

INTERVIEW WITH JAMES L. GRIFFITH, MD

Global Mental Health, One Refugee at a Time

By MARIE ROHDE

James L. Griffith, MD, is the interim chair of psychiatry, director of the psychiatry residency program and a professor of psychiatry and neurology at George Washington University School of Medicine and Health Sciences, Washington, D.C. His keen interest in global mental health and in the mental health treatment of immigrants and refugees in the United States led him to develop a psychiatry residency program distinguished for its curriculum in cross-cultural psychiatry, global mental health, mental health policy and psychosocial care for mentally ill patients. Griffith provides psychiatric treatment at Northern Virginia Family Services in Falls Church, Va., for immigrants, refugees and survivors of political torture. He has a clinical practice at the GW Medical Faculty Associates in Washington, D.C. This is an edited transcript.

HEALTH PROGRESS: How did you become interested in the mental health needs of immigrants and refugees?

GRIFFITH: I was in an Ethiopian restaurant in a very multi-ethnic neighborhood in Washington, D.C., and I had kind of an epiphany that in D.C. we don't have a state government and that at George Washington University — unlike most medical schools — we don't have populations we are accountable to. This was back in the 1990s, and the Internet was just coming into full swing, connecting us to the whole world. At that time, Washington, D.C., was on the front page of *USA Today* as having three of the country's five school systems with students who spoke more than 100 languages. They featured the school district where I live, where there were students from 186 coun-

tries who spoke 100 languages.

So it was just a matter of taking stock of this. George Washington University had no cultural psychiatry at all. As a matter of fact, we didn't have any community psychiatry at all. We set about creating a department largely organized around immigrants and refugees in this country.

The other part is that throughout my medical career, I had been mainly focused on family therapy, developing family-based approaches for caring for medical illness, psychosomatic illnesses. Nearly all of the practitioners who were developing family therapies in the 1970s and 1980s were doing work with immigrant and refugee populations by the 1990s. For most of the world — but not North America — a person does not identify as an individual, but as a family member. The skill sets used in working with families are the same as



those needed to have something to offer in immigrant communities or in other countries.

HP: Is the family therapy approach critical in dealing with immigrants and refugees?

GRIFFITH: None of these are absolute, but in general, it's true — historically, a person's identity has been very much wedded to the family, the nation, their relational identity. Around the world, this is usually the biggest mistake made — trying to make an individual-based treatment, as we do it here, rather than family-based, community-based approaches.

HP: Is there more, or less, acceptance of psychiatric care among immigrants and refugee populations?

GRIFFITH: That's an interesting question, but I think it's not a good question for this reason — every society that has been studied has stigma against psychiatry and psychiatrists. This probably speaks to something possibly about the evolution of human beings, I'm not sure. Stigma is everywhere, but what's more often the issue is that mental health services in this country are not organized in a way that would be welcoming to immigrants in terms of their communal ways.

I'll give you an example. Brandon Kohrt MD, who has a PhD in anthropology and graduated our program last year, is now a faculty member at Duke University in psychiatry, global health and cultural psychiatry. Brandon had worked for 15 years in Nepal. He's really a country expert. He recognized when the Bhutanese refugees from the camps in Nepal were being sent around the world, their suicide rates in the United States were higher than they were in the refugee camps and higher than in any other country. When he began looking at this, he realized that the way we think of the human mind doesn't make sense in terms of the Nepali mind, which is organized around the heart-mind, brain-mind, spirit-mind.

So Brandon set about taking three of our therapies that are commonly offered — cognitive behavioral psychotherapy, interpersonal psychotherapy and dialectical behavioral psychotherapy — and basically taking them apart and repackaging them to fit the Nepali model of the mind. We wrote a paper together and hoped that it would help community mental health centers better offer their services in a way that would be more understandable.



James L. Griffith, MD

Photos courtesy of James L. Griffith, MD

In the melting pot model, we kind of expect immigrants to come in and insert themselves into whatever services we have set up. That's really not the way to go if your aim is to engage and destigmatize. Work well done, I think, goes into the community and gets to know people in the community, the idioms of distress, how people show distress within that culture. If there is important medical information, how is it handled respectfully? Even that is often an issue. Do you first speak with an elder and get permission before you speak to someone? These are the kinds of things that, when well done, mental health services work well.

HP: It's cultural sensitivity. How do you acquire that?

GRIFFITH: Two old terms from anthropology are etic and emic. Etic is where you take your own categories of meaning and explain the other in terms of it. Emic is where you go inside, learn

from the inside how people look at the world and think about it, the language they use, and then organize whatever you do out of that. I think the approaches that go to the emic side tend to be successful.

HP: With the vast diversity among immigrants, how can providers do this?

