Wilder Research

Treating Co-occurring Disorders among Southeast Asian Refugees, Immigrants, and Asylum Seekers

Literature Review Prepared for Wilder Recovery Services

In 2019, Wilder Recovery Services commissioned Wilder Research to assist with the development and evaluation of a toolkit for providers to use with refugees, immigrants, and asylum seekers of Southeast Asian descent who have co-occurring substance use disorders and mental health conditions. As part of this project, Wilder Research conducted a literature review of peer-reviewed journal articles and reports published by entities that work with or advocate for this population to identify best practices in providing treatment. This summary presents the key findings of this literature review.

There is a significant lack of research on this population, including a lack of research assessing the efficacy of mental health interventions for Asian Americans (Huey & Tilley, 2018), services provided to refugees with co-occurring issues (Posselt et al., 2017), and specific approaches to cultural adaptations of treatments (Long, 2010). Additionally, there are few culturally informed substance use treatment programs for refugees (McCleary et al., 2016). Despite these limitations, existing literature indicates several best practices that can improve the services received by refugees, immigrants, and asylum seekers of Southeast Asian descent with co-occurring issues.

Culturally responsive interventions

Many mental health concepts, diagnoses, and measures were developed in a Western context and may have limited applicability with clients from other cultural backgrounds. Research has demonstrated that providing culturally responsive mental health and substance use interventions can improve access to services, improve treatment completion rates, increase client satisfaction, and improve client outcomes (Griner & Smith, 2006; Huey & Tilley, 2018; McCleary, 2017). Additionally, customized interventions for specific cultural or ethnic groups appear to yield more positive outcomes relative to those developed for multiple cultural or ethnic groups (Huey, & Tilley, 2018; Long, 2011; Murray et al., 2010).

There are several ways in which treatment can ensure cultural responsiveness, including incorporating cultural values, beliefs, and practices; staffing services with providers and support staff that have high levels of cultural competence or come from the same ethnic, cultural, or linguistic background as clients; taking a holistic and strengths-based approach that de-emphasizes pathology; and acknowledging the physical manifestations of distress.

Cultural values and practices

Western ideas of therapy, particularly talk therapy, are often new concepts to refugees, immigrants, and asylum seekers (Long, 2010). Clients from non-Western backgrounds may be more likely to view their mental health through a religious, spiritual, or supernatural lens, employing concepts such as fate, curses, or spirits (Minnesota Department of Health, 2013; Poole & Swan, 2010). Providers are encouraged to integrate cultural beliefs and values into treatment as much as possible (Hwang, 2006). As noted by Poole and Swan (2010), "When delivering a therapy, the best option is to work alongside these beliefs as much as possible, because such beliefs are often seen as being correct and helpful within a person's community. They may also allow the person to accept further treatment" (p. 38).

Researchers have suggested specific ways to build upon cultural values. Hwang (2006) recommends taking a goal-oriented and educational approach with Asian clients, two values consistent with some Asian cultures. Others have identified confrontation, a strategy sometimes used in Western-style treatment, as culturally inappropriate for some Asian cultures (Poole & Swan, 2010). Values that may be important to clients of Southeast Asian descent may also include acceptance of one's circumstances, fate, avoiding conflict, and humility (Long, 2010).

Clients may also benefit by the incorporation of cultural practices into treatment, such as acupuncture, traditional healing therapies, or spiritual and religious activities (Bemak & Chung, 2017; Hwang, 2006; Puri et al., 2018; SAMHSA, 2016, Poole & Swan, 2010).

Collectivism versus individualism

One of the most significant cultural differences between Southeast Asian cultural values and Western cultural values is the emphasis on collectivism versus individualism, and treatment programs can leverage this value in several ways (Hwang, 2006; Poole & Swan, 2010). These strategies may be particularly critical for refugees, immigrants, or asylum seekers that have lost social support connections, such as family and community relationships (Bemak & Chung, 2017; Poole & Swan, 2010).

In a study examining harmful alcohol use in a community of Karen refugees, respondents described how forced displacement led to the fracturing of their community and their culture, ultimately resulting in excessive alcohol use within their community (McCleary, 2017). Respondents described the importance of rebuilding and strengthening their community and their connections to their culture to address this problem. In a study of refugee youth with dual diagnoses, the most significant challenge youth identified was social isolation (Posselt et al., 2015). Other research has also identified the critical role that relationships and connection with culture and one's cultural community can play in recovery (Poole & Swan, 2010).

