Impact of Violence and Torture: On African Families’ Mental Health

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Abstract

This paper will discuss the impact of violence and torture as an everyday reality for families in many African Nations. Implications for mental health professionals working with immigrants who came from Africa will be explored. This paper reviews the literature on experiences of African immigrants who have gone through trauma and torture with a focus on women. These women come with the hope that they will be able to reconstruct their life from trauma they have experienced in their country, only to be disappointed and re-traumatized. The paper traces a real life story of one such woman and draws upon my extensive similar experiences as an African woman and a mother, as a community leader, as an interpreter at The Center for Victims of Torture in Minneapolis for more than ten years, and other events that happened in the community.
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Dedication

This work is dedicated to my beloved mother, Khadijah Abdullah Adam who always supported and empowered me. Her unconditional love, kindness, patience and encouragement throughout my life helped me to be a better mother and a wife. To my late father, Ahmed Mohammed Ibrahim, who helped me to learn the Qura’n and practice the religion to be a better Muslim. To my husband Mohammed Hassan Adam for his encouragement in my journey to pursue any endeavors I highly value in life. It would have been impossible to complete this program without his affirming support and patience. To my beloved son, Birra Mohammed H. Adam for his love and the technical support he provided me. Birra, without your help and patience I would not have done it. To My uncle, Ali Mohammed Ibrahim for inspiring and helping me understand the value of education. His support and encouragement is appreciated. To my aunt, Zabida Mohammed Ibrahim the courageous woman behind my higher education and success in life, who encouraged me to aim high and be the best I can be. To all my brothers, Abdul Hamid A Mohammed who supported me in many ways to achieve my bachelor degree, Abdul Rahman A. Mohammed, Abdul Basit A. Mohammed, Amin A. Mohammed, Omar A. Mohammed, my sisters and the rest of the family members who are always proud of me and encouraged me to excel.
Impact of Violence and Torture on African Families’ Mental Health

Introduction

Refugees and immigrants usually come to United States to escape persecution seeking a safe place for their families. Before migration they are targeted in their country of origin, for their ethnic, religious or political background. They suffer a great deal of trauma at the hands of their government. Torture experiences that the refugees share when they are interviewed are heart breaking. To save their lives, they run away to neighboring countries and become refugees. Here, at a refugee camps they are often traumatized by the hardship of refugee life. Some of them come with pre-existing health problems which add to their physical and psychological suffering.

Once the refugees go through resettlement processes they arrive at the host country. In the process of escaping they have lost everything. In the new country, language barriers and readjustment add more stress to daily life. For different reasons most of the time the whole family can not migrate together. Leaving behind loved ones is more stressful.

Department of Human Services, Bureau of Refugee Services (2003) defines refugee as a person who meets one or more of the following criteria: a) a person who has crossed an international border and who is unable or unwilling to gain the protection of his or her home country; b) a person who has been persecuted or has a well-found fear of persecution based on race, religion, nationality, and membership in a particular social group, or political opinion; c) a person who is forced to leave his or her homeland and does not have a choice of country in which to resettle. In addition, people meeting these aforementioned criteria often are unable to make prior arrangements regarding inclusion of family members in the move or to transfer property. Refugees do not have an option to return to their home country. Finally, a refugee is
eligible for support and general assistance once resettled in the United States (as cited by Gashaw-Gant, 2004). Everything happens unexpectedly, so fast and a person has no chance to prepare to face refugee life that awaits her or him. As a result the refugee has to start life all over.

Aantu, an Oromo woman from Harar, Eastern part of Ethiopia was happily married with four children. Aantu’s family owned a business; a kind of a corner store referred to as ‘kiosk’ and lived a comfortable life. She worked hard alongside her husband Deema to make the business successful. Both of them labored more than ten hours a day, seven days a week and as a result they were able to own a second store. Aantu’s achievements are even more remarkable given the political and military context in which they occurred.

In 1991 the military regime in Ethiopia was defeated. The Oromo Liberation Front (OLF), the Eritrean People’s Liberation Front (EPLF), and the Tigrian People’s Liberation Front (TPLF) formed a coalition for transitional government. The three groups opposed injustice and inequality. The transitional government formed by these groups planned to hold democratic elections within two years of seizing control, but this never occurred.

In fact, EPLF and TPLF – blood relations (same tribe in different states) captured and encamped members of the OLF and later killed most of them. Many leaders and their allies escaped to Kenya, Djibouti and Yemen. Those who tried to escape from TPLF rebel troops often chose to take their own lives, drowning themselves in crocodile-infested waters instead of facing almost certain death. Those who could not escape, certain leaders and supporters of the OLF were imprisoned and tortured.

The new regime that called itself ‘The Ethiopian Peoples’ Revolutionary Democratic Front” (EPRDF) began to target Oromo businessmen and women, claiming they had helped the Oromo Liberation Front leaders succeed financially. Aantu’s husband, one such leader, was a
target. After several attempts, the soldiers subdued him at home, and moments after he was taken, shot him in front of his wife and children.

Shocked at witnessing this tragedy Aantu asked, “What crime has he committed to deserve this?” They said, “Your husband provided shelter and helped the OLF leaders financially”. They dragged her husband’s body from the scene and warned her not to pursue them on penalty of death. The helpless woman collapsed with grief and wept as her children held fast to her and tried to restrain her.

After a few weeks, the soldiers returned to ask Aantu for the names of Deema’s OLF contacts and their hiding place. They asked her to reveal the ways in which Deema had betrayed the new regime. While she begged them to desist, they would not do so. The rebels threw Aantu to the ground, handcuffed her, and placed her under arrest. Pregnant when taken, she gave birth to a boy, her fifth child, in prison. She was released after appearing in court and found innocent. After a month and a half she was arrested again. During her second prison term, she was tortured and raped repeatedly by a group of soldiers. She became self-loathing, felt dirty and degraded.

Family friends, a couple preparing to resettle in New Zealand, offered to take Aantu’s infant son Dursa with them. Aantu agreed because she was not sure what would happen to her and wanted to save the boy. So, the child embarked for New Zealand with Rooba’s family.

Concurrently, Aantu’s captors released her again on bail. She knew for sure that the soldiers will come back to arrest her again. Therefore she managed to escape to Kenya where she was traumatized by Kenyan police that knocked at her door in the middle of the night. Aantu thought that there will be no safe place for her. After suffering as a refugee for some years, she joined her older son in Minnesota with her two other children. Even though, Aantu felt safe in Minnesota, she did not stop worrying and feeling sad because she was separated from her
youngest son who was still in New Zealand. She was depressed, suffered from lack of sleep and poor appetite most of the time. The doctors could not understand her physical symptoms because she did not share her traumatic experience with anyone. She felt shame to share her prison experiences through interpreter. Later through the encouragement of the interpreter and her close friend, Aantu was able to tell her story. The doctor and her therapist wrote support letters to strengthen the visa case for her son. After remaining for roughly a year in Minnesota, her son, who had been separated from her for twelve years, joined her. Aantu felt like it was a miracle.

Experiences of Refugees/Immigrants

Aroche and Coello, (2004 p.58) stated that one of the issues that make the experience of refugees so difficult is that their plight does not stop when they are able to flee from their country. For many, this is only the beginning of a long, arduous, and often extremely traumatic process. In the same way that some refugees were born and have matured in a context of war and conflict, some refugees live significant portions of their lives and developmental processes in precarious situations in refugee camps, with uncertain prospects and limited access to essential commodities. The sub-culture that develops in such permanently transient environments is an important factor in shaping identity and influencing worldviews.

Immigrant women from African countries usually come to the host country with their children. The husband is either missing, in prison or killed. The woman who has experienced trauma in her country and refugee camp struggles in the new country to learn new language, new culture and bring up children alone without support from anyone. Her social and cultural life has been eroded in many ways. The stresses from previous experiences and becoming familiar with the new environment can cause her to suffer physically and psychologically.
For most women learning English is an ongoing struggle. Refugees get frustrated when they are not working and not able to support their families here in the United States as well as families that are left behind. Not knowing English is the biggest barrier for refugees from non English speaking countries and most of them attend language classes (ESL). Many refugees reported that after going to this class for more than three years, they did not learn the language.

Role shifting in the family is hard on parents. Children learn the language faster and parents rely on their children for interpretation. Discipline is another struggle for parents because they fear that children might call the police on them if they use traditional and accepted in many countries physical punishment. Parents feel powerless.

