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GOING 'WALLI' AND HAVING 'JINNI'

*Exploring Somali expressions of psychological distress
and approaches to treatment*

By

Juanita Ryan

A thesis submitted in partial fulfilment of the requirements for the degree of

Doctor of Philosophy in Psychology

Department of Psychology

The University of Waikato

2007

Abstract

Western researchers conducting studies with Somali refugee participants have identified Somali-specific idioms of psychological distress as well as high rates of Western psychological disorders such as depression and post-traumatic stress disorder (PTSD) in this refugee group. Methodological limitations of these previous studies, however, have limited the validity of the conclusions drawn. These limitations include the use of Western psychometric instruments and diagnostic nosologies, limited information about the methodological procedures undertaken, the apparently unqualified use of terms such as “mental illness, “madness” and “craziness” in interview schedules, minimal exploration of psychosomatic idioms of distress, and limited applicability of some of the research findings to Somali women.. The current research primarily aimed to address these methodological short-comings and build on the findings of previous studies that have explored Somali conceptions of distress. Two additional objectives were to (i) identify protective and resilience factors which may decrease vulnerability to experiencing psychological distress in Somali women, (ii) gauge non-Somali health professionals’ understanding of (a) the nature of distress and suffering experienced by Somali women, and (b) effective treatment modalities to ameliorate this distress. The analytical style employed in all three studies of this thesis was thematic.

In the first study, ten Hamilton (New Zealand) based Somali women were interviewed. Particular areas of interest explored in the first study included psychological, physical and spiritual conceptions of distress, the symptoms of key

idioms of distress, and the way in which these are managed/treated at the individual, community, and family levels.

The findings of Study 1 identified spirit (*jinn*) possession as a form of distress known by at least some members of the local Somali community. Jinn appeared to be an explanation for both milder forms of distress akin to depression and anxiety, as well as more severe forms of distress similar to psychosis. Treatment for jinn possession tended to focus on Koran readings in conjunction with family and community-based support. Generally participants considered there was a very limited role for mental health professionals and Western psychiatric medication in the extraction of jinn.

Faith was considered a key protective factor against experiencing non-spiritual forms of distress such as stress, worry, anxiety and depression. Although war trauma was acknowledged to have an adverse impact on the psychological functioning of Somali women it was not considered to impact on a woman's ability to manage her day-to-day responsibilities. The impact of having family in refugee camps in Africa was, however, identified as a common and very distressing issue impacting on many Somali women. The only way of alleviating the distress associated with this stressor, according to participants, was reunification. Interviewees stated that Western interventions for distress were rarely pursued by Somali as they were not considered efficacious.

Given there is evidence that Somali communities residing in various cities in New Zealand are at various stages of acculturation, it was considered important to ascertain how valid the results from Study 1 were considered to be by women from

other Somali communities. Six focus groups were conducted with a total of 27 Somali women recruited from three New Zealand cities.

The findings of Study 2 identified numerous culturally specific forms of distress reported by participants. These states were *qalbijab*, *boofis*, *murug*, *welwel* and *jinn*. These Somali idioms of distress were akin to some Western psychological disorders, particularly the depression and anxiety spectrums. Treatment for Somali forms of suffering were reported to focus on Koran readings, in addition to family and community support. Generally, participants in Study 2 considered there was a very limited role for general practitioners (GPs) and mental health professionals in assisting Somali to deal with psychological and spiritual distress. Consistent with the findings of Study 1, faith was considered the most important protective factor, family separation was described as one of the most significant stressors, and war related trauma was suggested to cause significant distress only if the sufferer had family still in Africa.

Study 3 explored non-Somali health practitioners' understanding of Somali idioms of distress, as well as their perspectives about how to best treat Somali presenting with psychological distress. A total of 18 mainstream mental health practitioners, general health practitioners (both GPs and primary care nurses), and specialist refugee mental health practitioners took part in this research.

Few practitioners mentioned spirit possession as an aetiology for distress and none mentioned other Somali-specific forms of distress. The psychosocial stressors identified as contributing to the psychological distress of Somali women were relatively consistent across the three groups of practitioners and also consistent with

the stressors identified by participants in Studies 1 and 2 (e.g., family separation, social isolation, financial concerns). Interviewees did not consider PTSD to be a common psychological disorder amongst Somali women living in New Zealand.

Advocacy work and assistance with day-to-day concerns were suggested by many participants as more efficacious for the amelioration of psychosocial stressors than medication-based treatment. Generally, participants in Study 3 were supportive of traditional forms of healing being used as the treatment of choice by Somali clients.

The findings of the current thesis suggest that there are clear parallels between Somali idioms of distress and those of Western cultures. However, the data indicate that equating Somali idioms with Western diagnostic labels would be rejected by Somali. Regardless of the similarity of symptom profile of some of the Somali states to Western states, the manner in which these states are conceptualised, understood and treated is markedly different.

The findings of all three studies suggested that Somali tend to opt for their own traditional interventions to treat psychological and spiritual forms of distress rather than engage with Western mental health services. Numerous barriers including long waiting lists, mental health practitioners' apparent lack of knowledge/expertise working cross-culturally and poor treatment outcomes were provided for Somali not engaging with such services. The stigma attached to having a mental illness was also considered a barrier to engaging with mental health services.

With respect to improving service provision for non-Western clients, an intermediate service that sits between primary and secondary health care agencies is

recommended as an effective means of meeting the needs of non-Western clients experiencing psychosocial stressors and mild to moderate psychological distress. It is imperative, however, that any such service involves key stakeholders from the community groups it would serve, in the design, development, and implementation of interventions.

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CHAPTER 1

The International and National Refugee Context

Since the 1950s there have been at least 200 wars and armed conflicts throughout the world (Summerfield, 2000). The number of civilian deaths as a result of these wars and armed conflicts has steadily increased over the last 50 years. An estimated 5% of casualties during World War I were civilians, in World War II the percentage of civilian deaths increased to 50%, and by 1986, the United Nations Children's Fund (UNICEF) estimated that over 90% of those who died during war were civilians (UNICEF, 1986). The significant increase in risk of death to civilians has prompted an exodus of people from war torn countries, which, in turn, led to a six-fold increase in the number of refugees worldwide between the 1970s and the 1990s (Summerfield, 1998).

By the end of 2003, the United Nations High Commissioner for Refugees (UNHCR; 2004) estimated the number of refugees, asylum seekers, and internally displaced people, worldwide to be approximately 17.1 million, with UNHCR defined refugees making up 57% of this number (UNHCR, 2004). Africa and Asia tend to bear the greatest burden for protecting refugees (Richmond, 2002). This seems to be primarily because organisations that provide assistance to refugees typically want to relocate them close to their country of origin, or to a host country with similar cultural characteristics (Summerfield, 1999). Generally, it is considered undesirable for refugees from non-Western nations to resettle in Western countries that have markedly different cultures and are generally far away from the refugees' country of origin (Joint Un/NGO Group on Women and

Development, 1992). However, between 5-10% of all refugees are eventually resettled in Western countries (Summerfield, 1999).

International legislation has formally recognised and protected refugees within Western countries of asylum since 1926. In 1951, as a result of numerous global events necessitating ongoing protection for refugees, the UN Refugee Convention was established which defined a refugee as someone who:

...owing to well-founded fear of being persecuted for reason of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable, or, owing to such fear, is unwilling to return to it. (UNHCR, 1996; pg. 16)

One of the key provisions of the Convention is the obligation of states that are party to it not to expel or return a refugee to a state where he or she would face persecution (UNHCR, 2000). Other provisions in the Convention outline refugees' rights in relation to issues of employment, housing, education, social security, documentation, and freedom of movement.

The UN Refugee Convention originally only applied to those fleeing from events that occurred within Europe prior to 1951. However, in 1967 (primarily as a result of the decolonisation process in Africa), the geographical and temporal limits of the 1951 UN Refugee Convention were removed by the 1967 Protocol to the Convention, which made the definition of refugee in the 1951 Convention applicable to people in all parts of the globe (UNHCR, 2000).

The 1951 UN Refugee Convention and its 1967 Protocol is still the most important, and the only universal instrument of international refugee law (UNHCR, 2000). Over 131 nations have acceded to both the 1951 Convention and its 1967 Protocol (UNHCR, 2000). New Zealand is one of these nations. An

additional 138 states have ratified either one or both of these instruments (UNHCR, 2000).

The New Zealand Refugee Context

From the time World War II ended, New Zealand has been accepting significant numbers of refugees relative to the country's overall population (Refugee Resettlement Research Project; RRRP, 2002). Since the 1990s the number of countries from which New Zealand has accepted refugees has increased dramatically, with refugees now being received from at least 18 different countries (Spoonley, 2000). According to New Zealand Refugee Statistics (RefNZ, 2005) the number of people granted residence in New Zealand under the United Nations Refugee Quota Programme between the financial years 1992/1993 and 2004/2005 (inclusive) was just over 9,000 people. It was in 1993 that the first Somali refugees began arriving in New Zealand.

New Zealand Somali refugee statistics

RefNZ (2005) statistics report that 1728 of the refugees accepted for residency (under the Refugee Quota programme) since 1993 were from Somalia. The number of Somali refugees entering New Zealand during this period was surpassed only by refugees from Iraq (RefNZ, 2005). Hence, Somali are one of the fastest growing refugee groups in New Zealand, and Hamilton has the largest number of Somali refugees per capita of anywhere in the country (New Zealand Immigration Service, 2003).

It is important to remember that the RefNZ (2005) statistics only account for people granted residence under the Refugee Quota Programme. They do not include asylum seekers or family sponsored individuals. Hence the estimate of the overall number of Somali living in New Zealand according to calculations

conducted by Guerin and Diiriye (2004a) could be as high as 4954. This figure includes approved asylum seekers, those holding residency permits and those who were sponsored by family to immigrate to New Zealand. Obtaining accurate estimates is fraught with difficulties and this issue has been highlighted by recent research conducted by Guerin and Diiriye (2004a) in Hamilton, New Zealand. When these researchers compared their estimate of the number of Somali living in New Zealand by 2001 with Statistics New Zealand's Census Data (2001), Guerin and Diiriye's (2004a) estimate of 4495 was almost twice as high as the Census data (which estimated 1,971 Somali living in New Zealand). Guerin and Diiriye (2004a) suggested that factors such as reluctance to complete Census forms (possibly due to suspiciousness of how the data may be used) and trans-national movement (even though "home" may be considered New Zealand) may account for the apparent underestimation. This underestimation of Somali in New Zealand is of concern as it means that resources may be less available if the population is considered to be very small. Hence, significant issues which may be identified for this group through Census data (particularly with respect to employment and health issues) are not recognised. This is one of the key reasons why additional research of Somali living in New Zealand is necessary. Such research may act as an alternative means to identify significant issues facing this group and hence elucidate how these issues may be best addressed within the New Zealand context.

As asserted by Wing, Sue, Ivey, and Pedersen (1996) "culture always influences how one asks and answers questions about the human condition" (p. 33-34). If we are to assume that culture plays a key role in how individuals conceptualise psychological distress and wellbeing, it is essential to ensure that

research on psychopathology and resilience is strongly informed by the cultural norms of the group under study. Before an overview of Somali people and Somali culture is provided, however, it is important to first present the objectives of the current thesis. These objectives provide the context and rationale for the literature reviews outlined in Chapters 4 and 5 as well as the impetus for the three studies that comprise this thesis.

CHAPTER 2

Objectives and Overview of the Current Research

Objective 1

The first aim of the current research was to develop an understanding of what constitutes ‘psychological distress’ and wellbeing for Somali women living in New Zealand. That is, this research attempted to understand and explain ‘psychological distress’ in a manner which was consistent with the perceptions of the reference group, and tried not to reorder or restructure the information to ‘fit’ with Western ideas, psychological models, aetiologies or nosologies. It was appreciated, however, that the very nature of the current study – conducted by a Western researcher, in a Western country – means that imposing certain Western notions was unavoidable. Attempts were made to minimise and/or acknowledge this impact throughout the thesis.

Objective 2

As has already been stated, research with refugees exposed to trauma has focused more on risk factors than protective factors and resilience. Additionally, there appears to be only two studies assessing the nature of resilience in Somali refugees. Hence, the second objective of the current research was to identify protective and resilience factors which may decrease vulnerability to experiencing psychological distress in Somali women, and also highlight factors that contribute to wellbeing and adaptation in the New Zealand context.

Objective 3

The final objective of this thesis was to gauge non-Somali health professionals' understanding of (i) the nature of distress and suffering experienced by Somali women and (ii) effective treatment modalities to ameliorate this distress. It was hoped that the results of this study may help identify areas in which cultural misconceptions occur as well as areas in which non-Somali health professionals hold a relatively high degree of insight into cross-cultural differences (and similarities) between themselves and Somali clients. It was also intended that the results of this study would provide insight into the manner in which clinicians may or may not modify their practice when working with Somali clients and their rationale for the approach they take.