Providing group therapy specific to a culture may be a particularly advantageous treatment modality, as it can provide a connection to one's culture and community, reduce social isolation, and encourage a sense of universality (Minnesota Department of Health, 2013; Puri et al., 2018; Poole & Swan, 2010). Other research has emphasized the important role family members can play in a client's recovery (Hwang, 2006; Isakson et al., 2015; SAMHSA, 2016; McCleary, 2017; Yang et al., 2005).

Cultural competency training for staff and same-culture or same-ethnicity staff

Although it can be challenging to assess whether cultural competency training for staff improves outcomes for individuals served in mental health or substance use treatment programs, providers who receive this type of training often report significant improvements in their knowledge, confidence with working cross-culturally, and their skill sets (Long, 2011). Other researchers have identified the need for cross-cultural competency training (Posselt et al., 2017). It is generally recommended that providers should learn about the cultural backgrounds of their clients, intentionally build their understanding of cultural issues, and improve their self-awareness of their own cultural beliefs and how they work cross-culturally (Hwang, 2006; Murray et al., 2010).

Clients may benefit from providers or support staff from the same cultural or linguistic background as the client (Long, 2011), and research suggests that providers who are from the same culture or ethnic background as the clients they serve generally yield better outcomes, such as increased access to services and decreased crisis intervention (Long, 2011; Ziguras et al., 2003). However, this can be difficult to achieve with small populations of certain ethnic or cultural groups and the potential confidentiality issues that can emerge because of that. Some services have found success in hiring individuals from these groups that have not had formal mental health or substance use treatment training to serve as a liaison between providers and clients (Long, 2011).

Holistic and strengths-based treatment

Due to cultural stigma and that many mental health diagnoses were developed in a Western context, assessment and treatment should not solely rely on diagnoses; clients' whole identities and experiences should also be considered (Murray et al., 2010; Poole & Swan, 2010). Similarly, mental health measures are generally tested and standardized using samples from Western populations, and should be used with significant caution (Poole & Swan, 2010). Because of stigma, cultural beliefs regarding mental health, and possible significant trauma history, programs are advised to focus on clients' strengths (Minnesota Department of Health, 2013; Murray et al., 2010; Poole & Swan, 2010) and how clients have coped with challenges and distress in the past (Poole & Swan, 2010).

Somatic symptoms and physical health

Individuals from non-Western backgrounds often experience mental health symptoms somatically (Long, 2010; Poole & Swan, 2010) and may be more likely to view their mental health and physical health as inseparable (Minnesota Department of Health, 2013). Somatically expressing distress may also be less culturally stigmatizing (Minnesota Department of Health, 2013). Although research has demonstrated that somatic symptoms can be treated effectively through talk therapy, clients may refute the idea that their symptoms could be linked to a mental health issue (Long, 2010). Accordingly, traditional treatments that involve a physical component, such as massage or acupuncture, can be useful in treatment somatic symptoms (Long, 2010; Poole & Swan, 2010).

Hwang (2006) identifies the biopsychosocial model as particularly appropriate with Asian clients because of its holistic nature and its emphasis on the mind-body connection.

Psychoeducation

Due to stigma and possible lack of exposure to mental health and substance use information, psychoeducation can provide a crucial role in treatment (Minnesota Department of Health, 2013; WHO, 2018). This could include information on specific symptoms and diagnoses, such as PTSD and depression, but also general information about stress, trauma, social isolation, and substance use (Isakson et al., 2015; Poole & Swan, 2010).

The Minnesota Department of Health (2013) identifies psychoeducation as an important component of treatment, and the authors suggest using normalizing language, such as asking about "stress" rather than "mental health" and emphasizing that mental health and substance use issues are common reactions to such stress. Additionally, providers may want to share how coping styles and manifestations of stress vary across cultures (Poole & Swan, 2010). For individuals affected by substance use, identifying triggers for cravings and relapse is critical (SAMHSA, 2013).

