Somali Immigrants—How Cultural Conceptions of Mental Illness/Mental Health Affect Therapeutic Outcomes in Western Host Nations

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Abstract

The changes Somali immigrants have experienced, and the differences between their culture/country of origin and their new home countries, could hardly be more profound. As our Western mental health care systems must now find a way to work with and treat these new residents, it would seem appropriate to examine how they view mental illness, and how these views may affect the therapeutic outcomes they experience. This paper seeks to examine and discuss the question of how Somali cultural views of mental illness impact therapeutic outcomes, once Somali immigrants have become residents of Western countries. As there is currently relatively limited research on Somali immigrants or African immigrants in general for that matter, this paper also references some existing research on other African cultural and ethnic groups who begin new lives in Western countries, as well as some research on mental health diagnoses of African-Americans.
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Somali Immigrants—How Cultural Conceptions of Mental Illness/Mental Health Affect Therapeutic Outcomes in Western Host Nations

Since the beginning of the Somali civil war in the early 1990’s, millions of Somalis have become refugees, some within Somalia and some outside of Somalia. “Around 2 million Somalis have sought refuge in countries such as Kenya, Ethiopia and Yemen, while over 500,000 Somali refugees migrated to Europe, Australia, New Zealand and North America” (Warfa, Curtis, Watters, Carswell, Ingleby & Bhui, 2012, p. 2). Prior to their arrival in their new countries, many of these new immigrants experienced significant trauma. Many have seen family members killed, been violently assaulted themselves, and have in almost all cases been through a series of extremely difficult and highly traumatic experiences. Those that have arrived here have endured, have survived, but rarely without a cost to themselves and their mental health.

Kroll & Fujiwara (2011) found that 80% of Somali patients in their study presented with psychoses. Despite that study and a few others, Bhui et al. (2006, p. 400) observed that, “there are few mental health data for Somali people.” They noted that “this is due to the absence of culturally validated appropriate assessment instruments and methodological challenges”, among other factors. In short, we don’t yet know precisely what we don’t yet know, beyond the fact that we have limited data at this time.

Van der Ven, Bourque, Joober, Selten & Malla (2012) wished to test the hypothesis that ethnic migrants are over-diagnosed with psychosis, but they found no such evidence. However, they did conclude that when it does occur in ethnic migrants, psychotic symptoms tend to be more severe than with native populations. Schwartz & Feisthamel (2009) on the other hand, found that there is clear evidence for higher diagnoses of psychosis among African Americans than among European Americans.
Patterson, Kyu & Georgiades (2012) found that the length of time in a new host country and a younger age at immigration were directly correlated with an increase in symptoms, particularly symptoms associated with mood and anxiety disorders, and alcohol dependence. Pascual et al., (2008) studied incidence of Borderline Personality Disorder (BPD) among African immigrants in the U.K. in relation to the non-immigrant population. Contrary to earlier studies, they found that BPD was actually diagnosed at a lower rate in the African group, although younger patients were more likely to be diagnosed with BPD. Also interestingly, in contrast with a general perception in the West, among the female African immigrants, a higher incidence of BPD was not found in this study.

In the area of potential cultural influences, Lee (2011), in a study of Major Depressive Disorder among immigrant populations in the U.S., found that ethnic groups “experience different patterns of MDD onset over time” (p. 260). Lee goes on to describe the evidence that different cultural groups perceive, experience and manage mental health in vastly different ways, making it critical for practitioners to factor culture into their work with clients.

Guerin, Diiriye & Yates (2004) found that Somalis draw upon their experience of how people with mental illness are treated in Somalia in deciding how, when and even if to engage at all with Western mental health providers. Individuals in Somalia with psychiatric symptoms are reportedly ostracized and the problem is little understood. As a result, when they arrive in new countries, they tend to avoid seeking treatment or any assistance unless their symptoms are particularly severe. In a related vein, Finnstrom and Soderhamn (2006) and Simich, Maiter, Moorlag and Ochocka (2009) found that within the Somali culture, the ability to remain stoic and strong when experiencing pain is highly valued, especially among Somali men. Children are also
expected to control their expressions of pain. All of this would seem likely to contribute to an under-utilization by Somalis of mental health services available in their new host countries.

Another factor could be the ongoing trauma that according to Helms, Nicolas & Green (2010) occurs simply by being a minority immigrant living within a new culture, and that this daily ongoing trauma can be difficult for the individual to be aware of. The nature of being an immigrant entails being different. For perhaps the first time, immigrants often suddenly find themselves to be different, unusual, not belonging to the larger group in their new country/culture, and not fully understanding the rules, language and customs they must now learn to navigate. As any traveler to another country has found when he cannot speak the local language, this can be stressful. When we consider that these particular travelers must remain permanently in the new culture, and when the new and the old cultures are so vastly different, we can begin to see how this could be significantly traumatic. This is especially interesting within the context of the findings of Aragona, Rovetta, Pucci, Spoto & Villa (2012), who found that among African immigrants, and non-Western immigrants in general; there is a higher incidence of somatization.

As with most cultures, it is also important to consider Somali spiritual viewpoints and beliefs in seeking to understand the individual experience. Johnsdotter, Ingvarsdotter, Ostman & Carlbom (2010) have contributed a study describing Somali spiritual views related to mental health, including beliefs about spirit possession, perceptions of and ways of describing mental health symptoms, and Islamic influences on these perceptions. Also noted are the clear preferences in Somali culture to draw upon one’s social support network when in need of assistance, a characteristic which makes sense in a culture that was comprised of essentially nomadic family groups for centuries prior to immigration. It is precisely this and other specific
cultural aspects of the Somali experience in their new environments, and how these aspects affect, color and even determine outcomes that this paper will discuss. Some of the areas of Somali culture that will be reviewed, and any existing research related to those areas, include general Somali views on mental illness; conceptions of pain and emotional difficulty; the effect of ongoing trauma, and how and why this is a factor; somatization; Somali spiritual views related to mental illness; issues of gender and adolescence; levels of engagement with providers and attitudes toward medication and therapy; therapeutic outcomes; and a summary for practitioners of the main points they may want to consider when working with Somali patients.

**General Somali Views on Mental Illness**

Although the existing research is somewhat limited at this point, mainly due to the relatively recent arrival of Somalis in the West, there are sources we can draw upon. Guerin et al., (2004), cited above, found that Somalis have a conception of ‘mental illness’, but they tend to ascribe the concept only to the most severe cases. For example, “someone who appears mad or insane, or when they go around throwing stones, yelling, hitting, eating from dumpsters, and walking naked” (Guerin et al., p. 60). The authors also found that

When asked how these people are treated in Somalia, we are told that these individuals are considered a danger to themselves and others so are placed in seclusion facilities in hospitals, or if they live in the country far from a hospital, they are chained up to protect themselves and others. An important implication of these ideas is that if Somali hear themselves being described as having mental illness, this is the sort of picture they might envisage, and they might therefore resist treatment (Guerin et al., p. 60).

