

## **When the Poetry No Longer Rhymes: Mental Health Issues Among Somali Immigrants in the USA**

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**Abstract** To identify and explore cultural dynamics influencing the psychiatric care of immigrant Somalis in the USA, we reviewed demographic data from Minnesota Departments of Human Services, and interviewed health professionals, exploring community perceptions of medical/psychiatric needs, cultural characteristics, barriers to care, and potential solutions. An informal survey of 37 members of the Mayo Clinic Department of Psychiatry and Psychology, to determine caregiver perceptions of care of Somali patients, cited language barriers (74%), and cultural misperceptions (68%) as the most frequent obstacles. Difficulties working within the patriarchal family structure, limited community resources, poor compliance, and financial issues ranged between 18 and 8%. Additional barriers mentioned were problems working with interpreters from 'warring clan factions,' patients' fears of being labeled 'crazy,' difficulties viewing illness within an emotional framework, and the need to address mental health from a physical framework through a focus on somatic symptoms. Somalis rarely acknowledge psychiatric problems and common traditional treatments have become ineffective in the new context. Recommendations include alternative health care approaches utilizing family values, 'bargaining,' and educational approaches to acculturation.

**Key words** acculturation • culture • immigrant • psychiatry • Somali

## INTRODUCTION

The health and mental health needs of immigrants or refugees is a crucial aspect of contemporary health care in the USA. Even if the acculturation process follows a fairly predictable course, its outcome for these types of populations may be complicated by the impact of pre-migration losses, death, torture, and other traumatic events. Adaptation to the host society, encompassing areas as varied as weather, religion, language, clothing, legal principles, and financial pressures follows, in many cases, a 'collision course,' with enormous mental health implications (Mohamed, 2000; Purnell & Paulanka, 1998).

This article examines the realities of the Somali immigrants' life in the USA against the historical background of their country of origin, and the acculturative fractures suffered throughout more than 10 years of forced exile for members of at least two generations, now settled in the USA – and specifically in Rochester, Minnesota, which has, proportionately, one of its highest contingents. The demographic data were obtained from documents and reports of the Minnesota Departments of Human Services, Refugee Health, and Children, Family and Learning, and from the Somali Resettlement Community Resource Center. On the basis of clinical contacts with a health center in a small city, the article also describes the unique psychiatric needs of this population, the barriers encountered by caregivers, and ways to provide the best possible mental health care. Somali cultural views about health, illness (mental illness in particular), intrafamily relationships, coping styles, and religious beliefs, were described by Somali immigrants interviewed by the authors in three community groups of different ages and walks of life (teachers, interpreters, housewives, workers, and unemployed), over a one-year period. Finally, information on issues such as perceived psychopathology, utilization of mental health services, barriers to care, and possible solutions to alleviate detected difficulties came from unstructured interviews and surveys with mental health professionals (particularly psychiatrists and psychologists in our tertiary care referral center), counselors, employees, teachers, and community caregivers, as well as the immigrants themselves.]

### *THE LAND OF POETS*

Somalia occupies the zone commonly referred to as the Horn of Africa in the northeastern part of the continent. Its territorial area is slightly smaller than the state of Texas with the Indian Ocean on the east, the Gulf of Aden to the north, and Ethiopia and Kenya as its neighbors to the west and southwest respectively. A predominantly rural, underdeveloped country, it has very few urban areas, including its capital, Mogadishu (CIA World Factbook, 2003; Library of Congress, 2003).

Somalia has a long history of political conflict, dating back to 1969, when General Mahammad Siad Barré seized power over the state establishing a military dictatorship. Over the next 21 years, he maintained control over the social system by playing one clan against another until the country became rampant with interclan strife and bloodshed. Siad Barré's regime came to an end in 1991, leading to the complete collapse of the Somali state. In addition to a raging civil war between armed clan militias, the country was overcome by a severe drought leaving 1.5 million people starving, and one quarter to one third of the population dead (CIA World Factbook, 2003; Library of Congress, 2003).

The population of Somalia was placed at approximately seven million people before the civil war began in 1991 (Burke, 2001). Since then, an estimated 400,000 people have died of famine or disease, or have been killed. Nearly 45% of the population had to flee to other African countries, the Middle East, or countries of resettlement such as the USA and Canada (CIA World Factbook, 2003; Library of Congress, 2003).