On the other hand a man who survived torture and arrives in the host country feeling powerless with less ability to provide for his family because of unemployment or status change. He has to figure out the new life in the new country. It is frustrating for a man when he is not able to find a job and his wife assumes the role of bread winner. The vulnerable man needs to heal to be able to function and support his family.

Children on the other hand suffer from having witnessed violence in their native country. At their new country they try to fit in and belong. Some of the children suffer from bullying by other children in the school. As mentioned above, the parents are struggling with their past experiences and trying to adjust to their new life. When these parents are emotionally not present for their children, children in return suffer because parents are occupied with their own trauma.

Recently two young Somali men killed two Somali shop keepers and an Oromo customer in Minneapolis. On January 27th, 2010 the Minnesota Public Radio (MPR) midday program presented a three-part series about Somali Americans. It was discussed why Somali young boys join gangs. It was mentioned that these young boys struggle to adapt to a new culture, experience
identity crises trying to fit in and language barriers. It was also mentioned that parents talk about the beautiful beaches of Somalia while all the kids remember is a war torn Somalia. A young man whose life improved when he was treated for mental illness explained that parents do not understand about mental illness so they may not be supportive. The community rejects young boys who behave differently and are perceived as deviant behavior. These young boys become isolated because of lack of knowledge about mental health. The community needs to work hard to raise awareness that mental illness is physical illnesses. The community needs to be educated and parenting skills are also crucial for refugee parents to help them understand the behavior of their children.

Halcon et al. (2004) stated that “Somali and Oromo refugees, including youth, have survived extreme trauma. They have demonstrated remarkable strength as survivors of war and torture throughout their relocation process, but many continue to experience mental and emotional problems” (p. 24). The authors recommended attention to needs of youth, especially to isolated females. They also argued that cultural barriers and stigma are a major problem for immigrants and contribute to their reluctance to pursue western mental health services.

Murray et al. (2002) stated that, in an era of conspicuous political violence and war, civilian populations suffered both bloodshed and the loss of social and cultural foundations which provide stability and connectedness (as cited by Robertson et al., 2006, p. 578). Gasseer et al. (2004) stated that women civilians often experience the highest burden during conflict and they may be subjected to all forms of violence, including torture (as cited by Robertson et al., 2006, p. 578). Ashford et al. (2000) adds that amidst food shortages, the collapse of health infrastructure, increasing chaos and displacement, women struggled to maintain responsibility for their families’ physical, emotional and financial well-being during war time (as cited by
Robertson et al., 2006). It is hardly extra ordinary; therefore, that suffering and resilience are often part of the legacy which accompanies refugees to countries of resettlement.

Eisenburch (1991) explained that “when women immigrate as refugees or immigrants, their social and cultural frameworks may be further eroded through the multiple losses of language, extended family, social belonging, cultural values, social and economic status, and general connectedness to community” (as cited by Robertson et al., 2006). Sideris (2003) stated that successfully navigating the resettlement experience requires resilience, clearly demonstrated as refugee women exercise power, gain agency and become actively involved in trying to improve their health and the health of their families (as cited by Robertson et al., 2006).

“Nevertheless, many women live often in poverty and isolation, and may believe themselves disempowered. They feel less able to reduce family stress than they did before immigration (Mollica et al. 1987, D’Avanzo et al. 1994, Fox et al. 1994, 1995, Iglesias et al. 2003). Their vulnerability to isolation is exacerbated by lack of general education, literacy and English language skills (D’Avanzo et al. 1994). Moreover, Frye and D’Avanzo (1994) identified broken ties and the ensuing grief as the most compelling theme in the lives of immigrant women” (as cited by Robertson et al., 2006)

Sylvia Karcher (2004, p.409) stated that, women who have been exposed to sexualized violence often report that they experience the physical boundaries of their bodies as though they are permeable resulting in feeling of defenselessness. Here their memories manifest themselves as anxiety, depression, and somatoform pain states, such as headache and back pain, abdominal ailments, bladder disorders, indigestion, menstrual disorders, feelings of disgust, and eating disorders. They describe their bodies as not belonging to them, as alien, stained, and depreciated.
Severe dissociative disorders, which can be interpreted as a protection against shame, are conspicuously frequent.

The article “Somali and Oromo refugee women: trauma and associated factors” by Robertson et al., discusses experiences of Oromo and Somali refugee women who were victims of political violence. These women resettled in the United States after a long journey of being displaced from their homeland. The authors talk about demographic characteristics, trauma, and torture these refugees experienced as well as health and social problems they are facing now while going through life adjustments. In their country women carried the highest burden during the conflict. It was revealed in this article how these women struggled during war time, to maintain responsibility for their families despite the utmost difficulties they faced including physical and emotional problems.

Robertson et al. (2006) stated that nearly all refugees have experienced losses including extended families, language, cultural values and general connectedness to their community. Many have suffered multiple traumas including torture. The study on Somali and Oromo women found that older women with large family were statistically more affected by torture and trauma events compared to younger women. This study also found that women were exposed to torture at a higher rate as compared to men.

Robertson et al. (2006) believe that “the sadness of the refugee women is not psychological pathology”. The authors added that “recovery from the losses associated with political violence is often less likely to occur in a care provider’s office than through a gradual reconnection to the activities of day-to-day life” (Robertson et al. 2006).

According to Toole (1994), “during the past several years, many ethnic conflicts in diverse regions of the world have forced millions of civilians to flee their homes and seek refuge
in other areas of their country or neighboring countries”. Author explained that this “epidemic” of population displacement has burdened both host countries and the international community as they struggle to furnish protection and assistance”. Additionally Toole reminded about “an urgent, unprecedented need to develop and implement methods to assess the public health needs of displaced populations” (p.200).

Toole (1994) stated that, “prior to the end of the cold war, most acute public health emergencies aggravated by mass population movements involved those who crossed international borders to escape political persecution or civil war. Once settled in the country of asylum, these refugees usually received the protection and assistance of the international community through the Office of the United Nations High Commissioner for Refugees (UNHCR)” (Toole, 1994, p. 200).

In this article Toole (1994) discussed the importance of rapid assessment of health problems in refugee and displaced populations. He argued that rapid assessment from the outset of crisis is essential to help organize an effective response with appropriate supplies of emergency foods, medicines and psychological services.

*Refugee Mental Health*

Watteres (2001) stated that for the past decade the approaches adopted towards the mental health care of refugees by national and international healthcare organizations have been the subject of a sustained and growing critique. Much of this critique focused on the way in which Western psychiatric categories have been ascribed to refugee populations in ways which, critics argue, pay scant attention to social, political and economic factors that play a pivotal role in refugees’ experience. Summerfield (1999) points out that “typically when most refugees are
asked what would help their situation they are much more likely to point to social and economic factors rather than psychological help” (as cited by Watters, 2001, p. 1709).

Garcia-Peltoniemi (1991) argued that “international data suggests that, compared with host country populations, refugees and immigrants experience increased rates of serious psychopathology”. “In the United States, research has shown that refugees and immigrants are at greater risk for depression, anxiety, and post traumatic stress disorder than are the general population” [(Barnes, 2001; Hauff, & Vaglum, 1995; Garcia-Peltoniemi, 1991)] (as cited by Gashaw-Gant, 2004, p. 1).

Barnes (2001) stated that “the previous experiences of refugees and immigrants, in their countries of origin, during flight, and in nations of first asylum (prior to arriving in the United States) place them at special risk for acculturation stress, mental health problems, and systemic health risks” (as cited by Gashaw-Gant, 2004, p. 1).

Keleinman (1988) suggested that effective diagnosis and treatment of these conditions demands a comprehensive understanding of cultural interpretations of symptoms, symptom expressions, and the meanings immigrant populations attach to these symptoms (as cited by Gashaw-Gant, 2004, p. 1).

There is much discourse regarding the phenomenon of specific cultural mental disorders. Westermeyer (1991) argued that there are no culturally unique psychiatric disorders, because all culture-bound conditions include the universally observed combination of psychiatric signs and symptoms.