So when Somalis hear the term “mental illness” they may very well perceive that this extreme level of difficulty, along with the associated ‘treatment’, is what is being proposed for
them. Regardless of what the real message is intended to be, if a patient hears his practitioner proposing to tie him up to a tree, so as to prevent him from harming himself or others, the practitioner should not be surprised if treatment is resisted. So it is possible that all but the most severe symptoms may go untreated and unacknowledged in this population.

In addition, as Miranda and colleagues remind us, that in any discussion of cultural conceptions of mental illness, it must be considered that once the parameters for mental illness are established by a given culture, its treatment, remedies, and cures are also determined within them. Many cultures establish complex relationships between illness, myth, and ritual. Myth sets the stage for the ritual to address the illness. However, culture, especially for those sojourners from other lands to the United States, may not be conceptualized as static. Rather, the process of acculturation renders cultural identity dynamic and influential in all aspects of mental health, its expression, and its treatment (Miranda et al., p. 424.)

The authors go on to note that “Frequently, individual idiosyncrasies are considered normative when there is a commonality formed by shared experiences. These experiences provide a common base of understanding that, in turn, allows for communication to occur between persons from a similar culture.” (Miranda et al., p. 423). Here we find another of many suggestions in existing research that what a member of one culture may interpret in a given way, such as the presence or absence of mental illness, may, in fact, be something else, or may at least be different within a cultural context, then an outsider would interpret it to be within the framework of their own cultural context.

Guerin and colleagues also found two apparent parallels between Somali and Western conceptions of mental illness. “The first Somali category we describe is that of serious 'madness'
or belief in possession of an individual by a ghost or spirit, which in western terms relates very generally to manic depression (bipolar disorder) or the more severe forms of schizophrenia” (Guerin et al., 2004, p. 60). We will discuss the spiritual/religious implications of this conception later in this paper.

The second broad category of mental illness perception found by Guerin is the Somali conception of a general lack of well-being. Somali conceptions of this category seem to relate to Western views of depression/anxiety, or general stress. It is important to note about this second category that in the Somali view, Guerin et al. found that Somalis do not regard these symptoms as belonging to the broad category of mental illness. Rather, they view these categories of difficulties as simply a part of life, to be endured as best one can. Or, they simply deny that these symptoms even exist for the Somali population. This concept is important, as it illustrates that again, when a Somali hears the words ‘mental illness’, he or she very likely conceives of the most severe forms of what Western practitioners describe as ‘mental illness’. These understandings of the concept of mental illness can influence their decisions to seek treatment or to even acknowledge their difficulties, and at least two research teams (Johnsdotter et al., cited above, 2010) and Guerin et al. (2004) found that this is indeed the case.

Some interesting linguistic insights have also been discovered in the existing studies. Guerin et al. found that the word that is generally used in the Somali language for ‘crazy’ or ‘insane’ or ‘mentally ill’ is the word Walli, which appears to carry a much broader meaning than the corresponding terms in English. For example, Walli can be used to describe a great number of conditions, such as ADHD, forgetfulness, dementia, depression, general stress, as well as what Western practitioners consider psychosis. Walli is perhaps best translated as ‘not feeling oneself’. When we in the Western model attempt to use our specific words for the many types of mental
illness of which we conceive, many if not all of these terms are generally translated as Walli, which seems to cause difficulty for Somali patients to really understand what their Western practitioners are trying to describe. One is reminded of Adler’s concept of holism here: “One can never regard single manifestations of the mental life as separate entities, but…one can gain understanding of them only if one understands all manifestations of a mental life as parts of an indivisible whole” (Ansbacher & Ansbacher, 1964, p. 190). In a sense, what Westerners may view as a linguistic peculiarity, and a frustrating and challenging aspect of the language, can also be viewed as a Somali conception of holism, as a conception of the individual as an indivisible whole. Whereas the Western view seeks to dissect, divide, segment and separately describe a potentially limitless list of ‘disorders’, and to place each one neatly in its proper place in the psychiatric toolbox, perhaps the Somali view is more synthetic, less divided, and more in line with Adler’s view.

Somali Spiritual Views Related to Mental Illness

There is evidence that Somali spirituality affects their views on mental health and illness. For example, Johnsdotter et al. (2010), cited above, found that a traditional Somali belief holds that people can be possessed by evil spirits know as ‘Jinn’, which may cause the individual to hear voices, speak strangely, or otherwise behave in an unusual manner. “Jinn are beings that all Muslims are obligated to believe in” and “among Muslim scholars a majority maintain that such spirits can enter into people’s bodies and possess them” (Johnsdotter et al., p. 744). Delbar, Tzadok, Mergi, Erel, Haim and Ronem (2010) note that “People in some societies in Africa…often integrate the natural and supernatural causes of health and illness in their system of beliefs…In most Western countries as well as among Western trained professionals in some developing countries, people expressing this behaviour would be diagnosed as neurotic or
psychotic and treated accordingly” (Delbar et al., p. 278). So it seems clear that there is a significant potential for misunderstanding in this area. A Westerner who told his psychiatrist about spirits who had entered his body, possessed him and made him ill would quite possibly be hospitalized, whether he wanted to enter the hospital or not. And, we in the West would say that it is likely the case that this person is, in fact, quite psychotic. However, given the above information, should the Somali who tells his psychiatrist the same things also be hospitalized? The answer is less clear, to say the least.

Johnsdotter et al. also found a belief among some Somalis that a person can be affected by ‘Sexir’, which involves negative feelings originating from another person, who may wish to inflict harm upon the person due to feelings of jealousy, or other negative feelings towards that person. The researchers also found conceptions of the ‘evil eye’ among Somali informants, a diffuse, malevolent intent which can emanate from any number of sources, or can simply reflect the will of God, which is one of the findings reported by Wallin and Ahlstrom (2010).

Traditional strategies to deal with these perceived causes of mental illness vary, and often involve the Koran, the Muslim holy book. Reading of the Koran is regarded as a particularly effective, and required, method to effectively treat mental illness. Johnsdotter et al. (2010) found that “reading of the Koran is a key strategy to deal with mental ill health. This reading takes place either in smaller groups of friends and family or by religious scholars who read special suras, verses in the Koran. Several interviewees explained that the Koran has the power to heal” (Johnsdotter et al., p. 745). Guerin et al. were told by their informants that the Koran is effectively the solution for all problems that Muslims may encounter. Bentley and Ahmad (2008) state that “In Somali culture, the Islamic faith has a profound influence on the way the world is viewed. Medical and psychological hardships are viewed to occur under the will of God (Allah).
As a result, the Koran is effectively the first treatment tried when someone is experiencing psychological symptoms” (p. 2). This has profound and far-reaching implications for Western psychiatric practitioners. If a patient believes that his suffering is caused by God, and that he is deserving of his suffering even if he does not understand why, this is problematic to say the least. For the practitioner, this does not necessarily mean that the patient cannot be treated, or that the practitioner cannot at least engage with the patient, with actual treatment coming later. However, some sort of cultural dialogue, exchange, and even a sort of cultural negotiation will be critical to maximize the patient’s chances of receiving care. Western practitioners do this already with their Western patients; they simply do not always realize they are doing it, as the cultural disparity is less profound, and therefore less remarkable.

