

Somali Mental Health

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I. Introduction

Over the past seven years, there has been a vast influx of Somali refugees and immigrants making their new home in Minnesota, with the overwhelming majority residing in the Twin Cities area of Minneapolis and St. Paul. While official estimates indicate that less than 20,000 Somalis are in Minnesota, it is well accepted that there are actually 50,000–75,000. It is difficult to pinpoint the exact number due to limitations in census data collection and the continual growth resulting from such factors as secondary migration. Since Minnesota has welcomed African immigrants, family members who live in other states within the U.S. and Canada continue to join many newly arrived families. The prospect of Somali immigrants and refugees returning to their homelands is unlikely. Continuing war, civil strife, and economic crises make the outlook for return bleak. Therefore, it is important that Minnesota continue to embrace and welcome Somalis into the community and assist in their acculturation process.

II. Challenges

A. Health and Acculturation

The difficulties facing Somali immigrants and refugees in the Twin Cities are complex and their needs are great. Besides facing enormous cultural and language differences, many of these Africans contend with

racism, often have limited literacy skills, hold jobs that barely pay the minimum wage, and thus have difficulty providing for their families. Clinical studies show that rates of Post-Traumatic Stress Disorder among immigrant and refugee populations range from 39 percent to 100 percent (compared with 1 percent in the general population), while rates of depression range between 47 and 72 percent.¹ The impact of war trauma, social isolation, and change in social status make acculturation difficult. These have a significant impact on psychosocial adjustment. In order to best respond to the needs of Somali clients, it is important to understand their unique experiences and circumstances.

B. Impact of War Trauma

The U.S. Surgeon General's report, *Mental Health: Culture, Race, Ethnicity—Supplement*, highlights the overwhelming burden of mental illness that racial and ethnic minorities face compared to their white counterparts.² Immigrants and refugees often have encountered additional stressful events that contribute to mental illness or adjustment problems. These populations experience multiple losses, including loss of homeland and loved ones. Immigrants, and most certainly refugees, have likely endured one or more of the following traumatic events prior to resettlement: malnutrition or famine, violence, political persecution, or torture. Often trauma goes untreated until long after resettlement. Past trauma and current adjustment challenges increase the risk of behavioral and mental health problems.

Trauma experienced by many Somalis is likely to have a profound impact on mental health functioning. Available accounts by Somalis suggest that many have suffered repeated trauma. These events occurred in the context of the significant societal and family upheaval of civil war. Because civil war is longstanding in Somalia, nearly all Somalis have been in some way affected by trauma. Research indicates that the impact of trauma on an individual varies according to many factors.³ These include:

- The duration of the stressful event
- Whether the trauma was one single event or multiple events
- Stability of the individual's family life prior to the stressful event
- Presence of effective coping skills
- Personal characteristics
- Presence or lack of a support system

Somali adults and children alike witnessed the murder or torture of family members and friends during the war. Often Somali women and men endured torture or rape, both of which were widely used as a means of terrorizing the population into submission. They have either experienced violence directly, witnessed it with their own eyes, or have close relatives or friends who have experienced or witnessed it. Many Somalis suffer from traumatic memories, flashbacks, depression, and anxiety.

A 45-year-old Somali man described symptoms of severe guilt, flashbacks, feelings of worthlessness, emptiness inside, fatigue and “thinking too much.” During the civil war in Somalia, militiamen broke into his house. When he tried to stop them, he was beaten with rifle butts and tied up. While he watched helplessly, the men raped then beat his wife and killed his father. To this day he carries unbearable guilt that he didn’t try harder to stop them or die trying. The memories of that trauma return to him every day and sometimes seem like they are real—happening again and again. He has been unable to work and support his family because of these symptoms. His shame about not being able to care for his family is added to his guilt about his past.

How individuals cope with traumatic events varies. Yet, despite individual strengths that enable many Somalis to manage this stress, the severity and extent of trauma is likely to have had a considerable psychological impact.

C. Social Isolation

Many Somalis with mental illness are socially isolated. The pain of this isolation is felt especially intensely because Somali culture is traditionally communal and family oriented. While people with mental illness may be ostracized from the community, their fear of stigma may be even more powerful. Whether the ostracism is created by the community or self-imposed due to anticipated negative responses, the social isolation creates a profound worsening of the mental illness. This social isolation can be very disorienting and can make the process of healing very difficult. In fact, even without prior mental health problems, isolation from community alone can contribute to the development of depression.