Desjaraus, Eisenberg, Good, and Kleinman (1996) argued that societies draw on multiple healing traditions not only to treat mental illness and other psychological problems, but also to make sense of these maladies, to categorize them, to explain their causes, and to organize
personal and community resources in response (as cited by Gashaw-Gant, 2004, pp.1&2). There is a unique culture bound syndrome called Zar, a general term applied in Ethiopia and other parts of the world. Persons possessed by a spirit may experience dissociative episodes that include shouting, laughing, hitting the head against a wall, singing or weeping to mention few (American Psychiatric Association, 903).

Gashaw-Gant discussed about the mental health needs of East Africans in her article. She explains that little has been written about the perspectives of East Africans regarding mental health treatment and cultural concept. The study conducted a behavioral health project, was a model for providing mental health services to East Africans (Ethiopia, Sudan, Somalia and Eritrea-ESSEA) based on their worldview.

The project ESSEA provides mental health services by using holistic and culture specific technique to supplement existing mental health services. Evaluation indicates that the model is effective (Gashaw-Gant, 2004). The author suggests to professionals to look at other factors that impact mental health before treating individuals.

What helped the project to be successful according to Gashaw-Gant was working closely with four faith-based organizations as primary sources of outreach in a behavioral health and spiritual approach. She also said that the project developed what may be the first set of culturally appropriate bilingual health and mental health education material for East African refugees/immigrants. Gashaw-Gant said that through community education forums, the project successfully increased awareness regarding mental health issues.

The author, Gashaw-Gant stated that, “in East African culture, religion plays a major role and governs all aspects of life. Both Muslims and Christians believe that fasting and abstinence
are the best ways to strengthen the physical and spiritual aspects of the body” (Gashaw-Gant, p.13, 2004).

From the review, Gashaw-Gant discusses that “the research shows the existence of doctor-patient discrepancies in defining illness and expectations from treatment. Health providers usually respond to the literal meaning of the patient’s words failing to understand the concepts behind them”.

In her article, Gashaw-Gant talks about East African participants who believe disease is caused by divine, evil, spirits or witches and is seen as punishment. For mental illness they seek spiritual help not medical treatment. Christians use holy water for treatment. Muslim healers write verses of Quran with ink on a plate wash it with water and the ill person drinks it. Stigma with mental illness is strong in East Africans. Most refugees do not continue taking the prescribed medicine due to lack of knowledge about mental health problem and Western treatment (Gashaw-Gant, 2004).

The project ESSEA translated education materials for the community in Tigringa, Amharic, Somali and Arabic. Even though Oromo language is spoken by the largest group in Ethiopia, unfortunately the material was not translated into Oromiffaa (Oromo language).

The project demonstrated that integrative methods can be effectively implemented and can offer creative solutions to complex mental health issues. Gashaw-Gant suggests to professionals to be cognizant of effect of culture and continue to receive training. She also mentioned the importance of employing bilingual workers who can provide services to intended communities, training them thoroughly in the area of service and the vocabulary of the mental health field.
Gashaw-Gant (2004) stated that “Project ESSEA has proven to be effective in reaching the East African population in San Diego. The model, however, needs to be replicated. It is my hope that this project evaluation will serve as a template for a primary prevention model, with viable structure, created to serve the health and mental health needs of people from other cultures” (Gashaw-Gant, 2004, p. 120).

The Center for Victims of Torture in Minneapolis, Minnesota has been working with clients individually and in group settings to help in the healing process. To understand refugees’ health and serve them better, the providers of the Center reached out to schools and community centers in the Brooklyn Park area. Alice Tindi, from Kenya, is one of the social workers, who developed Minnesota’s first African Food Shelf for that community. The idea was not only to serve the community members with the food that is familiar to them, but also to facilitate a place for social interest, get to know one another and share ideas. This coming together gives them a chance to meet new people. It becomes an outing for grandmothers who are isolated and through this opportunity have a chance to socialize with other elder women in the community.

Refugee Health Practices

Toole, (1994) discussed that, “Since 1990, however, acute mass population migrations have occurred in increasingly complex and dangerous environments in which displaced populations remain trapped in their own countries where international conventions on the rights of refugees do not apply. In countries such as Liberia (1990), Somalia (1992), south Sudan (1992-94), Angola (1992-94), Bosnia and Herzegovina (1992-94), Afghanistan (1993-94), Burundi (1993), and Rwanda (1994), governance has collapsed, resulting in wide-spread anarchy, banditry, and violence”.
Toole, (1994) stated, “among refugees in Rwanda, Tanzania, Burundi, Zaire, bacillary dysentery has been the most important health problem. Among Somali refugees in Kenya, in 1991, a massive hepatitis E epidemic caused many deaths, especially among pregnant women”.

According to Toole (1994), “rate of acute malnutrition prevalence rates among refugees during the early, post-influx phase, have been unusually high, reaching 50% in the case of Eritrean refugees in eastern Sudan in 1985 (CDC). In Somalia and southern Sudan, acute malnutrition rates among displaced persons were as high as 80% between 1991 and 1993. Several scurvy epidemics have occurred in refugee populations in Ethiopia, Somalia, and Sudan; one of the largest outbreaks of pellagra since World War II occurred among Mozambican refugees in Malawi in 1990; and an outbreak of beriberi was reported among Bhutanese refugees in Nepal during 1993”.

Toole (1994) talked about how civilian populations, both those who were trapped in the areas of conflict and those who escaped to refugee camps, suffered severe public health consequences. He suggested timely public health assessment before mortality rates and malnutrition rates increase. Moore PS, Marfin AA, Quenemoen LE, et al. (1993) stated that community leaders, health workers, and religious leaders should be interviewed to assess the degree and nature of pre-displacement deprivation, pre-existing health problems, belief and behaviors, pre-displacement health service coverage (e.g., vaccination coverage) and relevant cultural attitudes to health services. The low immunization coverage in Somalia indicated that mass measles immunization campaigns were a top priority during the famine in that country in 1992 (as cited by Toole, 1994).

It is very important for service providers to understand refugees’ health and mental health, as well as their experiences prior to migration. This will help the service providers
determine what they are treating and how to treat. If rapid health assessment is in place for
refugees at the refugee camps, as Toole mentioned, mortality rate might go down and the needed
help will reach refugees in time to provide remedies.

Instability in any country causes everyone to suffer in general and women in particular.
They may be traumatized by political violence in a number of ways, having lived through
political conflicts, war, genocide, repressive regimes and colonial rule. Going through all these
and in addition being harassed by their own governments, makes life very hard for these women
where ever they go. In most cases women with children run away from this violence because the
husbands are either killed or in prison. They have no choice but to find a safe place for the rest of
the family. This requires a lot of sacrifices to health, contributed to by having to walk day and
night to cross the border, sometimes without food or water and facing the danger of wild
animals.

After arriving at their destination to supposedly a safe place, women might face another
danger—rape. By the time they cross the border, they have lost everything. Their homes, loved
ones and their country. Once they are at refugee camps which are usually over populated, the
safety of women continues to be at risk. They suffer greatly with their children from malnutrition
and physical illnesses. These women pay a high price in all the illnesses because of their
caregiver roles where they have a tendency to self-sacrifice and thus become self-deprived. It is
hard to imagine what refugee women with their children experienced. The saddest part is that
they are not getting medical or psychological treatment early enough, and at times it is not at all
available to them.

In most cases, refugee women have children who were exposed to war violence and are
traumatized. There are no male figures to serve as role models. After they resettle in any country,
their experiences haunt them because they did not get mental health treatment. It has not been discussed with anyone and the children have never talked about it. Later these women show symptoms of mental illnesses and their children express their problems either in school or by joining a group of other children with similar problems. Women and their children who came from war zones and have traumatic experiences must be assisted in their healing process with culturally appropriate healthcare and psychological treatment.

Parenting Issues in new Country and Skills needed

Raising children in any culture is a challenge. Parenting for refugees in unfamiliar environment adds more stress. Parenting styles in their country of origin is different from that of the new country. In Africa, parenting or raising children is not the responsibility of parents and family members only, the whole village is responsible. Most African parents expect obedience from their children and respect for elders. When parents have gone through violence, trauma and war, it is a challenge for these parents to give the kind of nurturing that their children need.

Gewirtz, Forgatch & Wieling (2008) stated that, “trauma research has identified a link between parental adjustment and children’s functioning and the sometimes ensuing intergenerational impact of traumatic events. The effects of traumatic events on children have been demonstrated to be mediated through their impact on children’s parents. However, until now, little consideration has been given to the separate and more proximal mechanism of parenting practices as potential mediators between children’s adjustment and traumatic events”.

