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Leena Fatima Malik March 31, 2014

Somali Refugee Women and their Explanatory Models of Mental Health

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Abstract
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Somali refugees in the United States have been of interest to researchers due to research that puts the prevalence of mental health issues of Somali refugees at 1 in 3 people (WHO). Somalia has an intense history with great focus in the west put on the torture, murder, and rape of Somali people during the Somali Civil War. Despite research on prevalence of mental illness in refugees from a western perspective, multiple studies cite the lack of culturally-relevant research to the area of mental health and well-being. It is vital to study the cultural constructs, history, and experiences of Somali refugees because the expression of psychological distress is inevitably culturally bound. This means views of well-being and mental health are also culturally bound and cannot be understood without first-hand accounts.

The goal of this paper is to explore the facets of life as a Somali woman refugee that shape Somali views of mental health. I conducted semi-structured interviews using a framework called EMIC to ask questions related to mental illness and well-being. These interviews helped clarify explanatory models of mental illness and well-being and allowed me to extract 6 important themes of Somali women refugee mental health. While my original hypothesis was that the explanatory models of Somalis and Americans were radically different, in fact, many beliefs in the causes of mental illness run parallel in the two cultures. Ultimately, well-being in this population comes from three important cultural values: family, community, and religion. Other facets of daily life such as work, sleep, and dress promote strong cultural bonds and are vital to mental health and well-being in this population. Mental health promotion and mental illness prevention in America for Somali refugees should take into account these important facets that form Somali identity.

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Chapter 1: On Somali Refugees

My Personal Account

The Somali dugsi is located in an inconspicuous apartment complex off N. Indian Creek Rd in Clarkston, Georgia. Many of the apartments have been transformed into business centers. Among them, the dugsi is located on the bottom level. A dugsi in Somali means protection and shelter, it protects whomever is within it. In Somalia, a dugsi is a place where anyone feeling difficulties can come and be safe. It is also a place to learn. The best western translation of a dugsi is a community center, although community center hardly seems accurate to describe the warmth and safety of a dugsi. Among the apartments, the Somali dugsi consists of three small rooms and a restroom. The floor of the main area, seemingly the old kitchen and living room, is covered in plush carpets while the walls are lined with long pillows. The walls are big bricks painted white, unglamorous and without frills. In the smaller room, Dr. Asha Ahmed's daughter teaches the children Arabic. In the bigger room, Dr. Asha gives lectures on Islam, followed by prayer, every Saturday and Sunday.

The women are dressed in traditional Somali clothing. Long, flowing dresses and tightly wound headscarves that cover the ears and part of the forehead adorn the women. As they move, their dresses shift gracefully with them. As each woman enters, she grasps the hand of every other woman present with a heartfelt "Salaam" returned by a "Waalaikum Salaam". If the woman has not been seen in a while, the greetings are supplemented by a kiss of the hand.

Today, like most days, Dr. Asha teaches *tafseer*[1] and Arabic grammar. I pick up a Qu'ran translated into Somali and I am intrigued at the roman alphabet inside. The Somali language is a unique one. The Somali alphabet is much like the Latin alphabet with Arabic sounds assigned to each one, and the same five roman vowels[2]. The Somali language has a Latin alphabet with Arabic phonetics. Truly, this represents the situation of the women well—somewhere between the western world and their homes.

Dr. Asha then informs me that we are going to bless a new baby. Generally, this occasion occurs after the woman has finished post-natal bleeding. About 20 Somali women and I gather outside the dugsi and get into cars to head to the home of baby Salma. Chairs are set up in the apartment; many women sit on the ground, as at the Somali dugsi. I understand no Somali, one of two official languages of Somalia (the other one being Arabic). However, with occasional English phrases thrown in and the help of Dr. Asha, I can catch bits of conversations. We all sit together with the baby in Dr. Asha's lap and we all admire her. Then, baby Salma goes back to her mother and lively conversation begins. Dr. Asha tells me the women are talking about baby names. One woman comments that back in Somalia, names were taken from the Qu'ran, but now names come from anywhere, movies and books included! The women laugh heartily. I tell Dr. Asha that my own name was picked from a baby book and she finds this amusing.

The women have many celebrations. Someone has finished reading the Qu'ran, someone is getting married, someone has a baby, these are all causes for celebration! On these occasions, the ritual looks like nothing I have ever witnessed. The ladies sit on the

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[1] Tafseer is translation and meanings of the Qu'ran

[2] Hi: Haye. What is your name? Magacaa?. Nice to meet you: kulanti wanaagsan.

ground, with the food and drinks set up in a corner. First, soda: Coke, Sprite, original Fanta, and grape Fanta are handed out to us by the hostesses. Then water is passed out, then utensils and napkins. Then Somali coffee, with ginger and cinnamon, is poured. Then a Styrofoam container comes with the good stuff—simmered meat, rice, injera[3], paratha[4], salad, chicken, and gravy I want to put on everything. Then, as served with all meals, a banana, followed by fruit pudding. Is it over? No. An entire extra Styrofoam box of dessert: dates, pound cake, shortbread cookies, and what seems like a fruit jelly. All the while, the bustling hostesses hand out each round of food and utensils to each woman individually.

Maghrib[5] time comes around. The dining table chairs are moved away and sheets are put on the ground. I wash myself during wu'du[6] and squeeze myself between two ladies. Unlike the women, my hijab[7] is done haphazardly and loosely and I struggle to keep it on my head as we read prayer. After prayer, new baby and mom sit in the middle of the room. We individually cup our hands together for a prayer, and then we stand up and bless the two by moving our hands over them in a single motion as if we were coating them with a blanket of blessings. Then it is time to leave, and we bustle as a group towards the door.

[3] A spongy bread, also eaten in Ethiopia
[4] Similar to a flour tortilla
[5] The prayer at dusk
[6] The ritual Muslims do to cleanse themselves before prayer
[7] headscarf

A Brief History of Somalia

Somalia has a long and rich history, although much of its ancient past remains unrecorded and passed on only through oral traditions. One word seems to sum up Somalia's story better than any other: fragmented. Clearly, a basic understanding of Somalia's disjointed history is necessary to place these contemporary narratives into context.

In pre-colonial Somalia before 1855, the clan was the largest unit of political organization. Approximately 100,000 to one million members belonged in a clan. Dir, Isaaq, Darod, Hawiya, Digil, and Rahanwein were the original tribes. Each tribe had its own policy. This created a decentralized government, established within a nomadic culture. Despite government administration being on a tribal level, each tribe conducted itself democratically. Leaders were rotated in and out and land was shared. Even so, a national Somali identity itself was not well established before colonial rule.

By the 1900's, three European powers and one African power had divided Somalia into four regions despite Somalia's disparate attempts at resistance. Three of these regions were ruled by European powers (Britain, France, and Italy) and one region was ruled by Ethiopia. Each of the four regions had different policies, but all created a power imbalance between the rulers and the ruled. The rural folk generally did not interact with the Europeans, thus their allegiance remained to their clans. Those in the cities were affected more; the urban population became westernized and yet submissive to the Europeans. Many prominent Somali writers have blamed Somalia's current situation on poor colonial leadership from the 1900's to 1960 and claim that this poor leadership created a culture of fragmentation. As an example, Italian Somaliland used

Somalia's banana crop industry to increase exports. However, these exports were mainly to Italy and this deincentivized Somali farmers to seek other markets. Thus when Somalia gained independence, the country did not have the infrastructure to export elsewhere.

In fact, the prevailing belief among Africans is that European colonial control caused Somalia's current issues. Regardless, whether European colonial rule can be blamed for Somalia's current situation or not, the colonization of Somaliland did indeed disrupt alliances among local clans. In her memoir *Unbowed*, Nobel Peace Prize winner Wangari Maathai states "some micronations found themselves stranded between two neighboring countries. The consequences of these divisions continue to haunt Africa" (Maathai 2006).

During colonial control in 1899, Sheikh Mahammad Abdille Hassan (known as "Mad Mullah" by the British) rallied his Dervish followers around a cry for independence from colonial powers. Hassan and his Dervish clan became the face of Somali independence. In fact, Hassan had caused the British and the Italians to create a united front against him. Hassan's influence was so strong that it appeased interclan rivalry in favor of Somali nationalism. Instead of identifying with clans (previously the most important unit of identity), people began identifying themselves as Somali. However, the united European front was too strong, and Hassan did not succeed. In 1920 Hassan died from pneumonia, but his efforts planted the seed of further African resistance. From this seed, the Somali Youth Club (SYC) was formed in 1943, the organization that preceded the Somali Youth League (SYL). The SYL advocated independence and for the elimination of interclan tensions. In 1950, the UN allowed Italy to have Somaliland as a

trustee territory for ten years. An administration called AFIS[8] was assembled to ease Somalia into independence. Thus, by 1960, Somaliland was granted independence and the Somali Republic was formed.

The country was on a freedom high. They successfully elected Dr. Aden Abdullah Osman as President, however, being independent was more difficult than originally believed. Before colonialism, Somalia did not have a central government or a strong economy. The task at hand was to build a democracy from nothing. At this crucial point in Somalia's history, the country found itself disillusioned about building the nation. The economy was simply not strong enough to uphold a stable political system of any kind, and the educational system was not well structured. While the UN Trustee government pressured the Italian administration to build schools, there were not enough teachers, and nomadic Somali's often dropped out. From 1960 to 1969, the country deteriorated, torn by interclan rivalry and stifled by poverty.

By 1969, the country's political infrastructure was weak enough that General Siad Barre took over in a military coup with virtually no opposition. Barre originally took over promoting socialism and the eradication of "colonial hangovers." His regime promoted the education of women, increasing the literacy rate, and quality healthcare. Barre also built up the army in an attempt to gain respect in the international community. However, Barre's regime was riddled with controversy. He was against tribalism, yet his closest confidantes were from his own tribe. Clan identity remained strong, and despite Barre's effort to educate and create Somali nationalism, the problems of poverty and interclan rivalry remained and corruption took over his regime.

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[8] AFIS in Italian stands for Amministrazione Fiduciaria Italiana in Somalia and means Trusted Italian Administration of Somalia

The Somali National Movement (SNM), a rebel group founded to overthrow Siad Barre, gained support throughout Barre's regime. The SNM was made up primarily of people from the Isaaq clan, and Barre used systematic destruction and genocide to stop his opposition. The United Somali Congress (USC) was formed, an anti-Barre group launched from factions of people united against him. The SNM and USC united in 1990 to coordinate a military campaign against Barre. By 1991, Barre's despotic dictatorship was overthrown by these opposition groups and he fled to Mogadishu. In May of 1991, the northern region seceded from Somalia and formed the Somaliland Republic. The situation turned even worse. Without a central government, multiple clans and political factions fought for power. Food shortages, environmental degradation, and general anarchy ensued. Ali Mahdi Mohamed declared himself interim president in January 1991. Mohamed Farah Aideed was another warlord fighting for power. Conflict and violence engulfed Mogadishu, as more Somalis fled or died. Factions continued to fight for power in a divided nation. The agro-based economy, the selfish leaders, and the superiority of clan identity over national identity only aggravated the situation.

The UN intervened in March 1992. A ceasefire agreement between factions resulted. The UN began delivering humanitarian aid to Somalia under mission UNOSOM I[9]. Under UNOSOM I, international observers were sent to the area as well as security forces. Throughout the mission, factions were fighting and General Aideed's forces began attacking the UNOSOM I troops. In addition, Mahdi's troops tried to control the nation's main port.

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[9] UNOSOM stands for the United Nations Operation in Somalia

In 1992, president of the US George H.W. Bush decided to become more involved and launched Operation Restore Hope under the UN's United Task Force (UNITAF). UNITAF-US was sent to secure Somali ports and disarm factions. While UNITAF-US was largely successful in taking command of the area, violence between factions continued. When Bill Clinton became president of the US, he began UNOSOM II in March 1993. In hindsight, UNOSOM II lacked an understanding of the true nature of the situation in Somalia, thus they came in unprepared. Aideed and Mahdi saw the weakness in UNOSOM II. Aideed sent armed militia to attack the UNOSOM II employees and humanitarian employees. In June 1993, Aideed's troops killed 24 Pakistani UN troops, causing the UN to declare Aideed's party a fugitive group. UNOSOM II attacked Aideed's meeting, killing many, thus tarnishing the UN's peacekeeping mission. At that point, it was Aideed's party versus the UN.