There would also seem to be an apparently dramatic difference between U.S.-born white women in one study, and their African-born counterparts who have immigrated to the U.S.: “Only 54% of U.S.-born Whites indicated that faith would be helpful in dealing with their perceived emotional problem, compared with…82% of immigrant Black women, and 79% of U.S.-born Black women (Nadeem et al., p. 100).

Also of note here is that two sets of researchers, Guerin et al. and Johnsdotter et al. were told by participants that when an individual experiences any mental health symptoms, it is through the context of his social network that he may expect to find relief. A Somali’s social network, his family and friends, is intertwined with his religious/spiritual beliefs. Maintaining strong social bonds, and using them in times of need, is considered a requirement of the Koran. To seek assistance outside of this network (which is what one is effectively doing when working with a Western mental health practitioner) is considered inappropriate except in the most
extreme cases, and potentially un-Islamic, or at a minimum, a source of great embarrassment and shame for the family of the individual.

The most important strategy to deal with mental ill health seems to be the mobilization of social networks. Many informants expressed their astonishment at the existence of special services to deal with mental health and declared that, ‘We are all psychologists to each other.’ Other informants, some of them well integrated into the Swedish society and familiar with western psychiatry and psychology, described the situation in terms of concealment of mental ill health because of the stigma” (Johnsdotter, et al., p. 745).

Stewart, Makwarimba, Beiser, Neufeld, Simich and Spitzer (2010) note the following: “Social support is a resource for coping with stress caused by immigration and resettlement challenges. Support provided by community members of similar ethnicity is associated with positive health outcomes, whereas lack of social support has a detrimental effect on mental health” (p. 92). The researchers go on to note that immigration often effectively damages or greatly reduces the effectiveness of these very social networks that are relied upon for successful management of mental health and other acculturation challenges, leaving the individual to cope with his difficulties alone.

The existing research in this area would seem to strongly suggest that Somali spirituality plays an important role in their overall mental health, and in their engagement with Western practitioners. Most significantly, there appears to be evidence that Somali spiritual and religious beliefs often effectively prevent them from engaging with and receiving care from Western practitioners, primarily due to the perceived shame associated with mental illness in general, but also due to the belief that mental illness is somehow associated with God’s will, and as such cannot and should not be influenced by Western practitioners.
Psychological Conditions

Kroll & Fujiwara (2011), cited above, who compared relative percentages of Somali immigrants’ diagnoses of psychosis to non-Somali patients’ diagnoses of psychosis treated at one clinic studied in the West, the CUHCC clinic in Minneapolis, found a significantly higher percentage of psychosis among the Somali male patients there, a disparity particularly apparent in younger patients. “The study confirmed that almost half of the Somali male patients are under age 30, 80% of whom presented with psychoses, compared with the rate of psychosis (13.7%) in the non-Somali control group of same-aged males at the clinic” (p. 481). This is a very interesting result, and we will discuss this further in the coming pages.

In addition, there are a number of apparently conflicting studies at this point. For example, Van der Ven et al. (2012) researched African immigrants in Montreal, Quebec, studying and evaluating the age at which, and in what contexts immigrants are first diagnosed with psychoses. The authors then compared these details to the larger, native-born population. As the authors state, in reference to other published studies, including some research that suggests that psychosis is over-diagnosed in ethnic minorities, “There is now consistent evidence for an increased incidence of psychotic disorders in many migrant and ethnic minority groups across various countries” (p. 301). However, in their research on First Episode Psychosis (FEP) the authors discovered that

A comparison of FEP patients from different ethnic groups and native-born Euro-Canadians revealed no significant differences in the nature of positive symptoms at first presentation or in age at onset, suggesting that there was no evidence for the hypothesis that ethnic minorities are misdiagnosed as psychotic. Increased severity of negative symptoms and general psychopathology, specifically among the black ethnic minority
group, may have implications for the role of ethnicity for the treatment and outcome of the initial episode of psychotic disorders (Van der Ven et al., 2012, p. 300).

The authors defined “negative” symptoms as Flat Affect, Alogia, Apathy or Anhedonia, and those described as “positive” are all other general psychopathology symptoms, including Somatic Concern, Anxiety, Guilt Feelings, Depression, and others. In other words, in contrast with the data obtain by Kroll and Fujiwara in their 2011 study cited above, in which fully 80% of Somali patients presented with psychosis, Van der Ven and colleagues found no evidence that psychopathology occurs more often in African immigrants, but they did find evidence that when it does occur, the symptoms of psychosis appear to be more pronounced. Could this apparent disparity between Somalis and other African immigrants be accounted for by especially traumatic experiences in the Somali population? Further research is certainly warranted here. It would be particularly interesting to study what specifically about the Somali experience may account for the higher incidence of psychosis found by Kroll and Fujiwara. If a clear indication as to the origin of those findings is found, do other immigrant groups who have also experienced significant trauma show similar levels of psychosis diagnoses?

In a similar vein, Patterson et al. (2012), found that “the longer immigrants had resided in Canada, the higher their rates of depression and alcohol dependence, or rates of mental health decline” (Patterson et al., p. 215). In other words, they seem to suggest that residing in a new country, even though their new environment may very well be dramatically safer and less stressful from the standpoint of physical danger and more abundant resources, is still a highly stressful experience for the immigrant, and apparently more so as time goes on. And perhaps more importantly,
Younger age at immigration is associated with elevated risk for mood and anxiety disorders. Although risk for mental disorders in immigrants may be multi-faceted, results from our analyses demonstrate that even after accounting for multiple socioeconomic and demographic factors, age of arrival continues to account for unique variance in the prediction of mental disorders. As such, we believe it is an important predictor that deserves further research (Patterson et al., p. 216.)

So the earlier the age of arrival, the greater the risk and expected occurrence of psychiatric problems. The authors did not evaluate how the length of time in the new country may or may not affect outcomes, and this is an area for further research.