Exposure to mass trauma typically disrupts the social system of care, protection, and meaning that surrounds individuals. Family relationships are often impaired, leaving family members feeling isolated, depressed, and incompetent to manage the many adversities facing them. It is increasingly emphasized that recovery after trauma is a process connected to the
family, social, and cultural contexts in which people live (National Institute of Mental Health, 2002) (as cited by Gewirtz et al. 2008, p. 177).

Gewirtz et al. (2008) discussed that little attention has been paid to the direct impact of the parent-child relationship on the sequel of trauma. They also mentioned in their literature how previous research on the consequences for mass trauma events has been directed towards individuals and is psychopathological in its orientation. They also talk about the limitation mentioned by other researchers who work in the field of trauma and how they advocate for the development of family-based interventions. The authors recognize that working with trauma using a lens focused on social interactional relationships is new field with few studies and no evidence-based intervention.

Gewirtz et al (2008) talked about the importance of parenting practice and the adjustment of the children. They propose interventions that strengthen parent’s capacity by helping them move towards available resources and encourage healthy interactions among the family members which in return help them adjust better. They also believe that parenting practices support children’s resilience post-trauma. Gewirtz and her colleague also said that several variables can influence the quality of parenting following trauma, the relationship between trauma exposure and child adjustment, and how intervening with parenting skills improves children’s outcome significantly. They pointed out that post-traumatic stress disorder is linked too, particularly if a child is exposed to repeated traumatic events.

Freud & Burlingham (1944) noted that, “war acquires comparatively little significance for children so long as it only threatens their lives, disturbs their material comfort, or cuts their food rations. It becomes enormously significant the moment it breaks up family life and uproots the first emotional attachments of the child within the family group” (p. 37) (as cited by Gewirtz et
al. 2008, p.181). Therefore, separation of children from parents causes more stress than the actual trauma event.

This understanding especially concerns the writer who is herself a refugee and a mother. As mentioned in earlier pages regarding refugee experiences, one of the most difficult stressors for mothers is the separation from their children. It is even more stressful for children who were left behind in several circumstances without their caregivers.

In general this article explains how a mother’s mental health influences children’s behavior problems. Gewirtz and her colleague stated that the outcome data from parenting intervention studies with children exposed to traumatic events can provide valuable information regarding the contribution of parenting practices to child adjustment and as tests of theoretical models of influence.

The authors suggest that an intervention with families where parent(s) have preexisting or severe mental health needs must address both individual psychopathology and parenting skills. Where children have significant post-traumatic stress symptoms, (i.e., meet diagnostic criteria for PTSD), a parenting intervention would be accompanied by individual child trauma-focused treatment (Gewirtz et al., 2008)

Forgatch & Ogden (2006) stated that from a practical standpoint, there are several reasons to consider Oregon Model of Parent Management Training (PMTO) as a “first-line” or universal intervention for families exposed to mass trauma events. Unlike treatment interventions, PMTO can be implemented by well-trained paraprofessionals. This is a critical factor for the many post-trauma environments (in the USA and especially in developing countries) in which mental health professionals are scarce resources. PMTO can be delivered in different modalities, including community, small group, and individual family formats. While
yet to be tested for populations selected by virtue of their exposure to mass trauma, PMTO has been implemented with diverse cultures and in several countries beyond North America (as cited by Gewirtz et al. 2008 p.187)

*Interpreting Rules and Challenges*

One day a Somali patient came without an interpreter where the writer worked as a Medical Assistant. The doctor needed help with interpreting. The writer learned Somali language as she was growing up by listening and talking to friends and had not used this language for a long time. As the saying goes, ‘if you don’t use it you lose it’. Most of the Somali words are similar to Oromo words, but using it in a medical or a mental health setting can be a challenge.

The doctor wanted to know if the patient had liver problems. The writer struggled to recall how to say liver in Somali language. Again Hepatitis B came up and the concept has to be explained to the client. Knowing the language and interpreting accurately to convey the correct message are very different.

The role of professional interpreter is to understand the client’s problem and have the ability to send the true meaning or the message across. It is important for the interpreter to be ethical and to interpret as accurately as possible what has been said. The interpreter does not add to or omit from what was said by the client or the provider. The professional interpreter’s job is not to talk about his or her experience in the session but to interpret the client’s story. A good interpreter can work as linguistic and cultural bridge between the client and the service provider.

Krog (2007, p.225) stated that, “through translation we could access our deepest emotions and feelings. Interpretation and translation is absolutely necessary if health, healing and transformation are at stake”.
Professional interpreters help the health provider to better understand the refugee or immigrant client’s problems and his or her world view since poor interpretation of illness, what it means to the client, and how it is perceived culturally could lead to misunderstanding. It is necessary to find a qualified interpreter who can bridge the gap of cultural differences. Through the service of a good interpreter, the necessary care can be delivered.

Scarry (1985) & Danieli (1998) stated that “in order to start the process of healing, one needs to find words for one’s experience. It seems that the closer the words are to the experience, the better the handles to get hold of the experience and take control of it” (as cited by Krog, 2007, p.226).

In his book Culture and Mental Health, Leslie Swartz (1998) underlines the importance of translation and interpretation in the area of health. Swartz explores four views of the interpreter’s role: the invisible interpreter, the interpreter as culture broker, the interpreter as junior colleague and the interpreter as client advocate. He also explores several problems that could arise in such a relationship (as cited by Krog, 2007, p.235).

Krog (2007) suggested that, the interpreters during Truth and Reconciliation Commission (TRC) process be close to invisible, it seems that if the interpreter is physically not present, it can create an important sense of direct communication with the interviewer. The other suggestion was that the interpreter should be a cultural broker afterwards to clarify their own questions and assumptions.

In a country trying to move out of past discrimination and a highly uneven set of skills, translation is a crucial strategy for survival, not only for all the untranslated narratives, but to free us (South Africans) from those who assume that they can translate the untranslated through their
own perspectives, or worse, those who believe un-translated means not worthy of the trouble of translation (Krog, 2008 p.236).

Krog (2008) argued that, “translation creates space for one’s heart in a language. Translation allows us to understand the fullest extent of one’s personality expressed in the native and the most authentic language. Translation lets the osmosis of human knowledge take place between cultures. Translation ensures that all kinds of concept are being brought into one’s language for which one has to discover equivalents, which in turn, leads to a more perceptive and empathic patient, doctor and interpreter. Translation always brings empowerment with it”. “In one’s mother tongue one has access to the entire majestic pipe-organ of one’s body and brain and all its registers of emotion and observation; in the dominating language, one often tries to express oneself on a toy piano. Allow the patient to use everything she or he has, and allow the doctor to have a nuanced conversation with her or his client” (p. 236).

During apartheid in South Africa, the Whites dominated for three hundred years. Blacks were looked down upon and their voices were not heard. This journal, “My heart is on my tongue: the untranslated self in a translated world is about the importance of accurate translation or interpretation of a language. It also explains how the content of the issue can be changed or understood completely different from the original. In the process of transcription, if some of the words are mistranslated, the meaning of the content changes. The author stated that the South African Truth and Reconciliation Commission (TRC) was the first body to provide translation in all the languages of the country.

Krog (2008) explained about one Truth and Reconciliation Commission testimony and one Bushman story. Both were translated from indigenous languages and pose enormous moral
dilemmas. Krog explained that when the narrative was read from Western perspective it seemed ethically problematic, whereas the narrative interpreted in an indigenous worldview made sense.

Krog discussed about Mrs. Konile’s testimony whose son, Zabonke, was murdered by the security police. Her testimony was not translated correctly and the transcriber also made a mistake. Through the cultural and geographical knowledge of her two colleagues, ten years later Krog translated it correctly it made perfect sense. With the accurate translation they learned that Mrs. Konile didn’t see the goat, she dreamt about the goat. The word ‘dream’ was omitted in the translation. As Xhosa cultural sacrifice, the goat was an indicator of bad news to come (Krog, 2008). This article illustrates the importance of accurate translation and interpretation.

Some refugees do not speak the English language at all and some have limited English ability. It is mandated by law to provide an interpreter for such clients. Therefore, to be able to ascertain the client’s problem, it is impossible without the help of an interpreter. Refugees feel comfortable when they work with an interpreter for some time. They like to work with a familiar interpreter who has earned their trust. Refugees’ trusts have been violated by their own government and sometimes by friends. Therefore trust is very important and can only be established over time.