With CIA information about an impending attack from Aideed on Mogadishu, the US made a drastic move and launched a missile attack, which killed 70 Somali's. With chances of peace in Somalia fading, the US sent a Task Force to capture Aideed and his leaders. Aideed appealed to President Jimmy Carter for peace. Meanwhile, Somali anger towards the US presence had risen as innocent Somali's were killed in an attempt to capture Aideed.

A pinnacle moment in the history of Somalia occurred on October 3, 1993. On this day, known as "Black Hawk Down" or "Day of the Rangers," the US learned that two of Aideed's advisors were meeting in Mogadishu. The Task Force Ranger sent aircrafts and soldiers to the area. Local Somali's rushed to the site of the attack, giving shooters an opportunity to bring down a Black Hawk helicopter. The rangers had to

rescue their soldiers from the ensuing crowd. Given Somali resentment towards the US presence, this turned out to be a difficult and dangerous task. The angry mob mutilated the bodies of three US soldiers. Two days later, the US pulled all US forces out of Somalia. By 1995, all UN forces had left Somalia. This incident had a tremendous influence on US foreign policy in Africa over the next decade, with the US refusing to intervene in the Rwanda civil war in 1990 and the war in Darfur in 2003.

In 2007, the radical Muslim group al-Shabaab began military opposition against the Transition National Government (TGF). Al-Shabaab attempted to indict sharia law into effect. Since then, Somalia's government has been a series of unsuccessful and unstable temporary governments. Somalia remains without a national government. Amnesty International has reported that hostage taking, torture, rape, and ill treatment abound in Somalia. While Al-Shabaab have been forced out of Mogadishu, food shortages, violence, and piracy continue. (Njoku 2013)

Out of Somalia's population of 10 million, approximately 1 million have been internally displaced, 1 million are living in neighboring nations of Kenya, Ethiopia, and Yemen, and 100,000 have been resettled in the United States since the conflict began. (UNHCR) Kenya has about 430,000 Somali refugees. One of the largest refugee camps is located in Kenya, the Kakuma camp. It provides for 125,000 refugees primarily from Somalia and Sudan. Somali refugees have been resettled in the US, Australia, Canada, and Europe. Clarkston, Georgia hosts thousands of refugees in its 1.1 square miles.

Clarkston and The Refugee Experience

Clarkston, Georgia is a unique town. Located about ten miles outside of the city of Atlanta, Clarkston has a rich history that reflects the changing landscape of America. While Clarkston is no longer accepting refugees[10], the city is one of the most diverse cities in the United States. It was picked in the late 1980's as a place of resettlement due to its proximity to the public transportation and the availability of cheap apartments. At this time, conflict was increasing in Somalia and by 2004 the US had accepted 55,000 Somali refugees into its borders. ("Somali History") Within a decade, Clarkston changed from 90 percent white and English speaking to a city with a population that spoke over 50 languages. In 2014, the 1.1 square miles that make up Clarkston house a populace that is only 14 percent white. Just years earlier, a nearby Stone Mountain had served as a site for Klu Klux Klan cross burnings. Some Clarkston natives were outraged at the changes occurring in their city. In an interview, local Clarkston resident Graham Thomas said, "You wonder sometimes if I've got any buddies anymore that think the way I do…they [the refugees] need to be taught the American way so that they don't goof up."

Other cities that received a large number of Somali refugees are Minneapolis, St. Paul, Columbus, Seattle, and Kansas City. Refugees who come to the US are 'lent' a one-way ticket to the US, which has to be repaid. Then, they are given three months of housing and food stamps, but after three months they are expected to have a job and work independently. This short turnaround time causes previous doctors to work as grocers and previous lawyers to work in chicken factories. The general problems facing refugees constitute a book in itself; the pressure to assimilate, the language barriers, and finding a

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[10] Clarkston accepts refugees who have family ties. I met one refugee who had just been in Clarkston for a month

job are some of the most pressing issues for refugees. And these problems are post-migration; refugees also carry with them problems inherent to the very nature of a refugee status including an unstable country, lack of safety, witnessing murder, experiencing rape and torture.

Besides struggling with their own problems, refugees in Clarkston face external problems relating to the rapid changes that occurred in Clarkston. Media coverage of Clarkston has focused on the amazing explosion of diversity in such a short time. In a way, Clarkston is experiencing the same changes that America at large is experiencing, but in a much smaller area, and at a much faster pace. To understand the social climate into which these Somali women at the dugsi on N. Indian Creek Road entered upon coming to America, it is necessary to more thoroughly understand some of the issues highlighted in the media.

A piece in the NYtimes called "A Sunday in Clarkston," featuring author of *Outcasts United*[11] Warren St. John, speaks to the amazing transformation of Clarkston by focusing on the Clarkston Baptist Church's challenge in reaching out across many cultures. Before the 1990's, Clarkston Baptist Church was a primarily white church. When Clarkston was picked as a city of resettlement, some white families fled. Brenda and Robert White had been members of the church for more than 20 years when they left, stating, "I don't think it's fair that we had to cater to the foreign people rather than them trying to change to our way of doing things." (St. John 2014) Ultimately, the church changed its name to the Clarkston International Bible Church and held different congregational meetings in different rooms of the church so that the broad demographic

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[11] *Outcasts United* is a book by Warren St. John that chronicles the journey of a refugee soccer team in Clarkston, their coach, and their struggle to form a winning team.

of people from Kenya, Malawi, Nigeria, the Philippines and others had a place to worship. In 2014, the church hopes to integrate into one large congregation.

Another major Clarkston controversy has inspired *Outcasts United* as well as a play called *Third World* directed by Lisa Adler. In 2007, under pressure to gain votes, the mayor of Clarkston, Lee Swaney, declared there would be no more soccer games in Milam Park. Only baseball and football matches would be allowed. Many Clarkston locals saw soccer as a sign of foreignness. Swaney was caught between pleasing his voters and opening the public field to refugees. (St. John 2007) The refugee team that became the subject of St. John's book became known as "The Fugees." Young men, ages 9 to 17, from Africa and the Middle East, wanted to use Milam Park for practice under the direction of their coach, Luma Mufleh. Mufleh inspired many articles about her dedication to the team, and she ultimately convinced the mayor to let the team practice at Milam Park on a trial basis for 6 months. Ultimately the Fugees became a successful team despite the adversities they faced.

These two stories represent the type of media coverage Clarkston received in the focus on tensions between locals and refugees, the meaning of assimilation, the conflicts between American values and refugee values, and the political power constructs in the city. In the same way soccer was seen as "foreign," refugees represented the "other" in a city historically familiar with the discourse of "us" versus "them," "west" versus "east," and "third world" versus "first world." These dichotomies put American values at the forefront, pushing immigrant culture and knowledge out. In terms of refugee mental health, the problem is not that Americans are forcing refugees to assimilate to their values. Rather, the conflict is that citizens do want to help, but the process of paternalism

creates a difference in power that puts refugee values to the side. In psychiatry, this means that professionals may understand and treat refugee illness in terms of US values, when in reality refugees have a different cultural constructs of disease and the American mental health categories may not apply. This brings us to Kleinman's category fallacy, discussed later in the paper. Applying nosological categories from one culture to another culture does not make sense, because disease is culturally understood and culturally treated.

Refugees in American Media Frames

The interaction between refugee stories and the media also propagates the use of a Western model of mental health to help these people. The way the general population of the US views refugees is heavily shaped by media frames. Media frames are "particular ways in which journalists compose news stories to optimize the accessibility and impact of a story on a particular audience." (Steimel 2010) An examination of the media of frames of refugees can bring to light the dominant social discourse about refugees in America. A study looked at the major US newspaper articles in 2008 to study how refugees are portrayed in human interest stories in the media. The general themes that were found were refugees as prior victims, refugees in search of the American Dream, and refugees unable to achieve the American Dream. A strong theme throughout refugees as victims was death; death of parents, death of children, death of friends. This victimization of refugees in the media through human interest stories has a profound affect on the way the public, including mental health professionals, view refugees. When "a preference for portraying individual refugees as victims needing protection and aid" is

the prevailing media frame, it takes away agency from the refugees themselves. (Steimel 2010) More importantly, the media captures refugees as victims of their country and victims of their culture, thus privileging the Western perspective. Refugees are characterized by the horrors of their homelands through the media and as people who need help. Providing the victimized refugees with mental health services is an easy fix for those looking to help; clearly, their countries are doing a poor job, they need western mental health services to help them.

Besides local media, victimization of low-income countries is present in even more conspicuous places in academia; the field of global mental health. Shekhar Saxena is the Director of the Department of Mental Health and Substance Abuse at WHO. Saxena argues for more mental health services in low and middle income countries (LMI countries). While at first his endeavor seems a positive one, a closer look shows the flaws in Saxena's argument. In 2007, Saxena wrote an article reviewing the state of mental health services in many LMI countries. Saxena says, "A very large or very small number of psychiatric beds relative to the mental health budget can indicate that services for people with serious mental disorders are not adequate." (Saxena 2007) However, the concept of hospitalization of the mentally ill is a western concept. By measuring ability to provide mental health care by number of psychiatric beds, an inconsistency is created; the measurement of mental health care quality is set at a single, western-based standard that ignores other forms of mental heath care such as religious leaders, spiritual healers, and other sources. This was a major criticism of epidemiological studies done by organizations such as WHO that attempted to quantify the frequency of mental health illnesses in different regions. WHO was attempting to show that rates of expression of

mental illness like schizophrenia were the same across cultures, thus giving validity to certain psychiatric categories. However, anthropologists questioned these methods.

Such a narrowly defined definition of mental health services will make it seem as if no infrastructure for help exists in LMI countries, when in reality, mental health support may exist in places that western measurements are not detecting. Perhaps the reason that only .34 beds per 10,000 people are available to those in Africa while 8 beds in 10,000 people are available in Europe is a testament to how different cultures choose to receive care rather than a lack of resources. (Saxena 2007) This proves to be another example of Kleinman's category fallacy. By saying these LMI countries need to scale up their mental health services, the western world victimizes them as inferior, incapable, and in need of outside help while ignoring local types of care.

A recent op-ed in the New York Times by Alex De Waal, a British researcher on African issues, addresses the Western involvement in Somalia's affairs. De Waal's argument is that Somalia was not the incredible mess that the US and UN perceived it to be, and that the involvement of foreign nations was uninformed. Somalia was successful because of its "booming private sector," and more importantly, Somalia's clan-based system was not the enemy of a stable government but rather the basis of a stable government. De Waal claims that "rather than seek a solution in Somalia's traditions and proven successes, Western policy has favored pursuing direct action against suspected terrorists, recreating a central government based on power sharing among the factions and establishing formal state institutions to solidify security." (DeWaal 2012) This sentiment of ignoring Somali systems in favor of Western strategies mirrors the dilemma occurring in global health discourses. In fact, one could argue that importing a foreign

government system by ignoring local systems is a form of category fallacy. By ignoring Somali frameworks of mental health belief systems in favor of western categories, Western nations are, in a way, making the same mistakes that they made in trying to establish stability in Somalia. It is more go with the grain of Somali culture rather than "through distrusted foreign intermediaries." (DeWaal 2012)

Chapter 2: Perspectives on Mental Health

Global Mental Health

Global Mental Health (GMH) as a discipline debates important concepts relating to refugee mental health. GMH is a relatively new discipline that has yet to define its own mission. Loosely, GMH attempts to provide information about mental health and attempts to identify cost-effective ways to meet mental health needs globally. One debate surrounding GMH is if global mental health is really just a way to homogenize the field of mental health to a western framework. Another debate in GMH is if psychiatric categories have an underlying cause in the brain, and if it even matters since psychological illnesses are socially constructed as shown by a current lack of underlying etiology. The most important debate relevant to my research is whether or not mental health categories as described in the DSM are universal, or if human distress is so culturally bound that attempting to equate other categories from other cultures is a form of hegemony because there are cultural differences in expressions of distress. This debate has often applied to high-income nations providing humanitarian aid or trying to reform mental health care in low- and middle-income nations, but it also applies to

refugees in the US and can help answer the question: Are using the DSM and western diagnosis protocols a legitimate route to take when working with men, women, and children from different cultures?

