

Overview

The Federal Republic of Somalia has endured turmoil for many decades, contributing to the current lack of a strong health infrastructure or integration of mental health services into mainstream healthcare services. Civil war and ongoing violence have caused complex trauma among many Somalis. While the first presidential election in many decades in 2012 is indicative of some progress in advancing human rights, there still exist violent forces working against establishing a peaceful democracy. The militant group Al-Shabaab continues violent altercations against civilians and the federal government, creating a hostile and unstable environment.

Country Info

Official Languages: Somali and Arabic

Population: 10,787,000 (2015 UNDESA)

Religion: Islam (official)

MH Services: 12 out of 100,000 individuals utilize hospital-based mental health services

MH Providers: .06 psychiatrists and .03 psychiatric nurses for every 100,000 individuals; 0 psychologists

Avg. Family Size: 6 family members

Other: *khat*, a commonly used plant with amphetamine like qualities shown to have negative mental health effects.

Context

Due to the stressors of relocating as well as the war trauma experienced particular to Somalia, there is a high prevalence of post traumatic stress disorder, depression, and generalized anxiety disorder after the resettlement period among Somalis. Complex and challenging aspects of resettlement, such as acculturation and changing of family roles, can create emotional distress and exacerbate existing symptoms. Recognizing the broken environment many Somali individuals come from, it is easy to see how they might struggle adjusting to a new life in the U.S., including building a community. Having access to a halal grocery store, speaking with a healthcare receptionist who knows your language or can easily access an interpreter, and seeing neighbors who look like you, can alleviate some fear of losing precious cultural values, language, and social customs. Yet, the racial and religious complexities a Muslim, African refugee faces living in the U.S. can be daunting. Many Somalis will find themselves having to navigate through unfamiliar and complex social nuances in their new country. Consider the implications of resettlement on mental health and how to best help Somali neighbors.

"Qalbiga caafimad qaba, cagli caafimad qaba ayuu leyahay"
- Somali idiom "If your soul is healthy, your mind is healthy"

Helpful Tips for Resettlement Workers and Mental Health Providers

- When describing a concept like depression or PTSD, try using the symptoms, instead of the clinical definitions
Examples: Sadness, reoccurring nightmares, hyper vigilance, isolation from friends or family, etc.
- Acknowledge and incorporate the client's spiritual beliefs of the origin and treatment of their illness
Example: If a client describes the illness as caused by an evil spirit, ask "Can you tell me more about how the spirit is affecting you?" This provides a culturally sensitive mode for the client to further engage on the topic.
- Normalize the use of common clinical interventions (such as ongoing therapy) and medication (such as anti-depressants) within the United States to help alleviate stigma associated with these concepts
Example: "Many people in America see a psychiatrist for the same reasons you are visiting this clinic today."
- Keep in mind that discussing an individual rather than the family as a whole may be unfamiliar due to the communal nature of the Somali culture. Emphasize the mental health effects on the entire family
Example: "How do you feel this symptom (constant worrying, isolation, etc.) can affect your children?"
- Remain patient and curious, as it will take time for many Somalis to build a trusting relationship
Example: Offer additional follow up appointments. Ask questions like: "How have you cared for yourself in the past when you have experienced these symptoms?"
- Partner with Somali elders to help educate Somali refugees regarding mental health symptoms and treatment
Example: Hold an open discussion or forum with community leaders to learn more about the culture and offer to collaborate on community education for the benefit of the entire Somali community within the area.

Mental Health Data

Studies have identified varying degrees of mental health symptoms reported among Somalis, perhaps due to reluctance to report symptoms, or lack of data within Somalia. One study found 21-26% of households have an individual struggling with a mental or behavioral health disorder. Another study revealed 34% of a sample size of 143 Somalis exhibited symptoms of depression and anxiety. Additionally, comorbidity among Somali refugees appears quite high; specifically, 80% who meet diagnostic criteria for post traumatic stress disorder also meet criteria for anxiety or depression.

Words and Phrases

Note: There are no literal interpretations of anxiety, depression, or PTSD. The following phrases are commonly used to address these symptoms. Clinicians may want to discuss these with interpreters.

- **Qulub:** Severe depression
- **Shaki:** Worrier, obsessive, compulsive worry or doubt
- **Murug:** General sense of sadness or mild depressiveness
- **Waal:** Crazy or mentally unfit
- **Jinn:** Spirits that possess supernatural powers capable of controlling human processes including psychological processes.
- **Buufis:** Contemporary word that rose from the Dadaab camp in Kenya, referring to the longing for life after resettlement and the negative psychological effects if those hopes are disappointed.

Symptomatic Expression

Note: Distress is often described through physical symptoms. If a client describes a marked decrease in appetite and continuous difficulty sleeping, they may be struggling with symptoms of depression. It is important to keep a holistic perspective when working with a Somali client/patient.