The Research Questions

Specifically, the current research aimed to answer the following questions:

- 1 How do Somali women describe psychological distress?
- 2 What are the symptoms of distress Somali women describe?
- 3 What meaning do Somali women attach to the onset and maintenance of these symptoms (e.g., physical, spiritual, psychological)?
- 4 How do Somali women manage or treat these forms of distress?
- 5 What do Somali women consider indicators of resilience and protective factors against experiencing distress?
- 6 In what ways do mainstream health professionals currently conceptualise Somali psychological distress and wellbeing?

- 7 How do mainstream health professionals typically approach treatment with Somali clients?
- 8 What do mainstream health professionals consider the biggest barriers to developing more effective services/interventions for Somali?
- 9 Can intervention approaches (both traditional and Western) be improved to better meet the needs of Somali women experiencing psychological distress?

Structure of the Current Thesis

The current thesis is divided into nine chapters. The first five of these chapters constitute the introduction to the thesis. Chapter 1 (the previous chapter) describes the international and national refugee context. Chapter 2 (the current chapter) outlines the objectives and structure of the current research. Chapter 3 provides a general overview of Somalia, its people and culture. Chapter 4 outlines a review and critique of refugee psychopathology research. The final introductory chapter, Chapter 5 outlines the findings of Western research which has explored Somali conceptions of distress and wellbeing and also provides a critique of this research. This chapter ends with a general outline and rationale for the methodological approach taken in the current thesis.

The three studies that form the basis of this thesis are outlined in Chapter 6 (Study 1), Chapter 7 (Study 2) and Chapter 8 (Study 3). A comprehensive description of the method and results for each study are provided in these chapters. The final sections of Chapters 7, 8, and 9 provide a brief discussion of the findings and possible interpretation of the meaning of the results. The last chapter of the thesis, Chapter 9 provides a general discussion of the overall findings of the three

studies. A preliminary perspective on how Western researchers and clinicians may conceptualise Somali forms of distress is also presented in Chapter 9 as are some of the possible implications of this research. Additionally, Chapter 9 outlines the strengths and limitations of the thesis as well as some suggestions for future research.

In order to be able to understand Somali conceptions of distress and resilience and how these constructs may manifest, it is first necessary to understand the historical and current cultural and political context of Somalia and the Somali people. The following chapter provides an overview of these issues.

CHAPTER 3

Overview of Somalia, its People and Culture

The Geography and Population of Somalia

Somalia is located in the most eastern part of Africa. The country's north and east coastlines form what is called the Horn of Africa. Somalia has a surface area of approximately 637 000 square kilometres (World Health Organisation; WHO, 2001). It shares borders with Djibouti, Kenya, Ethiopia, the Red Sea and the Indian Ocean. Somalia is largely savannah grasslands with rain and drought dominating much of Somali life. Although there is no formal census data of the Somali population, it is estimated to be between six and seven million (Griffiths, 2002).

Traditional Somali Life

Traditional Somali life is based on clans which primarily act to provide safety, support and resources to clan members (Vemuri, 2002). Somali residing in Somalia primarily live as nomadic herders or as farmers (Vemuri, 2002). Rural Somali often live in collapsible shelters while those living in Somali cities tend to have permanent housing (Vemuri, 2002). Somali often live in extended family groups, with males typically assuming the role of head of the family and also maintaining responsibility for the financial wellbeing of the group. Women and men tend to socialise separately. Marriages are often arranged and are traditionally considered to have more political and economic value than romantic value (Vemuri, 2002). Divorce and remarriage is common, and divorce does not hold much stigma in Somali society (Abdullahi, 2001).

According to Vemuri (2002), the favourite leisure activity for Somali is conversation with friends and family. Somali tend to entertain themselves through sports, games, songs, storytelling and poems. Some Somali cities offer entertainment such as nightclubs and cinemas, however, these forms of entertainment have largely been disrupted by war. Education is officially compulsory at primary school level however, due to the nomadic nature of most Somali, sending children to school is typically impractical (Vemuri, 2002). Although drug and alcohol use were traditionally uncommon habits in Somali society, there is growing concern that psychoactive substances are being more frequently used and abused by Somali (WHO, 2001). There is one university in Somalia which is located in Mogadishu (Vemuri, 2002).

Somali Religion and Parareligion

Islam is the religion of approximately 99% of Somali and Islamic principles are interwoven into the every day life of the Somali people (Abdullahi, 1999). While there is no organised clergy within Muslim religion officially, amongst Somali (as is the case with Muslims from other ethnic backgrounds), certain people are considered to have more knowledge of the religion and these people are referred to as *wadaad* (Abdullahi, 2001). In Somalia, these men (they are always men) travel throughout the country and offer their religious expertise to people (Abdullahi, 2001). The *wadaad*'s role in rural Somalia is not only that of a religious expert but also as a traditional medical expert, and additionally may at times "use a large measure of psychotherapy" (Abdullahi, 2001, p. 60). This 'psychotherapy' typically consists of blessing amulets (which contain Koranic verses) as a type of palliative care when medical treatments have not been effective. The blessings of *wadaads* for infertility problems and chronic illnesses

are also described by Abdullahi (2001) as a form of psychotherapy. Additionally wadaad provide a caretaker role in large mosques, and in this setting are referred to as Imam (Abdullahi, 2001).

Although pre-Islamic cults existed in Somalia prior to the arrival of the Muslim religion, no pre-Islamic cults have survived, although some semblance of the ancient practices associated with these cults are still said to exist (Abdullahi, 2001). *Zar* or *Sar* spirit possession is one such semblance of pre-Islamic Somali culture which has received some attention in Western literature (see Abdullahi, 2001; Kapteijns, 2000; Lewis, 1989; Littlewood & Lipsedge, 1985). The zar spirit primarily (although not exclusively) possesses married women. Symptoms of zar possession may be psychological (such as mild depression or anxiety) or physical (Lewis, 1989). Once it has been identified that a zar spirit has possessed an individual, a ceremony takes place which consists of exorcism, feasting, and ritualistic dancing. Although not all Somali accept the authenticity of zar possession, and religious leaders tend to discourage such beliefs, Islamic orthodoxy and parareligion have coexisted for hundreds of years (Abdullahi, 2001). In fact, Abdullahi suggests that one of the reasons that the cultural practices associated with zar possession have survived for so long, is that the ceremonies that take place are akin to psychotherapy for individuals experiencing high levels of stress. Abdullahi states that the dancing and eating that accompany a zar ceremony offer a rare opportunity for women to spend time together in a more relaxed manner which contributes to healing at both a personal and spiritual level.

Evil spirits, mentioned in the Koran and known to all Muslims are called *jinn*. Jinn ('jinn' is plural and 'jinni' is singular) possession is considered to be

caused by an entity akin to Satan in Christian teachings. These spirits are seen as a separate force from Allah that can act to affect anyone regardless of their social or religious status or previous wellbeing (Abdullahi, 2001). According to some researchers, when a person is possessed by a jinni they may become violent, break and throw things, cry and shout, appear outwardly nervous and stressed, experience inner voices, and talk continuously (see Carroll, 2004; Tiilikainen, 2000). Furthermore, Western medicine is considered to have no therapeutic effect in treating jinn possession. Reading the Koran is generally considered the only possible cure for jinn although family and community support are also important aspects of intervention.

If an individual's suffering is not considered to be caused by a jinni, there are two other primary explanations within Islamic lore for the reason someone may be experiencing hardship. The first of these is viewing the suffering as punishment from Allah for past wrong doings and the other is accepting that the suffering is a test or trial from Allah (Tiilikainen, 2000). Islam asserts that as Allah has supreme power, the human response to suffering has to be accepting their current situation as God's will, while also maintaining patience and hope (Tiilikainen, 2000; Silveira & Allebeck, 2001). Additionally, Islam teaches that humans cause their own suffering. As such, if someone believes that he or she is being punished for wrong doing by Allah, engaging in good deeds is thought to alleviate this punishment.

The most common forms of healing employed by Somali are praying and reading the Koran (either read by the person suffering, relatives/friends or by an Imam; Carroll, 2004; Halcón, Roberston, Savik, et al., 2004; Tiilikainen, 2000). Koran readings are used as a form of healing for all illnesses either alone or in

conjunction with other Western or traditional Somali remedies. Community and familial support is also a key component of therapy for Somali. Relatives and friends will typically provide support, both practically (i.e., by assisting with household tasks), emotionally, and spiritually (by reading the Koran to the person who is unwell). Women tend to support women while men tend to support men (Tiilikainen, 2000).

Civil War in Somalia and the Current Somali Situation

In 1969 Somalia's government was overtaken in a military coup organised by Major General Mohammed Siyad Barré. Barré's regime rapidly became corrupt, brutal, and repressive (Abdullahi, 2002). The history of forced migration in Somalia dates back to the Ogaden war instigated by Barré in 1977 (Griffiths, 2003). From 1988 onwards, there was a constant flow of refugees out of Somalia (Griffiths, 2003).

Increasing anger against Barré and his government eventually triggered the outbreak of a civil war in 1991, which led to Barré's fall from power (Abdullahi, 2002). However, a further consequence of the civil war was a major humanitarian crisis with approximately 400,000 Somali fleeing to Ethiopia, 50,000 being killed by government troops, and an additional 500,000 becoming internally displaced (Adan, 1994; Africa Watch Report, 1990). It was as a result of this conflict that refugees from Somalia began arriving in Western countries (Griffiths, 2002).

Conflict continued in different regions of Somalia in the latter part of the 1990s (Griffiths, 2003). By 2000, Northern Somaliland and North-East Puntland were relatively stable although violence was still commonplace in the south, east and west of the country (Griffiths, 2003). A decade of civil war, massive population displacement (of about 700,000 people), and the cumulative effects of

drought, famine and flooding has led to Somalia being one of the poorest nations in the world (Griffiths, 2003).

Somaliland is now generally considered safe, but suffers from weak infrastructure and minimal economic resources (Griffiths, 2003). Between 1997 and 2001, the UNHCR facilitated the return of approximately 170,000 refugees to Somaliland. Another 350,000 are estimated to have returned voluntarily to the region during the same period (Griffiths, 2003).

Southern Somalia still has no formal government (Abdullahi, 2002). Clan factionalism divides many parts of Somalia, particularly Mogadishu (the southern 'capital') where there still exists well-defined clan boundaries (Griffiths, 2002). Continuing violence in the southern parts of Somalia led to an exodus of 25,000 people during 2000 (Griffiths, 2003).

Mental Health Resources in Somalia

There are three psychiatric hospitals in Somalia and in 2001 there were five trained psychiatrists working in the country (WHO, 2001). The WHO describes conditions at these hospitals as generally primitive with largely no medicines and food supplies, reliant on charity. There were no clinical psychologists or psychiatric social workers in Somalia in 2001 (WHO, 2001). Psychiatrists are not involved in outpatient clinics unless they have set up their own private practices (WHO, 2001). Although the WHO, in consultation with mental health professionals in Somalia, identified key national objectives to improve mental health services, little else has been written about mental health resources in Somalia, including a lack of information about the types of illnesses or difficulties that led to admission to these hospitals.

Somali Women

Women have suffered significant hardship during the Somali civil war. In particular, women from opposing clans have suffered organised rape which has been used as a tool in warfare (Griffiths, 2003). Rape is a means of disrupting the genealogies of a clan and ensuring that children are born to the opposing faction (Griffiths, 2003). Women who have managed to flee to Kenya and secure refugee status will invariably have to subsist in poorly monitored camps in which sexual attacks and maltreatment of women is thought to be prevalent (Immigration and Refugee Board of Canada; IRBC; 1994).

Once they have been relocated to their country of refuge, it is particularly important for Somali women to be able to access and receive adequate assistance with orientation to their new country, as well as appropriate health care, as they bear the major responsibility of caring for each other, the children, and the community generally. Maintaining and obtaining adequate levels of physical and psychological wellbeing could be considered essential in ensuring these women can carry out their familial, social, cultural and religious responsibilities.

Prior to reviewing the empirical literature which has explored psychological distress and wellbeing in relation to Somali refugees and female Somali in particular, it is first necessary to provide a general overview of the empirical literature that has explored concepts of psychopathology and resilience in various refugee groups. Reviewing and critically evaluating this body of literature is useful in as much as it provides the rationale for the objectives and methodology of the current thesis.

CHAPTER 4

Review And Critique Of Refugee Psychopathology Research

The purpose of the current chapter is to provide a review and critique of the literature which has explored refugee psychopathology. This begins by looking at some of the common forms of psychological distress studied in refugee groups and some of the issues with respect to utilising Western diagnostic categories uncritically in cross-cultural research. Additionally, the empirical literature that has employed Western-based treatment approaches with refugees is reviewed and critically discussed. The role of resilience and the (very small amount of) research which has explored resilience in refugees is also outlined, along with a discussion of why a greater focus on factors promoting wellbeing in the face of adversity is so vitally important in the refugee literature. The chapter concludes by outlining possible new directions for refugee psychopathology research which encourages a greater focus on collaborative, ethnographic, qualitative and community-based research approaches.