Journalist Ethan Watters in *Crazy Like Us: The Globalization of the American Psyche* captures the essence of what is happening in global mental health by chronicling instances in Sri Lanka (among other nations) that show local idioms being replaced by western idioms. His chapter about the Sri Lankan tsunami, in which "western experts on the ground in Sri Lanka took to training the locals in the latest techniques of treating PTSD," claims this wave of psychologists and psychiatrists ready to assist the needy Sri Lankans against PTSD was actually harmful because "little about the human reaction to trauma is universal." (Watters 2010) Watters chronicles the negative consequences of categorizing all distress seen in Sri Lanka as PTSD, including the unauthorized distribution of antidepressants. As much as Americans believe they are practicing cultural competency, western culture tends towards the almighty 'diagnosis,' however, Watters argues, this is not how other cultures operate. In addition, to ignore the fact that Sri Lankans probably had a framework for understanding and coping with trauma already in place shows that Americans were not exhibiting cultural competency at the time of the tsunami.

Another important distinction in the field of social science research comes out of Watters work; the distinction between the emic and etic approaches. Although Watters is a journalist, he distinguishes the emic and the etic. The etic approach to social science research puts a western scientific lens on the experiences of local people. It attempts to categorize their experiences into something more generalizable, and allows the researcher

to interpret their findings in context of other research. The etic approach is useful because it facilitates comparisons across research projects and across cultures. An example of research conducted from an etic approach is Mark Nichter's piece on expression of distress among South Indian Havik women. (Nichter 1980) Through the etic approach, Nichter is able to quantify psychosocial problems and hypothesize how Havik women express anxiety and distress. The drawbacks of the etic approach can be seen in his conclusion, however, for he resolves that for a Havik woman, "outside opportunities for the expression of distress are limited in comparison to other Hindu castes," implying that expression of distress is a necessary component to healing, when in reality it may be more beneficial for Havik women not to overtly express these feelings. On the other hand, the emic approach takes a local view of experiences.

The emic approach takes a local view of experience. It attempts to discover meaning from an individual or community point of view instead of imposing an outside lens upon the analysis. Emic research generally involves using qualitative measures in order to obtain local phenomenological descriptions.

In terms of mental health, the emic versus etic debate is best illustrated in the debate between Derek Summerfield and Vikram Patel.[12] In 1995, Patel published an article examining explanatory models of mental illness in Africa. In the conclusion, he states, "emic psychiatric instruments need to be developed if future cross-cultural psychiatric research is to be both comparable and culturally valid." (Patel 1995) However, in a later article, Patel expresses almost the exact opposite conclusion in a

[12] Derek Summerfield is a psychiatrist in London who researches the psychiatric effects of war. He has been heavily involved in GMH and argues that ethnopsychiatric definitions need to be considered in research. Vikram Patel is a Ph.D. who practices public health in India and sees a human rights crisis in the lack of access of LMI nations to mental healthcare.

broader study of global mental health. Patel concludes that it is a human right for all to have access to psychiatric care, and because this care can be universalized, the fact that "low- and middle-income countries are home to more than 80% of the population but command less than 20% of the share of the mental health resources" causes a treatment gap. (Patel 2010) This approach is clearly an etic one because local forms of mental health treatment were ignored and mental illness was measured using western instruments. By assuming that these low- and middle-income countries need mental health resources is to assume they have many mental problems and are incapable of dealing with them properly. Additionally, the classification of 'mental health resources' only included psychiatrists, psychologists, nurses, and social workers and left out local healers, traditional healers, and other mental healthcare stakeholders in low-income countries. A dugsi would certainly not be included as a mental health resource despite its clear role in protection and promotion of mental health. Patel believes treatment is not up to "acceptable standards" in LMI nations because of the treatment gap in schizophrenia and other disorders that are receiving no treatment through medication. Though it may seem beneficial to bring western mental health treatments to other countries, in fact, a study by the World Health Organization found that health outcomes for those with schizophrenia were actually *better* in developing countries than in the western world. (Watters 2010) Ultimately, Vikram Patel and other public health scholars focus on universalizing mental health care using western models as the gold standard.

Derek Summerfield, on the other hand, claims that mental health is entirely culturally based and there is nothing universal about it. (Summerfield 2008) Summerfield uses the evidence of a changing DSM as evidence that mental illness categories are

dynamic and change with time and culture. Summerfield is responsible for coining the phrase "medical imperialism." Medical imperialism is the idea that the ruling nations impose their medical conceptions upon other nations and that the ruling nations see these developing nations as having low mental health literacy. What is lost in medical imperialism is a two-way exchange—because mental health is more culturally bound than heart disease or diabetes where we understand the physiological mechanisms, there is no etiological truth to mental health yet. Thus, imposing western values on non-western nations occurs primarily because of differences in power and beliefs about who has the best 'knowledge'. Although Patel argues "knowledge can and must flow in both directions between high-income and low- and middle-income countries," he is fighting for the spread of western-based models of treatment, such as drug therapy and hospitalization. (Patel 2010) The debate continues regarding whether or not mental health is universalizable, or particular to each culture. But either way, it is clear that *knowledge about* and *expression of* mental health is culture specific and thus an emic approach is needed to understand the constructs of mental illness within a specific culture.

As the universalizability of mental illness debate continues, there is a more concrete argument about the expression of mental illness. There exists a dichotomy in mental illness known as the form/content dichotomy that may explain the universalizability of mental illness. Roland Littlewood talks about this dichotomy in his book *Pathologies of the West*. (Littlewood 2002) Littlewood distinguishes form as those aspects of mental illness that psychiatry can claim to explain, whereas content explains those aspects of mental illness that are culturally bound. For example, in schizophrenia,

the form is the symptom of hallucinations and paranoia. The content, however, may be paranoia of the CIA versus paranoia of God or other beings. However, as Littlewood argues, we know so little about the biological underpinnings of mental health, that this form/content dichotomy is often almost impossible to discern. The form/content dichotomy is not sufficient to explain cultural differences. For example, diseases such as dhat and koro[13], with visible symptoms such as loss of semen, have no form equivalent in the DSM. In other words, mental health is inextricably tangled within cultural constructs.

Values within a culture shape explanatory models, which ultimately dictate how treatment is offered. For example, Americans values reason and the scientific method. American treatments are based on science, biology, the interaction between biology and environment, and a Cartesian mind/body split. Also, western psychotherapies are based on the concept of an internal locus of control—the idea that one has the power to change his or her outlook. However, in Somalia, most people value religion and communal culture and do not view the mind and the body separately. (Eagle 2005) Thus, treatment can have spiritual roots. Also, past research has shown that the Somali people believe in gods and spirit and that "traditional healers…they read the Koran and help, and things will go away." (Carroll 2007) There appears to be a difference in belief about treatment of mental illnesses. The first step to understanding these conflicts is to figure out what exactly Somali refugees believe about mental health, its causes, and its cures. My own research found that mind and body are linked so that a healthy mind leads to a healthy body, and a healthy mind comes from practicing religion and getting adequate sleep. The

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[13] Dhat is a condition found in the Indian subcontinent that is characterized by males suffering from impotence or premature ejaculation as well as weakness and exhaustion. It is classified as a culture-bound syndrome in the DSM. Koro occurs worldwide and is characterized by a belief that the genitals are shrinking or retracting and may be fatal, and the symptoms include anxiety and fear of death. Culture-bound syndromes have a separate chapter in the DSM.

fact that the word dugsi does not appear in any research on Somali mental health highlights something Dr. Asha told me: people either know Somali culture or American culture. The researchers come from a western perspective and want to translate the terms into western words for doctors. The reason dugsi is rarely mentioned in research is because most Somali's do not read and write English, and the researchers puts their research in western terms. There is little overlap between those who know the Somali culture and those who do research in the US, so there is a lot of hidden knowledge that needs to be teased out of these unique spaces by taking an emic perspective.

Mental Health in Sociology

In London, researcher David Palmer did a study on psychosocial factors and Somali utilization of resources. He talked about the importance of community to refugee mental health, as well as the importance of social capital. Social capital consists of "stock of active connections among people: the trust, mutual understanding, and shared values and behaviors that bind the members of human networks and communities and make co- operative action possible." (Palmer 2007) These social connections, as stated in multiple sociology papers[14], are vital to human mental health. The process of losing identity and the disintegration of community and then the process of redefining identity and rebuilding community after migration can be studied on the local level. Palmer used semi-structured qualitative interviews from an emic approach in order to extract themes from the interviews. I planned some of my own research on his model. Palmer found some important sociological themes such as the differences in conceptions of mental

[14] See Social Capital: Prospects for a New Concept. Adler 2002.
The Employment Experiences of Canadian Refugees: Measuring the Impact of Human and Social Capital on Quality of Employment. Lamba 2008

health of Somali and American people, differing opinions on the efficacy of talk therapy, and the importance of community groups. These same themes emerged in my research as well.

One of the important themes in London from Palmer's research that also applies in Clarkston is the problem of housing. There was little adequate housing, and as a result people were moved around and lived in cramped spaces, a serious stressor. While there are many apartments in Clarkston, they are small for some families and usually much smaller than homes in Somalia. Other stressors include being separated from families and having flashbacks to traumatic memories in Somalia. I found that viewing Somali mental health in terms of stressors can be very beneficial. Somali refugees understand stress in largely the same way sociologists and psychiatrists do. "Too much stress" as a cause of mental illness was a strong theme throughout the interviews, however, it is still important to look at the Somali conceptions of mental health. Palmer speaks about the gap in understanding between Somali and American citizens. Of course this gap is not due to lack of Somali understanding as many medical papers have claimed. These same papers blame 'lack of mental health literacy' and rally around 'cultural competence' as a solution to promoting mental health in refugee populations. However, the problem is not due to Somali misconceptions, in reality, it is due to deeply embedded western practices that have become common-sense, leaving all other views of mental health out. As Palmer states, "eight interviewees observed that the concept of stress or depression did not exist in their country of origin" and that Somalis believe in craziness or insanity, but not depression. (Palmer 2007) There is limited language for talking about someone being in mental distress without them being crazy. Additionally, due to the tight community,

Somali's seem to gossip, thus increasing stigma and fear to admit needing help. In fact, Palmer found that being diagnosed with a mental illness can further separate one from the community.

One unexpected finding from past studies like this is that when treating refugees, much emphasis has been put on PTSD, but in reality, PTSD is only a fraction of the problem. Rates of PTSD in the general refugee population is estimated to be between 4-86%; this extreme range indicates that studies probably both overemphasize and underemphasize PTSD in refugees. (Bolton 2007) Refugees are resilient and able to cope with trauma, but other psychosocial needs in the community must be met first. Creating job opportunities, community support and quality housing should be first priority. Fixing these problems related to basic needs will likely give refugees more resilience in promoting mental health, seeing as Maslow's hierarchy puts safety and comfort needs before esteem needs. Refugees are people who have lost their social capital and connections. Imagine the strength of a spider web, suddenly torn apart by turmoil. To re-establish these connections, social capital, connections, and support systems need to be restored in a way that promotes Somali refugee mental health. The best way to understand these social needs is to conduct emic research and understand what living healthily means to a Somali woman. One important part of the web for the women I interviewed was knowing other Somali's. Focusing on mental diagnoses and applying western constructs of healthiness and happiness to these displaced people is controversial; rather, we must aim to understand their sociological constructs and their concepts of healthiness to promote mental health. The focus on western constructs is

particularly relevant to recent debates around the Diagnostic and Statistical Manual of Mental Disorders.