A young Somali man felt extremely depressed ever since coming to Minnesota. He deeply missed his mother, siblings and other relatives in Africa. He talked

about his powerful obligation to stay here to earn money to send back home to help his family. At the same time he found it very difficult to work because of the intense symptoms of depression. When he returned to Africa for a visit, his depression lifted. Because of the family obligation, though, he returned to Minnesota to earn money.

D. Change in Social Status

In a pattern repeated with every group of new Americans, children learn English and become acculturated more quickly than their parents. Often immigrant and refugee parents are in the position of being forced to learn the language and culture from their children. Children become responsible for communicating with the outside world and are in charge of such things as reading the mail and paying bills. For any family this role shift can cause a strain on parental authority. It is particularly difficult in cultures such as the Somali, in which adults are not accustomed to learning from children. When children have English language proficiency and parents do not, this creates an imbalance of power in the family, which makes parenting and acculturation very stressful and confusing. Another dynamic in families occurs when a parent, usually the father, has lost his stable role as primary breadwinner. When resettling in a different culture, previous work skills are often not easily transferable. As a result, it can be very difficult for a parent with little or no English language ability to secure a job. When parents require financial assistance from the government, they usually feel distressed that they are not providing for their families. This can lead to feelings of guilt and worthlessness.

A 39-year-old Somali woman is raising five school-aged children as a single parent. The children's father remains in a refugee camp in Africa. With all her responsibilities, she has little time to learn English while her oldest child, a 14-year-old son, is fluent. She depends on him to deal with their landlord and read mail and notes from school. When the telephone rings the children usually answer it. The son tells his mother when it's time to pay the rent or other bills and if she should attend a school meeting. She no longer feels that she's in charge of the family and feels depressed and worthless.

III. Cultural Concepts of Mental Illness

Significant stigma shrouding mental health issues prevents many Somalis from seeking treatment or assistance. In Somali culture, con-

cepts of mental health in the Western sense are not well developed: one is crazy (*waali*) or one is not crazy. There is no conceptual framework that includes a spectrum of health and disease, mental health and mental illness. Beliefs in the causes of mental illness are predominately spiritual or metaphysical: mental illness comes from God or evil spirits (*jinn*). Illness can also be brought on by another person or oneself through curses or bad behavior. Somalis traditionally explain behavioral problems as an expected result of spiritual causes or possession by an evil spirit. Healing for these problems is provided by religious leaders or by traditional healers.

In stark contrast, the Western view of mental health is based on a combination of biological and environmental factors. There are many different kinds and degrees of mental illness. Mental illness is seen primarily as a result of nature (chemical imbalance, brain problem, genetic or birth defect) or nurture (response to trauma or learned behaviors). According to Stark, "The Western model of psychotherapy is based on individual therapy apart from society and physical health."⁴ Focusing on the individual rather than the family or clan unit is an unfamiliar concept to Somalis as is talking about problems outside the family or clan.

In the Western view, there is no room for religious or spiritual causes or treatments. Mind, body, and spirit are perceived as separate. If Americans go to the doctor they will usually report physical symptoms separately from emotional symptoms. In Somali culture, these are traditionally seen as an undivided whole. Consequently, Somalis are more likely to report physical pain when they are experiencing depression or sadness. Moreover, because mental illness is not conceptualized as a bio-psychosocial phenomenon, physical symptoms that are present are interpreted as relevant to emotional or psychological events. Psychological problems are often expressed somatically as headaches, chest pain, and forgetfulness, while sleep problems are expressed through nightmares and sweating. Western mental health (*caafimaaadka maskaxda*) and treatment are still relatively new concepts among many Somalis. Depression, for example, has no direct translation in Af-Somali. Instead, it is described: "*qulub, qalbi-jab iyo murugo joogto ah.*" *Qulub* refers to the feelings a camel has when its mate dies. When discussing mental health topics, Somali mental health providers often have to describe the illness through its recognized symptoms rather than by category or label, such as depression. The other terms mean despondence and permanent sadness.