However, a discussion of Schwartz and Feisthamel’s research must also be included. These authors found that African-Americans (who are not Africans, clearly, and the reasons for introducing this population into the discussion here will become clear shortly) are diagnosed disproportionately higher with psychoses than are European-American patients. The authors conducted a literature review, and found that although this question had been researched in regard to psychiatry and psychiatric practitioners, the earlier studies had not included counseling professionals’ diagnoses in their evaluations. The authors found essentially the same results with counselors as previous researchers had found with psychiatrists: “Results of this study showed that counselors disproportionately diagnose African Americans with psychotic and childhood disorders. These findings are consistent with those of prior research studies with psychotic disorder and mood disorder diagnoses among noncounseling professionals” (Schwartz & Feisthamel, 2009, p. 298.) So the same apparent disparity with regards to higher diagnoses of psychotic symptoms was found among counseling professionals as among psychiatric practitioners. The authors go on to note that “…additional research is needed to determine
whether these findings reflect racial/ethnic diagnostic bias among mental health professionals or higher rates of mental illness among African Americans. The research design for this study did not include the collection of (nondiagnostic) psychosocial data that may have affected counselors’ diagnostic decisions” (Schwartz & Feisthamel, p. 300.) In other words, the authors acknowledge that the reasons for the apparent higher diagnoses of psychotic disorders by all practitioners in the African-American population may be due to actual higher incidents of such disorders among those who seek mental health services, and may not be entirely or exclusively due to racial bias among the practitioners, and may not be due at all to such practitioner bias. The possibility of actual higher rates of serious mental illness among African Americans patients is of particular interest to this discussion, considering the higher diagnosis of psychotic disorders found by Kroll & Fujiwara among Somali immigrants in Minneapolis. Both populations have been through significant trauma, one very recently, the other arguably perhaps more distantly in the past, and precisely how much ongoing trauma has been experienced by African Americans in general since the end of slavery in the U.S. is a topic for another discussion. However, could it be that a mutually-experienced high degree of trauma has resulted in higher incidences of serious mental health issues in both populations? If the answer is yes, it certainly would not be a surprising finding, but additional research will be needed to answer that question.

And among the Somali population, could these diagnoses, these incidents of mental illness, be in some fashion an example of a cultural syndrome? Could these examples be essentially unique to the Somali immigrant experience, precisely because they are unique to the Somali culture, at least in this specific presentation? “As discrete phenomena, mental illnesses are conceptually valid when the established criteria distinguish a disorder from another” (Miranda & Fraser, 2002, p. 423). So we diagnose a particular disorder when it presents as
different enough from the criteria which define other mental illness diagnoses, that those others can be eliminated from the range of possibilities. As noted in the DSM-5, “Cultural syndromes are clusters of symptoms and attributions that tend to co-occur among individuals in specific cultural groups, communities, or contexts and that are recognized locally as coherent patterns of experience…Across groups there remain culturally patterned differences in symptoms, ways of talking about distress, and locally perceived causes, which are in turn associated with coping strategies and patterns of help seeking.” Culture as a shared experience is critical to this discussion, and to any psychological or psychiatric evaluation of a particular population. Somalis’ common experiences, in a general sense, shape, color and inform their reactions to their new world, as is the case for all cultural groups.

Pascual et al. (2008), cited above, studied the incidence of diagnosed Borderline Personality Disorder among African immigrants who presented at emergency psychiatric clinics in the U.K. The authors wished to test the concept that BPD tends to be diagnosed at higher rates in immigrant populations, possibly indicating a bias among diagnosticians, or perhaps some cultural issue. The results indicated that precisely the opposite was true in this particular context: “Our results showed that in the psychiatric emergency service borderline personality disorder was diagnosed less frequently in the immigrant group v. the indigenous group. Our results do not support the concept of migration as a risk factor for borderline personality disorder” (Pascual et al., 2008, p. 471). However, interestingly the authors also found that Younger patients were more likely to be attributed a diagnosis of borderline personality disorder than older patients. Men had less risk of receiving a diagnosis of borderline personality disorder than women. All subgroups of immigrants were less likely to be
diagnosed as having the disorder than the indigenous group, independently of age and gender. (Pascual et al., 2008, p. 471)

In fact, the authors noted that “the sub-Saharan African subgroup had more than seven times less chance of being diagnosed with the disorder” and North Africans “presented about two times less risk. In our study, immigrants presented more psychotic symptoms but fewer depressive symptoms than the indigenous patients” (Pascual et al., 2008, p. 474).

The finding that younger patients were more likely to be diagnosed with BPD than older patients, may very well be related to the age at which the individuals emigrated. As the majority of African immigrants to Western countries have arrived within the last 20-30 years, younger people in this study are more likely to have been at a more formative age upon emigration, particularly for Borderline Personality development. It is not difficult to imagine that young children undergoing what many African immigrants have experienced would feel a sense of abandonment and other early experiences often associated with BPD.

Also noted by the same authors was that “as in other studies, we also found that immigrants were unlikely to seek medical help for depression. It is possible that these patients do not seek medical care as they do not consider their symptoms as an illness” (Pascual et al., 2008, p. 474). Again we see the theme of only the most severe symptoms and negative experiences being viewed by Somalis as problematic, or worthy of attention or treatment.

What, conversely, could be behind the finding that “all subgroups of immigrants were less likely to be diagnosed as having the disorder than the indigenous group”? (Pascual et al., 2008, p. 471). Is Borderline Personality Disorder strictly or primarily a Western affliction? Is there a bias at work among the diagnosticians, or a case of cultural misunderstanding? One possible explanation was discussed by the authors: “These societies are likely to provide
protective rules, values and roles that tend to induce acceptance of family and community expectations and inhibit emotional expression. Western societies, on the other hand, offer more flexible values and rules, favouring individualism and greater emotional expression” (Pascual et al., 2008, p. 475). Linehan’s discussion about Western societies generally prioritizing personal achievement, and viewing negatively what is perceived as low motivation or a lack of discipline, could quite possibly be at play here also. Might it be the case that the individualism which is so prized in the U.S., and perhaps to a lesser extent in other Western countries, contributes to the formation of personality disorders? It is a very interesting question, and if there is validity to this concept, it would certainly fit much of the existing data, especially the results observed by Pascual and colleagues.

The authors also acknowledge that the answer may, in fact, be simpler: “As a second explanation it cannot be ruled out that our findings might be explained by some methodological artifact in the diagnosis. If diagnosis of borderline personality disorder is particularly difficult in a psychiatric emergency service, it is even more complicated when there are cross-cultural differences” (Pascual et al., 2008, p. 475). Indeed, a personality disorder diagnosis is not easy to make under ideal circumstances, so it is plausible that this final point is at work here.

This writer found very limited research on African immigrants to the West and incidence of depression. However, Lee (2011) in Racial Variations in Major Depressive Disorder (MDD) Onset Among Immigrant Populations in the United States, found that “Findings from this study reveal that different racial groups experience different patterns of MDD onset over time. Exploring the factors associated with MDD onset will help mental health providers identify vulnerable subgroups among immigrant populations and, in turn, promote adequate mental health services for them” (p. 260). This study provides us some very interesting information
which, although quite limited in its scope, makes sense. We have seen already in this paper that there appears to be some validity to the general concept that different cultural groups experience or encounter mental illness diagnoses differently, at different times in their lives, and under different circumstances. We know enough at this point only to say that further, more detailed research is needed.

**Conceptions of Pain and Emotional Difficulty**

At least two research teams, Finnstrom and Soderhamn (2006) and Simich, Maiter, Moorlag and Ochocka (2009) found what would appear to be important aspects of Somali perceptions of pain or general emotional difficulty, as well as important linguistic aspects of these conceptions. “Somalis, especially men, are expected to be stoic about pain. Children from the ages of 6–8 years upwards were expected to control their pain expression. For some of the women, consulting a psychologist was not a culturally acceptable way of seeking pain relief” (Finnstrom et al., 2006, p. 418).