GRIFFITH: As an individual or as a clinician, I think it's more to develop a strong capacity to convey interest, respect and a sense of not knowing, of really going into reverence for the other and always learning. With my residents, I say you have to be forgiven when you are wrong. There is an art to that.

HP: Multiculturalism is an important part of your practice at Northern Virginia and as a part of the residency program, isn't it?

GRIFFITH: That's accurate. The agency is free-standing, they were there before we met them. They are a large social services agency, and we provide the psychiatric component. As for our residency, I don't know if there is another one like it in the country. We have the capacity to offer a four-year track in global mental health. A part of each residency year, a resident can spend time in international settings.

It's not that anybody can come do this. You have to show that you have the skills, the capabilities. But all of the residents get training in medical anthropology, ethno-pharmacology — how medications are handled differently in different ethnic or racial groups — sociocultural assessment, just the different skills you would need. That's kind of standard fare. Maybe a fifth of our residents do a more intensive level of scholarship and training in a global mental health track.

I think [acquiring cultural sensitivity] is to develop a strong capacity to convey interest, respect and a sense of not knowing, of really going into reverence for the other.

HP: Is this sort of training going to be more common or needed more?

GRIFFITH: Yes. It was not that long ago when global mental health essentially did not exist. People assume there is a hierarchy of needs, and that people need your basic medical/surgical treatment first and mental health last. But it's also that international mental health projects embarrass regimes. They display the torment of populations.

It was slow developing, but it's moving at a fast pace now, and with global economies, it just makes sense that we should expect there will be more mental health experts who can work across the gaps of culture.

We use a very generic definition of "culture." We have a rotation for treating the deaf and hard of hearing, another for the gay and lesbian community. These call on a lot of the same kinds of skills you need if you are meeting someone from a different religious, ethnic, racial community. So both within the country and globally, there is going to be a growing need for skills that are not just locked in to a homogenous group.

HP: What do the various immigrant and refugee populations have in common?

GRIFFITH: All groups are going to go through a process of identity transformation. How do you hold on to what is good in the old and embrace what is new? One pull is nostalgia, which is idealizing what we left and trashing the new place. Or over-idealizing the new and forgetting the old. That's pretty universal.

Migration is always going to involve some loss and, often, trauma. A colleague from India talks about it by saying, "Where are the elephants?" There are none here, but in south India you can look out the window and see elephants. That's a loss. Often the loss is ambiguous; a loss that is most present for you is not visible to other people.

But there's often also a downward drift in social status. I've got volunteers at our clinic who were professionals in other countries, but there's no way that they would get through the whole system of retraining and get licensed in the U.S.

Pretty often there can be a burden of delegation for kids. It may just be anecdotal, but I think of a number of Asian families where the parents came to this country and worked very long hours, with no hope of professional lives or accomplishments. Everything was for their children. Then



Griffith and a team of Nepali clinicians in Kathmandu discuss how to create an initial family interview format in Nepali language and reflecting Nepali culture.

the children go to schools here and get to know other kids, and maybe they don't want to be a doctor. It can give rise to really intense conflicts and, in some cases, suicide attempts.

Every culture has its idioms of distress. There are a lot of things that are unique to cultures, but a lot that is just human experience.

Another factor is whether there is a community. There are 45,000 Afghans in Northern Virginia. They have their own cable TV channel, lots of restaurants, community centers. On the other hand, the Kurds have a similar culture but there are not many in Virginia, so they really don't have a community. That can be a big factor in how they adjust. It makes it harder to maintain a sense of identity when you don't see the culture every day. You are not being validated by those around you.

Also, the divisions of the old country tend to reproduce themselves here. So often, you need to know the local politics. Around the city of Tabriz in northern Iran is a largely Azerbaijani population. In the old Soviet Union, they had their own country but were absorbed into Iran. They are continuously trying to rebel, get their own coun-

try. We made some serious errors when we tried to bring in a translator — this happened more than once — when we were bringing in an Iranian, Farsi-speaking translator. We didn't realize the patient viewed this translator as the enemy.

HP: How much of a roadblock is language in providing care?

GRIFFITH: It's a very big one, and a bigger one in mental health than in the rest of medicine. I think it's said correctly that any exact translation is a bad translation. Our human experience, especially in mental health, is highly nuanced, often metaphoric. Your best translation is if you have a translator who understands your work, what you are trying to accomplish. The worst cases are when we are forced to use family members. One of the things I most regret is, years ago after the ethnic cleansing in the Balkans, there was a survivor in Bosnia and inadvertently, because we had no one else, we were using as a translator, a sister-in-law. Things that had been kept secret because they were so horrific were revealed.

A lot of times we are referred an Afghani, Pakistani, Iranian older woman who does not speak English, and the husband insists on being the translator. Obviously we have no idea how to interpret what is being said.

