decisions in the Congolese population are often strongly dependent on the perceived cause of the condition. However, many things that seem to have similar effects could have different causes. A first step in the process of seeking help would be to discover the cause, and in particular, to resolve it if supernatural factors were believed to be present. For *erisire*, the use of traditional healers such as Mukumu, herbal healers such as Musaki, and even Christian pastors to pray for the patient are prevalent. "In the case of sorcery, one should go to a traditional healer [Mukumu]. In the case of bad spirits, one has to chase the spirit away by praying and rituals in the church, and in cases that do not have a supernatural cause, one should go to the hospital." However, treatments offered by these healers are not always seen as effective. In the aforementioned study, the syndrome of *erisire* was considered to need treatment, but people did not really know where to go. Patients with *erisire* were thought to improve through treatment with western medication unless sorcery or spirits were the cause of the condition. This study found

that the people of Butembo similarly wanted medical treatment for *erisire* but did not know where to go for help. In this situation it is recommended for them to find access to trained psychiatric professionals and institutions.

However, syndromes resembling nonpsychotic mental disorders were not regarded as mental disorders, but instead they are considered states caused by circumstances such as social or spiritual problems. Therefore, they were not seen as a health condition for which help should be sought within the healthcare system. Rather, such conditions were expected to improve through social and emotional support from relatives, traditional healers and community members. For example, “A person suffering from *alluhire* can be helped by providing material assistance, work or a good house. It can also help to seek distraction, so he will not always think about the bad things, for example by visiting the person. The family of the person should be advised how they can help. Praying with the person can also help. With good assistance, a person with *alluhire* will become normal.” In summary, the treatment options for *alluhire* were to provide money, goods or work, visit the person, pray for the person, ensure the person is not alone, and involve him in communal work in the village. Another study similarly found differences in the understanding of mental illness and treatment within the Congolese (5). This study also reported other barriers including hesitancy to disclose private information to strangers, stigma toward mental illness, lack of awareness of one’s emotional needs, and logistical obstacles.

Lack of Mental Health Screening

A study gathered information from 43 local resettlement agencies serving Congolese refugees after their arrival in the US (6). The survey included questions that evaluated the most common deficiencies in Congolese care, which included mental health. A few challenges that were specifically outlined by this survey were a lack of interpretation services, lack of appropriate mental health screening, and a client’s refusal of services.

From 2010 to 2012, among the 3,577 Congolese refugees examined by physicians overseas, 1% were found to have a mental health condition. The most common mental health conditions included mental retardation 0.39%, adjustment disorders 0.34%, schizophrenia 0.11%, mental disorder not otherwise specified 0.08%, depression 0.06%, and a specific developmental disorder of motor function 0.6%. However, with the heavy prevalence of symptoms of PTSD and depression within a sample group in the DRC in the aforementioned study, it is likely that much more than 1% of these refugees have a mental health illness as

well. In addition, another study mentioned that screening can be limited due a couple of other barriers: lack of documentation or knowledge of prior mental illness or mental illness within their family and lack of mental health specialists.

Possible Interventions

Provide Service within the Community

There is a difference in the understanding of mental illness within the Congolese population along with how to appropriately treat or approach these patients. A couple of studies concluded that an appropriate intervention is to empower the “natural” social support systems already in place, including counselors and community health workers (3,4). With those reluctant to use mainstream mental health services, services within the community may be more feasible such as through their faith.

Besides medication, cognitive behavioral therapy is used to treat many of these mental health illnesses. However, this requires specific resources within a population with limited resources and professionals that can serve this population. A study evaluated whether individual therapy and group therapy would be of benefit in low-income, conflict-affected countries with a few mental health professionals and low literacy rates specifically with PTSD, depression, and anxiety symptoms and low function in female survivors of sexual violence in eastern Democratic Republic of the Congo (7). The services were provided by psychosocial assistants who underwent 2 weeks of in-person training with trainers based in the United States. Results were collected at 1 month and 6 months post-intervention. Both individual support and therapy groups had significant improvements during treatment with effects maintained at 6 months. However, those in the therapy group showed significantly greater improvement. The relative risk of meeting the criteria for depression, anxiety, or PTSD were significantly greater with individual support than group therapy at the end of treatment and 6 months after treatment. With appropriate training and supervision, psychotherapeutic treatments such as cognitive processing therapy can be successfully implemented and can have an effect even with limited numbers of mental health professionals.

Education

Along these same lines, education about the connection of trauma with depression, PTSD, substance abuse, sexual violence, domestic violence, and anxiety can be helpful (4). Sessions can be in the form of focus group discussions, lectures, and/or home visits.

Mental Health Screening

The lack of appropriate mental health screening includes overseas screening, screening upon arrival and 6 months after arrival (6). Concerning the overseas screening, the CDC recommends taking this opportunity to educate refugees about mental health issues and expected stress response in a new country (2). Those providing evaluations should educate themselves about the history and cultural beliefs of the Congolese refugee population. Medically trained interpreters should be in use whenever possible.

In addition, refugees may not volunteer or admit to symptoms at their initial screening, but these may emerge several months or years after resettlement. Therefore, these refugees should be screened for mental health illness again upon arrival and in a few months after spending some time in the United States.

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