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| • Body Pain | • Low energy |
| • Headache | • Nightmares |
| • Insomnia | • Poor memory |
| • Fatigue | • Thinking too much |
| • Decreased appetite | • Gastrointestinal problems |
| • Weight loss/gain | |

For research purposes please contact NPCT for references.
<http://gcjfc.org/refugee>



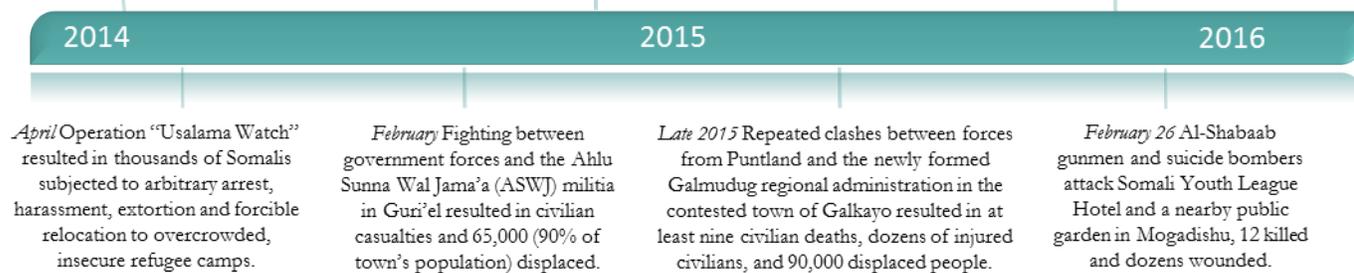
Brief Timeline

March 26 Joseph Ole Lenku, Kenya's Cabinet Secretary for the Ministry issued a press statement ordering all refugees to return to and remain in the camps, citing security challenges.

Jan-Aug More than 116,000 people were forcibly evicted from informal settlements by the government.

April 11 Deputy President William Ruto of Kenya said the government must close Dadaab refugee camp within three months and return its residents to Somalia, otherwise Kenya would 'relocate them ourselves.'

February African Union leaders agree on need for more funding and support for their military presence in Somalia after weeks of increased Al-Shabaab attacks on public spaces and pro-government troops. Government and African Union troops recapture southern port of Merca that Al-Shabaab briefly seized.



Healthcare in Somalia

The public healthcare system within Somalia was virtually destroyed during years of internal conflict and is now heavily dependent on international organizations for assistance. Somalis are generally comfortable accessing primary care through a hospital or clinic. It is common to visit a pharmacist when a family member is ill, which may influence treatment expectations during a physician visit in the United States. The country's private health sector locations, especially pharmacies, are utilized more often than public clinics, perhaps for the higher quality services and facilities. Somalis may visit a traditional healer prior to and/or concurrently with visiting a primary care doctor.

There are three mental health hospitals within Somalia, indicating modest progress in access to mental health services. Primary care facilities do not incorporate mental health assessments or coordinate service provision with mental health providers. Patients are often chained and/or confined within mental health hospitals, creating an unhealthy experience for patients and a dismal view of mental health services for the general public. The lack of integrated mental health care and poor treatment of patients pose significant barriers to accessing services, made evident by low usage rates (see *Country Info*). Programs such as [Chain Free Initiative](#), a Somali program addressing mental health stigma and lack of awareness, are working to improve the public approach and patients' circumstances within mental health settings.

In Somalia, mental health is separated into two categories: "Mental Wellness" and "Mental Illness", or "Sane and "Insane." The idea of a mental health spectrum, as defined in Western mental health tradition, is a new concept for many Somalis resettled in the United States. Common symptoms associated with Anxiety and Depression are not necessarily considered worthy of clinical treatment, but rather a part of normal life stresses.

The Somali culture is a culture of community. Since mental health carries a heavy stigma, many would be ostracized from their community if they voiced any mental health specific concerns. The social isolation, in the context of such a communal culture, would inevitably aggravate mental health symptoms.



Beliefs and Customs

When interacting with refugee clients, it is important to be aware of the various support systems they may rely upon to emphasize a strengths-based approach to casework and treatment. This guide will highlight some traditional Somali support systems that may be relevant for service providers in the United States. Somalis are storytellers. They have a rich heritage rooted in oral tradition; and this attribute is often made evident when discussing family history or current symptomology. For instance, Somalis are not necessarily familiar with being asked direct questions or providing concise answers. Within a Western medical facility, give and take between client and provider can last over multiple appointments.

Somali perception of mental health has a strong spiritual component, with many beliefs and customs interweaving both culture and religion. Spirituality is a vital piece of comprehensive healthcare, and among Somalis, it can act as a protective factor against suicide. While many Somalis uphold the teaching of the Quran that suicide is a sin against god and therefore not an option, some studies reveal suicidal ideation is still present among the Somali population. Beliefs such as an individual's physical or mental illness being a punishment from god or a consequence of previous sin may influence the thinking around mental health origins and viable cures. Many feel that adverse mental health symptoms, such as insomnia and frequent nightmares, can be caused by evil spirits (*jinn*) and alleviated through religious readings and ceremonies (see *Interventions*).

Another traditional support Somalis have is family. Family is often a large and strong unit with core and extended families maintaining close connections. Elders are treated with great respect, and children are expected to care for their parents as they age. As a component of post-natal support, women are often provided for by family and friends for a full 40 days after delivery.

Mental Health Interventions

With the prevalence of mental health disorders, it is important to examine the interventions most commonly utilized by individuals from Somalia. Psychiatrists and other mental health professionals are few in number within Somalia (see *Country Info*). Primary modes of addressing mental health concerns include reading the Quran (often the first method of intervention and used during various healing ceremonies); seeking guidance from a sheikh or religious healer called a *minga* or *waddad*; receiving counseling from community elders, family members, and/or close friends; and discussing concerns with a neurologist (considered a knowledgeable professional for distressful symptoms).