In a mental health setting, interpreting can be a challenge. There is no word for word translation for interpreting in Oromo language. The concept has to be explained to the client to make sense. The clients usually talk about their many losses, especially the loss of one’s country, which painful to anyone who will not be able to go back and visit. The writer was usually reminded of her own losses by listening to clients’ stories. It is unique and close to the writer because she is of same background. During interpreting for any client, the good and bad experiences of the client are received first by the interpreter before the therapist. A support
system is needed to educate the interpreters about how to take good care of themselves and how to manage transference. During therapy, the interpreter’s role is to deliver as accurately as possible what was said by the client as well as the therapist. It is important for the interpreter to understand that it is the client’s therapy, and also not to interrupt the flow.

One challenge of interpreting in a medical setting is convincing the patients not to expect a prescription every time they visit the doctor’s office. Most African refugees do not understand why the doctor orders several tests. They come from a culture where medication is guaranteed by visiting a doctor or a traditional healer. Refugees who have experienced trauma usually complain of physical pain. The doctor tries to treat this pain not knowing what is beneath that pain. The client who is stressed because her children are still in a refugee camp might not think it is important to raise this issue with the doctor. Usually the doctor finds out about the stress accidentally. May be that morning the client’s children called and told the mother that they were rejected to immigrate to United States. The client might be teary and frustrated by the bad news from her children. This is how the doctor discovers the sources of her stress and refers the client to a therapist. Healing practices differ greatly in Africa from that in the West.

Boundaries in cultural aspect

Barnet (2007) stated that boundaries and multiple relationships have been widely addressed in psychology’s professional literature in response to, and as a result of, the great challenges they present to psychologists. In Pope and Vetter’s (1992) national survey of the challenges and dilemmas faced by psychologists, those of “blurred, dual, or conflictual relationships” were reported by respondents to be the second most troubling ones faced in their day-to-day practices (p.399). Despite guidance being provided in the American Psychological Association’s *Ethical Principles of Psychologists and Code of Conduct* (APA, 2002), psychologists are continually
confronted by situations that do not fit nicely into easily applied standards. And regardless of psychologists’ good intentions, they may often find themselves in situations with no easily discernable “right answer.” Therefore, it is suggested that psychologists need a clear understanding of the concept of boundaries and multiple relationships, as well as the relevant standards of the APA ethical code and applicable state laws. In addition, psychologists should be familiar with models of ethical decision making and should have the ability to apply them in a thoughtful, respectful, and flexible manner, eschewing attempts to rigidly adhere to strict admonitions that may overlook nuances of situations and the best interests of clients.

The standard of the AAMFT Code of Ethics (2001, 4.1.): Marriage and family therapists are aware of their influential position with respect to clients, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships with clients that could impair professional judgment or increase the risk of exploitation. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists take appropriate precautions (Corey, G., et al. 2003).

The ACA Code of Ethics and Standards of Practice (1995, A.6.a.): Counselors are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of clients. Counselors make every effort to avoid dual relationships with clients that could impair professional judgment or increase the risk of harm to clients. (Examples of such relationships include, but are not limited to, familial, social, financial, business, or close personal relationships with clients.) When a dual relationship cannot be avoided, counselors take appropriate professional precautions such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no exploitation occurs (Corey, G., et al 2003).
It is widely accepted in the professional literature that boundaries may be crossed without harm occurring to a client (Lazarus, 1998; Smith & Fitzpatrick, 1995; Williams, 1997; Zur, 2001). For example, it is considered acceptable to extend the time of a psychotherapy session when a client is in crisis, to hold a psychotherapy session in a client’s home for the homebound individual, to shake a client’s hand or touch him or her on the forearm or shoulder as a means of comforting a grieving client, to share some personal information that is consistent with the client’s treatment plan and would help achieve therapeutic gains that might not otherwise be achieved. It is similarly accepted in the professional literature that boundaries should not be violated (Barnett, 2007, pp.401-402).

The people in Ethiopia are comprised of many diverse ethnic groups with different historical, cultural, and religious background. The Oromo people are one of the largest ethnic group in Ethiopia. The three religions that the Oromo people practice are Islam, Christianity and traditional practice called Waaqeffata. In general, people from Ethiopia shake hands and even hug the opposite sex because that is how they great one another. For Muslims it is different, women usually do not shake the hand of a man. In Islam, it is not allowed for any man to touch a woman outside his family members. For treatment, usually a Muslim woman feels comfortable to see a female doctor or therapist. This does not mean that a Muslim woman cannot see a male doctor or therapist, but she may prefer a female when possible. Provider needs to be careful when they are not familiar with the culture or religion of the client. For providers doing research about clients’ culture, religion and background could help them better understand their clients.

Barnett (2007) stated that, “Thus to cross boundaries may be considered clinically relevant and appropriate. In fact, to not cross some boundaries might be seen as inimical to the goals of the psychotherapy relationship. For example, professionals must consider culture and
other aspects of diversity that are relevant to boundaries. For some clients, culturally based
differences exist in personal space, the use of touch, and self-disclosure. To pull back physically,
refuse a touch on the arm or a hug, or to refuse to share personal information about oneself might
be alienating to the client and have a harmful or negative impact on the treatment relationship.
Such action might be viewed as cautiously attending to ethics standards and risk-management
practices, but failure to attend to the potential impact on clients may also cause harm”.

Barnett (2007) argued that although avoiding all boundary crossings may in fact help
prevent boundary violations from occurring, doing so is not seen as realistic or practical, and the
result would likely be a sterile and artificially effective one. As Borys (1994, p. 267) stated when
considering how psychotherapists address boundaries, “the motive is therapeutic effectiveness
not defensive practice” (as cited by Barnett, 2007, p. 403).

Determining when crossing a boundary becomes a boundary violation may pose a more
difficult challenge for well-intentioned clinicians. Thus, to use touch may be clinically relevant
and appropriate for one client, but for another with a history of sexual and physical abuse, the
same action may likely be construed as a harmful and unwelcomed boundary violation. In
summary, one person’s intended crossing may be another’s perceived violation. A thoughtful,
premeditated approach with open discussion with the client before engaging in actions that may
be misinterpreted or misconstrued is strongly recommended (Barnett, 2007, p.403).

A woman who has experienced torture and rape might be suspicious of any move made
by any man. It is hard for her to differentiate between positive and negative intention.

Perception of Mental Health in African Refugees

Van Dyk and Nefale (2005) stated that Africa is a continent that comprises a diversity of
cultures, and this is evidenced by the different cultural practices that prevail in many of its
countries. South Africa has 11 official languages, which translate into the different ethnic cultures found in that country. Matsumot (1997) stated that research acknowledges the dynamic nature of culture, and many of Africa’s countries have been affected by colonization. From the process of colonization, the cultures have become diluted; hence, one very rarely encounters a pure, traditional African culture (as cited by Van Dyk & Nefale, 2005)

“Practicing psychotherapy within such diverse settings has its challenges. One such challenge involves dealing with clients who present with conflict in their life that results from cultural clashes-mostly because they are not practicing one pure culture” (Van Dyk & Nefle, 2005).

In some areas of African countries, pure traditional African healing may not be easily found. Those who live in towns or cities have easy access to medical care and mostly use both, medical treatment coupled with traditional healing. In remote areas only herbs and traditional healing are used.

Van Dyk and Nefale (2005, p.50) stated that the “split world” of young African psychotherapists and their clients led to a “split healing model for Africa. The split that exists between individualistic and communalistic values led to a more individualistic psychotherapeutic model and a communalistic traditional healing model.

Madu (1997, p. 10) gave more detail about the two healing models for Africa and also explained why the latter is more appropriate for Africa than the former. About traditional healing as a model he wrote the following: “Many traditional oriented Africans, when they have a health or emotional problem, go to a traditional healer. Traditionally Africans believe that sickness (especially, one of an emotional or psychological nature) originates as a punishment from the gods for evil, the belief is that they can only get rid of the punishment through traditional
sacrifice. The expectations of Africans, as clients, are passive or dependent. Traditional healers work with the client and their family—not on an individualistic basis (as cited by Van Dyk & Nefale, 2005 p. 50).