When asking their Somali study participants about conceptions of mental health and illness, Simich and colleagues found the following:

A Somali participant said, ‘People are treated shamefully and so they are used to hiding their problems…in our country, people suffer alone.’ Some participants remarked that the symptoms of mental illness are not known in their communities; therefore, there may be no response because they have been missed. Even talking about mental illness is equated with being crazy. (Simich et al., 2009, p. 211)

Here we have another example of just how different the Somali view is from the Western view, and how differently the topic of mental illness is treated. Although residents of Western countries still may experience some shame and embarrassment associated with mental illness,
the Western societal conversation on this topic is established and ongoing. This increasing comfort with discussing mental illness may, over time, be adopted by these new immigrants.

We can see from the examples above that Somali conceptions of pain and emotional difficulty significantly affect their willingness and ability to seek and receive effective treatment in their adopted Western countries. In fact, McCrone et al., (2005) found that although their Somali research participants in London routinely visited general medical practitioners at a rate substantially equivalent to their non-Somali counterparts, the Somalis appeared to use psychological or psychiatric services at a dramatically lower rate than their non-Somali counterparts. This particular study did not attempt to ascertain the reasons for this disparity, but this is clearly a critical difference, and further research is warranted.

**Ongoing Trauma**

Another possibly relevant study was done by Helms, Nicolas and Green (2010). In their published study “Racism and Ethnoviolence as Trauma: Enhancing Professional Training” in the journal *Traumatology*, the authors assert that mental health professionals must expand their conception of the causes of trauma, to include ongoing racism and micro-aggressions experienced in the new host countries: “When defining potentially traumatic stressors, researchers and practitioners typically have not focused on racism and ethnoviolence as causal or aggravating factors in the development of PTSD or related symptoms of stress disorders...reactions to either racism or ethno-violence alone or combined with other traumatic events may pose threats to a person’s psychological and physical well-being that may be as psychologically debilitating as reactions to natural disasters or other types of physical or psychological endangerment” (Helms et al., 2010, p. 54). In other words, the authors posit that what may often be viewed as relatively minor experiences, could very well have a dramatic
impact on mental health, particularly in the context of high levels of unresolved and unacknowledged trauma having already been experienced. This is certainly an interesting concept—might it be the case that perceiving rejection, or hate, or general dislike from one’s new neighbors, which are all emotional in nature, might be as potentially damaging as being violently assaulted at gunpoint, or seeing one’s family members killed, or any of the other thousands of highly traumatic experiences many of these new immigrants have experienced? The authors suggest that it is precisely the ongoing nature of these subsequent micro-aggressions, which follow the initial, highly traumatic event(s), which make them so potentially difficult to overcome. So in other words, it is not necessarily the dismissive or hateful treatment by itself that is the culprit. Rather, it is that these experiences follow the larger traumatic experiences, and then threaten the cultural identity and supports that are so crucial to recovery and success in a new society, that make these seemingly small events so potentially significant. One is strongly reminded of Adler’s concepts of Apperception, Biased Apperception and the Antithetical Mode of Apperception. In the antithetical process, the individual organizes and categorizes all experiences into extremes, such as all or nothing, yes or no, good or bad. “The apperception-schema of the patient evaluates all impressions as if they were fundamental matters and dichotomizes them in a purposeful manner into above-below, victor-vanquished, masculine-feminine, nothing-everything, etc.” (Ansbacher & Ansbacher, 1964, p. 333). Biased apperception refers to the unique perception/viewpoint, and the associated unique interpretation of a given event that each individual person creates, for himself or herself. Again, as conceived by Adler,

The world is seen through a stable schema of apperception: Experiences are interpreted before they are accepted, and the interpretation always accords with the original meaning given to life. Even if this meaning is very gravely mistaken, even if the approach to our
problems and tasks brings us continually into misfortunes and agonies, it is never easily relinquished (Ansbacher & Ansbacher, 1964, p. 189).

So, precisely because Somali immigrants have experienced a traumatic world, and in many cases have presumably decided, or interpreted this to mean that ‘the world is always thus’, the aforementioned micro-aggressions experienced in their new country, although perceived by the outside observer as considerably smaller and less traumatic than many of their earlier experiences, are perceived by the individual as equally threatening.

**Somatization**

Aragona et al., (2012), cited above, investigated somatization tendencies among several immigrant groups, including African immigrants. The authors undertook their research because “Vague somatic complaints that often remain medically unexplained are one of the major reasons for outpatient visits to primary care physicians” (p. 477). The authors also note that “Early studies found that people living in developing countries, and in ethnic groups that have immigrated to the Western world, tend to express emotional distress with somatic symptoms” (Aragona et al., 2012, p. 478). In other words, although somatization certainly exists among Westerners, there may be some indication that non-Westerners experience somatic symptoms, and conceive of or convey emotional distress somatically, more often than Westerners. The authors found that: “Among the 3051 patients who completed the BSI-21, 782 (25.6%) were somatizers, and approximately one-fourth of socially disadvantaged immigrants who accessed primary care services used somatization to express their distress” (Aragona et al., 2012, p. 477). The authors also note that “Non-Western cultures, particularly those that are traditional and rural, might be more prone to manifest their distress through physical complaints because they are less accustomed to communicating in psychological terms” (Aragona et al., 2012, p. 478). Here is
another warning to the Western practitioner. We cannot assume that our non-Western patients will understand our segmented and analytical approach. We should not assume this with our Western patients either, but this is particularly important when working with non-Western cultures.

Lien, Claussen, Hauff, Thoresen & Bjertness (2005) researched somatization among several immigrant groups to the West, including Africans, the majority of whom were Somali. The authors found that

There was a strong association between increasing numbers of bodily pain and mental distress score…the association between numbers of pain and mental distress was strongest for respondents from Sub-Saharan Africa, followed by Western Countries…a large percentage of the participants were recent asylum-seekers coming from war-torn areas, which might explain the increased number of pain sites reported from these groups.

(Lien et al., 2005, pp.373-374)

The authors also discuss the idea that pain, as a concept, is not necessarily conceived of or viewed in the same way in every culture: “In many non-western cultures pain experiences are a part of traditional rites, and that pain is seen more in a collectivistic view, with acceptance of pain as a normal part of life” (Lien et al., 2005, p. 374). Pain as a ‘collectivistic’ experience—this is extremely interesting and germane to this discussion. Could it be that pain can be, and in fact is, experienced by members of some cultures as a group experience? Most individuals have suffered, the group has suffered, and both pain sources are felt and expressed individually? If true, we have another example of how different cultural backgrounds can involve dramatically different individual and group experiences.
Summary

We can see an apparent connection between Somalis’ belief that if they discuss or acknowledge mental illness, that they will be subjected to extreme treatment, such as being chained up in a hospital. This belief appears to result in a lower likelihood of seeking treatment. Combined with a cultural belief that pain should be endured silently, and the fact that people with mental illness are often ostracized from their communities, this belief results in a situation in which there may be a great many Somalis who could potentially benefit from treatment, but who are unlikely to engage with the Western models of their adopted countries without further education, outreach, and a degree of acceptance from within their communities.