The DSM Controversies

> *"The experience of illness (or distress) is always a culturally shaped phenomenon (like style of dress, table etiquette, idioms for expressing emotion, and aesthetic judgments)…Furthermore, professional and lay interpretations of experience are communicated and negotiated in particular relationships of power (political, economic, bureaucratic, and so forth)" –Arthur Kleinman (Kleinman 1988)*

The Diagnostic and Statistical Manuel of Mental Illness (DSM) is used by clinicians, insurance companies, pharmaceutical companies, and other entities in America to classify mental illnesses based on symptoms. The World Health Organization (WHO) publishes another disease classification system called the International Statistical Classification of Diseases and Related Health Problems (ICD). The ICD is now in its 10th edition and releases a special edition for classifying mental health illness. The DSM and ICD committees work together, but publish separate works. The ICD is supposed to be even more universal because a single country does not produce it and it is multidisciplinary and multilingual (unlike the DSM). Despite this, the language in the ICD classification of disorders is similar to the DSM. Below are the definitions of depression in the ICD 10 and the DSM:

Depression in the ICD-10	Major Depressive Disorder in the DSM IV
Diagnostic criteria for depression ICD-10 uses an agreed list of ten depressive symptoms A The depressive episode should last for at least 2 weeks There have been no hypomanic or manic symptoms sufficient to meet the criteria for hypomanic or manic episode at any time in the individual's life The episode is not attributable to psychoactive substance abuse or to any organic mental disorder B Depressed mood to a degree that is definitely abnormal for the individual, present for most of the day and almost every day, largely uninfluenced by circumstances, and sustained for at least 2 weeks Loss of interest or pleasure in activities that are normally pleasurable Decreased energy or increased fatigability C Loss of confidence or self-esteem Unreasonable feelings of self-reproach or excessive and inappropriate guilt Recurrent thoughts of death or suicide, or any suicidal behavior Complaints or evidence of diminished ability to think or concentrate, such as indecisiveness or vacillation Change in psychomotor activity, with agitation or retardation (either subjective or objective) Sleep disturbance of any type Change in appetite (decreased or increased) with a corresponding weight change. Mild depressive episode All A+minimum 2 B+minimum 2 C Moderate depressive episode All A+minimum 2 B+minimum 4 C Severe depressive episode All A+all B+minimum 5 C	DSM-IV Criteria for Major Depressive Disorder (MDD) • Depressed mood or a loss of interest or pleasure in daily activities for more than two weeks. • Mood represents a change from the person's baseline. • Impaired function: social, occupational, educational. • Specific symptoms, at least 5 of these 9, present nearly every day: 1. Depressed mood or irritable most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). 2. Decreased interest or pleasure in most activities, most of each day 3. Significant weight change (5%) or change in appetite 4. Change in sleep: Insomnia or hypersomnia 5. Change in activity: Psychomotor agitation or retardation 6. Fatigue or loss of energy 7. Guilt/worthlessness: Feelings of worthlessness or excessive or inappropriate guilt 8. Concentration: diminished ability to think or concentrate, or more indecisiveness 9. Suicidality: Thoughts of death or suicide, or has suicide plan DSM – V proposed (not yet adopted) anxiety symptoms that may indicate depression: irrational worry, preoccupation with unpleasant worries, trouble relaxing, feeling tense, fear that something awful might happen. Screen for conditions that may mimic or co exist with Major Depressive Disorder: • Substance abuse causing depressed mood (eg. drugs, alcohol, medications) • Medical illness causing depressed mood • Other psychiatric disorders: mania, hypomania, bipolar, schizoaffective, schizophrenia, etc. • Bereavement unless symptoms persist for > two months or show marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Due to the fact that my study looks at Somali refugees in America, I will focus my attention on the debates surrounding the DSM even though the same debates likely surround the ICD because both classify diseases using symptoms as the primary guide. On the American Psychiatric Association (APA) home page, the DSM is "the standard classification of mental disorders used by mental heath professionals in the United States." (APA) Much controversy surrounds the DSM as a standard. One criticism comes from the National Institute of Mental Health (NIMH), claiming that the DSM is based on subjective experiences. Another criticism is that the DSM medicalizes normal behaviors. The literature is fraught with opinions on the medicalization of grief. A third criticism addresses the question of culture. There has been a continuing discussion about if these codified mental illnesses are universal. Does depression have an underlying etiology like diabetes does? The answers to that question may be related to neurotransmitters, but in reality, the research results are unclear. While antidepressants have been shown to help in severe cases of depression, some studies have shown that placebo's are equally as effective[15]. Between the billions of dollars involved in drug companies and our lack of knowledge of the etiology of many mental illnesses, the American consumer is left in confusion. Add to this discussion the fact that some mental illnesses are local phenomena and only observed in certain parts of the world, and the picture of mental illness only gets messier. Clearly, the field of mental illness is very

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[15] Khan, A. "Symptom Reduction and Suicide Risk in Patients Treated With Placebo in Antidepressant Clinical Trials: An Analysis of the Food and Drug Administration Database." *Archives of General Psychiatry* 57.4 (2000): 311-17. Print.
Kirsch, Irving, and Guy Sapirstein. "Listening to Prozac but Hearing Placebo: A Meta-analysis of Antidepressant Medication." *Prevention & Treatment* 1.1 (1998): n. pag. Web.

confusing within the US. The DSM remains the golden standard of diagnosis, but examining the cultural relevancy of the DSM is vital to understanding mental health.

Ethan Watters takes a controversial standpoint on the issue. He and many others in sociology and anthropology agree that expressions of mental illnesses are culturally bound, thus the symptoms that characterize PTSD in America may be different than the symptoms that characterize PTSD in Somalia. Additionally, local terms of mental illness would obviously be different. In his account of eradicating smallpox in Africa and India in his book *House on Fire*, William Foege says "another lesson I have learned over time is to respect culture as a powerful force; when you tangle with it, culture always wins." (Foege 2011). And yet it seems that the western model of mental health prevails when treating people of other cultures and those other cultures have been left in the dust regarding 'advancement' of western mental illness treatment. America has universalized mental illnesses not only within its own walls, but globally as well with the introduction of the DSM.

Mental illness definitions are not static, they are culturally bound, and they change over time. The first DSM was released in 1952 and was only 129 pages long. DSM I contained hysteria as a diagnosis and referred to Downs Syndrome as 'mongolism' because the features of downs syndrome shared similarities with the Mongolian race. The DSM I also classified homosexuality as sexual deviation under "sociopathic personality disturbance" along with pedophilia and sexual sadism. (APA 1952) The newest version of the DSM, the DSM 5, was released in 2013 (13 years after

the updated DSM 4)[16] and has not been developed without some controversy. The NIH covered some of the major controversy surrounding the development of the DSM 5. One of these controversies is that 18/27 members of the task force responsible for developing the newest version of the DSM have direct links with pharmaceutical companies. The task force has defended themselves by saying industry and researchers are inextricably linked. ("Controversy" 2013)

The second important controversy surrounding the development of the new DSM is the medicalization of normal behaviors. The definition of normality has always been an issue in assessing mental illnesses, but particularly more recently because Allen Frances (who was on the DSM 4 taskforce) noted that the threshold for diagnoses of things like generalized anxiety disorder and major depressive disorder are much too low. The changes in the diagnoses to major depressive disorder are particularly interesting as we talk about how culture plays into these diagnoses. The original definition of major depressive disorder in the updated DSM 4 is as follows:

DSM-IV Criteria for Major Depressive Disorder (MDD)
• Depressed mood or a loss of interest or pleasure in daily activities for more than two weeks.
• Mood represents a change from the person's baseline.
• Impaired function: social, occupational, educational.
• Specific symptoms, at least 5 of these 9, present nearly every day:
1. Depressed mood or irritable most of the day, nearly every day, as indicated by either subjective report
(e.g., feels sad or empty) or observation made by others (e.g., appears tearful).
2. Decreased interest or pleasure in most activities, most of each day
3. Significant weight change (5%) or change in appetite
4. Change in sleep: Insomnia or hypersomnia
5. Change in activity: Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Guilt/worthlessness: Feelings of worthlessness or excessive or inappropriate guilt

[16] The DSM-I was published in 1952. The DSM-IV was published in 1994. The updated version of the DSM-IV, the DSM-IV-TR, was published in 2000 and the DSM-IV was published in 2013.

8. Concentration: diminished ability to think or concentrate, or more indecisiveness
9. Suicidality: Thoughts of death or suicide, or has suicide plan

Screen for conditions that may mimic or co exist with Major Depressive Disorder:
• Substance abuse causing depressed mood (eg. drugs, alcohol, medications)
• Medical illness causing depressed mood
• Other psychiatric disorders: mania, hypomania, bipolar, schizoaffective, schizophrenia, etc.
• Bereavement unless symptoms persist for > two months or show marked functional impairment, morbid preoccupation with
worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

The newest DSM simply removes the bereavement clause, meaning that grief after death that fits the symptoms of MDD may receive a diagnosis and thus pharmacotherapy treatment. This has been criticized as medicalizing normal reactions.

News of recent changes in the DSM reached the national media amid much controversy. On NPR's "All Things Considered," for example, Jerome Wakefield from the NYU Department of Psychiatry discussed the changes to MDD and says, "you're basically medicating people who are going to remit on their own, are probably going to do fine…it's a mistake to make it routine to open up people to medication under these circumstances." (Cornish 2013) The NPR piece also discussed other changes, such as the addition of hoarding disorder to the DSM-V. Hoarding disorder is exactly that; "For individuals who hoard, the quantity of their collected items sets them apart from people with normal collecting behaviors." (APA 2013) An eminent disorder to be discussion for inclusion in a future DSM is "internet use gaming disorder," characterized by playing "to the exclusion of other interests" and "results in clinically significant impairment or distress."

These two pending disorders demonstrate an important fact about the DSM: the DSM shapes how westerners experience mental illness. Allen Frances is an American

psychiatrist who was the chair of the task force that created the DSM IV. Frances gives an apt example of this in his ten criticisms of the new DSM V. Frances says "the everyday forgetting characteristic of old age will now be misdiagnosed as Minor Neurocognitive Disorder." (Frances 2012) Frances goes on to say that Minor Neurocognitive Disorder has no treatment and will create anxiety in those diagnosed with it. It also highlights another important facet of the DSM: the DSM is put out by the American Psychiatric Association (APA) and thus far largely ignores other non-western cultures.

In fact, the DSM IV was largely criticized for the way it incorporated culture. (Mezzich 2008) A multidisciplinary task force called the Culture and Diagnosis Work Group including sociologists, medical anthropologists, and representatives of ethnic minorities were entrusted with assembling suggestions for the DSM IV. However, the final DSM ignored many of the suggestions made by the task force. Culture took a back seat to the idea of universalizability of disorders. The task force proposed a glossary of culture-bound syndromes and idioms of distress. While the culture-bound syndromes were included, the idioms of distress were not. Also interestingly, the group proposed some western culture-bound syndromes be included in the index to explain anorexia and multiple-personality disorder, but the western-culture bound syndromes were excluded. This left the glossary looking like "a museum of exotica" rather than a legitimate way to conceptualize nosological categories. (Mezzich 2008) While inclusion of culture through the Culture and Diagnosis Work Group is an improvement, the DSM ignored many of the group's suggestions, particularly ones that negated the DSM as universally applicable.

As long as the etiologies of the illnesses in the DSM are unknown, it must be

assumed that culture plays a large role in the way mental illness is experienced, understood, and treated. That is why it is important to grasp other cultures' conceptualizations of mental health and mental illness. Somalia has a unique history and approximately 50,000 Somali refugees have come to the US. The culture is very different than America's, so the population serves as an interesting and unique space to study conceptions of mental health.

Chapter 3: The Study and Methodology

Somali Refugees and the Need for Cross Cultural Research

As a child of Pakistani immigrants growing up in America, my first approach to refugees in America was a sympathetic, pitying one. I had this idea that refugees were victims and needed to be helped, and the way to do it was to make sure they were taking their medications in order to get better from these inevitable mental health issues. Although altruistic, I have learned that this approach has actually been counter-productive and has caused many problems in the past. First of all, to assume that refugees are in need of mental health services is to assume that refugees are suffering, and then to medicalize this suffering. Renos Papadopolous states in his book on therapeutic care for refugees states that the only experience refugees share is losing their homes; not necessarily trauma. (Papadopolous 2002) That being said, refugees do experience trauma due to the nature of crises in their homelands, but refugees and mental illnesses such as PTSD need not be inextricably linked. Assumptions about such a connection can lead to unintended consequences and stigma. I believe by focusing on

emic approaches to mental health and mental illness, Americans can better see refugees as resilient and use this resilience to formulate a framework for working with Somali refugees based on their cultural strengths and, as opposed to imposed western ideals. For example, I found that Somali refugees find strength in religion and community. These values need to be considered in promoting mental health.

According to the United Nations High Commissioner for Refugees, "a refugee is someone who has been forced to flee his or her country because of persecution, war, or violence." (UNHCR 2014) Immigrants, on the other hand, leave a country voluntarily. Should they return, immigrants continue to have the protection of the government whereas refugees cannot safely return. The very nature of being a refugee—being forced from home by turmoil—implies hardship, stress, and a potential for trauma. Particularly in the experience of Somali refugees, rape was often used as a control device, people were killed in front of their families for intimidation, and people were frequently robbed. As discussed above, Somalia's recent history has been one of unstable governments and fights for power. Most recently, the Al-Shabaab militant group had been terrorizing opposition. As a result, Somalia has had over 1 million refugees, with approximately 100,000 resettled in the United States. (CDC) Clarkston, GA is a small city of 7,554 where refugees were given resettlement opportunities just outside of Atlanta. Clarkston is home to thousands of refugees, many of whom are Somali. ("About Clarkston" 2014)

Somali refugees in the United States have been of intense interest to researchers because studies indicate that the prevalence of mental health issues among Somali refugees affects 1 in 3 people. (WHO 2011) Western researchers working with Somali refugees emphasize the effects of torture, murder, and rape during the Somali Civil War.