The spiritual healing in Islam is different from traditional. “We human beings do not have only our body and mind; we also have a soul. The soul is sometimes described as spirit (ruh) or heart (qalb). Spiritual health is as important, if not more, as the physical and mental health. On the physical and mental health depend our meaningful life and success in this world, but on the spiritual depends our success and salvation both in this world and in the hereafter” (as cited by Islamonline, 2009).

A Muslim spiritual leader treats the physical or emotional illness by reciting some verses from the Quran in the healing process. Muslims believe that the ultimate Healer of all the diseases is Allah, and at the same time seeking medical attention is encouraged.

One has to be mindful of how to deliver or build a bridge between Western tradition and traditional healing and community values. When we work with Africans we do not want to run the risk of being rejected by the traditional group, especially when the treatment comes in conflict with traditional, religious and community values.

For centuries one turned to family members—an aunt or grandmother for emotional support. One shared his or her difficulties with a close trusted friend, an elder from the neighborhood and a spiritual leader for guidance. This is true for most African countries where communal and an interdependent structure made it easy to find helpers that one can rely on for their experiences and wisdom.

Van Dyk & Nefale (2005) discussed the difference between treatment based on Western and European models of illness, health and healing, and traditional healing. They also argued
that applying the Western-and European-based principles of illness and health to non-Western or non-European clients tends to result in conflict (p.48)

Mnyandu (1997) stated that ubuntu indicates an inner state of complete humanizati Ubuntu is based on the philosophy and world view that emphasizes collectiveness and interdependence. This world view implies that human nature is defined as interdependent, inseparable whole. (as cited by Van Dyk & Nefale, 2005, p. 54).

Van Dyk & Netale (2005) stated that most psychotherapy training in South Africa and in most parts of Africa is based on Western conceptualizations of illness, and subsequently, techniques that are Western in origin are employed to resolve problems of a psychological nature. The authors propose the ubuntu model as an integrative approach to psychotherapy that embraces these Western theories and techniques and adapt them to the African clients’ unique situation and context.

According to Butollo (2000), psychotherapy seems to increasingly adopt an approach that borrows theoretical concepts and techniques from different therapeutic paradigms (as cited by Van Dyk & Nefale, 2005, p. 56).

People from Africa along with people throughout the world suffer certain universal mental disorders. What differs is the nature of their symptoms, and the way these disorders are expressed. Throughout the ages, a majority of African people sought and received mental care from a Traditional Therapist or Healer (Oni, 2009).

Oni (2009) stated that mental illness among people from Sub-Saharan African is usually explained as demons or other religious delirium nature or “furious madness”. There is no universal meaning or definition for mental health. From a cross-cultural perspective, it is virtually impossible to define mental health comprehensively. Mental illness is defined by
culture, and culture defines what constitutes “madness or craziness”. In most African countries, having one form of mental illness or another is believed to be a curse. The person is seen to be possessed by evil spirits. In African society, a mentally ill person is sometimes seen as an object for amusement (Oni, 2009)

Many refugees from the African continent who have treated their illnesses with herbs, roots and oils cannot understand why medical or psychological tests are done. The symptoms that they show might mean several things. The doctor also wants to make sure what to treat and how to treat it. The challenge for doctors and therapists is to help their clients understand how the process works. Some of the refugees have never seen a doctor in their entire life, some have been seen only when they were seriously ill. When some patients are diagnosed with illnesses like diabetes or hypertension, they deny it to the extent that they refuse to take medication.

Western Treatment vs. Traditional—Cultural definition of Illness

Aroche and Coello, (2004, p.53) stated that culture is an ever present reality in the work we do as counselors, therapists, and helpers. It is also a construct that has attracted a multitude of definitions and has been the subject of many academic debates.

Laungani (2004) argues that counseling and psychotherapy within a multi-cultural setting raise several unresolved issues that are specific to the process of counseling and therapy, such as the language(s) spoken, meanings shared, verbal and non-verbal misunderstandings, the uses and misuses of metaphors, differential expectations, and conflicting values systems of the client and therapist (p.195).

Laungani (2004) discussed subsequent studies by ethnologists, including Lorenz, Hinde, Ekman, and others, explaining that communication, both among animals and humans is an extremely subtle and complex process. In certain instances, failure to perceive subtle non-verbal
and/or bodily cues with accuracy can mean the difference between life and death. Eternal vigilance is not just the price of democracy. It is of invaluable help to both the client and the counselor in promoting a deeper understanding of the client’s problems. Since counseling situations are often charged with a variety of emotions, it is not always easy to perceive them correctly. The situation assumes even greater importance when a therapeutic encounter occurs between counselors and clients of different cultural backgrounds. It is imperative for the parties concerned, in particular the therapist, to be vigilant and sensitive enough to read correctly the differential forms of verbal, non-verbal, and other physical cues the client knowingly or unknowingly may display to the therapist. Failure to acquire such skills would condemn the therapist to remain chained like the prisoners in Plato’s cave, who mistake appearance for reality and shadows for substance (Laungani, 2004p. 196).

Laungani gives a scenario of a cross-cultural therapeutic encounter between a therapist and a client. Then he explains the client’s worldview, how the client failed to understand why the therapist was not offering guidance to the client to solve his problems. On the other hand he talks about the therapist’s worldview in that he operates from euro-centric model and that he sees his role as that of facilitator as well as a clarifier of confusions. Laungani (2004) concludes by saying, “is there a way by which one might transcend the cultural boundaries in counseling and psychotherapy? The answer is a cautious yes” (pp.200 &206)

*Touch in Therapy*

The writer’s favorite part was interpreting in the labor and delivery room. The first few hours were hard to see clients go through labor aches and pains. In African culture where touch is acceptable, clients will ask for a massage on the lower back. Many refugees are here without close relatives. That makes it the right time to give as much support as one can give in the
moment of need. That is the time when one gets reminded of the loved ones who are very far. What a pleasant experience for one to be part of the team who helped in the process of babies being borne. It definitely creates closeness to the mothers and the babies delivered in one’s presence.

In Oromo culture, touch is a way of expressing affection, comfort and closeness. Touch also used in healing and blessing. It is a way of communicating with others. Even though it is acceptable, there are conditions when touch is not appropriate. For example, a Muslim man cannot touch a woman unless she is blood relative. The same is true for a Muslim woman. We have to take culture into consideration. It is perfectly fine to see two male friends or female friends holding hands and walking down the street in most of African countries and no one interprets it differently.

McNeil-Haber (2004, p. 129) stated that, when thinking about ethical considerations of touch, it is essential for professionals to have some understanding of the possible usefulness of touch, the harm of withholding touch, and the possible negative consequences of touch. Some adult clients find touch meaningful in therapy. Indeed, they have endorsed perceiving touch as positive in therapy.

Horton et al. (1995) in narratives taken from adult patients stated that the four most highly endorsed themes were that touch created feelings of closeness and caring from the therapist (69%); “communicated acceptance” and enhanced self-esteem (47%); helped to “create a new mode of relating” (21%); and/or gave the patient feelings of strength, assurance, comfort, and healing (p.451) (as cited by McNeil-Haber, 2004, p.129).

Geib (1998) conducted a study with in-depth interviews 10 adult women who experienced touch in psychotherapy. Women who found touch in counseling therapeutic reported
feeling that touch helped them feel connected to reality, that they experienced a new way of relating, and that the touch communicated acceptance or increased their self-esteem (as cited by McNeil-Haber, 2004, p.129-130).

Geib (1998) found similar factors that were related to the client’s experience of touch as positive (six clients) or negative (four clients). These factors included whether the clients felt in control of the touch, whether they felt like the touch was for them or the therapist, how open the touch was discussed, and congruence of the physical touch and the emotional intimacy.

There were four themes among those women who found touch counter-therapeutic (Geib, 1998). First, the experience was so gratifying that it made exposing negative feelings impossible. Second, the women felt anger about the resulting difficulty in discussing negative feelings, the lack of discussion of boundaries, and guilt related to feeling angry. Third, they felt that their therapists were vulnerable and needed protecting from their negative feelings. Finally, the women experienced the touch as repeating problematic dynamics they had experienced in their family of origin (as cited by McNeil-Haber, 2004).

In any culture, touch is not only considered positive but can be a reminder of bad experiences. Women who are rape victims and torture survivors might associate certain touch with their difficult memories. One must be cautious when dealing with such individuals. The human body carries good and bad memories for a long time. As a counselor, one must seek consultation regarding the use of touch in therapy.