The official language is Somali but Arabic, English, and Italian are also commonly used. A written form of the Somali language was only adopted in 1972, so all the past history of the country was passed on through oral memorization and narratives. Children start attending Qur'anic school for religious education at the age of five. After several years, they may enter regular school if available (Burke, 2001; CIA World Factbook, 2003; Library of Congress, 2003).

Somalia has a birth rate of approximately 47 per 1000, compared with 15 per 1000 in the USA. The death rate is about 18 per 1000 compared with 9 per 1000 in the USA. Infant mortality is extremely high, at 124 deaths per 1000 births in Somalia, compared with 7 per 1000 births in the USA. The average life expectancy is 47 years, compared with 76 years in the USA. Endemic diseases are widespread including tuberculosis, malaria, and tropical and parasitic infections. Only 31% of the population has access to safe water, resulting in intestinal parasitic infestations in 70% of the people. There is malnutrition and famine due to warfare and drought. There are also occasional epidemics of measles, cholera, and meningitis (CIA World Factbook, 2003; Jimale et al., 2002). Unlike some other areas of Africa, HIV/AIDS is not a current problem in Somalia as it affects less than 1% of the population (Jimale et al., 2002; Scott et al., 1991). This appears to be changing somewhat, however, after relocation to other parts of Africa in refugee camps, and immigration to the USA. AIDS is never discussed in the Somali community. In Minnesota, African-born immigrants make up less than 1% of the state's population, but accounted for 16–21% of the new HIV cases reported in 2002. Women were infected in higher numbers than men and most immigrants report that they became infected by a heterosexual partner (Gouldin, 2002;

Grumney, 2002; Remafedi, Henry, Fahia, & Minnesota Department of Health, 2002).

### *Somali Culture*

Somalia is known throughout the African world as the Land of Poets due to highly valued skills of storytelling and poetic lyrics among its people (Andrejewski, 1964). From a sociological perspective, clans represent a positive as well as a conflictual aspect of life for Somalis. The clans provide protection, political power, and help to gain access to water and land. However, clan differences are significant, and affect how an individual is viewed and treated by others. For example, at the local hospital, patients from a more powerful clan would have a mattress on their bed, unlike those from a less powerful clan (Paquet, 1993). Somali people pride themselves on independence, with an unwillingness to submit to authority. This has resulted in ongoing clan and subclan conflicts through the country's history (Library of Congress, 2003).

The Somali family is a source of identity and security, reflected in the question 'Whom are you from?' rather than 'Where are you from?' when asking about origin and lineage (Costello, 2002; Thatcher, 2000). The family represents the traditional Somali values of legal marriage, honesty, good behavior, respect for elders, cooperation with others, and group responsibility. In this paternalistic family structure, men are the authority figures, and the oldest males are the decision-makers. The oldest son holds a very important position in the family picture, and female children are expected to obey male siblings. In many Somali families currently living in the USA, the father has been killed, leaving the oldest son as head of the family. Often, this oldest child is not of an age to make family decisions; with no other male available to assume this role, many unprepared women find themselves in a position of authority. Women may have subtle power which is not allowed to be socially visible; they are responsible for raising children and caring for their home, although many also work outside the home (Jimale et al., 2002; Thatcher, 2000). Family is expected to care for aging or ill members.

Most Somalis are Muslim, with a significant minority being Christian. Variations of religious practices range from the enforcement of extremely strict rules, including the acceptance of multiple wives and female circumcision, to more liberal approaches probably facilitated by acculturative processes. Ramadan observance may pose special problems for medical care in terms of diet and medication intake.

### *Somali Immigration to the USA*

The first wave of Somali refugees into Minnesota arrived in 1993. Since that time, there has been a 17-fold increase in Somali arrivals. There are

now more Somalis living in Minnesota than anywhere outside East Africa. Thirty-five percent of all Somali primary refugees entering the USA in 2000 settled in Minnesota, and there are also many Somalis that have migrated to the state from other areas of primary settlement. Current Somali population estimates for Minnesota range from 15,000 to 40,000 (Burke, 2001). In the 2001–2002 school year, there were 5123 Minnesota students who reported speaking Somali as the primary language in their home. This is five times the number of 4 years earlier (Grumney, 2002; Minnesota Department of Health, 2000). In Rochester, there are between 3000 and 4000 Somalis living, working, and attending school.