Despite research on prevalence of mental illness in refugees from a western perspective, multiple studies cite the lack of culturally-relevant research to the area of mental health and well-being. It is vital to study the cultural constructs, history, and experiences of Somali refugees because the expression of psychological distress is inevitably culturally bound. This means views of well being and mental health are also culturally bound and cannot be understood without first-hand narratives.

Past research on Somali refugee mental health is limited in quantity and scope and mostly takes place from an etic approach. Guerin et. al. researched Somali conceptions and expectations of mental health in New Zealand. Their research states "Although there have been many cross-cultural approaches to understanding mental health, they have often focused on westernized groups such as Asian Americans or Hispanics. Literature relating to mental health of refugees resettled in western countries is more limited." (Guerin 2004) The research related to Somali refugee mental health has generally taken place in the form of qualitative interviews in various fields including global mental health, psychology, psychiatry, and sociology.

The findings of these emic qualitative interviews reflect unique attitudes of Somali refugee women towards mental health. First of all, having any mental illness is heavily stigmatized and is the equivalent of being 'crazy'. One important role of Somali women is the head of the house, and thus the women are expected to be strong. This leads to a 'get on with life' approach to mental illness; in addition, it causes Somali women to conceal their distress as a means of coping. Another important facet of coping for Somali refugees is religion; Somalis are Muslim and the Qu'ran serves as familiarity and stability in their lives. Additional research has classified some Somali-specific

idioms of distress such as zar, walli, and jinni, all related to spirits and mental illness. However, we must be careful with these findings. Even though these were themes across culture, many were framed from a Western, etic perspective. In fact, the word 'dugsi' does not come up in any of the research despite the dugsi's importance in Somali culture and in healing. The interviews were done and analyzed by westerners. Despite this, the qualitative data showed general consensus among themes relating to Somali refugee mental health[17].

Values of a culture shape explanatory models, which ultimately dictate how treatment is offered. For example, America values reason and the scientific method. Western treatments are based on science, biology, and the interaction between our biology and our environment. Also, western psychotherapies are based on the concept of an internal locus of control—the idea that you have the power to change your outlook. However, in Somalia, they value religion and communal culture. (Eagle 2005) Thus, treatment can have spiritual roots. Also, the Somali people believe in gods and spirit and that "traditional healers…read the Koran and help, and things will go away." There is a clear conflict in these values and these beliefs about mental health. The first step to understanding these conflicts is to figure out what exactly Somali refugees believe about mental health, its causes, and its cures. One way of accomplishing this is by studying explanatory models using the Explanatory Model Interview Catalogue.

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[17] Guerin 2004
Palmer 2006
Schuchman 2004
Carroll et. al. 2007
Scuglik et. al. 2007

The Explanatory Model Interview Catalogue and Narrative Research

In the same way that knowledge is being lost with fewer qualitative studies, French philosopher Michel Foucault argues that the way institutionalized knowledge is structured allows for other knowledge to be deemed inferior and remain marginalized. Narratives bring this type of marginalized knowledge into the open. These stories and narratives are not just stories; it is not just about a life history. It is about how the story is constructed which gives a glimpse into how our own identities are constructed. (Berger 2005) Psychologist Dan McAdams studies narrative psychology and in his book he traces the history of narrative as a form of research. Only in the 1980's did narratives come to be seen as valuable to the formation of self-concepts. (McAdams 2001) McAdams argues that "individual life stories reflect cultural values and norms, including assumptions about gender, race, and class." Life stories can also lead to insights on what McAdams terms *imagos*, or an idealized personification of the self. Imagos help give an understanding of what the person believes about himself or herself; in the context of mental health, it can lead to clues about the roles that are most important to these women.

Specific to Somali culture, Robyn Ramsden is a researcher who has done work in Australia that shows that Somali's create narratives to forget. This same spirit of forgetting is reflected in Palmer's qualitative data: "Why should I talk about problems? I don't want to remember, I want to forget." (Palmer 2007) It was also occasionally reflected in my own research. When I asked an interviewee about Somalia, she said she did not want to talk about it. Another said "I have no stories form Somalia". According to Ramsden, Somali language was not written down until the 1970's, so oral tradition is important to Somalis. Refugees' views of their past experiences are largely shaped by

memory and memory adjustment in such a way that promotes collective memory. It is therapeutic to reframe the way events occurred, particularly as a collective. Somali life is extremely collectivistic with the family unit staying together throughout life. Refugee status sometimes breaks these family ties, making it more difficult to reshape or recover memories. Most Somalis in Ramsden's study remembered Somalia as peaceful and happy. In my own research, women see Somalia positively and say that "there is no stress in Somalia…in Somalia, people help each other. There is less stress and it is peaceful despite the war." They also reminisce about strong community ties, friendly neighbors, and safe neighborhoods. The questions I have written for my original research stem from a qualitative method of data collection called the EMIC (Explanatory Model Interview Catalog). It addresses the informants views and opinions of mental health in order to grasp a better understanding of what is important and valued within Somali to culture.

Discerning approaches to discovering explanatory models had been fragmented until the development of the EMIC by Mitchell Weiss in the field of transcultural psychiatry. (Weiss 1997) EMIC uses semi-structured interviews to find patterns of distress, perceived causes, and general illness beliefs. EMIC arose out of the new cross-cultural psychiatry movement, began by Arthur Kleinman, and it attempts to incorporate non-western values into mental health treatment systems. In a way, the DSM is the embodiment of western explanatory models, while interviews can give epidemiologists and anthropologists insight into other cultures' explanatory models. EMIC is based off eight questions created by Arthur Kleinman in his attempts to uncover explanatory models. Kleinman is a leader in anthropology and cultural psychiatry. His work first

peaked my interest in explanatory models and illness narratives. In 1977, Kleinman wrote an article introducing the concept of a category fallacy. In this article, Kleinman called for a 'new cross-cultural psychiatry' that would differ from the old transcultural psychiatry by obtaining local phenomenological descriptions of disease. Kleinman's 'category fallacy' became the primary criticism of the old transcultural psychiatry. Category fallacy is the error of imposing one culture's cultural categories upon another. In my research, imposing American cultural categories and mental illness measurements onto Somali culture would create invalid diagnoses. (Kleinman 1977) The questions from Weiss's EMIC are based on Kleinman's research. The questions elucidate explanatory models of illness, and I have adapted them to speak about mental illness and I have adapted them to speak about their experience from a distance rather than exclusively personal experience. This allowed for a less invasive conversation about mental health and illness to transpire.

A study done in in Bombay used EMIC to examine the effects of a leprosy diagnosis on mental health as well as the perceived causes of leprosy. (Weiss 1992) The study used 56 patients and used semi-structured interviews with the EMIC questionnaire to examine perceived causes of disease. The interviewers made consensus ratings and discussed the data from the interviews to uncover important themes. The perceived causes of disease were summarized in a table, with macro-religious explanatory models occurring in 50% of patients. My research has been modeled after a portion of that study, particularly the use of EMIC and the extraction of themes.

The original 8 questions are as follows:

What do you think has caused your problems?

Why do you think it started when it did?

What do you think your sickness does to you?

How severe is your sickness? Will it have a long or short course?

What kind of treatment do you think you should receive?

What are the most important results you hope to receive from this treatment?

What are the chief problems your sickness has caused for you?

What do you fear most about your sickness?

I have adapted those 8 questions to talk about Somali culture in general. The reason for this is that mental health is a sensitive issue, and to ask personal questions about it would not be conducive to an honest conversation. Instead, the questions were adapted to talk about Somali culture in general. A problem here is that the EMIC questions are designed for individuals to answer about themselves. In this manner, the EMIC encapsulates beliefs about a specific disease to a specific person. My adaptation will ask about Somali culture in general. Since "efforts to develop the EMIC aimed to provide a method for cross-cultural research," I find it appropriate to apply these questions to a specific culture. (Weiss 1997) In light of the fragmented history of Somalia, the debate is then whether Somali women refugees can be considered a single culture such that the views of mental illness are relatively consistent. Because Somali's share language, a collective memory of Somalia, religion, and the experience of being a refugee, I believe these women can be seen as sharing a common culture.

Collective trauma is part of the reason the Somali women are being treated as a unified population. It is a term that describes the forces behind migration as well as experiences after migrating due to massive traumas. In Somalia, living under harsh dictatorship and unstable government conditions causes collective trauma and tears in the social fabric of communities. Seeing as "collective events and consequences may have more significance in collectivistic communities," the Somali people are particularly vulnerable to collective trauma because of their strong identity as members clans, communities, and families. (Bhugra 2004) If the communal culture is strong enough, "nuclear and extended families tend to function and respond to external threat to trauma as a unit rather than as individual members." (Bhugra 2004) Families often face these threats and stresses together. Unfortunately many Somali family units have been separated by immigration. This makes building a Somali community even more important. It is important not to diminish the individual beliefs of these women—their beliefs varied considerably, from some believing in no treatment for mental illness to others believing in pills. However, many consistencies in beliefs were found from the interviews.

Another issue with the adaptation of these questions is that they need to be adapted specifically to mental health. The challenge here is identifying how to ask about mental health without disturbing answers given. Since EMIC is designed to be open-ended so that the interviewee can provide his or her own answer without interviewer biases (i.e. no mention of terms like depression and stress), I used the term "mental illness" in each question to create unbiased answers. That way, whatever mental health meant to the interviewee is what was asked about.

Adapted Questions:

What do you think causes mental illness?

Why does mental illness begin?

What do you think mental illness does to somebody?

How severe is mental illness? Does it have a long or short course?

What kinds of treatment should mental illness receive?

What results can people expect from this treatment?

What are the chief problems mental illness causes for people?

What do people fear most about mental illness?

The interviews were conducted at the dugsi. Some interviews required a translator and others did not. The interviews began with the 8 EMIC questions, and depending on how it was going, I would ask further questions about life in Somalia, life in America, well-being, and other questions relating to the journey of these women.

Chapter 4: The Interviews

Findings

When I walk into the dugsi to conduct interviews, I go around and firmly grasp each woman's hand and say "salaam". Dr. Asha sits on a chair while everyone else sits on the ground. The women are speaking in Somali, as far as I can tell they are swapping stories as they laugh. When the room looks pretty filled, Dr. Asha beckons me to come sit closer to her. I sit on the floor beside her chair, and she starts speaking in Somali. I

can tell she is introducing my project. I try to smile, look pleasant, but I am nervous that my project on mental health will be seen as unwanted nosiness. I look at the group of women, and see that some are looking at me as Dr. Asha speaks. When she finishes speaking, a few women agree to take part in the study, and I am thrilled! I scoot over to the woman with Dr. Asha, and we begin. She tells Dr. Asha she does not want to be recorded, so I get my pencil and paper out. In fact, none of the women want to be recorded.

The interviews themselves were a bit out of my control, as I was conducting them in the dugsi under Dr. Asha's direction. I had expected to conduct lengthy, one-on-one interviews with individuals but the atmosphere was much more casual than that. Instead, I would begin talking to a woman and another lady would hear the questions and jump in. I believe this speaks to the communal culture of Somalia and the importance of community. Despite or perhaps due to Somalia's history of fragmentation, community is of utmost importance and this was prevalent even during interviews.

While I expected the interviews to be long and intensive, speaking through an interpreter is exhausting. Thus, many of the interviews were shorter than anticipated. Not only that, but the women were much more comfortable interviewing in the main room rather than individually. I decided to cover the 8 EMIC questions first, and then move on to collect some information on their personal lives and life in America if the women were willing.