Among the most frequent somatic symptoms described by Somalis when seeking help in a mental health clinic are:

- Physical complaints including body pain, headaches, sleep problems, fatigue
- Decreased appetite and weight loss or gain
- Low energy

In addition to somatic symptoms, other problems are also reported. Flashbacks, nightmares, and a heightened startle response are commonly reported as well as cognitive problems like poor concentration, poor memory, and rumination (thinking too much). Although not conveyed in association with trauma experiences, many Somalis willingly report emotional experiences that are causing distress. These include sadness, worries and anxiety, and feelings of guilt and worthlessness. An inability to express usual feelings, such as love, caring, or happiness, is also commonly reported.

When Somalis exhibit mental health symptoms, families usually provide the primary care. They may also seek help from elders, religious leaders, or traditional healers. Again, since mental illness is attributed to spiritual causes, psychotic symptoms may be treated by a healer reciting verses of the Quran or by preparing an amulet to protect the person from evil spirits, or *jinn*. Seeking assistance from a resource outside of the community for these types of problems is considered shameful or unlikely to produce results.

A. Suicide

Cultural and spiritual beliefs prescribe how individuals account for life circumstances. How Somalis explain the cause of trauma has consequences for psychosocial adjustment. Some Somalis feel that the war or violence occurred because God was punishing them for past wrongs, while others accept what happened during the war as destiny. While grieving, some may desire quick solutions to their personal pain and question why they cry continuously. Culturally, this emotionality is seen as a sign of weakness. When the initial survivor's guilt has dissipated, many trauma survivors experience a "nagging remorse [that] seems to grow stronger, shifting the focus away from the immediacy of the intrusive imagery to a repetitive anguish about the role of one's own actions and choices in the tragedy. It is part of the human condi-

tion to assess experiences from a moral framework, what philosophers call moral emotions."⁵ These feelings of worthlessness might be reinforced by current situations, past trauma, and conflicting moral emotions.

A Somali man admitted to contemplating suicide. Before the war, he was a strong man, dignified and a well respected, contributing member of the community. He told me that he lost his manhood and is now worthless because everything has been taken from him. During the war he was forced to sit under a gun while his wife was raped in front of him. He doesn't forgive himself for not acting to protect his family and blames himself for not fighting them although he was under the weapon. He says that as a man he wasn't brave enough. Therefore, my role has been to give him a bit of hope and that he does have worth. (Staff Interview, 2003)

According to the Quran, suicide is seen as a crime against God. While faith in Islam might act as a protective factor in discouraging suicide, it also might prevent someone contemplating suicide from seeking help. For Somalis to consider suicide, they probably have strong feelings of worthlessness. Since Somalis are fairly new to the Twin Cities, there is limited data on the incidence of suicide in the community. One critical barrier to gathering this information is that all deaths, both homicide and suicide, of African-Americans and Africans are reported under the category "Black." There is no distinction made between these ethnic groups. However, some evidence suggests that the number of suicides is increasing. The Minnesota Office of the Ombudsman for Mental Health and Mental Retardation stated that of the sixty deaths of African Americans who received mental health services at Anoka Regional Treatment Center, six were suicides. Of these six suicides, four were Africans. Consistent with this finding, the number of Somalis who are civilly committed⁶ for serious and persistent mental illness has increased dramatically. Behind these statistics are Somalis who contemplate suicide yet are not getting any professional help.

Youth are particularly at risk for developing mental health problems because of the age at which they experienced trauma. During the civil war, countless Somali youth were taken in by relatives or neighbors, and have subsequently resettled in the U.S. Focus groups of Somali community members and 82 Somali students, conducted by Minneapolis Public Schools staff, revealed high rates of anxiety, truancy, depression, and chemical use among Somali students.

IV. Somali Mental Health Program

The Somali Mental Health Program was started at Community University Health Care Center (CUHCC) in Minneapolis, Minnesota, in 1998. With a long history of working with Southeast Asian refugees, CUHCC prepared to meet the needs of the community's newest refugee influx, East African Somalis. The CUHCC mental health clinic provides a variety of outpatient services for Somalis. These include psychiatric assessments, medication management, individual and group therapy, and case management for adults and children. Day treatment group services provide help for seriously and persistently mentally ill adults. Counseling and advocacy is provided for victims of child abuse, domestic violence, and sexual assault.

Mental health services for refugees and immigrants are implemented within the framework of a community health approach. The CUHCC mental health clinic has formal partnerships with several other community health clinics in Minneapolis to provide mental health services on-site. Through these approaches, mental health information, support, and treatment are brought directly to the community, making help more readily accessible.