The Post-traumatic Stress Disorder Controversy

The primary criteria for post-traumatic stress disorder (PTSD) are being confronted by an event that is life threatening, or threaten a person's physical integrity (American Psychiatric Association; APA, 1994), and, in addition, the person's response to the traumatic event must involve feelings of horror, terror or helplessness. If these critical criteria are met, then assessment for symptoms of (i) hyperarousal (e.g., hypervigilance, exaggerated startle response, anger), (ii) re-experiencing (e.g., flashbacks, nightmares, unavoidable memories/thoughts), and

(iii) avoidance (e.g., avoiding smells, people, places that may remind them of the traumatic experience) is undertaken by the clinician. The individual being assessed must be experiencing at least one of the symptoms from each of these three symptom clusters to meet the diagnostic criteria for PTSD. Additionally, for a PTSD diagnosis to be made, the symptoms need to be causing clinically significant distress or disruption to the individual's day to day life. Hence, if an individual reports numerous symptoms of PTSD yet does not report they are causing significant distress (regardless of the number of symptoms reported), a diagnosis of PTSD should not be made.

Historically, research with refugee groups has suggested that they are particularly high users of mental health services. There is a considerable body of literature assuming that illnesses such as PTSD are particularly prevalent in refugees exposed to war. For example, Mollica, McInnes, Sarajilic, Lavelle, Sarajilic, and Maggagli (1999) reported prevalence rates for PTSD of between 18% and 53% in Bosnian refugees receiving psychiatric treatment. Additionally, in a retrospective study of hospital records conducted by Jamil, Hakim-Larson, Farrag, Lafako, Diqi, and Jamal (2002), rates of PTSD identified from written documentation were 81.4% for a group of Iraqi immigrants and refugees. According to Sue, Sue, Sue, and Takeuchi (1998), estimated prevalence rates of PTSD in Southeast Asian refugees are around 70%, while prevalence rates of PTSD in Laos and Cambodian refugees have been estimated to be 95% and 92% respectively. For other papers espousing similar prevalence rates see Geltman, Augustyn, Barnett, Klass, and McAlister-Groves (2000), Hodes (2002), Kinzie, Boehnlein, Leung, Moore, Riely, and Smith (1990), Kinzie and Jaranson (2001),

Paunovic (2001), Riding-Malon (2004), and Weine, Kuc, Dzudza, Razzano, and Paunovic and Öst (2001).

These rates for PTSD are considerably higher than the estimates provided by the American Psychiatric Association (APA, 1994) for American adults – approximately 8%. Although the rate in American adults is expected to increase to 30% following wars and natural disasters, even taking this higher estimate into account the figures for non-Western refugees are still typically considerably higher than those for American adults. Stubbs (1999) hypothesised that the apparently inflated PTSD rates in research papers exploring psychopathology in refugees is due to aid agencies and non-governmental organisations overstating the prevalence of psychological distress in refugee groups. He suggested that although many of the statistics cited in the literature are based on generalised and unscientific assumptions, they are a primary means by which resources for mental health work are mobilised.

Regardless of whether researchers are intentionally inflating statistics as a means of obtaining resources or not, doing so is likely to lead to stereotyping refugees as traumatised and psycho-pathologised by the mere virtue of their experiences (Summerfield, 1998; Watters, 2001). What is more, researchers who commonly employ Western diagnostic nosologies to describe, define and make sense of ‘symptoms’ relayed or observed in non-Western cultures, appear to be rooted to an ‘absolutist’ position (Berry, Poortinga, Segall, & Dasen, 2002). According to Berry et al (2002), an absolutist position assumes that psychological processes are largely the same regardless of an individual’s cultural background. Based on this perspective, Western concepts of psychological distress such as ‘depression’ and ‘PTSD’ are considered to be essentially invariant across cultures.

However, this absolutist approach ignores the values, traditions and beliefs of the refugees' country of origin and the role their own cultural norms may have played in understanding and coming to terms with their experiences.

Although many studies have reported high prevalence rates of PTSD in refugee groups, other studies have suggested very low prevalence rates of this illness in refugees (e.g., Elmi, 1999; Geltman, Augustyn, Barnett, Klass, & McAlister-Groves, 2000; Yates, Diiriye, Guerin, & Guerin, 2003). Even from an absolutist perspective, this does not seem a surprising outcome. Posttraumatic stress disorder is a pathological psychological condition, which arguably pertains to trauma responses that are more extreme and distressing than would typically be observed in a particular cohort. In fact, if PTSD is a valid and identifiable illness in non-Western countries, it would still be most likely to affect only a small minority of individuals. Rather (as would be the case for any group of people subjected to trauma), the majority of refugees are likely to experience distress associated with their traumatic experiences that could be considered an understandable and normal response (Ramsay & Gorst-Unsworth, 2003).

Even when studies find a lack of psychopathology in particular groups, however, this can often be interpreted as denial, minimisation of symptoms, or lack of psychological awareness on the part of the research participants (e.g., Kinzie, Boehnlein, Leung, Moore, Riley, & Smith, 1990; Silveira & Ebrahim, 1998; Somasundaram, 1996). Additionally, in other studies, indicators of distress are interpreted as clinically meaningful and suggestive of psychopathology even if the participants do not meet diagnostic criteria for a psychological disorder (e.g., Geltman et al., 2000; see also Summerfield, 1999 for a critique of this literature). Summerfield asserted that it is a mistake to assume that because phenomena (such

as symptoms of PTSD) can be regularly identified in different cultural settings that it naturally follows that they hold the same meaning in these different settings. For example, the meanings of nightmares (a common symptom of PTSD) are likely to vary across cultures, with some cultures perhaps interpreting these as messages from ancestors or a prompt to visit their doctor about an unrelated matter. Hence, checklists or structured assessment interviews to diagnose PTSD may fail to place the apparent symptoms in a meaningful (and non-pathological) cultural context. Summerfield also warned that in offering someone a victim identity there may be a danger in triggering a self-fulfilling prophecy. At least one published study has found evidence to support this assertion (see Eastmond, Ralphsson, & Aldinder, 1994). The danger of pathologising 'normal' psychological responses to trauma is that refugees are not encouraged to strive to meet their full potential in their new host country, but rather are assumed to be psychologically 'disordered'. This is not only a burden for the refugee and their family, but may also perpetuate stereotypes and discrimination towards refugees within the larger society of their host country.

Although it is likely that there are some aspects of people's reaction to trauma that are universal, PTSD as a universal construct is questionable (e.g., Bracken, & Petty, 2001; Bracken, Giller, & Summerfield, 1995, cited in Bracken & Petty, 2001; Summerfield, 1999). Post-traumatic stress disorder as a description of the trauma response in culturally diverse groups fails to capture the complexity of the trauma experience. Additionally, as a pathological condition, PTSD individualises the impact of trauma and ignores the adverse effects of trauma on wider social networks (such as families, communities and societies, Miller & Rasco, 2004).

Other Forms of Psychopathology Studied in Refugee Populations

Anxiety and depression

Depression and anxiety disorders have been considered by some researchers to be prevalent in refugee groups. Silove, Steel, McGorry and Mohan (1998) found a high incidence of both depression and anxiety in Tamil asylum-seekers and refugees living in Australia. Additionally, Mollica et al. (1999) reported that 39% of Bosnian refugees who took part in their research met the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV; APA, 1994), diagnostic criteria for depression. Lie, Lavik and Laake (2001) also reported rates of depression and anxiety in 48% of the Bosnian and Kosovo-Albanian refugee participants recruited from a non-clinical sample. Other researchers also report high rates of psychological distress, particularly depression, in refugees (see Brune, Haasen, Krausz, Yagdiran, Bustos, & Eisenman, 2002; Kinzie, Sack, Angell & Manson, 1986; Mollica, Poole, & Tor, 1998; Riding-Malon, 2004; Uprety, Basnet, & Rimal, 1999).

In her research with East African women (from Ethiopia, Eritrea, Sudan and Somalia) living in Australia, Tilbury (under review) found little evidence for a Western form of depression and no equivalent to the term 'depression' in any of the communities she interviewed. Tilbury's participants said depression was uncommon in their home country and some suggested that this was due to culturally embedded protective factors and/or because social conditions which produce depression do not exist in East Africa. Additionally, some of participants considered that very low rates of depression in their home country were related to their perspective of what was most critical to focus their energy on – that is, the struggle to stay alive outweighed concerns about one's emotional state.

Participants who did describe symptoms similar to depression were most likely to attribute these to post migration stressors such as lack of employment, discrimination, and limited English language proficiency as well as concern and worry for family members left behind in East Africa.

From this research, Tilbury suggests that these womens' distress is a normal and understandable reaction to the stressors and adverse life events they have confronted. Furthermore, given the evidence that depressive symptoms vary significantly transculturally (e.g., Karasz, 2004; Matthey, Barnett, & Elliott, 1997; Mukherji, 1995), it seems difficult to justify uncritically the use of Western diagnostic manuals, formal interview schedules, and psychometric measures when exploring psychiatric diagnoses in non-Western cultures.

Psychosomatic distress

According to the DSM-IV, the central features of psychosomatic presentations of distress are symptoms indicative of a medical illness that cannot be adequately explained by a general medical condition. In addition, the symptoms causing concern are not feigned by the sufferer who typically believes there is a genuine medical explanation for their physical distress.

Psychosomatic disorders are considered significantly more prevalent in non-Western cultures (e.g., Berry, Kim, Minde, & Mok, 1987; Ho, Au, Bedford & Cooper, 2002; Mollica, Donelan & Tor et al., 1993; Somasundaram & Sivaykoan, 1994; Summerfield, 2000). To account for this apparently higher rate of psychosomatic distress in non-Western cultures, Ryder, Yang and Heine (2002) proposed the somatisation hypothesis. The somatisation hypothesis asserts that people from non-Western cultures are more likely to deny psychological distress, interpret it as somatic illness or present distress as physical illness in medical

settings. Mukherji (1995) suggests that somatic symptoms may be the most omnipresent expression of psychological distress and points out that physical distress in various forms is invariably considered a component of most, if not all, psychological disorders.

Some researchers, however, suggest that those from non-Western cultures are no more likely to deny emotional distress than Westerners and that physical symptoms are just as strongly associated with psychological distress in Western countries as in non-Western countries (Guereje, Simon, Ustun, & Goldberg, 1997; Mukherji, 1995; Kirmayer, Robbins, Dworkind, & Yaffe, 1993). Kvale (1996), for example, suggested that one of the reasons somatisation may be so readily identified in non-Western cultures is due to the difficulty of accurately interpreting metaphors, expressions, and symbols used in language cross-culturally. For example, a non-Western research participant's description of 'problems of the heart', if not explored in more depth, could be interpreted as a psychosomatic expression of distress. This plausible hypothesis with respect to the potential for over diagnosis of psychosomatic disorders in non-Western cultures seems to have received little research attention.

Treatment Issues

Not only is the issue of diagnosis of psychopathology from a Western perspective controversial, the treatments used by Western-based clinicians and services who work with refugees living in the West have also come under scrutiny. Watters (2001) asserts that as research and social policy often assume that mental health problems are caused by historical factors such as trauma, scant attention is often paid to factors operating in the new host country which may be contributing to psychological distress. Studies that have focused on post-

migration factors suggest that stressors confronted in the host country (such as underemployment, unemployment, separation from family members, racism, and inability to speak the language of the host country) do play a moderating role in the manifestation of psychological distress in refugees (e.g., Elmi, 1999; Lie, Lavik, & Laake, 2001; Noh, Hyman, & Fenta, 1999; Silove & Ebrahim, 1998; Sinnerbrink, Silove, Field, Steel, & Manicavasagar, 1997). It is likely, then, that focusing on and investigating what refugees consider to be the aetiology of their difficulties may lead to a more collaborative approach and therefore more successful outcomes.

Such an approach, however, of hearing the refugees' views of psychopathology, is currently extremely rare (Watters, 1998) because mental health services infrequently provide the opportunity for refugee service users to identify what they want from the service (Watters, 2001). Evidence for this assertion is provided in a survey carried out in 18 European countries which found that only two of these countries had developed mechanisms for including refugees in the decision-making procedures affecting them (Watters, 1998). Without opportunity to relay their experiences in a manner that is meaningful to them and identify their own priorities for treatment, the perception of refugees as traumatised war victims suffering from some form of psychopathology remains the status quo (Watters, 2001; Eastmond, 1998). Such an approach serves to reinforce institutional structures within the health and social care field (Watters, 2001) and as coined in the health management literature, this response to refugees can be characterised as "service-led" rather than "user-led" (Watters, 2001; p. 1710).