Other Considerations for Providers

Gender

As gender is generally understood in the Western view to play a strong role in Somali culture, this writer had hoped to find some existing research on any potential differences between how men and women view concepts of mental health and treatment, and how cultural views on appropriate gender-specific behavior affect Somali immigrants and their mental health. However, only very limited existing research could be found. This writer did find a paper presented at the American Psychological Association 2008 Convention entitled Mental Health in the United States: Perspectives of Somali Women (Barazanji, Nilsson, Heintzelman, Shilla, & Siddiqi, 2008). However, although the contributors did discuss their respondent’s’ perceptions of and reactions to changes in perceived gender roles in their new countries, no comparison with Somali male perceptions was found in the existing literature. Somali culture is generally very attentive to traditional gender roles and associated behavior, and these aspects of daily life are a significant
component of Somalis’ inter-personal relations, and relations with their adopted cultures. As such, this area merits further research.

Again, however, there is some research we can review that may be helpful. Ethiopia is very close geographically to Somalia, and perhaps shares some cultural similarities. And like Somalia, Ethiopia is also a country that has experienced serious and ongoing violence, war and large numbers of displaced people. Hyman, Guruge and Mason (2008) reviewed the effects of migration on the marital relationships of Ethiopian couples in Toronto, Canada:

In Ethiopia, much emotional support was provided to married couples by members of the extended family and close friends. As described by one separated 41 year-old male, ‘In our culture back home, when a husband and wife fight, family members try to help to bring them back together so they can live in peace and raise their children together.’ In Toronto, this support and advice was not readily available, nor did individuals feel they could consult with those back home as many of the issues and problems were considered to be outside the experience of support networks in Ethiopia. (Hyman et al., 2008, pp. 153-154)

In other words, not only was the traditional approach of seeking advice and support from family and social networks hampered by distance, the specific nature of the problems encountered by the couples in their new environment were perceived as so radically different and new, that the couples did not feel that family and friends in Ethiopia would be able to even comprehend the issues involved.

The authors did find what one might expect in the context of such dramatically increased stress—higher levels of marital conflict:
One of the major negative impacts of migration was increased marital conflict…another prime source of conflict arose when couples were unable to renegotiate new gender roles and responsibilities. For example, some men were unwilling to take on certain tasks; particularly those they felt belonged to women. Female participants reported that they were more likely to assume the double burden of work and family which often led to resentment. As two married women described, "70% of the work is mine," and, "In Canada, we both are working, but I still take most of the responsibilities." (Hyman et al., 2008, p. 156)

Interestingly, this is a complaint often heard from Western women, that the men in their lives do not share the work equally, and so the bulk of it falls, by default, to the women.

On a potentially positive note, not all of the researchers’ findings were overtly negative: “among the couples who remained together post-migration, there was evidence of increased mutual dependence. In other words, couples began to rely more on each other for support and help, rather than family and friends” (Hyman et al., 2008, p. 157). The authors go on to cite several examples of couples who report a greater sense of mutual cooperation, and resulting closeness in their relationship, as a result of not being able to depend on wider family networks as much as before. Clearly these couples are becoming more Western in that respect, and both positives and negatives of these changes can be expected.

It is certainly not at all surprising that immigration would result in higher levels of marital conflict. Any source of increased stress can be responsible for that. What is interesting however, and perhaps a bit surprising, is the positive side of these developments that the authors found (or perhaps, that they interpreted)—that is, the reported increased communication among spouses, increased mutual reliance, and some reported stronger relationships. What would be
very interesting to study further would be the question of if these reactions, or changes in the marital relationship, are stages toward successful assimilation in the new culture. Do these changes help the couples to join their new culture, and do these changes result in stronger, more lasting marriages? Or, conversely, are the couples not able to bridge that gap, and if some are and some are not able to navigate these challenges and new relationship patterns, who is successful and who is not?

Adolescence

Again, there is very limited research on which to draw, but Stevens, Veen and Vollebergh (2014), in their study Psychological Acculturation and Juvenile Delinquency: Comparing Moroccan Immigrant Families From a General and Pretrial Detention Population, published in Cultural Diversity and Ethnic Minority Psychology, find that

It may not be the acculturation orientation per se, but the acculturation gap between adolescents and their parents that may play a pivotal role in the development of adolescent delinquent behavior...Children typically become involved in the receiving culture faster than adults, creating an ‘acculturation gap’ between generations that is thought to foster parent–adolescent conflict.” (Stevens et al., 2014, p. 256)

So a hypothesis of this study was that the acculturation gap between children and their parents is directly related to resulting delinquent behavior. However, the authors found that their hypothesis was not supported by the research. In fact, they found that the young people studied experienced an acculturation gap as wide with their peers as with their parents: “In this study, Moroccan immigrant boys in pretrial detention as often encountered an acculturation gap with their parents as their peers from the general population and no differences occurred between both populations when taking into account the direction of this acculturation gap” (Stevens et al.,
2014, p. 262). These results are somewhat counter-intuitive, as we often assume, as the authors point out, that young people adapt to new cultures much more easily and fluidly than older people do. While this is certainly and demonstrably true with language acquisition, is it always true with a more complete acquisition of culture? It would be very interesting to take this study further, to attempt to ascertain what was being seen in those results.

So it would seem that in the critical area of multi-generational cultural adaptation to new societies, we know very little about how Somalis or other Africans experience these changes. However, it is known from research and observation with other immigrant groups that this generational “gap” and a certain amount of resulting conflict, is likely a universal experience, at least to some extent. What we do not know, however, is how each specific cultural group navigates this work, and even if this is indeed a challenge for every group of immigrants. Common sense would seem to imply that each group does find this to be a challenge, but how, why, when and what solutions are consistently found are the questions which leave future researchers with many potential areas of inquiry.

**Engagement with Providers & Treatment**

Kirmayer, Weinfeld, Burgos, Galbaud du Fort, Lasry and Young (2007) begin with the statement: “Research in the United States tends to attribute low rates of use of mental health services by immigrants to economic barriers” (Kirmayer et al., 2007, p. 295). In other words, in the United States, where care is generally not cost-free to the consumer, that cost is what is thought to account for the relatively low use of mental health services by immigrants. As Canada’s health care system is largely cost-free to the consumer, Kirmayer and colleagues wanted to determine why a similarly low rate of use of mental health services among immigrants to Canada also exists. Kirmayer and colleagues found that “despite having ready access to care
owing to the availability of comprehensive community and hospital clinics, immigrants were significantly less likely than Canadian-born respondents to use mental health services” (Kirkmayer et al., 2007, p. 301). So economic barriers would not seem to be a primary reason for this disparity.