Traumatic experiences and trauma symptoms

One of the most important considerations in developing a treatment program for clients from this population is acknowledging and addressing the considerable trauma they may have experienced. Refugees may have suffered significant and multiple traumatic experiences, given that refugee status necessitates risk of danger or violence in their home country (Murray et al., 2010; Poole & Swan, 2010). Clients may have experienced persecution, oppression, and even torture in their country of origin, and rates of post-traumatic stress disorder (PTSD) and depression among refugees is high (Isakson et al., 2015; Poole & Swan, 2010). They may have spent extended periods of time in refugee camps, experienced forced separation from their family members, and may have experienced a strong sense of uncertainty, instability, loss of "home," or lack of control over their lives (Poole & Swan, 2010). Once resettled, they also may encounter racism and discrimination (Bemak & Chung, 2017). All of these factors can result in negative mental health outcomes (Poole & Swan, 2010), and it is important to note that PTSD and other mental health issues may result from experiencing multiple stressful or traumatic events (Isakson et al., 2015). Research has also found that substance use may be used as a coping mechanism to alieve symptoms related to trauma, isolation, feelings of uncertainty, and stress (Ezard, 2012; Weaver & Roberts, 2010).

To address these challenges, treatment should be trauma informed (McCleary, 2017). In their review of key considerations when adapting and implementing evidence-based practices for use with refugee youth who have experienced trauma, Isakson and colleagues (2015) identify the below components:

- Supportive, respectful, and validating therapeutic relationship
- Psychoeducation about trauma
- Cultural competency
- Training on strategies to reduce stress and regulate emotions
- Client-directed goals
- Activities aimed at increasing self-acceptance and self-awareness
- Addresses social isolation and separation
- Addresses loss of culture and community
- Addresses experiences of discrimination

Language barriers

Language can pose a significant challenge to accessing mental health and substance use treatment (Posselt et al., 2017). Past research suggests treatment is best provided in the client's own language or by incorporating an additional staff member fluent in the client's language and ideally from the same cultural background (Dubus, 2009; Poole & Swan, 2010; SAMHSA, 2016; WHO, 2018). Similarly, in a review of research exploring treatment and access to treatment for alcohol use disorders among individuals of South Asian ancestry living in Canada and the U.S., the authors concluded that programs may better serve clients by using materials in the client's language (Puri et al., 2018).

Interpreters are frequently used, but they may lack adequate training specific to mental health and substance use. Interpreters without this type of training are less likely to pass on accurate information with sufficient detail regarding medication side effects and symptoms (Flores, 2005; Karliner et al., 2007). Research has demonstrated similar findings when a client's family member serves an interpreting role, leading to poor quality care and greater medical costs (Flores, 2005). Interpreters with mental health and/or substance use training can improve access to services, reduce medical costs, increase client satisfaction, and increase their understanding of their diagnosis and treatment options (Flores, 2005). It is also recommended that treatment providers receive training on working with interpreters (Isakson et al., 2015; Kirmayer et al., 2003).

Client trust

It is important to allow for time to establish rapport and build trust with clients. Immigrants, refugees, and asylum seekers may not be familiar with the Western health care model and may be distrustful of the health care system (Posselt et al., 2017; Poole & Swan, 2010). They may have experienced racism or discrimination or significant trauma, which can affect how they interact with others, including providers (Bemak & Chung, 2017; Poole & Swan, 2010; WHO, 2018). Clients may also reject the suggestion that they should share personal information, particularly problems related to mental health or substance use, with providers; these types of problems may have been handled within their family, community, or with a traditional healer in their country of origin (Minnesota Department of Health, 2013). To address these challenges, providers can take time to build trust and rapport, focusing on orienting their clients to the therapy experience (Hwang, 2006). Research has also found that preparing clients for treatment far in advance can increase the likelihood of a successful referral (McCleary et al., 2016).

Practical support

Because of the significant challenges refugees, immigrants, and asylum seekers face, providing practical support to navigate systems and access resources may also benefit clients, in addition to mental health and substance use treatment they may receive (SAMHSA, 2016). The World Health Organization (2018) identifies social integration as key to promoting mental health among refugees and migrants, which may involve securing basic needs such as food and facilitating access to education. Access to basic needs and resources, such as housing and employment, promote improved outcomes for refugees (Isakson et al., 2015). The Minnesota Department of Health (2013) states that treatment for refugees may involve providing support or services related to "food, clothing, shelter, finances, health care, social support, vocational training/rehabilitation" (p. 9). Similarly, to ensure the comprehensive needs of individuals served are met, collaboration across agencies and services is recommended (Isakson et al., 2015; Long, 2011). It is also important to note that refugees, immigrants, and asylum seekers, particularly those relatively new to the U.S., may not be aware of services and resources. In a study of refugee youth with dual diagnoses, youth reported a general lack of awareness regarding the services available to them (Posselt et al., 2015).

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