### MENTAL HEALTH AND MENTAL ILLNESS AMONG SOMALIS

#### *EXPRESSIONS OF EMOTIONAL DISTRESS*

'Somalis tend to say everything is fine even when things are bad' (Jimale et al., 2002). A person may even describe a problem, and then deny that it is really bothering him or her. In general, Somalis are more likely to talk about somatic symptoms such as headaches, stomach or muscle aches, heart palpitations, and tiredness, than about mental distress. They may deny suicidal thoughts or passive death wishes due to the religious belief that this is a serious sin. Many Somalis adopt a fatalistic stance: whatever happens is 'God's will,' and it should not be questioned (Jimale et al., 2002; Lennon, 2000).

Traditional medicine is frequently sought when the family needs help with a problem. Beliefs in the supernatural may still carry much more weight than western medicine, science and technology (Rafuse, 1993). Somalis may look to a Sheik healer to provide guidance from the Qur'an. They may also seek assistance from a traditional healer, known as a *minga* or *waddad*.

#### *COPING MECHANISMS AND FOLK HEALING PRACTICES*

There are culturally sanctioned equivalents to somatization and conversion reactions that follow particular patterns. Many Somalis believe illness results from spirit possession, or the *waddado* of the spirit world. These illnesses are treated by a human *waddad*, who is someone who has recovered from the illness. The *waddad* prays over and bathes the patient in special perfumes or, still in a secretive manner, sacrifices a goat or other animals, while dancing and interpreting visions that will eventually exorcise the spirit (Jimale et al., 2002; Library of Congress, 2003). Somalis also believe in the concept of the 'evil eye' which can be directed at someone, purposefully or inadvertently, through comments or praise from

another person. Somali mothers may be upset if a doctor describes their child as 'big and fat,' out of fear that the evil eye will cause something bad to happen to the child (Rasbridge, 2005).

Possession by a *zar*, another type of spirit, is treated with exorcism, within the *zar cult*. Those possessed are, generally, women with grievances against their husbands. Signs of possession include severe agitation and fainting fits. Exorcism is performed by a woman who has been previously afflicted with these symptoms, and now has established 'authority' over this spirit. The ritual consists of a special dance in which the victim tends to reproduce the symptoms and falls into a trance. This 'illness' may enable a disgruntled wife to express her hostility toward her husband without actually quarreling with him (Jimale et al., 2002).

Another form of spirit possession known as *gelid* or 'entering' involves the spirit of an injured person troubling the offender. A jilted girl, for example, cannot openly complain if the marriage arrangement has been broken. Instead, her spirit may enter the bridegroom causing him to become ill. The exorcism includes readings from the Qur'an with a *wadad* commanding the spirit to leave the afflicted person (Jimale et al., 2002).

In a common healing practice known as 'fire-burning,' a stick from a special tree is heated until it glows, and then it is applied to the skin in order to cure an illness. This is used to treat pneumonia and hepatitis, where the stick is applied once to each wrist and four times to the abdomen. It is also used to treat malnutrition (*marasmus*); when the head appears to be too large for the body, the heated stick is applied to the head in order to decrease its size.

#### ATTITUDES TOWARDS MENTAL ILLNESS

Highly educated Somalis may be very accepting of psychiatric help, while others, including members of the Bantu and Banadiri groups have had little contact with western medicine, let alone psychiatry. It was not possible, in our survey, to specify the group or subgroups of origin, but our observations could be applied to the vast majority of individual immigrants contacted. What westerners consider a psychiatric problem might not be perceived as such in the Somali context. For example, many Somali individuals would view post-traumatic stress disorder (PTSD) symptoms from rape or murder, as something to be dealt with primarily as an insult to the family, requiring a *Diya*, a compensation paid by a person who has injured or killed another person (Costello, 2002). In general, psychological problems are not acknowledged openly. Traditionally, people are viewed as either 'normal' or 'crazy,' with nothing in between. Mentally ill people are viewed as being cursed or possessed by Satan. Mental, as well as physical, illness is frequently viewed as a

punishment for something done wrong (Jimale et al., 2002; Lennon, 2000; Mohamed, 2000; Rafuse, 1993).