One answer could be, according to the authors: “Low rates of mental health service use may not indicate a problem if distressed immigrants make use of other sources of help” (Kirkmayer et al., 2007, p. 300). So, if immigrants have other sources of support, such as family and community networks, what initially appears to be a case of large groups not receiving needed treatment, may not, in fact, be an issue. However, the study did not find such an alternative route is routinely being taken by the study subjects:

This study clearly demonstrates that immigrants are less likely to make use of mental health care when they are distressed, even in a setting where universal health insurance and ready access to community and hospital clinics make services easily accessible. This underuse of mental health services cannot be explained by compensatory use of other community sources of help or other traditional or alternative medicine. Nor can the lower rate of use among some immigrant groups be accounted for simply by a shorter length of stay in Canada and consequent unfamiliarity with the health care system. The implication is that other aspects of immigrants' social position or cultural background influence the help-seeking response to somatic or psychological distress or life problems. (Kirkmayer et al., 2007, pp. 302-303)

So, the challenge of ensuring access to services is more complex than simply making those services available. An active outreach program, which works within and in the context of specific cultures, may be needed. Further research into the question of why these immigrants
often do not seek treatment, and whether and how this should be addressed by the health care system, is also needed.

**Medication & Counseling**

Very little research was found on the topic of attitudes toward treatment with medications. Only one study was found by this writer: Nadeem, Lange and Miranda (2008) found that female African immigrants were “significantly less likely to indicate interest in medication than were U.S.-born white women” (Nadeem et al., p. 99). In fact they found that female African immigrants were approximately one-fourth as likely to believe that medication could help, relative to the non-immigrant white population. “it is clear that ethnic minority women may have some concerns about the utility of or the negative consequences associated with taking medications to help with emotional problems” (Nadeem et al., 2008, p. 99). It would be very helpful for researchers to examine the reasons for this apparent disparity. It would also be helpful for practitioners to understand how these populations do address their mental health symptoms, if not with medication.

Nadeem et al. (2008) also found that African immigrants tended to show a much greater interest in counseling and therapy than in medications. They stated that “over two-thirds of the women in our study viewed individual counseling as helpful for dealing with emotional problems” (p. 100). This result is somewhat encouraging, if it is true also of other groups, or of wider populations. What would also be interesting would be a comparison of immigrant attitudes towards counseling compared with attitudes found in Western populations.

**Therapeutic Outcomes**

This writer hoped to find some existing research on therapeutic outcomes and specific approaches that work within the larger context discussed above. However, although there is
some limited research on Somali views of mental health and mental health needs, and how their spiritual beliefs affect their overall approach to their mental health, no research was found on specific therapeutic outcomes within the Somali community. Additional studies would be very beneficial for practitioners and Somalis alike. Evaluating what Western treatments seem to work best in the Somali cultural context, as well as which treatments or approaches do not seem to work well, is essential in order to provide a framework of evidence-based approaches for practitioners, as well as Somali immigrants themselves, upon which to base treatment decisions. What works well for other populations may or may not work well for a specific cultural group, and further research is needed. Of particular interest would be a study evaluating techniques and approaches used by Somali mental health practitioners in Western contexts, and the relative results obtained. It seems likely that a practitioner who shares the same cultural background as the patient, but who has also been trained in the Western model, has great potential to be able to develop a synthetic approach, incorporating aspects from both cultures. It seems likely that such an approach would offer significant advantages, but further research is needed to answer these questions more definitively.

Notwithstanding the relative lack of existing research, there is at least one published study that we can review and discuss for context. Sargent and Larchanche (2009) argue that an approach which integrates the concept of ‘cultural difference’ is by far the most effective paradigm. Rather than viewing mental health or mental illness solely through the lens of their Western conceptions, practitioners who view their patients/clients as members of that person’s own cultural traditions, families and societies, will be much more successful. They argue for an approach based on ‘ethnopsychiatry’, which incorporates the client’s cultural background, including spiritual beliefs, conceptions of his/her family and societal roles, etc. As Sargent and
Larchanche (2009) state, “ethnopsychiatry draws on psychoanalytic theory, anthropology, sociology, linguistics and psychology” (p. 4). They go on to state that their approach is based on the premise that migrant suffering is most effectively alleviated by situating it in the cultural context. For migrants from West and Central Africa referred for ethnopsychiatric intervention, this has meant prioritizing the use of syncretic forms of ‘African’ healing…the patient or family members are encouraged to present their perspective on illness etiology, including the possibility of mystical causes of ill health or social problems. Treatment may involve group psychotherapy as well as use of sacred objects and rituals proposed by the therapists.” (Sargent & Larchanche, 2009, p. 10)

Essentially, one size does not fit all, especially in the case of different cultural and experiential histories, and practitioners must adapt, or inevitably be less effective, and our patients experience less helpful outcomes.

Sargent and Larchanche (2009) also point out that the context in which this approach has been proposed, however, is one that could be described as an opposite paradigm, one in which cultural and ethnic viewpoints are discounted or dismissed entirely. The authors are writing of the French mental health system, but their observations could also be applied to many Western models of therapeutic psychiatry/psychology, in which the ideal is considered to be an approach which effectively moves culture off to the side, in favor of a sort of universal humanistic approach: “This emphasis on secularism and universalism presumes that attention to ethnic and cultural difference is not only irrelevant, but inappropriate” (Sargent & Larchanche, 2009, p. 3.) In other words, people are people, and in order to most effectively treat illness, the practitioner must attempt to remove the extraneous, the cultural aspects and features of the patient, aside, to more clearly see the individual and his or her illness.
However, despite this universalistic approach common in Western nations, in many cases in a practical sense, immigrants are, in fact, treated within a cultural context, at least to some extent:

Attention to ethnicity has been central in organizational efforts to address health and social welfare issues for West and North African migrants. This is especially the case in the domain of mental health services, which has seen a proliferation of clinics, ‘centers’, private associations and state-funded organizations since the late 1970s targeting migrants identified as needing psychiatric intervention. (Sargent & Larchanche, 2009, p. 3)

So within the paradigm that essentially denies the utility of attention to cultural relativity, the authors find some positive signs of a developing parallel cultural awareness.

**Provider Engagement & Probable Outcomes**

With the existing research as a backdrop, we can speculate on certain likely outcomes, tendencies and consistent behaviors with respect to utilization of mental health services by Somali immigrants in the West, as well as how the therapeutic outcomes they experience may be likely to differ from their peers born and raised in the West.

Undoubtedly the most apparent theme is family and cultural connections, and how important these are to most Somalis. Because of the cultural attitudes promoting the search for assistance within the social group, and what is effectively a prohibition to seek assistance outside that group, Somali immigrants would seem less likely to use help that is available, and therefore less likely, we can presume, to experience positive outcomes, at least as defined by the Western model. Add to this the strong expectation that pain be endured in silence, as well as only the most extreme symptoms being viewed as worthy of note, and the prognosis for many of these
immigrants is likely to remain, unfortunately, somewhat poor in the near term, again based on Western views of what constitutes a positive outcome. However, as with any new immigrant group, the more they become acculturated (the earliest arrivals have only been here in the West for 20 years after all) the more their children engage with the new society, there is hope that a greater level of trust and participation in our mental health system can be expected.