Overall, the themes about mental illness are clear. While opinions were far from homogenous, there were some important threads that carried throughout each interview. These women came from diverse backgrounds. Some were older, some were newly

married, some had gone from Somalia to Kenya to the US, some had lived in Canada—the diversity in the room was rich. Other studies done on mental illness in Somali refugees speak homogenously about the population. For example, Palmer generalizes to say that "counseling is viewed as an alien concept," however quite a few of my interviews suggested seeing a doctor or therapist to talk about their problems. (Palmer 2007) Some causes of mental illness were consistent across the interviews, with stress mentioned in 9/10 interviews. Less sleep was mentioned in 3/10 interviews, thinking too much mentioned in 3/10 interviews, 2/10 mentioned genetics and getting it through the family, and 2/10 mentioned mental illness coming from a physical blow. However, other beliefs about severity and treatment options varied widely. While some women suggested there is no treatment at all for mental illness and that only God can control how one feels, others suggested going to a doctor. Other less frequently mentioned causes of mental illness were a "disrupted balance in the brain", verbal abuse, and keeping problems inside.

These numbers may seem to indicate inconsistencies in beliefs, but the way the EMIC is set up is to allow the interviewee to mention the most important causes for the interviewees without the interviewer prompting them. For example, if I had asked specifically about sleep, it is likely it would have been mentioned in more interviews, but the structure of the interviews allowed the interviewee to control the degree of emphasis. For that reason, the quantitative aspect of the research is much less important than the qualitative aspect. At the heart of this research is the individual. By teasing out belief systems and understanding where each woman is coming from, we can identify what is important to these women as a collective as well. While many of my findings matched

well with previous work on mental health in Somali refugee women, some of my research provided some interesting insight to the plasticity and range of beliefs held by this group of Somali women in Clarkston, Georgia.

In Mountains Beyond Mountains, Tracy Kidder tells the story of anthropologist and doctor Dr. Paul Farmer whose mission was to provide quality care to third world countries, with Haiti being his first area of interest. (Kidder 2003) Farmer found that in general, Haitian health staff blamed patients for non compliance with their medicates for tuberculosis, because patients believed TB came from enemies through sorcery. The health professionals blamed the Haitian's explanatory models for the compliance issues. Farmer subsequently did a study that essentially asked patients about their explanatory models of TB. He found that belief in sorcery or not did not affect treatment outcomes, but the addition of more resources (such as child care and food stipends) did. Farmer was confused by the study—how did beliefs not affect the outcome? In an interview with one of his patients he found his answer. She believed in TB as a function of both sorcery and germs; "it dawned on [Farmer] that he knew plenty of Americans—he was one himself—who held apparently contradictory beliefs such as faith in both medicine and prayer" (Kidder 35). The danger of trying to sort out beliefs of causes and effects in mental illness is oversimplification of belief systems. Beliefs are based on a complex network of history, culture, learned knowledge, and values. The graph made below is a crude way to summarize something that is nearly impossible to summarize, but it allows some patterns in the qualitative data to emerge.

Here in the chart I stripped the EMIC interview questions down to the bare, basic answers. Occasionally answers have been reorganized. For example, a treatment method

may have been mentioned in a separate question. The EMIC questions have been abbreviated to one word and are listed again here:

1. What do you think causes mental illness?
2. Why does mental illness begin?
3. What do you think mental illness does to somebody?
4. How severe is mental illness? Does it have a long or short course?
5. What kinds of treatment should mental illness receive?
6. What results can people expect from this treatment?
7. What are the chief problems mental illness causes for people?
8. What do people fear most about mental illness?

Interview	EMIC	1 Causes	2 Why?	3 Symptoms	4 Severity	5 Treatment	6 Results?	7 Problems?	8 Fear?
1		Stress Thinking a lot See someone get shot Accident (shock, a fight, neighbor is attacked) Shock	less sleep Genetic Brain out of balance	Cannot focus Angered easily Yell a lot Violent Dizzy Brain does not function fully	Depends on stress and when they find out. It can last a long time, forever.	Mental doctors. Read Qu'ran to balance brain. Family should help.	Get better with help, should read Qu'ran. Sometime the body is sick and it is mistaken for mental illness, only the doctor can tell you	Talk to yourself, lose belongings.	They get scared someone will kill them or they get scared that they will die
2		Stress Family Lifestyle changes Culture differences		Destroys their life Violent		Do not bury it, it will get worse and you can die. Get therapy. Share with family and friends. Use religion, read Qu'ran. Pills work sometimes but only if taken correctly. Having a social life and laughing is the first therapy. The dugsi is like a support group.			
3		Pressure Problems Trauma Genetic	When problems accumulate.	Causes harm, causes people to be suicidal. Depression. It can come from grief, children, economic problems, domestic violence, and shock. Culture	Can last a lifetime	As long as the problems remain, there is no treatment. There is no medicine, it is forever.	There is no treatment.	Risk of suicide. People have no life, no hope, and no trust	People fear being crazy, losing their mind and losing their abilities

				differences. It can also come when people hear about Somalia on the news, it triggers problems.					
4		Less sleep and stress	Less sleep, a physical blow to the head. Genetics.	Dizziness and migraines		Doctor can give treatment. In Somalia, take a hot rod and put it against the head (not in US). Take leaves and make a paste.			
5,6,7		Less sleep. Thinking too much.		They become nervous. They hate their family, they lose weight, they don't sleep. They may talk too much.	. In the US you get pills. In Somalia, they don't believe in medicine, people won't take it.	The Qu'ran. Sheikh. Qu'ran is better than medication. The family is responsible. Somali community and Sheikh can help too.	You can expect to get well. Medicine can take forever to work. Qu'ran helps the most.	The person who is sick thinks someone will kill them. Families are afraid the sick person will cause harm.	
8		Less sleep, less food. Stress. When you think you have nothing.	Begins with stress. When you think too much. Sometimes like a block in the veins, and it bursts and goes all over the body.	It causes problems in the family and stress.		Doctor can give medication. For craziness, use medicine. Use whatever the doctor gives you.			
9		If a woman is doing too much. She may talk to herself and then develop mental issues.	Low self confidence, mental abuse			For mild cases, people should take time off. Talk them, have them take it easy. If it is bad, see a doctor. Sometimes, going back to Somalia helps.			

The Themes

I looked at 5 articles[18] that explored Somali refugee mental health issues through interviews and compared their themes. These five papers conducted interviews with Somali individuals living in a western country of resettlement (America, Europe, or Australia) to extract themes related to barriers to mental health treatment and beliefs of Somali individuals on mental health issues. Some of the themes from the articles were similar while others differed. In my own research, some aspects agreed with the other papers and some of my findings did not. Here, I will examine important themes of Somali culture that emerged from my research: language, stigma, communality, religion, the brain, and sleep.

1. Language

One problematic issue facing refugees in terms of mental health is the language barrier. Somali Refugees come to the US suddenly, often from refugee camps in Kenya or Ethiopia. Somali refugees primarily speak Somali, and do not know English. When they come to the US, they are given little time to adjust and only three months to become independent and pay for their own housing. Even though ESL (English as a Second Language) and other classes are offered in refugee communities, there is little time to

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[18] Guerin 2004
Palmer 2006
Schuchman et. al. 2003
Carroll et. al. 2007
Scuglik et. al. 2007

take them. As a person born and raised in America, this was my first encounter with the frustration of not being able to understand somebody. As part of my research, I went to the Clarkston Somali dugsi, observed, and chatted a bit with the ladies. However the language barrier prevented me from understanding the conversation around the room. More importantly, I conducted many of my interviews through an interpreter, which obviously causes transcripts to lose a layer of meaning. Some of the interpreted interviews seemed to be stripped to the bare essentials and some meaning lost along the way. If that is my experience, I can only imagine trying to communicate some sort of ailment with a physician and how difficult that is for a Somali woman.

Language is so vital for simple tasks such as buying food. In the dugsi, I am told a story of a woman who went to the grocery store to buy tuna. She went to the store and looked for the cans that looked like tuna. She found some cans but she could not read the labels, but she bought them anyways. The food was cat food. The women in the dugsi say this would not have happened if the woman had had more support. Three of the interviewees mentioned language as a significant stressor that added to the problems that the Somali women experience in America. One woman says "here there is a different language, a different religion, who do you talk to?" While not knowing the language was seen as a contributor to mental problems, knowing the language of people around you was associated with mental health. The same woman says "That is where mental health comes from. The community is very important: the language, the culture."

An additional facet of language is that it throws off power dynamic in families. Children go to school and learn the language faster than their parents, and they are then the primary communicators between the family and other English-speaking people.

(Scuglik 2007) This is different than in Somalia, where children are very submissive to authoritative figures. When the family unit is so important in Somalia, these changes create stress for parents and for children.

2. Stigma

Past research has stated that the Somali perception of mental illness is vastly different than in the US. This is not to say that the explanatory models are different, but rather the term itself is highly stigmatized in ways it is not in the US. Articles of stigma in mental health abound in psychiatry research, however, the stigma in Somalia is much stronger. Past research has indicated that mental illness in Somalia is almost exclusively reserved for the most severe forms of mental illness, and the term is associated with 'madness' or 'craziness'. During my interviews, I used the word "mental illness" to describe what I imagined as depression, stress, anxiety, schizophrenia, etc. Basically a wide variety of mental illnesses. It seems for some Somali women, mental illness indicated something more severe, resembling schizophrenia. As one women said, "with mental illness, you talk to yourself. You might talk so much that your family gets a headache". These symptoms are generally associated with more severe forms of mental illness. Other studies have found the same thing, that being crazy is a severe form of mental illness. Despite some women understanding mental illness as something extreme, others had a more nuanced understanding of mental illness and answered that "there are many types" and that "it can come from families". These understandings of mental illness for different individuals negates the idea that all Somali's understand mental illness as being totally crazy.

Even for those studies that found Somali people attribute mental illness to jinn[19], I found slightly different explanations in my interviews. (Guerin 2004, Scuglik 2007) The jinn are directly associated with Shaitaan[20] If you have good iman[21], then the Shaitaan is unlikely to come in and cause problems. However, if you are weak, Shaitaan can enter. The jinn take advantage of a weak mental state and mental illness and will tell the person untrue things. These untrue things may be associated with schizophrenics hearing voices, but it is not entirely clear. Either way, it is not necessarily the jinn and shaitaan that cause mental illness. Rather, the jinn and shaitaan take advantage of a person who has already been weakened by mental illness and subsequently cause problems.

Clearly, from these conceptions, when we talk about mental health services a Somali individual would avoid these types of services, particularly when in the US mental health services can mean something very minor. Only those with very severe forms of mental illness would stay in a hospital in Somalia; minor forms are treated through the family and religion. While stress causes mental illness, having stress itself is a normal aspect of life. In 4/10 interviews, depression was listed as a cause of mental illness as opposed to a symptom; this implies that depression happens and that is normal, but if it progresses beyond depression then it becomes mental illness. In western frameworks, stress is not a mental illness but depression is. In the same way that stress leads to depression in western frameworks, stress and depression lead to a more severe form of mental illness in Somali culture but depression is not seen as a mental illness in

[19] Jinn in Islam are supernatural creatures mentioned in the Qu'ran that can be good, bad or neutral. Here, we are talking about the bad jinn
[20] The Shaitaan is the devil in Islam.
[21] Iman an all encompassing word for faith in God through prayer, belief in God, belief in the prophets, belief in the angels, and belief in the afterlife.

and of itself. If depression is seen as a mental illness, it is generally seen as a minor one that can be absorbed and treated by the family.

3. Communality

The communal nature of Somali culture offers the most insight into the Somali beliefs about mental health. Despite this, only two of the five articles reviewed talked about community as important for mental health. (Schuchman 2004, Scuglik 2007) When asked why she comes to the Somali center, one woman answers "I come here to learn and talk to my friends. Every other day I work and I come back and cook…it is routine." Another woman describes to me her experiences in Florida. She had moved from Somalia to Kuwait and finally settled in Orlando for 20 years where she married. However, she says "I was by myself. I used to cry all the time." One weekend she came to Georgia for a vacation and did Friday prayers at masjid Momineen[22], a masjid less than a mile from the dugsi. She said "I saw Somali's, so many Somali's! I cried because I hadn't seen another Somali in 20 years and I was so happy to hear Somali spoken. I would go to the Somali plaza and say hi, people must have thought, is she crazy? I packed my things immediately to move". She emphasizes the importance of community, and having people that look like you around. Although she says there were some

[22] Masjid Al Momineen was donated by 100 Afghan immigrants. It used to be a 4 bedroom home but has now expanded into three buildings. This is the masjid on Eid

Muslims in Orlando, it was not the same as having the Somali community in Clarkston. This story highlights the importance of having a Somali community wherever resettlement agencies operate. While diversity has long been a key tenet of America's identity, Somali refugees belong in the same communities to promote mental health.