When individuals experience mild psychiatric symptoms, the family simply 'absorbs' the problem. Somalis tend to rally around emotionally ill family members, and will work through symptoms such as sadness, loneliness, marital conflicts, and concerns relating to children. Mental illness is never talked about, and this attitude may prevent many Somalis, especially men, from seeking help when they are suffering (Jimale et al., 2002; Lennon, 2000). As a result, there may be no perceived need for psychiatric care, unless a family member is afflicted with a severe psychotic illness. Even then, if safety allows it, the family may choose to care for the patient at home, institutionalization being the last option. The Somali family approaches each individual's problem as a group, thus dissipating the individual's stress, anxiety, or depressive symptoms (Jimale et al., 2002; Rafuse, 1993). This sociocentric system has a preventive dimension. The 'mental illness' label does, however, put a tremendous stigma onto the entire family, and affects its basic social structure. For example, if a daughter is considered 'crazy,' she will likely never marry, and will remain dependent on the family indefinitely.

#### THE ACCULTURATION EXPERIENCE

To the traumas of civil war, the added impact of acculturation to a vastly different host society has generated significant need for mental health services among Somali immigrants to the USA. Like other immigrant groups, expectations about life in the USA may have been an exhilarating fantasy that crashed in the face of reality. During individual interviews with Somali immigrants, several common themes related to this fantasy versus reality dichotomy emerged. These included the emotional stress of past trauma and torture experiences, language or other communication difficulties, deterioration of their traditional family system, social isolation, financial stressors, dealing with the American concept of time, the emergence of domestic violence, and parenting issues (Jimale et al., 2002).

#### *TRAUMATIC MEMORIES*

Prior to immigrating, many Somali families lived in refugee camps where there was a shortage of food, water, and firewood; inadequate medical and hygiene supplies mixed with successive deaths of loved ones. It was particularly dangerous for women, many of who experienced sexual and physical assault from bandits when they ventured outside the camps. The Somali police were untrustworthy, and used their power to their own advantage.

Children had no access to school (Kinzie, Boehnlein, Riley, & Sparr, 2002; Lennon, 2000; Rafuse, 1993). Many of these families continue to deal with these traumatic experiences, and the new stressors of living in a different culture induce an emotional vulnerability uncommon in Somali culture. In fact, in a recent study of a group of refugees that included Bosnians, Vietnamese, Laotians, Cambodians and Somalis, the latter were noted to experience the greatest deterioration of their sense of safety and security, in response to the September 11, 2001, attacks (Kinzie et al., 2002).

#### *LANGUAGE PROBLEMS*

Many Somalis face difficulties learning the English language. The consequences of this impaired communication include financial insecurity and unemployment, loss of government assistance when unable to complete required documentation, and inability to obtain required citizenship status (Jimale et al., 2002; Lennon, 2000).

#### *FAMILY ISSUES*

The family system has deteriorated due to separation by the immigration process and deaths from the war. This has resulted in social isolation and loss of family or social support, the latter buried beneath the struggle of individuals just to survive. People have lost their independence, self-esteem, and ability to trust. One Somali woman felt that dodging bullets and bombs in Somalia was less stressful and more predictable than contending with harassing letters from social services and the government, living in crowded conditions with a constant threat of eviction, trying to learn English, and understanding what was happening with her children in the American school system (Lennon, 2000).

Because many children speak English more fluently than their parents, they become the communicators with the outside world. This situation has dramatically shifted the family system by placing children in a position of control within the family. This not only allows children to 'edit' information their parents receive, i.e., school concerns, but it also distorts the normal parent-child roles. Furthermore, traditional disciplinary measures practiced in Somalia are looked upon unfavorably in the USA, with predictable confusion among parents. Many children have learned it is to their advantage to threaten parents with abuse charges when parents attempt to set limits. This loss of control has likely contributed to the increased involvement of Somali teens in gangs and their confrontations with the legal system (Jimale et al., 2002). Increasing incidence of domestic violence within these stress-laden families has resulted in further destruction of a once highly supportive group system.