And on the other side, mental health professionals in the West have only relatively recently begun the conversation on culture and treatment, and how to work with people from very different places and traditions. As we gain more experience and become more open to an essentially synthetic approach to treatment, we can also expect to increase our effectiveness. As has been the case with every other cultural group, these new immigrants can be expected to eventually assimilate to a greater degree than at present, but also to retain much of their original culture. The resulting mélange will be a unique creation, and it is only with the passage of time that we will be able to see what parts or specific aspects of that original culture will be retained.

**Clinical Implications--What Providers Should Consider**

The following is intended as a beginning for Western mental health practitioners who already work with or who are considering working with Somali immigrants. The points below are suggestions only, and by no means should be considered an exhaustive list of cultural considerations, which is not possible in any event. These suggestions are intended as a place to start.

1) If they make it into your office, you can be reasonably certain that they are experiencing extreme difficulties and symptoms. They have likely already tried and exhausted their primary sources of support, such as family and social networks and spiritual/religious
guidance. Coming to see you is likely an act of desperation, and your patient is probably highly symptomatic, even if you can’t see it on the outside.

2) Be very aware of gender issues. For example, it is considered inappropriate by many Somalis for a male to shake hands or otherwise physically touch a female. It may in fact be essential for female patients to be assigned to work with female providers, and male patients assigned to male providers.

3) Your patient is likely to feel a sense of shame and embarrassment at working with you. Yes, your Western patients also commonly feel the same things, but it may be more pronounced in this population, and may go much deeper. In some cases in fact, coming to see you may constitute a sort of betrayal of their family and value system, and it will be critical for you to be aware of this. Proceed with caution, understanding and cultural respect, as always.

4) Be aware of a potentially more holistic, collectivistic view of themselves and how and where they fit in. The family and social group carry a tremendous amount of influence, much more than is typical among Westerners in most cases. Although there is somewhat limited evidence for it at this time in this specific population, also be aware of issues such as a potentially higher rate of somatization, and of an almost cultural somatization. There is more evidence of these tendencies among more rural and/or traditional cultural groups which may apply here also. And, because the culture lacks the words and the concepts to match up exactly with our words and concepts in these areas, what we have no trouble describing as depression, or anxiety, or hallucinations, could be presented to you as a sensation in the abdomen, or a problem with the sensory organs, or any number of other experiences.
5) Consider the concept of ongoing trauma, and how this could very well be continuing to exacerbate your patient’s condition. Always be thinking about PTSD. It is difficult to imagine having had the experiences many of this population have had without at least a great many of them developing PTSD symptoms.

6) Consider your patient’s religious and spiritual needs, and remember that this part of your patient is likely to be extremely important to them, certainly much more so than for the majority of Westerners. Even the most devoutly religious American, Australian or Swede is unlikely to experience their religion/spirituality in the same way or as deeply, or be as intertwined with their belief system. This will not always be true, of course, but start from this place, assess, and adapt as needed.

7) A Cultural Formulation Interview, as described in the DSM-5 on pages 750-757, can be helpful and is recommended whenever possible, particularly for practitioners who may not have experience with Somali patients.

Final Summary

In studying the contributing factors to diagnoses of PTSD among Somali adolescent immigrants, Ellis, MacDonald, Lincoln and Cabral (2008) found that “while to date literature examining post-resettlement and mental health of refugee adolescents has focused on stressors such as financial or acculturative stressors, our study suggests that perceived discrimination is strongly associated with mental health outcomes even after other stressors and historical factors have been taken into account” (Ellis et al., 2008, p. 190). These results are cited here to illustrate the wide-ranging nature of factors that are likely to be involved in Somali engagement with Western practitioners and the therapeutic outcomes they experience. While cultural beliefs or attitudes such as the importance of stoicism, reliance on social networks, and linguistic...
differences which can cause confusion may seem somewhat obvious in hindsight, other potential factors, such as the degree of perceived discrimination experienced by an individual, may not be so intuitive to researchers, or to healthcare providers. Another example of this issue is the study cited earlier by Kroll and Fujiwara (2011), in which 80% of Somali male patients under the age of 30, who presented to one psychiatric clinic in Minneapolis, were diagnosed with psychosis. This extremely high percentage of psychosis, described by the authors as over five times higher than similarly-aged male patients of other cultural backgrounds seen at that same clinic, initially begs the question of how accurate these diagnoses really are. Certainly it is true that young Somalis have, by and large, experienced a great deal of trauma, much of it during their most formulative years, whereas their older counterparts may have been better prepared, simply by virtue of being older when the trauma was experienced, to process and recover from that trauma. However, the disparity is so large that might it be the case that something else is going on here, such as a key difference in cultural perception or belief, or a problem with an assessment tool which has been validated and perhaps used successfully with Western patients for many years, but may not, for whatever reason, be as reliable with the Somali population? As Delbar and colleagues state,

The different cultural perspectives of patients and health providers often affect the nature and the effectiveness of the health services provided to the population, especially to immigrants, minorities and refugee populations. It is therefore essential that health providers make every effort to familiarize themselves with the cultural backgrounds and identities of their patients and equip themselves with the competencies to engage actively and in the spirit of partnership with their patients, in order to provide them with appropriate and acceptable care” (Delbar et al., 2010, p. 285).
On the other hand, the high figure of psychosis could be more or less accurate. When we think of the aforementioned trauma, combined with the reticence to only seek treatment for the most severe of symptoms, it becomes much easier to imagine that this may be accurate. If the entire population has been traumatized, and the individuals will only ask for help outside their social networks when they feel they have no other choice, this then makes a great deal of sense.

These are the types of questions that must be asked by researchers, if the Western psychiatric and psychological communities are to be able to adequately serve this population, as well as possibly a great many other populations in the future. Particularly in the established, industrialized Western countries, who are actively receiving large numbers of refugees from around the world with increasing frequency, and more importantly, with increasing diversity, these questions are essential. Certainly it will never be possible to achieve, through development of culturally-sensitive assessment tools and treatment models, anything approaching a perfect method of working with cultural nuances. However, through the effort, we are likely to gain not only dramatically more effective tools and treatment options for culturally diverse groups, but we are also likely to improve our standard tools and models as a result. Further research is urgently needed in these areas, and this writer assertively calls for it, particularly in the United States, where we have, clearly, the largest diversity of immigrant cultural groups of any country in the world. It was striking to this writer to find during the course of his research, that very few of the studies that have been conducted thus far on Somali mental health have been done by researchers in the U.S. Most of the available research has been conducted, in fact, in countries hosting only a few thousand Somalis, and in some cases, in cities or regions which may have only a few hundred individuals. Not only does the U.S. now host the aforementioned wide variety of cultural groups, but Minneapolis has one of the largest, most concentrated populations of
Somalis of any city after Mogadishu, the capital of Somalia. Concentrated where it is within the city of Minneapolis, largely within *five miles* of a world-class, major research institution (the University of Minnesota) this writer asserts that the Somali population here in the U.S., particularly in Minnesota, offers researchers in the area of Minnesota the important opportunity to take the lead on this urgently-needed work.
References