Another area of growing controversy is the question of the appropriateness of employing Western-based psychological treatments with refugees from non-Western countries. Western psychotherapeutic approaches traditionally emphasise the provision of highly trained professionals within a clinic-based setting providing psychotherapy and psychiatric medication (Miller & Rasco, 2004). The focus in these settings is typically on ameliorating an individual's psychological distress and suffering, with little attention paid to utilising and/or strengthening natural community and family resources (Miller & Rasco, 2004). The extent to which clinic-based services for refugees are effective is largely unknown (Miller & Rasco, 2004). Nevertheless, such services continue to be developed, as are guidelines for how to best work therapeutically with refugees (Miller & Rasco, 2004).

There is a growing body of literature which has explored the efficacy of Western-based therapies with refugees. The therapies which have been included in these studies are cognitive-behaviour therapy, psychodynamic psychotherapy, stress-inoculation training, testimony therapy, non-specific psychotherapy and medication based interventions. This research has almost exclusively focused on the treatment of trauma-related difficulties, primarily PTSD (e.g., Brune, Haasen, Krausz, Yagdiran, Bustos, & Eisenman, 2002; Drozdek, 1997; Hinton, Safren, Pollack, & Tran, 2006; Kinzie, 2001; Kinzie & Fleck, 1987; Nicholl, & Thompson, 2004; Otto & Hinton, 2006; Paunovic, & Öst, 2001; Schreiber, 1995; Schulz, Resick, Huber, & Griffen, 2006; Snodgrass, Yamamoto, Frederick, et al., 1993; Weine, Dzibur Kulnovic, Pavkovic, & Gibbons, 1998).

While some of this research reports promising results (e.g., Brune et al., 2002; Kinzie, 2001; Kinzie & Fleck, 1987; Nicholl & Thompson, 2004; Paunovic,

& Öst, 2001; Schreiber, 1995; Weine et al., 1998), methodological and other difficulties limit the conclusions which can be drawn from the findings. For example, many of these studies fail to clearly define the demographic characteristics of the participants (e.g., Paunovic & Öst, 2001) or the components of the intervention most likely to have led to therapeutic change (e.g., Hinton, et al., 2006; Otto & Hinton, 2006; Paunovic & Öst, 2001). Additional concerns about this body of research include the exclusion of participants that could not speak English (e.g., Paunovic & Öst, 2001), failure to adequately control for the therapist allegiance effect (e.g., Hinton, et al., 2006; Otto & Hinton, 2006), failure to consult with key stakeholders within the refugee community being studied about the proposed interventions (e.g., Schulz, et al., 2006), and failure to adapt the therapy and/or therapy monitoring methods to increase their applicability/relevance to the world view of the refugees involved in the research (e.g., Hinton, et al., 2006; Otto & Hinton, 2006; Paunovic & Öst, 2001; Schulz, et al., 2006).

It is conceivable that psychopathology and consequent psychotherapy are not considered a priority to those refugees who have migrated to Western countries, given the many other significant challenges facing them, particularly during the initial period of adaptation. Given, however, that refugees living in Western countries are typically not involved in research on their own psychological wellbeing (Eastmond, 1998; Watters, 2001), the question of whether psychopathology or trauma-based distress are considered significant issues to them is left largely unanswered.

Overview of Cross-cultural Research Investigations of Resilience

There are numerous definitions of resilience, and these definitions tend to change depending on the population under study. Generally, however, resilience refers to an individual's ability to cope with stress and catastrophe. The factors which are believed to enhance the likelihood that someone will be resilient in the face of considerable adversity are called 'protective factors'. Such factors include coping strategies, environmental (i.e., familial, and community) support and characteristics employed by the individual, family, and culture to ensure survival in the face of imminent danger or adversity.

Numerous investigations have shown that there are individuals who, when confronted with difficult life events or enduring hardship, are able to maintain or regain high levels of wellbeing (e.g., Ryff, Singer, Love, & Essex, 1998; Singer & Ryff, 1999; Singer, Ryff, Carr, & Magee, 1998). Research has also clarified the contributions of various protective factors (e.g., self-concept flexibility, coping orientations, social comparisons) in maintaining wellbeing (e.g., Kling, Seltzer, & Ryff, 1997). Moreover, a study conducted by Ryff and Singer (2000) demonstrated that maintaining positive interpersonal relationships is health enhancing, and firmly maintained religious beliefs have also been demonstrated to act as a protective factor in circumstances of adversity (Ryff, Singer, & Palmersheim, 2005).

The study of resilience and the factors that contribute to resilience (including social, psychological, cultural and biological factors) are particularly relevant to the area of refugee research. Refugees, by definition, have been exposed to adverse and often extreme life circumstances. Strongly maintained social ties are a key feature of many non-Western refugee groups as are deeply

indoctrinated religious beliefs. Studying other factors that contribute to resilience in various refugee groups may provide particularly rich and enlightening data on what other factors contribute to effective functioning in situations of extreme adversity and trauma. There is, however, a paucity of literature focusing on the use of adaptive coping strategies by refugee groups resettled in their new host country. Consequently the current research intended to contribute to the resilience literature by developing an understanding of what factors may promote wellbeing for Somali female refugees and, in particular, what factors may protect them from experiencing significant psychological distress once resettled in New Zealand. To date, only two known research papers have explored factors promoting resilience within Somali culture. Prior to outlining the findings of this research (in Chapter 4), a general critique of the refugee and resilience literature based on a paper by Witmer and Culver (2001) is presented.

A review conducted by Witmer and Culver (2001) highlighted the lack of attention given to resilience and protective factors in recent studies conducted with Bosnian Muslim refugees. These authors identified a clear tendency of researchers working in this area to focus on Western constructions of psychopathology while paying minimal attention to factors promoting resilience. Research focusing on psychopathologising refugees' trauma experiences and developing and implementing psychotherapy programmes to "treat" these trauma "symptoms" has been documented in other refugee groups also (e.g., see, Brune et al., 2002; Paunovic, & Öst, 2001; Riding-Malon, 2004; Silove, Steel, McGorry & Mohan, 1998). In their review of the literature, Witmer and Culver (2001) also found that regardless of several studies acknowledging the cultural limitations of

the PTSD diagnosis, none of the studies explored resilience and psychopathology from the unique cultural perspective of the participants.

Although Bosnia may be considered a Western country (which employs Western psychiatric and medical models), Bosnian Muslims may nevertheless have their own conceptions of these theoretical constructs, which could differ markedly from the DSM-IV categories of mental illness. This may be especially likely given that this is a collectivist group (i.e., a cultural group in which interdependence is held in higher esteem than independence) which also identifies itself on the basis of its spiritual beliefs. This possibility however, was not actively explored in any of the studies that are cited.

Witmer and Culver (2001) also expressed a concern that only limited information is typically provided about the cultural context of Bosnian Muslim refugees. The authors assert that knowledge of such factors as family structure and relationships (and how these systems have been damaged/impacted by war trauma) within Bosnian Muslim culture is likely to inform research on psychopathology and resilience. Witmer and Culver suggest that, to remedy this short fall in the literature, Bosnian Muslims need to be involved in the design and implementation of research about their own communities and that research on psychopathology and resilience be strongly informed by the cultural norms of the group under study.

Although Somali refugees in many ways are likely to be different in their culture and world view from Bosnian Muslim refugees, both groups come from collectivist societies in which the cultural norms are enmeshed with their Islamic faith. For this reason, some of the studies exploring resilience in Bosnian Muslim refugees may shed light on the factors indicative of resilience in Somali refugees.

In the studies reviewed by Witmer and Culver (2001) that did explore resilience, resilience was often credited to strong family and cultural identity (e.g., Weine, Vojvoda, Hartman, & Hyman, 1997), maintaining cultural traditions and rituals (e.g., Markowitz, 1996), ensuring a secure environment for the family (Ajdukovic & Ajdukovic, 1993), and both personal and familial flexibility and adaptation (e.g., Weine et al., 1997). It is possible that similar factors may contribute to resilience in Somali refugees. What is more, the critiques and recommendations for future research with Bosnian Muslim refugees could be employed as the basis for research with many other refugee groups, including Somali, with whom the focus has primarily been on taking a deficits-based and/or Western methodological perspective (e.g., Abdullahi, 2001; Bhui, Abdi, Abdi, et al., 2003; Bhui, Craig, Mohamud, et al., 2006; Carroll, 2004; Ellis, Lhewa, Charney, & Cabral, 2006; Gerritsen, Bramsen, Devillé, van Willigen, Hovens & van der Ploeg, 2006; Guerin, Guerin, Diiriyie, & Yates, 2004; Kinzie, Boehnlein, Leung, Moore, Riely, & Smith, & 1990; Jamil, Hakim-Larson, Farrag, Lafako, Diqi, & Jamil, 2002; Rousseau, Said, Gagné, & Bibeau, 1998a; Tiilikainen, 2000; Warfa, Bhui, Craig et al., 2006; Zarowsky, 2004).

New Directions in Mental Health and Refugee Research

The limitations of previous refugee research have been articulated by Miller and Rasco (2004), who indicate concern that historically, studies have primarily been conducted using psychometric instruments and/or structured diagnostic interviews. Although these authors acknowledge that the significant volume of research conducted in this manner has yielded some consistent and pervasive conclusions about the impact of war and violence on people's mental health, they identify key areas for future researchers to explore using alternative

methodologies and approaches. These areas include: (i) collaboration with community members in the development and implementation of culturally appropriate interventions that blend local and Western ideas and practices, (ii) the integration of mental health and psychosocial interventions into familiar and non-stigmatised community settings, and (iii) a focus on enhancing the capacity of communities to cope effectively with displacement-related stressors, including the structural violence of poverty and discrimination, coupled with a parallel focus on alleviating distress related to experience of violence and loss.

Although qualitative and ethnographic approaches have been criticised in the literature (see Jacobsen and Landau, 2003, for a comprehensive critique of the methodologies employed in refugee research) for increasing the likelihood of producing a biased sample and compromising researcher objectivity, there are nevertheless compelling reasons to employ such approaches in cross-cultural investigations of refugee health. Some of the arguments for employing these approaches are outlined below.

Employing co-nationals to investigate the research question and to introduce the researchers to key members of the target group may, as Jacobsen and Landau assert, introduce another form of bias. Given the trauma and adversity already faced by refugees, often at the hands of their own governments or fellow country men/women, it is understandable that many refugees may be suspicious of co-nationals whom they do not know. Introduction to the researchers by a member of the refugee's own culture who is considered trustworthy and generally held in high esteem (by members of that culture), is one of the clear advantages of employing co-nationals (Berry et al., 2002). This

approach may be particularly important for those groups who tend to live in insular communities, even when they are in the midst of another country/culture.

Additionally, although Jacobsen and Landau were critical of the often small sample sizes in the studies they reviewed, Berry et al. (2002) argue that in fact large sample sizes are often unnecessary in ethnographic approaches as it is generally agreed that culturally specific beliefs remain reasonably consistent across members of a particular group. Also, with respect to practical considerations, it is often easier to identify and recruit participants for ethnographic studies due to the smaller sample sizes required to conduct the research.

Miller and Rasco (2004) identify a number of principles to ensure that refugee research maintains integrity when put under scrutiny. They also describe a number of issues that they recommend future research tries to focus more diligently on. First, they suggest a greater emphasis on developing theory as the basis of support for assessment and intervention models given that this has largely been lacking as the basis of refugee research. Additionally, Miller and Rasco recommend researchers ensure their approaches to understanding ethnocultural variations in distress and wellbeing as well as approaches to integrating Western and traditional healing practices can be replicated. They highlight the lack of well explained methodologies in many of the published papers on refugee psychopathology. Miller and Rasco encouraged refugee researchers to commit to staking out an alternative path for exploring and addressing the mental health and psychosocial needs of refugees. They suggest this path should be based on ecological models of intervention and that notwithstanding the challenges of this

research, working collaboratively with refugee communities will help to identify innovative and creative ways for these challenges to be overcome.

Based on the concerns raised in this chapter with respect to previous research on refugee psychopathology and resilience, the current research project was designed to be consistent with Miller and Rasco's (2004) aforementioned recommendations. That is, the thesis design was based on a collaborative, community-focused approach in which every effort was made to understand Somali conceptions of distress and wellbeing from the unique perspective of the Somali participants. This approach was taken to try to minimise the reliance on and use of Western paradigms of distress as the framework within which Somali psychopathology is understood. Prior to presenting the three studies that were conducted as part of this thesis, it is first important to review the empirical literature which has to date attempted to explore Somali distress and wellbeing. It was this literature which provided the impetus for the specific objectives of the present research.