An example of the importance of a Somali community to mental health can be seen in the form of blessings. The giving of blessings is one of the most simplistic and beautiful ceremonies I have ever seen. It is the epitome of the affect of a strong community on well-being. One day at the Somali center, two of the women were not feeling well. Dr. Asha said something in Somali, all the women except the two rose to their feet and cupped their hands. For two minutes or so, all the women whispered blessings in Arabic into their cupped hands, as if filling a small bowl. Then, the women surrounded the sick woman and washed the bowl full of blessings over her. They touched her head, her shoulders, and her arms in such a caring manner. The woman was clearly grateful and moved by their prayers. Dr. Asha smiled and said to me, "part of therapy." Another interviewee pulls me aside and says "see? We make people better." One week, before exams, Dr. Asha had me and her daughter sit in middle of the room. The women stood up around us and read the blessings into their hands and washed us in their blessings to make us do well on our exams. The experience was like none other, having so many people care for you and touch you was therapeutic in ways I cannot describe.

A fact not mentioned in the interviews but important to our discussion of community is that the dugsi serves as a place of celebration as well. I have had the opportunity to eat Somali food at least six times because of various celebrations held in

the dugsi. Twice there was a marriage, once there was a blessing of a new baby, and another time a woman had finished a chapter of the Qu'ran. At these celebrations, food and soda and tea are always had in honor of these accomplishments. Community celebration of success further cements the idea that a communal culture is vital to the well being of Somali women.

One of the articles I reviewed discussed the problem of working with interpreters from "warring clan factions." (Scuglik 2007). My research refuted this idea, as the dugsi was filled with members of different clans. Even in Somalia, the dugsi is a place where people from any clan can come. One woman tells me that while some clan tension exists in Somalia, in the US the clan tensions go away simply because there are fewer Somali's in Clarkston. The women come together here to form a community, and they identify as Somali as opposed to identifying with their clan.

Besides communal culture in the community, communal culture in families is also vital to mental health in Somalia. In 7/10 interviews, family was implicated in helping support a member with mental illness. It seems that for minor forms of illness, families are expected to care for the individual and absorb the problems. This was confirmed in four of the articles I reviewed. On the US Committee for Refugees and Immigrants website, it says "the majority of refugees are offered cultural orientation prior to coming to the United States. Most programs emphasize the importance of self-sufficiency in American society." (USCRI) The westerner's focus on individuality is presented to refugees before they even arrive. The difference in the communal versus the individual culture is a huge stress on Somali women when they arrive to the US. In an interview with one woman, she says, "In Somalia if you can't pay your rent it's okay, it's fine.

Here, they will kick you out, turn off your lights and your water. They are understanding there." Going from a place where you look like everybody else, dress like everybody else, and belong to a strong community (often based on clan divisions) to a place where you are a minority in race, dress, and religion is at the heart of the stress associated with Somali refugees. In the face of these difficulties, The Somali women have created a sense of communality at the dugsi. In Somalia, the dugsi is a place where, despite clan pride, people from all clans come together in the name of religion. In America, the Somali women have recreated a sense of unity through the Clarkston dugsi.

One day, I was sitting in the dugsi and I saw money changing hands. One of the ladies had a binder with a leger in it, and I had assumed they were collecting dues for the rent of the dugsi. When I asked Dr. Asha, she told me they were collecting money for ladies who had recently had babies. They gather cash for new mothers to spend on whatever they need and keep track of who gave what. This exchange underscores the amazing community that is as close knit as a family. One woman tells me "the purpose of the dugsi is to see each other. It is like a support group." She goes on to tell me that the dugsi is void of gossip because "we do not hurt people like that."

4. Religion

The role of religion in Somali refugees is important yet scarcely researched. Somalia is over 99% Sunni Muslim. One article discusses the role of religion in Somali women in Australia and concludes that "Islam provides an enduring 'home' that is carried throughout displacement and resettlement." (McMichael 2002) Comfort is found

in those things that are familiar, thus Islam serves as an important anchor to their previous rituals in Somalia. A research article based in Finland found that "Islam may represent temporal continuity between life 'at home' and life in the diaspora." (McMichael 2002) This is particularly true in Islam because religious Muslims pray five times a day at designated times. Compared to going to church once a week, prayer provides a more consistent ritual that provides one "with a familiar cyclical rhythm." (McMichael 2002) This rhythm is also established during the month of Ramadan, the most religious month for Muslims. Ramadan in Somalia is celebrated with women preparing lots of food for the breaking of the fast in the evening, celebrated with family. In the US, Ramadan looks a bit different without the call for prayer in the morning, but the general principle of going through Ramadan together as a family and as a community is the same.

The women I interviewed were the women who attend the dugsi, thus my understanding of the importance of religion is potentially biased because I interviewed those Somali women that come to learn the Qu'ran every week. However, a conversation with Dr. Asha indicates that religion is important in the lives of all Somali people and that the same themes would be found in those Somali women that do not attend the dugsi. Religion serves as an important factor in the prevention and treatment of mental illnesses. Belief in the Qu'ran and Allah serves as a commonality between the women and serves as ties to familiarity. The ritual of praying is the same between Somalia and America, and any other countries the women may have lived in. In 9/10 interviews, religion was directly implicated in helping with mental illnesses. Reading the Qu'ran, doing du'a,[23]

[23] du'a means calling on God to ask him or thank him for something

having a Sheikh read the Qu'ran over the person who is suffering, and doing prayers were implicated as rituals that would help ease mental illness. Also, having a strong faith was one way to prevent the onset of mental problems. Having a strong faith in Allah provides the women with assurance as well; assurance that everything will be fine. Islam teaches that Allah is all-knowing, so faith in God means knowing that everything happens for a reason.

One aspect of religion has a downside in the US. Two of the interviewees mentioned that being a Muslim and wearing a hijab made it difficult to get a job, because people judge and this contributed to their daily stress. The stress of looking different for a Somali woman in the US is a prominent one. In Clarkston, there is a community of refugees that dress in their cultural clothing. However, outside of Clarkston, the Somali dress is conspicuous. While religion plays an important role to a Somali woman in that it provides familiarity and belief, it also serves as a factor by which people discriminate.

The role of Islam in the lives of these women cannot be overemphasized. Religion is for curing illness, it is for creating bonds, it is for seeing friends, it is for learning, it is for common ground amongst strangers—religion is the primary way through which these women shape their understanding of the world. The most important knowledge is that which comes from the Qu'ran. For that reason, religious spaces are particularly important. The dugsi is one way to promote community and mental health in this population. Even though one interviewee understood the causes of mental illness as being from "the brain being out of balance," she still believed Qu'ran brings the brain back into balance. She did mention going to a mental doctor, but still Qu'ran had more importance in healing than a mental doctor did. This strongly hints that in any treatment

program and to promote mental health in general, the Qu'ran must be included. The dugsi serves as an important gathering place where women can read the Qu'ran and learn about Islam, but perhaps even more importantly, the dugsi allows the Somali women a place to talk, vent, gather, and support each other in their transition to the US.

5. The Brain

Most women in some way attributed mental illness to the brain, whether an imbalance (1 interviewee) or if they attributed mental illness to thinking too much (3 interviewees). While reviewing articles, it appeared as if mental illness in Somali culture was largely metaphysical. (Shuchman 2004) Often, in other cultures, mental illness is due to spiritual possession or problems with the heart. In this case, the Somali women generally saw mental illness as stemming from problems with the mind and a few mentioned the genetic nature of mental illness; the fact that it can be passed from parents to offspring. This is an important point—even a woman who said there is no treatment for mental illness said that people fear losing their minds. This connection between mental illness and the brain is an important one because it implies that first of all, people have agency over their mental health. Only one woman said that there is no treatment. All the others believed there were solutions, and these solutions focused on treating the mind. Sleep, Qu'ran, and family all exist as resources to ease the mind.

Additionally, All the women interviewed saw stress and problems as associated with mental illness. This includes a variety of stressors including family problems, cultural shock, children, economic problems, sleep problems, etc. And yet treatment was based in both spiritual roots and for some, in medication. This inconsistency between

belief in mental illness as coming from the mind yet treatment based in religion is not really an inconsistency at all. The mind is seen as directly affected by religion. Praying and reading Qu'ran do exactly that: bring peace of mind. As mentioned earlier, the jinn can take advantage of a weakened state of mind and can enter and cause mental illness. Reading the Qu'ran and having good faith means your mind is strong and you can resist the jinn.

Past papers on Somali refugee mental health have attributed zaar as a contributing factor. Zaar is a cultural construct (not a religious one like jinn is) that possesses women to act crazy. The woman may have fainting, agitation, and yelling as symptoms of zaar possession. To rid the zaar, a ritual is performed that involves dancing around a person. However, zaar was never mentioned in any of my interviews as a way to express distress or as a variable that affects mental illness.

Stress and problems were the greatest factors contributing to mental illness. Stress was often the first thing mentioned and mentioned multiple times. The stresses associated with moving to the US for a refugee are extremely heavy. Besides previously discussed stressors such as language barriers, unfamiliarity with the culture, and the stress of finding a job, other stressors exist too. Adjusting to appliances, adjusting to the weather, finding Somali clothes to wear, finding Somali food, having children in school—these are just a few of the adjustments a Somali woman must make when coming to the US. These stressors add together to shake the familiar foundations and rituals relating to sleep, food, and dress in Somalia.

Another theme related to stress is shock—shock and trauma was directly mentioned in three interviews as an explanatory model for mental illness. One woman

says, “if your neighbor is attacked, you may get a shock that causes mental illness” and another woman says, “mental illness can come from cultural shock.” These are clearly two different kinds of shock, but the idea that mental illness comes from sudden changes in normality is consistent among both explanations. This goes back to why religion is so important—it provides consistency in a world of changes and instability. Shock is simply a sudden change the routines and rituals that provide humans with stable networks. When something like safety is suddenly no longer a given, shock of the mind will result in a mental illness. This is consistent with American models of mental illness particularly relating to PTSD. Shock was a nuanced idea well understood by these women, arguably better than most people.

Other past papers have mentioned that the Somali expression of mental health is largely physical. Complaints of aches and pains, particularly headaches, are associated with mental fatigue and mental illness. However, these women were largely willing to discuss loneliness, isolation, trauma, stress, and low confidence indicating that mental problems are not only manifested as physical ailments.

6. Sleep

The most interesting finding from my research is the importance of sleep to mental health in the Somali culture. Past research has not mentioned sleep at all as important to the mental health of Somali people. However, less sleep was attributed as a cause of mental illness in 6/10 interviews. Interestingly, sleep is often ignored in the research of Somali mental health, and so I was no expecting to find sleep as a cause. In research articles, sleep is often noted as a symptom of mental illness, however in my own

research, less sleep was believed to be a cause of mental illness. Given that mental illness is believed to stem from the mind, and sleep was seen as a way to "calm the mind," it is natural that sleep would be a cause of mental illness. Sleep as a cultural factor is very interesting and complex. Previous research has mentioned time as being very different in Somali and western cultures. In western cultures, time is specific, based on the clock, and constant however, "in Somalia, time is seen and used in a more relaxed fashion." (Scuglik 2007) I noted this not in my interviews but just in my interactions with women in the dugsi and Dr. Asha. Westerners tend to very strict about time and meeting places, inside and outside of the workplace. At the Somali dugsi, time was leisurely and relaxed. This may have to do with the unhurried and relaxed nature of the people in Somalia. At least two of the women interviewed lived in Stone Mountain but worked 45 minutes away at an Office Depot distribution center in Buford. This most likely means early mornings and late evenings so people would get less sleep, and it would require the women to be very careful about time (whereas in Somalia and Kenya time would be more leisurely). This relates to sleep because Western culture stresses maximization of time, often by sacrificing sleep. However, in Somalia, sleep takes on an important role beyond resting the body. Sleep is also for resting the mind.

When looking at why sleep is so important, answers emerged during follow up interviews as well as in the Qu'ran. The Qu'ran values sleep very highly, and adequate sleep is very important for individual health. The following week, I conducted follow-up interviews about sleep and health. Sleep emerged as an important theme because "when you sleep, the brain calms down" and because "less sleep leads to a short temper." The connection between a well-rested mind, sleep, and mental health makes it clear that sleep

is a vital portion of well-being for Somali women. In Somalia, people generally go to sleep between 7-9 in the evening after night prayer. Then, everybody wakes up at 5 or at the latest, 7. At around 3:30, everybody goes home to have lunch and take a nap that can last for a couple hours. A cup of tea is had, and then back to work again. Somali's seem to sleep, on average, more than Americans and include an afternoon nap.