Religion and Therapy

Hedayat-Diba (2000); Kelly, Aridi, &Bakhtiar (1996) stated that generally, the concept of mental health and seeking therapy varies for Muslim Americans depending on ethnicity, acculturation and culture (as cited by Ali et al.). Weine & Laub (1995) pointed out that trauma,
such as posttraumatic stress, may be a relevant clinical concern for recent Muslim immigrants from Bosnia, Iraq, Afghanistan, and Palestine who have experienced wars and political strife (as cited by Ali et al., 2004). Some have described the severe postwar trauma of Iraqi refugees as beyond PTSD [post-traumatic stress disorder] (Nasser-MacMillian & Hakim-Larson, 2003, p. 156). According to the authors, the severe trauma in these individuals experienced contributed to attention-deficit/hyperactivity disorder, depression, and substance abuse (Nasser-MacMillian & Hakim-Larson, 2003). Sack, Clarke, & Steeley (1996) stated sometimes the trauma may be passed down generationally from parents to children (as cited by Ali et al., 2004)

When a clinician observes the behavior of a child he or she may think that the child suffers from some sort of mental illnesses. Such children might have parents who have experienced trauma in their own country. The child who grows observing angry and sad parents may act the same way. In order for a clinician to understand the child’s symptom, it is often helpful to know the parents’ background.

Volkan (2001) has identified the concept of “chosen trauma” to account for the transmission of such legacies across generations. He writes:

“Within virtually every large group there exists a shared mental representation of a traumatic past event during which the large group suffered loss and or experienced helplessness, shame and humiliation in a conflict with another large group. The intergenerational transmission of such a shared traumatic event is linked to the past generation’s inability to mourn losses of people, land or prestige, and indicates the large group’s failure to reverse……humiliation inflicted by another large group, usually a neighbor, but in some cases, between ethnic or religious groups within the same country” (as cited by Weingarten, 2004, p.52)
Almeida (1996) stated that “many Muslim societies tend to be collectivistic, individualism and individuation from families is discouraged” (as cited by Ali et al., 2004 p.638). Ali et al. discussed how the Qur’an encourages respecting parent. They also mentioned that Muslims are discouraged from disclosing personal and family matters outside the family. Because family structures are hierarchical and interdependent, members of the family consider talking to the elder before making most decisions (Ali et al. 2004).

Ali et al. (2004) stated that an important clinical issue receiving little attention in psychological research or literature is the prevalence and treatment of alcoholism in Muslim societies. Although the religion forbids the consumption of alcohol, it cannot be assumed that all Muslim Americans adhere to this principle. For example, it is quite possible that some Muslim American students who attend large universities where binge drinking is common are as susceptible as their non-Muslim counterparts to alcoholism. Similarly, recent refugees may turn to alcohol to cope with Post Traumatic Stress Disorder-PTSD and adjustment issues (Nasser-MacMillian & Hakim-Larson, 2003). The authors suggested that Muslim clients who seek help for alcohol problem may feel more comfortable with non-Muslim therapists to discuss the matter without feeling guilty or judged.

In a study of religious factors and coping with depression, Lowenthal, Ginnirella, Evdoka, and Murphy (2001) found that relative to other religious groups, Muslims believed more in the ability of Islam and social support to help them cope with depression than in mental health treatment. Hence, psychologists may be able to use religious practices and community social support to help devout Muslim client overcome depression (as cited by Ali et al. 2004). Suicide is forbidden in Islam and it is considered criminal act. Hedayat-Diba (2000) suggests when
assessing for suicide ideation, not to ask if he or she has thoughts of killing him or herself. The therapist could ask, “Do you wish that God would let you die?” (Ali et al. 2000).

Ali et al. (2000) attempted to familiarize psychologists and other service providers about the religion Islam, cultural aspects of Muslims, and how they can work effectively with their Muslim clients. They touched briefly on Islam, the five pillars of Islam, the historical background of how the Quran was revealed to Prophet Muhammad (may peace and blessing be upon him), Hadith which refers to the Prophet’s sayings and sunnah refers to his teachings.

Ali et al. (2000) mentioned other practices like dietary practice, gender role, customary dress family values and polygamy in Islam. Immediately following the 9/11 terrorist attacks, many Muslim Americans reported anti-Muslim incidents, such as acts of violence, threats, and hate messages or harassment (CAIR, 2002) (as cited by Ali et al. 2004, p. 638). The authors stated that consequently, Muslim Americans may be feeling anxiety and concerns over their own safety and may also question their allegiance to the Islamic faith. The writer disagrees with the questioning of Islamic faith that the authors mentioned. In the writer’s opinion, people whose faith is strong will not question their religion or go against it.

A presenter, Dr. Mona Amer, who studies Arab and Muslim-American mental health, spoke at a Board of Professional Affairs sponsored panel, at the American Psychological Association’s 2006 Annual Convention. Amer (2006) said, “Try to meet the community where it is rather than waiting for it to come to you”. Amer suggested that “psychologists offer their expertise through other routes such as giving presentations at mosques and community center health fairs. Other suggestions were to offer home services if possible, provide the option of a same sex practitioner, and establish rapport before asking questions about sex or alcohol use”.
Gender in Therapy

Nadelson, Nortman & McCarthy (2005) stated that “as in all areas of healthcare, gender is an important variable in the treatment of a variety of psychiatric symptoms and disorders. Gender is mediated by psychosocial factors and the physiological and metabolic differences between men and women”. Worell & Remer (1992, p. 9) argued that “gender as a concept encompasses culturally-determined cognitions, attitudes, and belief systems about females and males; it varies across cultures, changes through historical time, and differs in terms of who makes the observations and judgments” (as cited by Nadelson et al., 2005, p. 14).

Nadelson et al. (2005) stated that “identification with a therapist is important. Although the reasons for choice may be based on stereotypes, without regard for the characteristics of the specific therapist, the patient’s feeling of greater comfort or empathy can facilitate the initial development of a positive therapeutic alliance”.

The authors stated that some therapists make gender-based recommendations for clients. For instance they mentioned that some women who are victims of sexual abuse find it difficult to work with men, and it is suggested that women should treat such clients. They also discussed gender choice in couples and family therapy, to pay attention to bias whether the therapist is male or female.

Nadelson et al. (2005, p.15) stated that therapy groups with both male and female leaders permit men and women to deal with transference issues, both as peers and as leaders. Mistrust, competition, and anger that are not addressed in either leader or group members can be unproductive and inhibitory to group process.
The journey of Asylum Seeker

Most of the clients at The Center for Victims of Torture are asylum seekers. They need to tell their stories to their attorneys to apply for asylum. The therapists also encourage them to talk about their experiences. Some of them do not like to talk about their torture experiences over and over again. They state that talking made them hurt all over again. Sometimes it was a challenge for the therapists to help them understand that healing comes through talking.

Refugees can legally work and accept benefits, whereas asylum seekers cannot work and are ineligible for public assistance programs. They have experienced traumatic incidents in their country and suffered torture. More than refugees, the asylum seekers are uncertain about income, housing and food.

Sometimes asylum process takes a very long time and the seeker will not be able to work for quite a while. This makes it hard for clients who are unable to support themselves. One benefit is that, as long as they remain The Center’s client, they qualify for medical assistance. The client receives physical and psychological treatment. Those who do not yet receive medical assistance are transported by volunteer drivers. One of the volunteers explained his experience by saying, “Talking with each client was like traveling to different parts of the world”. Some clients do not speak English and they have a chance to practice the language when the volunteers take them out for coffee or show them around the city.

The story about Aantu is one of thousands of stories that tell about the suffering of women at the hands of their government. Most of them suffered even more in the second country in refugee camps. Here they lived on less food, dirty water and without privacy. Some also suffered other traumas like rape either by other refugees or soldiers. The suffering continued as
long as they lived in the refugee camp. They left their country for safety, and unfortunately, they suffered more. This kind of life leads to frustration, hopelessness and depression.

After going through the long refugee resettlement process, the time comes when their departure will be announced. It is beyond one’s imagination what goes through their minds. Many of them talk about these feelings. They say that they thought once they were in America, they would live a wonderful life and their sufferings would come to an end. Their expectations were very high and they had dreams of many opportunities.

For a few months upon arrival those dreams seemed to be true because they receive refugee cash assistance, food support, medical insurance and even a ride to their medical appointments. The honeymoon does not last long. Later they have to look for a job and learn the English language. Once the cash assistance stops the reality hits, their dreams and expectations are shattered.