CHAPTER 5

Western Research Exploring Somali Conceptions of Distress and Wellbeing

Resettlement Difficulties and Psychological Distress in Somali Refugees

Somali refugees may remain in refugee camps for as little as a few months or longer than 10 years while waiting to gain entry into a host country (Guerin, Guerin, Diiriye, & Abdi 2003). When they do gain entry into a host country they face a number of challenges adapting to this new country, especially when it is Westernised and not Islamic (Guerin et al., 2003). Guerin, Guerin, Diiriye and Abdi (2003), in their research with the Somali community of Hamilton, New Zealand, have documented a number of challenges refugees face in attempting to adjust to a new country. Such challenges include coping with significant language barriers, being exposed to and coping with racism, unemployment, difficulties understanding the schooling system and general bureaucratic procedures, and difficulties identifying and accessing appropriate health care.

As already outlined, such factors, coupled with pre-migration stressors have been suggested to increase vulnerability to suffering from psychological distress (e.g., Elmi, 1999; Silove, Steel, McGorry, & Mohan, 1998; Watters, 2002). Given the contrasts between Somali cultural orientation (e.g., with respect to language, dress, food preferences and religion) and that of the majority of Westerners (and in particular New Zealanders), it seems critical that a better

understanding of Somali needs, expectations and beliefs about issues such as health, education, family, and religion be ascertained. This will help to ensure that the Western countries that they migrate to develop the infrastructure to support Somali toward contributing financially and socially to their new country. There have only been a few studies, however, that have explored psychological distress in Somali refugees living in Western countries and, only one study of psychological distress in this group that was conducted in New Zealand. These studies are reviewed below.

Review of the Literature Exploring Psychological Distress and Resilience in Somali Refugees

There are no known reviews of the research on psychological distress and resilience in Somali refugees. What is more, many of the studies which have been conducted have not cited previous research conducted with Somali. This immediately places studies which have been carried out with this group at a disadvantage, as researchers are not contributing to theory development but rather seem to be working in isolation. The present review is an attempt to discuss and critically analyse this body of research - both the information it provides about psychological distress and resilience in Somali refugees and also the limitations of research in this field.

Resilience

Only two studies were found that explored factors contributing to resilience in Somali refugees. The first of these studies conducted by Rousseau, Said, Gagné and Bibeau (1998b) who assessed resilience in a group of unaccompanied Somali refugee youths in Canada. These researchers used unstructured and semi-structured interviews to obtain narratives (from 10 males

aged between 13 and 18 years) from their participants, which illustrated the ways the refugees had reacted and coped with the migratory experience. Rousseau et al. (1998b) also interviewed key adult informants from the Somali community as well as individuals who were responsible for assuming a parental role with the youths. These key informants were asked about their perception of the Somali teenagers' ability to cope with their current plight. Rousseau et al. (1998b) did not actually assess the level of psychological wellbeing, adaptation, or resilience of the participants in their study, rather, they inferred what factors may be critical to resilience based on their explorations of the coping strategies employed by Somali youth as part of the migratory experience.

It was unclear what specific factors were considered to contribute to resilience based on the findings outlined in Rousseau et al.'s (1998b) paper, however, general themes emerged from their qualitative ethnographic analysis. First, the researchers suggested that resilience might be indicated by an ability to cope with and navigate one's way between two distinctly different cultures. Furthermore, these researchers asserted that resilience may not be primarily a function of the person displaying it, but may be more strongly associated with the social context in which the person exists. Rousseau et al. suggested that the social networks and relationships that the youth has developed will determine their level of resilience and ability to cope with the stress of migration. They did not, however, elaborate or speculate on what the key components of these social relationships must be to foster resilience.

Rousseau et al. (1998b) suggested that although forced exile cannot be considered non-traumatising, nevertheless exile could lead to gains in positive coping attributes regardless of the nature and magnitude of loss and trauma. They

hypothesised that the special relationship such experiences have with the traditional meaning of sending Somali male youth away to learn about nomadic pastoral existence could explain such gains. That is, Somali youths' apparent capacity to recuperate and adapt to their new host country following the migratory experience, was suggested to be due to their training from an early age, to survive in harsh conditions away from home in nomadic cattle camps.

Although Rousseau et al. (1998b) were careful not to assume Western definitions of resilience or psychopathology, and in fact were critical of the absolutist assumptions often made by researchers in this field, the generalisability of the findings is nevertheless limited and could not be readily assumed to relate to other Somali subgroups (e.g., female adolescents or adults, urban [rather than nomadic] Somali) whose socialisation experiences and expectations are likely to be markedly different to the young male participants in this study.

The study conducted by Whittaker, Hardy, Lewis, and Buchan (2005) which explored factors promoting resilience in young Somali female is considered to have more relevance to the current thesis. These researchers assessed wellbeing in five young Somali female refugees and asylum seekers living in London, England. Group and individual semi-structured interviews were conducted using Interpretative Phenomenological Analysis. The findings of this study suggested that religion (Islam) was a critical factor in promoting psychological wellbeing and provided guidance at difficult periods of the participants' lives. In particular, the Koran was cited as a source of guidance in how to react, understand, and cope with loss and difficulties. What is more, reciting Koran verses, prayer, and other religious rituals was considered to protect against spirit possession.

Additional factors considered to promote resilience according to Whittaker et al. (2005) included overtly demonstrating adaptive coping behaviours (what the researchers described as the “Get[ing] on with it approach”, p. 181). Factors considered fundamental to adaptive coping were not clearly delineated by the researchers but were more stated as “deal[ing] with emotions quickly, to be strong, not to moan or dwell on problems, and to get on with their lives as they expected others to do” (p. 181). Family and community support was also considered vital to psychological wellbeing. Furthermore, some participants said that family and community support protected against spirit possession. Interestingly, a number of the Somali women said they would not share concerns about their psychological state with other Somali for fear that this information would not be kept confidential. Although the authors stated it was not clear from their transcripts why such concern was placed on keeping information about psychological distress concealed, they speculated that fear of being rejected or “labelled ‘mad’, ‘bad’ or ‘possessed’” (p. 190) by the Somali or Western communities services may be the primary reasons for not making such disclosures. Hence, non-disclosure of sensitive personal information was considered by participants to be helpful for survival and wellbeing.

Whittaker et al. (2005) acknowledged that the very small sample size limited the generalisability of their findings. They also recognised that working transculturally may have meant that interpretation of the data was potentially compromised. It is important to recognise that words and their meanings are often not interchangeable between languages (Tribe, 1999). Hence, both interpreters and bilingual participants in research projects such as Whittaker et al.’s are at best, delivering an approximation to the thoughts and ideas they actually want to

convey. Additionally, there were no Somali researchers involved in the project. Involving Somali as already indicated, not only serves to ensure research focuses on issues relevant to the community under study, but may also reduce the complexity of transcultural interpretation and translation by drawing on the co-nationals' knowledge of culture and language meanings. Notwithstanding these limitations, given this is the only known study of factors promoting resilience for Somali women, it provides an excellent starting point for other researchers to continue to explore some of the key themes and conclusions drawn by this research group.

Studies exploring psychological distress in Somali refugees

All but one of the studies reviewed took place in countries of European origin. The exception was the study conducted by Rousseau, Said, Gagné and Bibeau (1998a), in which some of the participants were interviewed in the Horn of Africa. Both quantitative and qualitative research papers, exploring Somali wellbeing and distress, were identified in literature searches. The focus of these studies was markedly different. Quantitative research papers employed Western based assessment tools to explore Western based psychological disorders. Qualitative studies tended to employ open-ended interviews and often took an ethnographic approach to data collection. Not surprisingly then, the findings of these two distinct methodological strategies were divergent. Given the contrasting findings between the quantitative and qualitative papers, they will initially be reviewed separately.

Findings of quantitative studies

Two of the quantitative studies identified low rates of Western-defined psychopathology in Somali compared to other immigrant groups (Silveira &

Ebrahim, 1998; Halcón, Robertson, Savik, et al., 2004). Silveira and Ebrahim hypothesised that Somali participants' unexpectedly low scores on a measure of anxiety and depression (Scale of Anxiety and Depression, SAD; Bedford, Foulds, & Sheffield, 1976) were due to denial of psychological symptoms because of negative religious perceptions of depression (taboo) and a lack of knowledge of (Western) psychological disorders. Halcón et al. (2004), however, concluded that the findings of their study, which employed an investigator-designed interview schedule as well as the PTSD Checklist (Civilian Version), suggested that many Somali were coping well in their new host country.

The other researchers who conducted quantitative studies described relatively high levels of psychological distress (including depression, PTSD, agoraphobia, panic disorder) in their Somali participants. Interestingly the participants in a number of these studies reported low levels of mental health service use (see Bhui, Abdi, Abdi, et al., 2003; Jaranson, Butcher, Halcón, et al., 2004; McCrone, Bhui, Craig, et al., 2005). In the quantitative studies reviewed, researchers typically asserted that Somali demand for adequate psychiatric intervention was high (e.g., Bhui et al., 2003; Bhui, Craig, Mohamud, et al., 2006) but that services need to be adapted to better respond to the needs of this group.

Aetiological factors associated with psychopathology in the quantitative studies included limited family support and community support (Gerritsen et al., 2006; Silveira & Allebeck, 2001; Silveira & Ebrahim, 1998), inadequate access to community services (Silveira & Allebeck, 2000), inadequate housing (Silveira & Ebrahim, 1998), decreased religious practices (Jaranson et al., 2004), employment concerns (Bhui et al., 2003; Silveira & Ebrahim, 1998), perceived racial/religious

discrimination (Silveira & Allebeck, 2001), traumatic experiences (Bhui et al., 2003; Gerritsen, et al., 2006; Halcón, et al., 2004; Jaranson et al., 2004), leaving Somalia at an older age (Jaranson, et al., 2004), being older generally (Gerritsen et al., 2006), being an asylum seeker (Bhui et al., 2006; Gerritsen, et al., 2006), being female (Gerritsen, et al., 2006), and inability to return to Somalia (Silveira & Allebeck, 2001). Qat, a substance with amphetamine-like properties that is chewed by Somali (Griffiths, 1998, cited in Bhui et al., 2003) was also found to contribute to psychopathology in two of the quantitative studies (Bhui et al., 2003; Bhui et al., 2006).

Some researchers also explored factors considered to protect Somali against experiencing psychopathology. These factors included speaking English (Halcón, et al., 2004; Jaranson et al., 2004), emigrating at an earlier age (Halcón, et al., 2004), having family members living in the same host country (Halcón, et al., 2004), completing formal education (Bhui et al., 2006; Jaranson et al., 2004), employment (Bhui et al., 2006), marriage (Jaranson et al., 2004), maintaining religious practices (Jaranson et al., 2004; Silveira & Allebeck, 2001), and adequate social support (Silveira & Allebeck, 2001).

Although some studies reported high rates of psychopathology, participants seldom acknowledged suicidal ideation. This was thought to be due to suicide being taboo according to Islamic lore (Bhui et al., 2003). Additionally, Silveira and Allebeck (2001) found that strong religious faith seemed to prohibit disclosure of symptoms of psychopathology among participants who perceived psychological difficulties as a sign of lack of faith in God or moral weakness.

One of the quantitative papers found, focused on validating a psychometric measure for use with Somali. Ellis, Lhewa, Charney, and Cabral (2006)

investigated whether the UCLA Posttraumatic Stress Disorder Index (UCLA PTSD Index; Rodriguez, Steinberg, & Pynoos, 1999) could be employed as a reliable and valid screening tool for PTSD symptoms in Somali adolescent refugees. No information was provided about whether or not the participants were experiencing any form of psychological distress. The researchers demonstrated that the UCLA PTSD Index has good reliability (Chronbach's $\alpha = .85$) and convergent validity (based on correlations with the Depression Self-Rating Scale; Birleson, Hudson, Buchanan, & Wolff, 1987 and the War Trauma Screening Scale; Layne, Stuvland, Saltzman, Djapo, & Pynoos, 1999). Based on their findings, the researchers concluded that the UCLA PTSD Index had adequate psychometric properties to be employed as a screening tool with Somali youth. No other studies were located in which attempts were made to validate psychometric instruments for use with Somali.

Findings of qualitative research studies

The qualitative studies tended to explore Somali conceptions of psychological distress using open-ended interviews often combined with an ethnographic approach. Numerous psychological states were described in these studies which did not map neatly with Western nosologies of psychopathology.