When I asked about sleep in the Qu'ran, I did not receive very solid answers or advise. One woman told me about a hadith[24] relating to sleep. She told me the hadith said that night time sleep is better than daytime sleep, so the best sleep comes in the nighttime. The Qu'ran also states directly "And He it is Who made the night a covering for you, and the sleep a rest, and He made the day to rise up again." (Quran) The Qu'ran speaks much about sleep and its importance and these same sentiments of sleep as calming was reflected in the interviews. The Qu'ran says "And We made your sleep to be rest to you," and makes other references such sleeping and waking early, sleeping at night, and the benefits of naps. Just because the women did not know how the Qu'ran references sleep, it is likely that these religious customs became embedded in Somali culture.

While the themes extracted from the interviews help give us a better understanding of Somali culture and how to promote mental health, it is only useful to an extent. Religion, sleep, community, and family are inextricably linked so that talking about them individually is only useful to an extent. Religion, family, and community serve as the legs of the stool of Somali women identity. Other important factors include diet, work, religion, dress and language.

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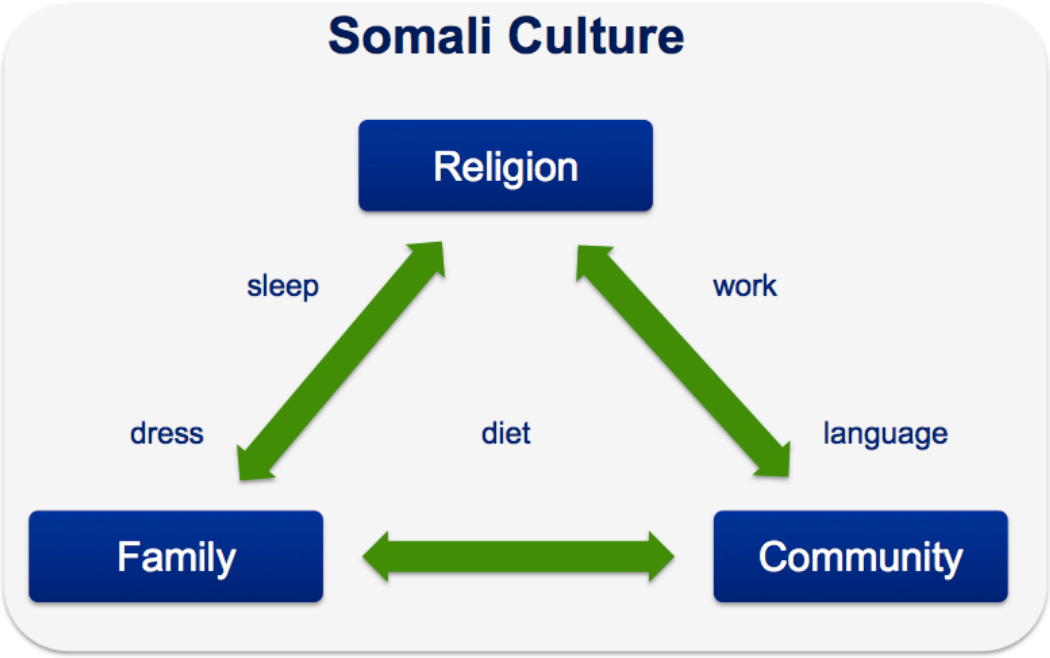
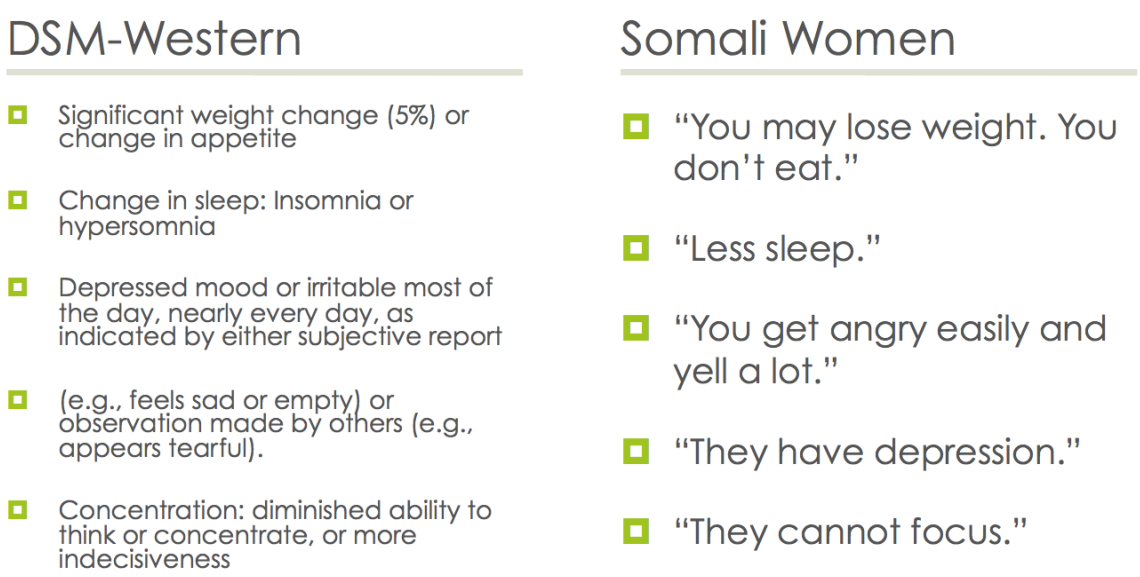
[24] Hadith are stories from the prophet that supplement the Qu'ran. Hadith are stories about the prophet and his own words, whereas the Qu'ran contains the words of God.

Belief Constructs



The subtlety and nuance with which mental illness was discussed is amazing. The understanding of mental illness as many things, ranging in severity, and brought on by stress are a few examples of the remarkable grasp these women had on the meaning of mental illness to them. Additionally, the range of treatment options, from the Qu'ran to family treatment to doctors, reflects the insightful discussion of treatment. While my original hypothesis was that explanatory models from the two cultures clash and thus treatment models would be seen differently, I am amazed at the integration and similarities between the Western and Somali understanding of mental illness. Below, a chart compares 5 of the 9 symptoms of depression as listed in the DSM to my interview responses:



The responses from the Somali women spanned two cultural worlds, taking what was important from both and integrating them to fulfill a better understanding of mental illness and themselves. To make sense of the interviews, it is logical to go beyond extracting commonalities and examine some of the stories and quotes that place these themes into context.

The purpose of the dugsi is to see each other, it is like a support group. We talk and we learn Islam. I come here to learn, to talk to friends. Everyday life is working and cooking. I get to see my friends here.

In this single quote, the importance of community, religion, and family appears. Many of the women have jobs and coming to the dugsi is a chance to relax and be immersed in the Qu'ran. Dr. Asha does translations of the Arabic Qu'ran into Somali so

that the women understand what they are reading and memorizing, and these activities are generally done in groups. Having a place for refugees from similar cultures to gather and talk is vital to promoting mental health in refugee populations. For Somali people, a space as simple as a dugsi to gather weekly serves as a secure place to talk to other women and learn with other women.

In Somalia, everyone is social. There are people everywhere. Here there is a different language and a different religion, who do you talk to? When you are isolated you begin to think, what is wrong with me?

Again, communality is emphasized as well as the importance of talking to other people to prevent mental illness and isolation as being a cause of mental illness. This view is corroborated by another Somali woman who says, "You need to have a social life, you need to laugh. That is the first therapy."

An older women worries about Somali youth being lonely because of identity issues. She says:

They don't look like Asians or Pakistanis. They don't look like Africans, so they are isolated. They cannot relate with others. They cannot claim they are African, they cannot claim they are Arab, it creates an identity crisis.

The identification with other Somali and having a Somali identity is important for the women. Somalia is such a unique nation because it is full of black Muslims where the women wear headscarves. This makes Somali women a minority in two ways in America, so it is even more important for these women to have a strong community.

The issue of medication came up in many of the interviews and it seems the issue is different for different people. While some women mentioned that medication was useful, others did not mention it or mentioned that they did not work. Perhaps the most varied opinions were on the issue of psychiatric medication. One woman describes a treatment in Somalia:

Some people use a hot rod and put it against the head and that helps with mental illness. That used to happen in Somalia, but that doesn't happen in the US. Sometimes they use the same treatment for strokes as well. Sometimes they take leaves to make a paste and put it on the body.

She goes on to say that the doctor can give treatment as well, showing the blend between old beliefs and new beliefs assimilating. Another women describes a similar mix of beliefs, or rather an understanding of the nations and using what is available:

In the United States, you get medicine and pills from the doctor. At home they have no medicine so they read the Qu'ran to make it better. It takes longer without

medicine. They don't believe in medicine in Somalia, there are other ways to treat it. They won't take it, you have to force them to take it.

One last quote on the discussion of medication further supports the idea that there are varying opinions on the idea of psychiatric medication, but religion was considered one steadfast way to treat mental illness. The following is a response to the question "What causes mental illness?"

In Somali culture the man won't help the woman sometimes. If she is doing too much, sometimes she might talk to herself. She may develop mental issues. Some women don't mind being alone and doing all the stuff, but some do. They go to a doctor and the doctor gives them medicine and that causes more problems. If they are not that crazy they don't need the medication the doctor prescribes. If you have issues, the medications help. But if its not so bad, the medications are not needed. There are no medications in Somalia, so it is good to tell a friend. You should not keep it inside, it may cause even more damage if you keep it inside.

Conclusion

With the help of Dr. Asha, I have been granted a unique opportunity to look into a space of Somali women, the dugsi, that has not been studied otherwise. The importance of this space to the mental health of these women is clear: it allows the women to practice and learn their religion, it allows the women to be together as a community under a national identity of 'Somali', and it provides the women with an

opportunity to celebrate each others' accomplishments. Being able to take the emic approach to studying these Somali women from a local perspective has shed light on the similarities in mental illness explanatory models in both culture and the differences in beliefs about treatment.

While I was expecting explanatory models of mental illness to be radically different in Somali culture and American culture, there were many similarities in the beliefs of causes of mental illness. Stress, problems, and loneliness as causes of mental illness are consistent across cultures. Additionally, changes in appetite and sleep are indicators of mental illness in the DSM and as mentioned by the women I interviewed. Overall, the explanatory models of mental illness were relatively consistent across cultures.

While beliefs in causes of illness ran parallel, the categories of disease and the way mental illness was viewed was different. The DSM categories mental illness based on a set of symptoms from the western view. While this is acceptable for use in western cultures who have been exposed to the DSM, the women who I interviewed (except for Dr. Asha) would not understand a diagnosis of PTSD. This renders DSM diagnoses as unhelpful in use with Somali refugee women. Additionally, therapy with a stranger was not seen as helpful because the Somali identity is so important and because therapy focuses on one-on-one interactions. We have seen that the Somali culture is one of family and communality, so to solely focus on the individual is to ignore an entire support system outside that individual that must be incorporated into treatment. Taking the emic perspective as opposed to pushing western idioms onto the Somali people is important. Incorporating their values into treatment can only help. Assuming the Somali

people are suffering from PTSD is dangerous because first of all, Americans hold a very specific idea of what PTSD is when really the experience of these women comes in different forms.

While explanatory models have been remarkably similar, belief in types of treatment have differed greatly. These Somali refugees have different values than Americans as shown by the belief construct map I have created. The American model would look different, with perhaps independence, career success, and family depicted as the main focus. Further emic research would need to be conducted to extract American values. From these values emerge beliefs about treatment, which explains how the western world looks within oneself for mental health treatment whereas Somali refugees seek treatment within family, the community, and religion.

The focus of my research was to discover what Somali women think about mental health, its causes, and its treatment. This project was meant to be a step in name of cross-cultural mental health research. One question that remains to be answered is how do we use this information to support mental health in the Somali refugee population? A few obvious answers come to mind, such as establishing a dugsi wherever Somali women are and allowing Somali people to resettle in areas with other Somali people. Another answer to promoting Somali mental health is to allow families to resettle together. Besides that, I have very little clinical experience in psychiatry and cannot make further inferences about treatment. However, understanding that different cultures will take on different explanatory models for mental illness is a step in the right direction to promoting mental health. The community in Clarkston has refugees from Ethiopia, Bhutan, and Sudan.

More cross-cultural research should be conducted in order to find out what the values that build belief systems in these countries are.

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