A. Treatment Approaches

A number of unique characteristics of the Somali Mental Health Program have evolved over several years. Initially, the model for working with Southeast Asians was used to design programs and develop interventions. Over time, the Somali Mental Health Program has been adapted to better meet the specific needs of the community. The following components have been found to be the most effective ways of working with Somali clients:

- Bilingual providers as primary mental health providers
- Multidisciplinary treatment
- Holistic orientation toward health and treatment
- Client advocacy
- Client and family education
- Treatment that is congruent with culture and religion

Many health and social service organizations use interpreters in their work with non-English-speaking clients. While this model is nec-

essary in certain settings, it has limitations. In this model, the interpreter is limited to word-for-word translation. With the absence of cultural interpretation, this can lead to cultural misunderstandings and incorrect diagnosis and treatment. In addition, there is often a different interpreter for each client contact. As a result, there is no ongoing relationship between the client and the bilingual interpreter. This can interfere with continuity of care and diminishes the development of the client's trust in the care providers.

As is well known and documented, the helping relationship is a key to the healing process. A more effective approach in the mental health setting is the bilingual/bicultural provider model. With this model, clients have a primary contact person from their community, who is also trained in Western mental health practices. Clients are able to develop a trusting relationship with this trained helping professional.

The Somali Mental Health Program uses a multidisciplinary approach to working with clients, which includes a variety of professional providers. These include a core team of Somali mental health counselors, psychiatric nurses, a family therapist, and a licensed social work supervisor. Other key professionals are both adult and child psychologists and psychiatrists. A high priority is placed on the coordination of services among providers in order to ensure the best possible help to clients.

The Somali treatment team meets twice a month to discuss community mental health issues and to review individual client care. Holistic treatment integrates mind-body-spirit approaches. By embracing how Somalis conceptualize their problems in this integrated way, clients are more effectively engaged and treatment is more successful. The typical "50-minute hour" of Western psychotherapy is inadequate in treating Somalis. In order to effectively help Somalis, their other needs must be met, such as obtaining government benefits, housing, immigration, and employment. Helping professionals must be willing to get out of their offices and walk and work alongside their clients.

Because of the many barriers that Somalis face in getting effective and appropriate treatment, helping professionals must act as advocates for clients accessing services within mainstream systems. Barriers often encountered include problems with language skills, lack of knowledge about health care and systems of treatment, lack of understanding about the importance of treatment compliance, and conflicts between recommended care and religious beliefs.

In addition, Somali individuals often need advocacy within their family and community in order to reduce stigma and prevent social isolation. Moreover, it is crucial to educate both clients and their families about mental health and mental illness. This is important to promote adequate monitoring of treatment compliance and side effects. Because of the strength of Somalis' connection to family, families play an important role in providing the needed support and encouragement to make treatment successful. Without this support, Somalis with mental illness may feel alone, adding to existing feelings of hopelessness and worthlessness.

For treatment to be effective, it must be understood by the client from a personal, religious, and cultural perspective. If a treatment is recommended that has negative cultural associations, the client will not accept it. If, on the other hand, the treatment is consistent with cultural and religious beliefs, the client will more likely be an active participant and the treatment will be more successful. Group therapy has been found to be very effective with Somalis. The Somali Mental Health Program has two-day treatment groups; one for men and one for women. Clients can be with others who have experienced similar histories and symptoms. A safe environment is created to ease social isolation and make it easier to accept and ask for help. Clients experience support and guidance from peers and group leaders, and develop healthy relationships within the group. In effect, this helps to re-establish the clients' family and clan support system.

A 50-year-old Somali woman who lived alone came to the clinic with intense pain in her arm, neck and head. Two of her adult children came with her to the initial diagnostic interview. She was so disabled by pain and depression that she was unable to cook and shower for herself. Even when her daughter cooked for her, she ate very little and was losing weight. By being part of the interview her children learned about her mental illness and the plan for treatment. Her adult daughter brought her to the group and stopped by everyday to help her and to make sure she took her medications. Within several weeks the mother started sleeping better and was less depressed. She feels hopeful that she will soon be able to take care of herself and even help with her grandchildren. She also wants to find a job.

In addition to direct mental health services, the Somali Mental Health Program has provided important education to both the Somali community and to Somali and non-Somali professionals. It has been vital to educate the Somali community about Western views of men-

tal health in order to make inroads into the treatment of trauma and psychosocial adjustment problems. This has also included information on resources for obtaining help. The many community presentations made in Minnesota have had a noticeable impact on the de-stigmatization of mental illness and the acceptance of Western mental health treatment. It has become easier and more customary for Somalis to request information and help from mental health providers and clinics for the treatment of mental health symptoms.