Welwel ama walaac

One of the most common complaints mentioned by participants in Tiilikainen's (1998) ethnographic research was *welwel ama walaac*. Welwel was defined as anxiety, agitation, or worry and walaac as preoccupation, nervousness, and "rambling talk" (p. 313). 'Stress' was used as a description of the full term 'welwel ama walaac' by Tiilikainen's participants. According to her research findings, Somali with this condition cannot eat, concentrate or sleep and may talk

continuously and/or to themselves. Thinking “too much” was also considered to be a reason for experiencing “stress”. Tiilikainen found that in Finland (where her study took place), loneliness, inability to take care of relatives in Africa, and being at home all day with children were some of the reasons provided for *welwel ama walaac*. Although Tiilikainen did not outline any specific interventions for this condition, she asserted that Somali suffering from *welwel ama walaac* require the support of others. No other research studies referred specifically to this condition although Zarowsky (2004) briefly referred to *wilwil* which she defined as “ordinary worry” (p. 196). *Wareer* was the term used by Zarowsky to refer to a more severe condition involving thinking/anxiety/dizziness/confusion caused either by febrile illness such as delirium, or life problems.

In Warfa et al.’s (2006) study, which used focus group interviews, Somali participants used the terms ‘stress’, ‘distress’, ‘worry’ and ‘anxiety’ to describe psychological ill health. According to their participations, these states of distress were considered to be precipitated by pre-migration and post-migration geographical instability (i.e., homelessness, moving houses and suburbs frequently). Participants indicated that residential mobility led to a loss of community support (due to moving away from this support) which in itself was considered a major risk factor for psychological distress. No Somali translation of these psychological states of distress were provided so it is difficult to determine whether Warfa et al.’s participants were also referring to the Somali state of *welwel ama walaac* or, whether they were conceptualising these states in some other way. Seeking assistance from general practitioners was apparently the most common form of help seeking for medical complaints for Warfa et al.’s participants. It was not clear whether the Somali in this study considered ‘stress’,

‘distress’, ‘worry’ and ‘anxiety’ as medical complaints and what other forms of traditional and Western interventions (if any) they may employ to seek respite from these states.

Qalbijab or niyadjab

Qalbijab or niyadjab is considered a more serious psychological state than *welwel ama walaac*, and was suggested by Tiilikainen (1998) to refer to a “broken heart or broken mind” (pg. 313). According to Somali participants in her research, *qalbi* means heart, mind, thought, feeling, memory, and courage while *niyad* means mind, thought, will or feeling. Tiilikainen defines *qalbijab* as discouragement, or demoralisation. She translates *niyadjab* as a state of depression, demoralisation, frustration or disappointment. Tiilikainen’s participants described *qalbijab* as a condition in which the sufferer cannot sleep, eat or concentrate, feels “bad” (p. 313), stays at home, is inactive and experiences anhedonia. Reasons provided by her participants for this state were memories of the civil war in Somalia, being unfamiliar with Finnish language and culture, unemployment, financial strain, and concern for family still living in Africa. Jealousy and unfulfilled desires or plans were also provided as possible reasons for *qalbijab*.

Zarowsky (2004) also provides accounts of *niyadjab* from her Somali participants. She provides a similar description to Tiilikainen of this condition which is “demoralisation, hopelessness, or broken will” (p. 195). Zarowsky’s participants, who were living in Ethiopia at the time of the study, stated that loss of farmland (due to the desecration of this land during the civil war) was the primary reason for *niyadjab*. Her Somali participants, however, also reported that *niyadjab* was a state that could be triggered in women by the death of children or a

husband taking a second wife. In order to treat or overcome qalbijab and niyadjab participants stated that a solution to the issue causing this condition was necessary (e.g., being able to fulfil unfilled desires). Additionally, if a person was not able to successfully overcome his or her grief or loss (or successfully address the reason for experiencing this condition in the first instance), Tiilikainen's participants suggested that there was a risk this condition could lead to "madness".

Murug

Murug or *Murugo* has also been identified as a description of psychological distress in two of the papers reviewed (Carroll, 2004; Zarowsky, 2004). These studies presented similar descriptions of this concept which primarily related to sadness and depression. Zarowsky asserted that this was considered a more serious condition than niyadjab and Carroll also considered this a potentially serious emotional state. Both Carroll and Zarowsky's participants suggested that murug could lead to "madness". Murug was described as "thinking or rumination about an insolvable problem or loss; sadness or depression" (Zarowsky, 2004; pg. 196). Symptoms of murug described by participants included headaches, loss of appetite, social withdrawal, tearfulness and sleep difficulties. If left untreated some participants said that murug could lead to medical problems such as high blood pressure, diabetes, constipation, anaemia and digestive problems.

Carroll (2004) suggested that the trauma of war and the stress of providing financially for family members still in refugee camps were two primary causes of murug. Zarowsky however, asserted that many forms of emotional distress experienced by Somali (including murug) were primarily related to social incohesion and injustice and not simply about private suffering. The most common and efficacious treatment approach for murug identified by Carroll's

participants was confiding in family and friends. Zarowsky also asserted that support from family and friends was the most common intervention. She suggested that the function of this support primarily acted as a means of distracting the sufferer from their thoughts (i.e., trying to engage them in activities which would distract them from the thinking about the issues causing the murug). Additionally Zarowsky said that community assistance with addressing the cause of the murug (e.g., assisting with family reunification) was also an effective means of ameliorating the symptoms. She stated that there was an implied duty for Somali family and friends to intervene when an individual was suffering from a “negative” emotion such as niyadjab or murug.

Walli

Walli was described in some of the qualitative studies as an idiom of distress in Somali culture (Carroll, 2004; Guerin, Guerin, Diiriye, Yates, 2004b; Tiilikainen, 1998), which was considered more serious than niyadjab. Carroll and Tiilikainen’s descriptions of walli were similar and indicative of a severe form of psychological distress that was defined as “madness” or “craziness”. Symptoms of walli described by Tiilikainen were shouting, aggression, talking incessantly, and crying. According to Zarowsky (2004), crying is discouraged in Somali culture as it is considered to indicate weak faith in Allah and Islam. As such, tearfulness demonstrated in the presence of other Somali is unusual and often indicative of severe states of distress. Public nudity, violence, mutism, walking without purpose, nervousness, and dressing “inappropriately” (p. 123) were identified as indicators of walli by Carroll. Guerin et al.’s (2004b) participants also described symptoms of a more serious form of psychological disturbance, which included aggression, eating from rubbish bins, and disrobing in public. This

research group however, described these symptoms as an indication of “insanity” which they considered was distinct from walli. Although Guerin et al. (2004b) discussed walli in their paper, they did not consider this a severe or serious psychological state but rather, suggested it was a condition akin to Western depressive or anxiety disorders.

Treatment for Tiilikainen (1998) and Carroll’s (2004) description of walli and Guerin et al.’s (2004b) description of insanity were, however, similar and included Koran readings, family support, prayer and if necessary compulsory hospitalisation. Somali participants in these studies did not consider mainstream mental health interventions effective to treat this condition.

Carroll (2004) suggested that extreme trauma caused walli. Tiilikainen (1998), however, stated that walli could be caused by *jinn* possession. Guerin et al. (2004b) also reported that jinn could cause what they described as “insanity”. Additionally, *welwel ama walaac*, or *qalbijab*, *niyadjab* and *murug* could lead to walli if these conditions were not successfully treated/overcome (see Carroll, 2004; Tiilikainen, 1998; Zarowsky, 2004). According to Tiilikainen, individuals considered to have walli are stigmatised in Somali society.

Jinn possession

Spirit/jinn possession was also provided as an explanation for out of the ordinary behaviour and negative emotional states (Carroll, 2004; Rousseau et al., 1998a; Tiilikainen, 1998; Guerin et al., 2004b) in some of the qualitative studies. As indicated above, jinn are thought by some Somali to cause extreme states of psychological distress (Guerin et al., 2004b; Rousseau et al., 1998a; Tiilikainen, 1998; Whittaker, et al., 2005; Yates, 2003), described in various studies as “craziness”, “madness” or “insanity”. In Rousseau et al.’s (1998a), Tiilikainen’s

(1998), and Guerin et al.'s (2004b) studies, it was unclear whether jinn and walli (or "madness" according to Rousseau et al., 1998a; and "insanity" according to Guerin et al., 2004b) were distinguishable states, or rather, whether jinn was one (of many possible) explanation/s for someone becoming walli. Hence, the symptoms of jinn in these papers were the same as those of walli.

The important distinction between jinn and walli according to Carroll (2004) seemed to be causation rather than symptom profile. Extreme fear, distressing dreams, disorientation, aggressive behaviour, disrobing in public, eating from rubbish bins, and experiencing "inner" voices were all described as symptoms of jinn by Carroll. Whittaker et al. (2005) discussed both *zar* possession (see Chapter 3 for a comprehensive description of *zar*) and jinn possession in their paper although it was not clear how or if their participants distinguished between these states. Some of the symptoms of *zar* and jinn possession described by the Somali women in this study were consistent with those described by Carroll's participants (i.e., crying, anger, and violence). Many of these symptoms of spirit possession are the same as those of walli.

In Carroll (2004), Tiilikainen's (1998), and Whittaker et al.'s (2005) studies, some participants suggested that jinn was in fact a mental illness rather than a spirit possession and these participants stated that they did not believe spirit possession could cause this level of sickness. These participants were in the minority in Carroll and Tiilikainen's study. A greater number of participants in Whittaker et al.'s study seemed to indicate doubt about the existence of spirit possession. According to the authors, these women had been living in England (where the study took place) for longer than those who did believe in possession.

Treatment for jinn possession primarily involves Koran readings (Carroll, 2004; Guerin et al., 2004b; Whittaker, et al., 2005), although Guerin et al. (2004b) also stated that hospitalisation may be necessary in some cases. Mainstream mental health treatment was considered by participants to be ineffective for the treatment of jinn, as mental health clinicians were thought to have no power over the spirit world (Carroll, 2004). Traditional intervention for jinn possession was considered to be of variable effectiveness by Carroll's participants, as many said that Koran readings might still not lead to the complete removal of the jinn. Participants in Whittaker's et al.'s study who did not believe in jinn possession but rather, considered the symptoms to be due to mental illness, did however state that mainstream mental health interventions (in conjunction with religious interventions) were the most appropriate treatment to seek for this state of distress.

Somatic concerns

Few researchers specifically explored the relationship between somatic concerns and psychological distress. As can be derived from the descriptions provided of various psychological states described by Somali, physical symptoms are a frequent feature of psychological distress.

Tiilikainen (1998) was the only researcher to directly explore somatic concerns with her participants. She found that pain, in particular, was a common complaint of Somali women. Reasons her participants provided for experiencing pain were memories of the war and "people shouting bad words" (pg. 314). Stress was also considered by participants to cause stomach aches and headaches. Isolation, limited social support, difficulty caring for relatives (particularly those still living in refugee camps in Africa) and racist attacks were factors considered

to pose a threat to women's health and wellbeing. No discussion of means to treat pain was provided by Tiilikainen.

Drug use

Drug and alcohol use was seldom identified as a risk factor for psychological distress. This is most likely due to Islam prohibiting the use of such substances (Bhui et al., 2003). *Qat* (a methamphetamine-like substance) use was, however, regarded as a particular risk factor for psychological distress (see Bhui et al., 2003; Elmi, 1999; Guerin et al., 2004b; Rousseau, et al., 1998a) and has been linked to the onset of psychosis (Yousef, Huq, & Lambert, 1995). The use of qat is more common in male Somali than female Somali (Bhui et al., 2003)

Summary of the key findings of the research exploring psychopathology in Somali refugees

The findings of the qualitative research studies demonstrate that interpretations of self, body and health are constructed within culture-specific belief systems which have unique conceptions of causality, nosology and healing approaches. When quantitative designs are employed in cross-cultural research, typically symptoms or difficulties are correlated with Western psychiatric diagnoses. Carroll (2004) asserts that this grouping along Western diagnostic lines could potentially superimpose a different diagnostic formulation than that understood by the non-Western client. Such an approach risks being overly reductionist in equating non-Western conceptions of psychological distress to Western diagnostic systems. Consequently, the review of the literature on psychological distress in Somali refugees provides strong support for taking a qualitative and exploratory approach to understanding idioms of distress as conceptualised by Somali participants.

Regardless of the divergent findings of the quantitative and qualitative papers, some general themes were identified across these two distinct research approaches. It was common in both the quantitative and qualitative papers for factors such as limited family and community support, housing problems, employment concerns, and traumatic experience to be associated with high levels of psychological distress.

Barriers to accessing mainstream mental health services tended to differ somewhat across papers (regardless of whether they were quantitative or qualitative studies) and may have been dependent on the country the research was conducted in and the consequent set up of mental health services in those countries. A common theme was Somali's low level of engagement with mainstream mental health services regardless of the country the research took place in. Some of the more commonly reported reasons for not attending mainstream mental health services included, perceived lack of efficacy of these services to treat Somali idioms of distress, cultural and language issues (including not being able to converse with health care providers without an interpreter present), lack of knowledge/information about mainstream services, stigma associated with having a mental illness, perceived racism, limited case-management and follow-up support, and delays in service delivery (Carroll, 2004; Elmi, 1999; Guerin et al., 2004b; Warfa et al., 2006).