The American view of time is a new concept to most Somalis. In Somalia, time is seen and used in a more relaxed fashion. When accompanied by language problems and concepts like 'daylight saving time,' this can be confusing. It is not unusual for Somali patients to show up at least an hour before or after a scheduled appointment time (Jimale et al., 2002).

The collapse of the fantasy created around life in America, and the realities of coping with new stressors have placed many Somalis at higher risk for developing mental illnesses. In particular, many Somali immigrants find themselves experiencing guilt, shame, humiliation and subsequent death wishes. The depression-anxiety-PTSD symptomatological triad is so common among this community that many have given it a name: they refer to these symptoms occurring together, as *puffis*, a multifaceted (and polysymptomatic) abnormality (Jimale et al., 2002). Many Somalis have noted that suicide, which was virtually unheard of in this population, appears to be more common, despite the strong religious beliefs that deny or condemn such behavior (Jimale et al., 2002).

#### THE CLINICAL ENCOUNTER

An informal survey of 37 members of the Mayo Clinic Department of Psychiatry and Psychology, to determine caregiver perceptions of care of Somali patients, cited language barriers (74%), and cultural misperceptions (68%) as the most frequent obstacles. Difficulties working within the patriarchal family structure, limited community resources, poor compliance, and financial issues ranged between 18 and 8%. Additional barriers mentioned were problems working with interpreters from 'warring clan factions,' patients' fears of being labeled 'crazy,' difficulties viewing illness within an emotional framework, and the need to address mental health from a physical framework through a focus on somatic symptoms.

#### THE EVALUATION PROCESS

The first step in the clinical evaluation process should aim at understanding how Somalis feel about doctors and medicine. Many Somalis who have experienced refugee camps and torture, see intervention as interference, and many of them have learned to view anyone in a position of authority (doctors, allied medical personnel, teachers, law enforcement, and government officials) as untrustworthy (Lennon, 2000). Partly due to this reluctance, many Somalis feel that the clinical interview should always begin with an objective focus on physical symptoms, and on how such symptoms have affected life and family. This is felt to be less intrusive and establishes a feeling of genuine concern for the patient's well-being.

Welcome questions are therefore, 'How is your sleep?', 'Has this made it difficult for you to care for your children, or caused you to miss work?', 'Have you been worrying so much that your appetite has deteriorated?', and 'How have these symptoms affected your family?' In short, a medically oriented approach to discussing mental illness is considered to be more culturally acceptable. In Somali culture, it is important not to be labeled as 'crazy,' and it is more acceptable to think of symptoms of depression or anxiety as a physical illness (Jimale et al., 2002; Lennon, 2000).

The Somali family system finds support in numbers. The greater the perception of illness, the greater number of family members, likely male, that will accompany the patient to the appointment. When asked how to best conduct an individual interview with the patient, without offending or threatening the family as a unit, however, most Somalis felt that it was more acceptable to begin the interview with the individual patient, and ask the family members to join in later. This will prevent 'excluding' them by asking them to leave the room halfway through the meeting.

The most significant suggestions involved the use of interpreters (Burke, 2001; Jimale et al., 2002; Rafuse, 1993). In most cases, the entire purpose of the interview is defeated if no interpreter participates. Similarly, maintaining confidentiality for both family and patient while working with an interpreter is of considerable importance. Feeling that privacy is not protected will severely limit communication. Furthermore, working through an interpreter is always a challenge, particularly in psychiatry where non-verbal language is as important as the exchange of words. It is vital that the interpreter not use words that would imply being 'crazy' or 'brain-sick.' It is also not advisable to use family members as interpreters since it may be difficult for them to remain objective: they may want to protect their family member by distorting the translation (Jimale et al., 2002).

Non-verbal behaviors definitely affect the climate of the psychiatric interview, and are often interpreted differently by different cultural groups. In the Somali community, there are three people who are usually and consistently respected: a teacher, an elder, and a doctor. However, they are expected to give something in return (Mohamed, 2000). One Somali woman suggested offering coffee at the appointment to promote a genuine desire to be helpful as a caregiver. Demonstration of trust varies among different cultures, but awareness of the meaning of this and other behaviors can prevent misunderstandings and concerns.