This is when the American dream stops and the reality of American life begins. This is where women like Aantu may come to seek professional help. Mental health providers must be prepared to deal with the many issues of refugees’ health and experiences that are going to challenge them.

**Conclusion**

This paper explained the suffering often experienced by African refugees/immigrants in general, women in particular. Ranges of mental health care were explored. The topics on the perception of mental health in African refugee/immigrants, cultural definition of illness, challenges in interpreting and its importance, touch, gender, and religion in therapy were discussed. Educating the community, raising awareness that mental illness is real, and parenting skills for refugee parents to help them understand the behavior of their children was
recommended. Clinicians are encouraged to consider psychosocial history and torture experiences that may impact mental health before treating individuals.
The personal journey of the writer

Before talking about my journey, here is the history about the Oromo nation:

“The Oromo nation is the largest ethnic group who was conquered by the Abyssinian Empire during the 19th century colonial partition of Africa among European colonial powers. Like all people who are subjected to alien rule, the Oromo people are being subjected to political, oppression, economic exploitation and cultural domination. As a result of the Abyssinian conquest and establishment of their alien rule, the Oromo nation lost political power in its own land, Oromia. The democratic and egalitarian Oromo Gada political system was banned and was replaced by Abyssinian autocratic/dictatorial rule. The Oromo people lost ownership and control on their own natural resources and were subjected to servitude. Their language, culture and values were dominated, denigrated. Afaan Oromo (Oromo language) was banned from official use for more than a century, children were deprived the right to learn in their own language, and Abyssinian Amharic language was imposed on the Oromos” (Oromia Speaks, January, 2004, volume 10, Issue 1).

The Oromo people have been deprived of basic human rights. My family is one of the best examples who have endured and lived under such condition. Under each regime, there were times when the situation got unbearable and many people often choose to leave everything behind for search of safety. Running from unsafe place I spent some years in other parts of the world prior coming to the United States. That life involved moving from place to place, not being able to call any place home yet. At last September of 1987, Minnesota became my home and I felt settled because my younger brother, Abdul Basit lived in Minnesota for five years.

I am the third child of eleven who grew up in a small town, Dire-Dawa. My family lived in a single compound that included paternal grandparents a step grandmother, uncles and aunts.
It was like a small community and I have learned wisdom from the elders as well as the respect and tolerance required for living together.

After completing Islamic school, I attended evening classes to learn English and Amharic. The teacher saw my potential and encouraged me to join regular school. I did well and even had a double promotion, completing two classes in one year. The generation before me had to struggle to be accepted in higher education. For an Oromo Muslim woman, most often the chances to continue higher education were very slim in Ethiopia.

In 1976, all high schools and universities were closed by the Marxist military regime, the “Derg”. All the students from high schools and Universities were relocated from their homes to different states to serve the country in a program known as “Zemacha” (a call of mother land). I was fortunate to be assigned not far away from my home town. I was attending a private high school at that time and a Canadian missionary was in charge of my group. This man assigned some students to transport the group every morning to the small villages around Dire-Dawa and came each evening. We served the villagers by providing nutritional foods, teaching sanitation, and building roads that connected these villages to the nearest towns. It was quite an experience of satisfaction to deliver needed services and to be one of the players in teamwork.

In 1977, in a period known as the “Red Terror” thousands of youth were killed mercilessly by the “Derg” soldier. At that time I have already served for one year in “Zemacha” and completed high school. I went to the capital city, Addis Ababa to get registered at the University of Addis Ababa. I could not join the university because of uncertainty and political unrest in Ethiopia. Every night I heard gun shots and the cry of mothers who have lost their sons and daughters. Most of the time people saw their loved one’s dead body on their door-steps when they were going to work in the morning. In another city, Harar, an Oromo radio reporter,
Abubakar was killed at night and the following morning people saw a hyena dragging and tearing his body. Nobody knew who killed these individuals. The horror and cruelty experienced by the people of Ethiopia was unheard of.

The only chance for me to survive was to leave my country. To leave one’s country or to escape involves walking to the border, starving on the way, risking life and often facing death. I was one of the luckiest to go to Djibouti, the neighboring country by plane. At the airport, because of some improper document, they almost sent me back to Ethiopia. That was the scariest day in my life because I would not have been here writing about it today if I was sent back.

Many Oromo people have suffered at the hands of consecutive Ethiopian regimes. Thousands of Oromos, including myself became refugees in the neighboring countries for fear of persecution. I personally know the effect of violence and trauma because my family member experienced it.

I was in Djibouti for few months and later traveled to Saudi Arabia. My aunt, Zabida M. Ibrahim, who was a business woman at the time, sent me to India to join medical school. Unfortunately my aunt was arrested and spent some months in prison. My younger brother, Abdul Hamid supported me financially while I was attending college in India. My uncle, Ali M. Ibrahim also contributed to help pay for my education. It would not have been possible without continuous support of my brother to graduate with a bachelor degree in science from Mangalore University, India.

From India, I traveled back to Djibouti, then to Republic of Yemen, and later to Kenya. I was hoping to settle, work and support my family. That did not happen. After staying in Nairobi, Kenya for a year, I was resettled in Minnesota as a refugee.

Here in Minnesota, like any other refugees, I have experienced many challenges to adjust. For sure knowing English language made my life easier than others. The hardest part though was
not being able to find any descent job or in the field I studied. I struggled through low paying and assembly line with temporary agencies. In 1990, I went back to school and got a diploma and worked as a certified medical assistant in hospitals and clinics. In 1995 when large groups of Oromo and Somali refugees arrived in Minneapolis, I felt the need was great for interpreting to help many refugees who did not speak English. I became a full time professional interpreter in medical and mental health settings.

Working at the Center for Victims of Torture as an interpreter, gave me a chance to be the voice of the survivors. Here is what one of the clinicians said about me, "You are tremendously conscientious in your interpreting and have a fine ear for what is said and also for what is not actually said in words; these types of listening skills are very important in general but crucial to competent delivery of mental health services". It was a privilege to be part of the healing team.

During 1999-2004 I worked as a community coordinator at the University of Minnesota for a research study from Somalia and Ethiopia (Oromo). In this study, “Somali and Oromo Refugees: Correlates of Torture and Trauma History”, I interviewed more than 250 Oromo women who were experiencing a great deal of stress resulting from life experiences of torture and violence in their country and refugee camps. Innovative stress interventions were developed from the data collected in this study. I was part of this study, “Somali and Oromo refugee women: trauma and associated factors”. In 2005, the group used these interventions in the community work. I co-facilitated in the pilot study based on what was called the Health Realization Intervention model.

After listening to the sad stories and working with these women, I could not rest and wanted to figure out how to help the refugees and immigrants. I understood that there is a
tremendous need for mental health professionals in our community. This was the turning point in
my life that urged me to choose this career path. I decided to join Adler Graduate School to be
equipped with skills and knowledge to better serve the community and help them heal from the
wounds of torture. Being 2009 Bush Fellow helped me to focus on school and community work.
I believe my community will benefit from having a therapist who speaks their language.

There are thousands of traumatized Oromo refugees from Ethiopia as well as other parts
of Africa with whom I would like to work. I would like to raise awareness about untreated
mental health problems as we often see delayed symptoms arise from trauma. Many African
immigrants do not seek mental health treatment because of the common stigma of mental illness.
My goal is to serve the community by providing psycho-education to reduce stigma in mental
health issues, how to obtain treatment and parenting skills to help them improve relationship
with children and be effective care givers. I believe educating the community is a preventive
approach. If they receive education, they will seek services when in need and this will act to
prevent emerging problems as well.

Some recent immigrants face difficulty adjusting to their new home in the United States
for many reasons, including coping with trauma experienced in their native country, overcoming
cultural and language barriers, and encountering discrimination. The effects of immigration on
psychological and social well-being are especially profound for certain populations, including
children, women, individuals with disabilities, and those with limited financial resources.

The clinicians need to educate themselves about social, political and cultural context of
their refugee clients. The clinicians are encouraged to inquire about the ethnic and cultural
backgrounds of their clients throughout therapy sessions. African traditions are based on oral
cultures and if encouraged the clients will be open to talk about their past experiences.
References


http://www.ippnw.org/MGS/V1N4Toole.html.