The findings of this review suggest that when Western psychometric instruments are used to explore psychopathology in Somali refugees, anxiety and depression are commonly identified as key idioms of distress. Interestingly, however, some of the quantitative research papers found lower levels of psychopathology in Somali compared to other immigrant and refugee groups.

Although PTSD was explored in some of these studies, there was not typically a high prevalence of this disorder in either the qualitative or quantitative studies. In fact, many of the papers reviewed provided evidence to suggest that significant (war) trauma-related psychological distress was not common for Somali (e.g., Elmi, 1999; Guerin et al., 2004b; Zarowsky, 2004). Most of the studies identified socio-political issues and post-migration stressors as major factors contributing to psychological distress. In particular, the erosion of social networks since arriving in the host country was frequently identified as a key factor contributing to psychological distress for Somali refugees (e.g., Carroll, 2004; McMichael & Manderson, 2004; Silveira & Allebeck, 2001; Silveira & Ebrahim, 1998; Tiilikainen, 1998 Zarowsky, 2004). Pre-migration trauma was only one of a number of risk factors for 'mental illness'.

The most interesting findings were identified from the qualitative research papers. Psychological states such as *welwel ama walaac*, *qalbijab*, *niyadjab*, *murug*, and *walli* were reported by participants as common forms of emotional distress or mental illness (in the case of *walli*). There was some evidence that these states existed on a continuum with *welwel ama walaac* possibly considered the least serious of these states and *walli* (and *jinn*) the most serious. *Jinn* possession was generally considered a spiritual state although not all participants who spoke about *jinn* actually believed it was due to a spiritual aetiology. These participants suggested *jinn* was a mental rather than spiritual illness. There was not always consensus between research papers with respect to description and severity of these conditions, but it is likely that this lack of consensus may be arbitrary and due to semantic differences or issues of interpretation, rather than actual differences in illness categories.

Although some interesting themes have emerged from this review of the literature, a coherent picture of key idioms of distress in Somali culture is lacking from the current research. What is more, a number of methodological weaknesses in these papers are likely to contribute to this incoherence. These weaknesses are discussed in the next section.

Methodological limitations of previous studies

A number of problems were noted in the methodology of previous research. These limitations are outlined below.

The use of Western psychometric instruments and diagnostic nosologies

Silveira and Ebrahim's (1998) and Silveira and Allebeck's (2001) rationale for using the SAD and the Life Satisfaction Index (LSI; Wood, Wylie & Sheafor, 1969) was that these instruments had been employed in previous cross-cultural research (see Morgan, Dallosso, Arie, Byrne, Jones & Waite, 1987; Baiyewu & Jegede, 1992). However, the SAD and LSI are not only outdated, but have not been validated on the two cultural groups participating in the study. Bhui et al. (2003), Ellis et al. (2006), Gerritsen, et al. (2006), McCrone et al. (2005), Jaranson et al. (2004), and Halcón et al. (2004) also employed Western psychometric instruments. Bhui et al. (2003) justified the use of the Hopkins Symptom Checklist (Derogatis & Melisaratos, 1983), Beck Depression Inventory (Beck, Ward, & Mendelsen, 1961), and Brief Psychiatric Rating Scale (Overall & Goreham, 1962) on the grounds that no such instruments had yet been developed for use with Somali. Participants were not interviewed however in this, or any of the other quantitative studies reviewed, to discuss their rationale for responding to certain items on the instruments in the manner that they did.

Additionally, the measures that were employed are based on Western diagnostic nosologies. Gerritsen et al. stated that they attempted to identify culture-specific symptoms of PTSD, depression and anxiety by giving respondents the opportunity to mention symptoms that were not included in the checklists they used (the Hopkins Symptom Checklist 25 and the Harvard Trauma Questionnaire). They did not describe in what way participants were provided with this opportunity to relay other symptoms and very little data was presented about the symptoms that participants did spontaneously relay. Bhui et al. (2006) developed a culturally adapted version of the Mini International Neuromental Interview to assess for the presence of mental disorders according to the classification system in *The International Classifications of Diseases – Tenth Edition* (World Health Organization, 1990) manual. Although the process they undertook to adapt the interview schedule was very comprehensive and based on feedback from Somali professionals and lay people, the adapted version was still firmly based on Western diagnostic nosologies.

In the other papers mentioned, it appeared that no effort was made to identify indigenous Somali descriptions of distress. The approach of the researchers mentioned above implies that the psychological constructs assessed by Western psychometric measures and diagnostic categories have universal cross-cultural equivalence. Such inferences, however, fail to acknowledge the possibility that Western nosologies of psychological disorder may not exist at all in some cultures (e.g., see Shumaker, 2001, for a critique of the universal application of the diagnosis of depression).

Limited information about methodological procedures

In the studies conducted by Tiilikainen (1998) and Zarowsky (2004) no details were provided about the number, gender, or age of participants and key informants interviewed. Ellis et al. (2006) and Elmi (1999) also provided limited methodological and demographic data. Rousseau et al. (1998a) failed to provide even minimal information about the contents or nature of their semi-structured interview, and how the integrity of translated material was maintained. Zarowsky and Tiilikainen did not mention if interview data required translation.

Furthermore, the actual data collected from participants and the conclusions and inferences drawn by the researchers were so enmeshed in Zarowsky's and Tiilikainen's investigations that it was not possible to separate what might be the thoughts and conclusions of the participants from those of the researchers.

Replication of the studies is compromised by these methodological limitations.

Only three research papers described audiotaping semi-structured interviews (Silveira & Allebeck, 2001; Warfa et al., 2006; Whittaker et al., 2005). It is not clear whether other researchers audiotaped their interviews. Additionally, most of the researchers did not describe the processes they undertook to ensure the integrity of the data collected. These are critical omissions from the research designs and perpetuate the perspective of qualitative research as being subjective and 'unscientific' (Elliot, Fischer, & Rennie, 1999).

The use of terms such as "mental illness", "madness" and "craziness"

Rousseau et al. (1998a) did not provide a rationale behind the use of the word "madness" throughout their paper. Although they did provide descriptions of what "madness" referred to in their study, they did not state whether this was a term used to define these symptoms by participants, or a term used by the

researchers to provide a framework for the symptomatology identified. Guerin et al. (2004b) employed the Western term “mental illness” in interviews with participants but did not assess the participants’ understanding of this term. Carroll (2004) used the terms “mental illness” and “mental problems” and also used the word “crazy” in her interviews with participants. Terms such as mental illness may have been primarily associated with the most severe forms of psychological distress/impairment (as suggested by Guerin et al., 2004b) and therefore participants may have been less likely to mention other forms of psychological distress which may have been of critical interest to the researchers.

What is more, although Carroll (2004) concluded that the term ‘walli’ was generally defined as meaning “crazy”, another definition for this word provided by some participants in her research was “nervous”. It would seem that these two terms could have strikingly different meanings in the minds of participants and it is difficult without further probing to ascertain how “crazy” and “nervous” could account for one construct (i.e., ‘walli’). No exploration of this apparent incongruence was carried out, however.

Given that terms such as “mental problems”, "mental illness", "craziness", and "madness" are generally considered pejorative in the West, and that there is some evidence that this is also the case in Somali culture (e.g., see Elmi, 1999; Guerin et al., 2004b), it would seem to follow that the use of such terms in research with Somali should be conducted cautiously. What is more, the use of these terms is controversial in itself as there does not exist in the Western world an agreement of what they actually mean (Tausig, Michello, & Subedi, 2004). Hence, any effort to translate these terms into other languages is likely to lead to different definitions in different studies and to perpetuate the current general lack

of empirical (Western) agreement about the meaning of psychological distress for Somali.

Limited research on psychosomatic idioms of distress

In most of the studies reviewed, researchers did not explore the possibility that Somali may express psychological distress somatically even though psychosomatic illnesses are considered to be very common in both non-Western (Mukherji, 1995) and Western cultures. Physical symptoms may not be consciously associated with psychological distress by the sufferer, but nevertheless may be correlated with psychological illness when further probing is conducted. Identifying the aetiology of symptomatology is important in so far as this information guides treatment decisions and will help ensure that the most efficacious interventions are employed.

Limited applicability of some research findings to Somali women

Given that in a number of the studies reviewed, the gender of the Somali participants was either not clearly stated or not stated at all (Elmi, 1999; Gerritsen, et al., 2006; Zarowsky, 2004), or there were considerably more male participants than females (Bhui et al., 2006; Halcón, et al., 2004; Rousseau et al., 1998a; Silveira & Allebeck, 2001; Silveira & Ebrahim, 1991), it is difficult to determine how relevant the findings of those studies may be to women. Additionally, in the study by McCrone (2005), in which there were approximately equal numbers of male and female participants, only very preliminary comparisons were made on the basis of gender. As there are distinct gender roles and expectations within Somali culture (Abdullahi, 2001), it may follow that idioms of distress are different for women and men. This difference may be more clearly highlighted if

researchers acknowledged and explored this possible difference in the aetiology, expression and treatment of distress between Somali men and women.

Interview questions

Rousseau et al. (1998b) and Zarowsky (2004) did not provide any information on the nature of the interviews they conducted. Warfa et al. (2006) provided only minimal information. Hence, based on the published methodologies of these studies it is difficult to assess the validity of the researchers' conclusions.

The Current Research

The research presented in this thesis aims to build on the useful but limited findings of previous research which has explored Somali conceptions of distress and resilience. A total of three studies form the basis of the current thesis. In the first study, a sample of Hamilton-based Somali women, some who have had experience with New Zealand mental health services and some who have not, were interviewed. A semi-structured interview schedule was developed based on themes identified as indicators of distress and resilience both in Somali as well as in other African cultures (see Appendix A). This interview was the primary data collection method employed in the first study. Particular areas of interest to explore in the initial study and which are the focus of the interview schedule include psychological, physical and spiritual conceptions of distress, the symptoms of key idioms of distress, and the way in which these are managed or treated (incorporating both mainstream New Zealand interventions and traditional remedies) at the individual and family and community levels.

Study 2 explored in more depth possible antecedents and maintaining factors contributing to distress in Somali women. Given there is evidence that Somali

communities residing in various cities in New Zealand are at various stages of acculturation, it was considered important to ascertain how valid the results from Study 1 were considered to be by women from other national Somali communities. As such, in an effort to increase the applicability of the findings of Study 1, participants who took part in Study 2 were recruited from three New Zealand cities. Somali women from Hamilton (only one of the Hamilton women also participated in Study 1), Auckland and Wellington were interviewed in the second study using a focus group format.

The first two studies of this thesis intended to improve on previous research in a number of ways. First, an open-ended questioning style was used by the researcher to explore areas of potential significance. Rather than primarily asking participants about their own symptomatology, they were asked what their perceptions and opinions were in regard to numerous different physical, spiritual and psychological states identified in previous literature. In Study 1, they were also asked what they considered were important indicators of resilience or success, as well as what they considered were the protective factors that acted as buffers against experiencing distress. It was hoped that such a dialogue would facilitate perspectives on these issues without the use of prompting or leading questions from the interviewer. Where consent was granted, interviews were audiotaped to help ensure the integrity of the data collected. Additionally, the results were reviewed and critiqued by a Somali female co-researcher to cross-validate the research findings. Throughout the interviews, reasonable attempts were made to use unambiguous language (e.g., “mental disorder”, “mental illness”) and closed ended questions (e.g., “what is mental illness”) minimally.

When participants did use terms such as “mental disorder” spontaneously, they were asked to define or explain what they meant by such terms.

Although the research was not typically ethnographic in nature, the principal researcher has been involved in voluntary work with a number of the women who have participated in this study, as well as with a number of women who have not participated. It was hoped that being involved with the local community in this manner would provide the principal researcher with a richer understanding of the Somali culture and key issues facing this culture in the New Zealand context. Additionally, the voluntary work may have led to a level of trust developing between some members of the Somali community and the principal researcher, which may have increased the likelihood that participants felt comfortable and safe discussing their ideas frankly and openly. Although being involved with the local Somali community may increase the risk of researcher bias (given a pre-existing relationship may have been developed with some of the participants), in most of the previous research conducted with Somali, this has been a common and fruitful means of collecting data (e.g., Carroll, 2004; Guerin et al., 2004b; McMichael, & Manderson, 2004; Rousseau et al., 1998; Silveira and Allebeck, 2001; Silveira and Ebrahim, 1998; Zarowsky, 2004). Traditional methods, involving random sampling and sending invitation letters to Somali households have yielded very low response rates (e.g., Carroll, 2004, Silveira & Ebrahim, 1998), and have typically been abandoned in favour of snowballing and more informal methods of recruitment (such as researchers involved in ethnographic research inviting known Somali acquaintances to participate).

