Somali Health Care Experience – Mental and Behavioral Health

King County Somali Health Board
February 7, 2013

The majority of Somali people living in King County came here as refugees, as result of being displaced by civil war in their home Somalia. The impacts of war and the refugee camps caused trauma and impacted mental health as well as the migration to the US where there is a very different culture and different language.

Diet, exercise and being surrounded by family play a role in their mental health. In the US, Somali community members don't eat as they used to in Somalia, don't walk as much and stay inside, have fewer family members and friends around them. Lack of sunshine, being black and seen as part of a "minority population", and also as Muslim likely all contribute to increased stress, depression and other mental health issues.

"You're either crazy or you're not"

The concepts of "mental health" and "behavior health" do not exist in Somali culture. Mental illness does exist and is heavily stigmatized. People are considered "crazy" if they display symptoms of mental illness.

Because the concept of mental health does not exist, any discussion of mental health issues is immediately stigmatized to mean "crazy". It is important to explain the difference between the Somali view of mental health = mental illness with the symptoms that may characterize someone experience mental health concerns (i.e. sleeplessness, loss of appetite). Somali people need to be educated on the difference between mental health and mental illness.

Education is also needed for Somali people to learn that mental illness (and mental health related issues) is a medical condition. Providers should focus on the symptoms rather than talking about "mental health". It's important for the provider to be aware of what they are saying and the words she/he uses.

Mental illness definitions in the United States focus on the biomedical approach to problem-solving which is based on questioning, physical or lab examinations and is not oriented toward the whole body or whole health. It does not take into account the concept of "soul sickness" that is prevalent in other cultures.

Post-partum depression is also more prevalent for Somalis in the United States than in Somalia. In Somalia, a woman and her baby will be cared for by friends and family members for forty days following the birth. In the US this cultural practice is rarely possible as more Somali women are working, more isolated and also have their own child care challenges.

Treatment, Trust and Relationships

Somalis often distrust the US healthcare system, to some extent due to their unfamiliarity with how medical services are provided here compared to their previous experience in Somalia. Individual providers will need to work to earn the trust of their Somali patients.

Additionally, Somali people might experience a lot of fear and paranoia from past experiences.

First step and initial stage in treatment should focus on building relationship and this takes time. How the provider talks to the person will help get to the roots of the trauma. Asks people questions, have prayer rugs in the facility, don't offer medications right away but include as part of the conversation. How a provider talks to the client about symptoms and how she/he approaches the client is important in whether or not the client will pursue treatment or help.

As a provider, it's important to remember to be visible in the community and not just about providing service to the one patient but the family members surrounding that person. Relationships and building trust are important to being able to effectively treat Somali patients.

Rumors and bad news spread quickly in the community. If someone receives poor care it will be shared in the community.

It is important to recognize that the US health care system is not well oriented toward building relationships. An example - a client who may have missed many appointments would likely be greeted with "how come you haven't been coming?" rather than being acknowledged for showing up to the current appointment. Acknowledging the effort of a person coming for appointments can help build rapport.

At Lutheran Family Services, they typically offer 2-3 hour intake assessments. They have prayer rugs in their facility. They ask questions that include: "What helps you?", "What makes you feel better?", "Who do you go to for help?" They use terms such as "soul sickness or suffering", terms that focus on the whole body, on whole health.

For any type of in-patient care or treatment - food is important and visiting hours, let people stay longer. To make care more appropriate for Somali patients, play the Koran in the room, let other family members in the room, and have appropriate food (halal).

Medication

Education should also include that healing/treatment take time and allow the medication time to work. Somali community may not take the medicine if they don't see the benefits right away. And providers may not understand the Somalis do not necessarily want to be on medications.

One provider advised that their approach to medication is only to offer it when the person's functionality is so impacted that she knows that the medication might be helpful.

Mental illness plays out with other symptoms (sore back, sore muscles). Good to offer other ways to treat besides medications such as massage.

Health is important and Somali's do take preventive measure to maintain good health, particularly through the use of herbal remedies such as black or nigella seeds (haba soda in Somali) and honey. Herbal medicine and traditional health practices are often used instead of or in conjunction with prescribed medication. Similarly, after learning about potential side effects of medication many would avoid taking it.

Role of Religion

The Somali way to deal with mental health is through religion. The concept of Jinn is hard to explain to providers and providers aren't typically aware of the importance of the religious element for the Somali client.

Faith healing is an important consideration and providers should be conscious of that. For example, if a patient thinks there is a Jinn then the provider should help them work through that and go where they are, maybe go to the mosque with them. The provider may find it easier to talk about other methods of treatment after acknowledging the role Islam/jinn plays in the Somali worldview.

There is a lot of strength in the Somali community that the US mental health system doesn't access. Imams at the mosques could be a helpful resource to providers.

Helpful Resources

Somali Refugee Mental Health Cultural Profile, Ethnomed. November 1, 2008
http://ethnomed.org/clinical/mental-health/somali-refugee-mental-health-cultural-profile

Daryel, Somali Women's Wellness Project
www.facebook.com/pages/Daryel-Somali-Womens-Wellness-Project/134686503282773

Somali Mental Health. Originally published in Bildhann – An International Journal of Somali Studies, available on Ethnomed.
http://ethnomed.org/clinical/mental-health/somali-mental-health

Possession, Jinn and Britain's Backstreet Excorcists
http://www.bbc.co.uk/news/uk-20357997