Providing education for health care professionals has been essential for improving their ability to effectively treat Somalis. American health and social service providers have profited from key information about Somali culture and Somali views of mental health and mental illness.

A 22-year-old Somali man lived in a Minnesota town of about 20,000 people. He had been in Minnesota long enough to attend and do well academically in high school. Because of some behavioral problems at school, he was evaluated by a psychologist with no experience in the assessment of ethnic minorities. This psychologist diagnosed him as developmentally delayed. He was put into a group home for mentally retarded young men. Within weeks the staff and administration realized that he didn't belong in this treatment setting and recommended a second evaluation. Somali Mental Health Program providers evaluated him. A comprehensive culturally adapted psychological and mental health diagnostic evaluation was conducted where it was concluded that he had an emerging major mental illness. However, despite the recommendation of the group home staff and the results of this comprehensive assessment, it took almost two years for the system to transfer the young man's care from services for the developmentally delayed to services for the mentally ill. During this time, he underwent several mental health hospitalizations.

If the school personnel, the community psychologist, and the case managers had had more knowledge about Somali culture and more experience with cross-cultural assessments, this young man could have been correctly diagnosed initially. Moreover, if the validity of the qualified professionals' findings had been accepted, it would have facilitated the shift to more appropriate treatment, and hospitalization may have been avoided. More importantly, the confusion and mistreatment would have been minimized. Information about culture, language, and beliefs is critical for appropriate care.

CUHCC has achieved respect in the community for its mental health work. Today, its Somali Mental Health Program is considered the premiere mental health resource for Somalis in the Twin Cities. The clinic

has successfully created a welcoming and trustworthy environment. The positive reputation of the clinic has helped break down barriers and create a way in which Somalis feel comfortable seeking help. In four years, the clinic has served over 500 Somali clients. Every week the program receives new self-referrals from Somalis who, through word of mouth, have heard about our services in the community.

Research shows that the degree to which a person experiences negative outcomes from immigration is affected by a variety of psychosocial factors. These include pre-migratory advantages (e.g., language proficiency and socioeconomic status); post-migratory opportunities (e.g., employment and education); strength of identification with ethnic group; personal family history of coping with stress; extent of similarities and dissimilarities between the culture of origin and the new culture; and the availability of friends and relatives who are already established in the new culture.^{7,8} Psychosocial support during the acculturation process increases the likelihood of positive adjustment and cultural adaptation. Providing mental health treatment in the context of culture and religion helps to engage the community and has proven to be effective. Yet the need for even more effective mental health services for Somalis is great. Expanding the capacity of Somali and mainstream mental health providers should continue to be a primary focus for our mental health service system. Improving our ability to meet the needs of the Somali community is paramount as we embrace them as legitimate and permanent members of our community. ●

Notes

1. James M. Jaranson et al., "Somali and Oromo Refugees: Correlates of Torture and Trauma History," *American Journal of Public Health* 94 (2004): 591-598.
2. U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, Md., 1999).
3. A. Link and S. Shoaee, "Mental Health and Well-Being. Lessons From the Field: Issues and Resources in Refugee Mental Health," The National Alliance for Multicultural Mental Health. Accessed at: <http://www.cmhsweb.org/nammh>, 4 December 2002.
4. Trisha Stark, "Exploring New Strategies to Improve the Delivery of Mental Health Services to the Somali Population of Minneapolis," Master's Thesis, University of Minnesota, 2003.
5. Jerome Kroll, "Posttraumatic Symptoms and the Complexity of Responses to Trauma," *Journal of the American Medical Association* 290 (2003): 667-670.
6. Civil commitment is defined as a judicial process in which the individual is documented by a court-appointed examiner to be a danger to self and/or to others. Invol-

untary hospitalization is often imposed when no less restrictive option is appropriate. Separate judicial processes are required to impose medical treatments.

7. R. Berger and T. Weiss, "Immigration and Post Traumatic Growth—A Missing Link," *Journal of Immigrant and Refugee Services* 1 (2002): 21–39.

8. D. Nesdale, R. Rooney, and L. Smith, "Migrant Ethnic Identity and Psychological Distress," *Journal of Cross-Cultural Psychology* 28 (1997): 569–589.

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