Sometimes the social status between the translator and the patient can be a problem. If there is a class difference, a difference in the ethnicity between the translator and the patient, that can give rise to all sorts of distortions and misinformation.

HP: Can you think of an example?

GRIFFITH: The most recent one was the Tabriz situation where the patient was getting so angry, so explosive, that all sorts of questions were being raised about whether he had a traumatic brain injury. We figured out that in his eyes, we were sitting him down with his enemy when we called in this translator. The translator was a very cultured Iranian-American woman who didn't get it.

Other times, when the issue is whether there was sexual violence, information is not going to be obtainable except by another female from a trusted group. In Muslim cultures, in many traditional cultures where the gender identity is very strong, it would be a shaming for me, a man, to even ask the question.

HP: Has there been an uptick in mental illness?

GRIFFITH: Much of what happened with globalization has been an erosion of traditional community structures, family structures, religious systems that provided a relational context for people to live in. Back in the 1980s, the average American had three close relationships. Now it's one. These are things that put stress on vulnerable people, so I would not be surprised if there was more mental illness.

In West Africa, the Horn of Africa and other places, the social structure is just devastated post conflict. Failed governments are not able to provide a civil society. These are all reasons you would expect to see a rise in mental illness.

HP: How can that even begin to be addressed?

GRIFFITH: At Harvard, their approach has been to take our best evidence-based practices here, go to say, Liberia, and develop a relationship with the Ministry of Health and teach them how to do it.

Our department at George Washington Uni-

I believe, based on my experience, there's always a part of a person that is still intact, no matter how bad the torture, the trauma.

versity has been more of a bottom-up approach, going in and asking, "Who is delivering any mental health treatment?" There might be one psychiatrist, no psychiatric social workers, but there are nursing schools and there are churches. In our approach, you go in and find the church ministries and you build upon that.

That's the approach of going in, taking stock of what is available and working with it. That's the two sides of the global mental health movement.

HP: Some of the refugees in the U.S., such as torture victims, have experienced such deep trauma that one wonders if there is any hope for them. Has that been your experience?

GRIFFITH: On the whole, torture survivors are a very resilient group of people. Often these are leaders, educated people with lots of skills. Often they were taking strong stands and they knew what the risks were. In arriving here, they may be suicidal and have very severe symptoms, but often the restoration of good sleep, getting in touch with good resources, getting some validation and trauma treatment, they recompensate very fast.

I can think of someone from Africa who was an outstanding athlete, but he was working with a political opposition party, utilizing his own prestige to advocate for human rights, and he was arrested and tortured very badly. After his release, he had explosive behavior and nightmares, but he quickly improved when he got involved with a peer group of survivors. His family was politically active and supported what he did. With this sort of purpose, and sense of solidarity and some help, he had a much better chance for recovery than a child in this country who was sexually abused.

The other piece to it — this is not something I can prove, but I believe it, based on my experience — is that there's always a part of a person that is still intact, no matter how bad the torture, the trauma. A Japanese art therapist working with a child said to me, "There is a sacred place inside all of us that no one can touch." She really built her therapy out of the idea that no matter how bad the



torture, the harm, the damage done, you have to find the intact person and help the person kind of rediscover himself, and that's what you build on.

Let me add one caveat about torture. We talk about the political activists, but people get tortured for lots of reasons. I've known of some women who were arrested and gang-raped just to put pressure on the father to turn himself in. A certain number of victims, once we get the full story, it turns out that they had carried out a lot of torture themselves. If you get into the Congo, one regime comes in and the torturers are then tortured. Then there's the perpetrator and PTSD. I didn't get this for a lot of years. There's a lot of diversity to it.

HP: Do you have any advice for someone who is in a general practice and encounters patients from other cultures?

GRIFFITH: General practice is kind of hard because, as I think about it, there's this rapid ... people present with their symptoms, not their stories. You have to take it to another level, be curious and ask, in order to get the story. Arthur Kleinman [psychiatrist and professor of medical

anthropology at Harvard Medical School] has something called the Eight Questions that, if you are going to take the time, is a good set. You ask, "In your culture, what is this called? What do people understand causes this? How is it treated?" I am paraphrasing, and I reduce it to the Cs — what do you call it, what is the course, what needs to change for it to get better among your people. It takes time, and that is the issue in our health care system. Americans don't ask any contextual questions, generally.

HP: Traditionally the Catholic health care system has played a large role in treating immigrants and refugees. Is that changing?

GRIFFITH: Oh, no. I am a terrific fan of Catholic Charities. They are one of the best, broadest, most organized groups that provide a wide range of services for immigrants and refugees. Even today, we had someone who wanted to come see us but he was some distance away, and the best resource was Catholic Charities in his community.

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