More often than not, the interpersonal communication style of Somali individuals may seem very intense to Euro-Americans in the mid-West of the USA. Conversations can rapidly become passionate, assertive, loud, and emotionally charged. Many times there is a pressured, confrontational feeling of 'I need you to hear me now, no matter what,' accompanied by

much physical gesturing. Many non-Somali interviewees reported that they found themselves 'backing off' to increase personal space in a situation that, unconsciously and 'culturally,' is interpreted as being overly assertive and at times maybe even aggressive, when compared with more 'culturally acceptable' interpersonal styles in the USA. On their side, many Somalis may interpret the others' tendency to 'back off' as offensive and disrespectful, further compounding mutually misunderstood intentions.

#### *TREATMENT OPTIONS*

Cultural beliefs can cause a disconnection between American doctors and Somali patients, and treatment is a specific focus of concern. For some, not receiving the 'expected treatment' leaves them feeling like they were not treated at all; they will likely not return to this physician or follow his or her recommendations (Burke, 2001). Non-compliance problems often are due to the fact that the patient and his or her family do not understand the therapeutic benefits of the medication. This makes the educational component of the doctor-patient relationship extremely important. Instructions to the patient and caregivers should be thorough, precise, and clear (Burke, 2001). Most Somali families are receptive to the use of medications; however, independence is important for them and, therefore, it may be beneficial to allow patient and family to retain some control over the situation (Burke, 2001), through what Somalis call the 'art of bargaining.' Although it is important for healthcare providers to hold true to their medical training, it is necessary for them to be flexible, receptive, and creative in allowing the incorporation of cultural beliefs into the treatment process.

#### DISCUSSION AND CONCLUSION

Being considered competent and maintaining pride are qualities that each Somali strives for. The acculturative transition of Somali immigrants to the USA has frequently been accompanied by pain and humiliation. Many types of psychiatric syndromes reflect the shattering of dreams, the sounds of a poetry that no longer rhymes in the heart and soul of these immigrants. Many Somalis, and especially those of the older generation, have had enormous difficulties learning English. Being unable to communicate adequately causes dependence and social isolation. Much of the difficulty with learning English stems from the fact that many of the language teachers are not fluent enough in the various Somali dialects and language uses. Promoting a more bilingual approach to teaching English may be a very helpful first step to improve communication and prevent emotional discomfort.

Somalis have many cultural values and practices that can be effectively utilized to promote treatment adherence and improve mental health care. The patriarchal family system, often described as 'controlling' and perceived as dictatorial, can enhance a strong family cohesiveness, and the need for family pride and respect; therefore, a family approach to the psychiatric care of any Somali patient could be useful (Costello, 2002). Similarly, family education and involvement can go a long way to improve compliance. Cultural values of honesty, cooperation, self-reliance, and a sincere desire to help are valued by Somalis, would promote a trusting relationship between patient and doctor, and stimulate group support and active participation in therapeutic endeavors.

Every Somali interviewed for this study was receptive to learning about American practices of limit-setting for their children (Burke, 2001), but did not know who to turn to, since this subject has become laden with fear of arrest by the police, and control issues with children. There was also a need for learning how to deal with marital concerns to decrease domestic violence and abuse. There is also a need to learn appropriate and expected behaviors regarding everyday structures of time and bureaucratic requirements. These are activities with which many Somalis, especially those women who have now been placed in a position of authority in their families due to loss of husbands and fathers, are unfamiliar.

The rapidly growing Somali population in the USA presents a unique challenge to mental health caregivers. Psychiatric problems are rarely acknowledged by Somalis and their families, making it difficult for them to seek professional care. Deterioration of the supportive family system has resulted in a concentration of stressors, focused on the individual. This has dramatically escalated the psychiatric needs of this population. Recommendations for optimizing a culturally sensitive approach to treatment and compliance may include using the family system and 'the art of bargaining,' establishment of community education programs addressing acculturation issues, and active use of cultural approaches to the clinical interview.

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