The third and final study of the current thesis is based on an interactive and reciprocal model of learning developed by Proctor (2003). According to Proctor,

this method of research-based learning allows for a reciprocal relationship of information sharing between the cultural group involved in the study and the mental health practitioners who treat these community members in mainstream settings. Proctor employed the interactive model of learning to gain a greater understanding of the perspective of both Australian migrants about their mental health needs as well as health practitioners' opinions about the needs of such groups. As such, it was intended that information provided by Somali in the previous two studies of this thesis could eventually be relayed to health professionals to enhance their knowledge and ability to work with this group, while information provided by mental health clinicians could be relayed to Somali and possibly enhance their understanding of, and willingness to engage with, mainstream services. It was also intended that the results of this study would provide insight into the manner in which clinicians may or may not currently modify their practice when working with Somali clients and their rationale for the approach they take. This study explored non-Somali health practitioners' understanding of Somali idioms of distress and wellbeing.

The interactive model of learning is somewhat unique in refugee research, as typically, studies which have focused on the mental health needs of refugees have tended to base their conclusions about barriers to mainstream services primarily on the perspectives of the refugees and have not interviewed mainstream service providers. Although in many cases the barriers identified in these studies are likely to reflect real and tangible shortcomings of mainstream services, there is also the possibility that some of these concerns are at least in part erroneous or misguided. Also, where such barriers are considered to exist by mainstream practitioners, these practitioners may be able to readily contribute to identifying

means to overcome or ameliorate these hurdles. Hence, this approach helps to ensure that the information obtained from Somali women about mainstream mental health treatment approaches is not assumed to be accurate, but is validated by also exploring the opinions and perceptions of mainstream practitioners.

CHAPTER 6

Study 1:

Exploring Hamilton-based Somali Women's Expressions of Distress and Approaches to Treatment

Overview

The intention of Study 1 was to explore Somali idioms of distress as well as antecedents and maintaining factors contributing to this distress in Somali women. In an effort to understand the context within which the participants describe their conceptions of psychological distress, the primary researcher engaged in volunteer activities with a number of Somali women and families in the Hamilton region. This role spanned the complete time frame of the current thesis - starting before the formal research commenced and continuing after the research was completed. Obtaining an understanding of the everyday life of the individuals in the Somali community by being directly involved with some of the members helped to enhance the researcher's knowledge of the Somali culture in a more detailed and in-depth manner than would have been possible by solely interviewing participants about issues of psychological distress. Additionally, according to Yates (2003), many Somali are wary of disclosing too much information about themselves or their families in case it will affect their residency status, access to services, or have other negative repercussions. Hence, the volunteer work was also intended to be a way to build a trusting

relationship with members of the Somali community, so that those who participated in the current research might be more willing to report their opinions and thoughts in an open and frank manner.

Method

Recruitment

Given that the current research is qualitative in nature, no effort was made to identify a representative sample of Somali women. Obtaining a representative sample of Somali in Hamilton or New Zealand would be difficult to achieve in any study given that there is evidence that the New Zealand census data underestimated the number of Somali in both Hamilton and New Zealand (Guerin & Diiriye, 2004a). Rather, the objective was to interview Somali women with diverse contexts and situations. However, due to the criticisms of previous empirical literature (e.g., biased samples being recruited via snowballing and other informal methods), this study attempted to recruit participants via multiple pathways. While most of these recruitment methods were unsuccessful, they are worth reporting for other researchers working in this area.

The first recruitment method involved sending a letter about the study (see Appendix B), as well as participant information sheets (both written in English and Somali; see Appendices C and D), to all of the Hamilton-based medical practices. This letter also informed practitioners that sample recruitment was underway and who potential participants could contact to learn more about the study. General medical practices were identified as a possible means of sample recruitment given that previous research with the Hamilton-based Somali community indicated that Somali

frequently visit their general practitioners (GPs) for assistance with both psychological/emotional and physical concerns (Guerin, Guerin, Diiriye, & Yates, 2004b). Guerin et al. also found that Somali are more likely to seek treatment for psychological distress from their GPs than from mainstream mental health services, and that Somali generally trust their GPs and find their advice and interventions helpful. Hence, it was hoped that Somali women approached for this study may show an interest in being involved if suggested or discussed with their GPs. However, no participants were able to be recruited via this method.

The second recruitment method involved placing information sheets (written in both English and Somali) in the waiting rooms of the local (government funded) community-based Adult Mental Health Services' (AMHS) client waiting areas. The AMHS is a multi-disciplinary service which provides free mental health care for individuals suffering from major mental illnesses (i.e., primarily Axis I, DSM-IV diagnoses). Although there are no statistics on the number of Somali being seen at this service (W. Tuck, personal communication, March 2005), it was anticipated that there would be a small number receiving treatment, some of whom might have been interested in taking part in this study. No participants, however, were able to be recruited via this method.

Participants were also invited to take part in the study by two of the co-researchers of this project. One of these co-researchers is a Somali woman who has lived in Hamilton for over 15 years. The other co-researcher was involved in work with Somali women in Hamilton for the six years prior to this study commencing but left Hamilton city in December 2005. All recruitment and data collection for this

study was completed before December 2005. Both co-researchers have conducted numerous studies with the Hamilton-based Somali community since 1999. This method of recruitment identified ten Somali women willing to take part in this research.

Finally, the information letter about the study was also sent to the co-coordinator of the Hamilton-based Refugee and Migrant Service (RMS), along with participant information sheets. The RMS co-coordinator had worked with refugees in Hamilton for approximately 25 years and had been involved in resettlement issues with the Somali community since Somali first arrived in Hamilton in 1993 (Lewis, 2002). Given her long-standing relationship with the Somali community, it was again hoped that Somali might be more willing to consider taking part in this project if discussed with the RMS co-coordinator. In response to the information letter, the RMS co-coordinator contacted one Somali woman who agreed to meet with the principal researcher. However, after the principal researcher initially met with this woman to discuss the project, she declined to participate in the study for unknown reasons.

Participants

It was decided that male Somali would not be included in the current study. This was primarily because the principal researcher was informed that being interviewed by a female would be considered inappropriate to Somali men (B. Guerin, personal communication, December 2004). Additionally, given the traditional division of responsibilities and expectations based on gender (Vemuri, 2002), as well as some of the evidence that psychological distress may be

experienced for different reasons and be expressed differently between Somali males and females (see Rousseau et al., 1998a; 1998b, Tiilikainen, 1998), it was decided to focus on interviewing females only in the current research.

The ten Somali women residing in Hamilton, New Zealand who had been recruited through the third recruitment method outlined above, participated in the current study. All participants were interviewed on at least one occasion.

Key informant interviews

Two of the participants were interviewed as key informants due to their expertise as interpreters for Somali women who had engaged with local mainstream mental health services. At the time this study was developed there were no known Somali working in mental health or counseling positions in the North Island of New Zealand. As such, interpreters who had worked within mental health settings were considered to have a higher level of exposure to, and hence a greater level of experience of, Somali suffering from psychological distress. It was also considered that interpreters might have a greater level of insight into how local Somali women conceptualise and chose to manage or treat psychological distress (using both mainstream and/or traditional interventions) than Somali who do not work as interpreters. The key informants were not asked about their own experiences of psychological distress. The focus of the key informant interviews was still to collect information about the participants own perceptions and beliefs about psychological distress, however, it was anticipated that they may have a greater frame of reference to base their responses on than the participants who had not worked as interpreters.

To protect participant anonymity, demographic data is not presented separately for the two key informants.

Participant demographic information

Although obtaining data on participants clan affiliations as well as what region of Somali they originally came from could have provided a richer understanding of the possible diversity of the results yielded, it was recommended by two of the thesis supervisors (Bernard Guerin and Pauline Guerin) that this information not be collected. Clan fighting was one of the corner stones of the civil war in Somalia and ongoing hostility between particular clans was considered evident in a number of ways in the New Zealand context. Hence, the thesis supervisors stated that many of the Hamilton-based Somali elders were discouraging Somali identifying themselves with respect to clan affiliations. Additionally, information on which geographical location in Somali participants resided prior to arriving in New Zealand was considered potentially irrelevant data. That is, it was thought that many participants would not have resided in their traditional homelands due to the disruption of war and long stays in refugee camps (sometimes of 10 years or longer). Consequently, it was not considered valuable to obtain demographic data on where participants lived prior to departing from Somalia.

Participants had resided in New Zealand at the time of the interviews for between 1 and 13 years. The average amount of time spent in New Zealand was 5.7 years. Prior to arriving in New Zealand, nine of the participants had resided in refugee camps within Africa. Time spent in camps ranged from 1 to 13 years. One participant had never lived in a refugee camp. Of the eight participants interviewed

about their own experiences of psychological distress (i.e., interviews with those participants who were not key informants), four had had involvement with mental health services as consumers. One participant had engaged in therapy during her six-week induction at the Mangere Refugee Reception Centre (Auckland). She was given a referral to pass on to a health provider in Hamilton on her arrival but had misplaced this and therefore never attended further therapy sessions. Those participants who had not engaged in mental health services as consumers all reported having family members who had suffered significant psychological distress that had required traditional or mainstream mental health intervention, or had worked as interpreters with Somali being seen by mental health services. Table 1 provides demographic information for each of the participants.

Participants were required to be at least 18 years old. No other exclusion criteria (with the exception of gender) were applied in the current study. Participants were not required to speak English. An interpreter (who was also the Somali co-researcher with the current project) conducted interviews with five participants who were not fluent in English. These participants were P6, P7, P8, P9 and P10.

Table 1

Participant Demographic Information

| Participant Identifier | Age | Household Composition | Education | Time in NZ | Time spent in Refugee Camps |
|-------------------------------|------------|------------------------------|------------------|-------------------|------------------------------------|
| P1 | Early 40s | 2 children 2 adults | secondary school | 11 years | 2 years |
| P2 | Early 20s | 1 child 6 adults | university | 5 years | nil |
| P3 | Early 20s | 2 children 6 adults | secondary school | 4 years | 6 years |
| P4 | Early 20s | 4 children 2 adult | secondary school | 13 years | 1 year |
| P5 | Early 30s | 3 children 3 adults | university | 9.5 years | 4 years |
| P6 | Late 30s | 6 children 2 adults | nil | 2 years | 10 years |
| P7 | Late 30s | 2 children 1 adult | nil | 4 years | 6 years |
| P8 | Early 60s | 8 children 3 adults | primary school | 5 years | 8 years |
| P9 | Early 30s | 8 children 3 adults | secondary school | 1 year | 4 years |
| P10 | Late 30s | 7 children 1 adult | nil | 2.4 years | 13 years |

The Interview Schedule

The interview schedule was primarily based on previous research with both Somali and Ethiopian participants that had explored conceptions of the aetiology,

symptoms and treatment of suffering and distress in these two cultures (e.g., Abdullahi, 1999; Guerin et al., 2004b; Mulatu, 1999). The literature on Ethiopian conceptions of distress and suffering were explored primarily due to the paucity of research at the time Study 1 was developed, about Somali understandings of psychological distress. A number of the papers exploring Somali conceptions of distress reviewed in the introduction section of this thesis were published during or after 2004, which is the year this study was conducted. Hence the information in these papers could not be used as the foundation of the current study. It was thought that given the close physical proximity of Somalia and Ethiopia and also, some of the relative cultural similarities between the two nations, looking at literature on Ethiopian issues may provide further areas to explore with Somali participants.

The thesis supervisors and the Somali co-researcher reviewed the original questions. Items were revised based on feedback from these sources. The interview schedule was divided into four sections (see Appendix E). The first section ('Part 1') gathered basic demographic information from participants. The second section ('Part 2') focused on exploring participants' conceptions of psychological distress. This section was divided into several subsections. The first of these sub-sections focused on identifying under what circumstances particular interventions (e.g., Koran readings, herbal/traditional Somali medicine, modern Western medicine, etc.) are implemented to address distress.

The second sub-section of 'Part 2' attempted to identify participants' conceptualisations of psychological, spiritual and physical states of distress or illnesses (e.g., jinn possession, excessive worry, tuberculosis) and how, if at all, these

conditions are managed within the Somali community. Some physical conditions were included in this section of the interview, as research with Ethiopian participants suggested that some medical illnesses were considered to be indicators of severe psychiatric illness (e.g., tuberculosis, poliomyelitic paralysis) and had significant stigma associated with them (Mulatu, 1999). Additionally, Mulatu's research suggested that the person afflicted with some of these illnesses were occasionally considered to be cursed or punished by God for previous wrong doing. It was thought that Somali may also hold alternative (non-medical) explanations for such illnesses, and hence the principal researcher considered some of their conceptions of such illnesses worthy of exploration. Participants were asked (i) what they would think about someone who was experiencing each of the psychological, physical, and spiritual states presented to them, (ii) how they thought the individual was likely to be feeling, (iii) how the experience would likely impact on the individual's family life, and (iv) how someone would typically behave who was experiencing the concern under discussion. Participants were also asked what they thought the typical Somali community response would be to this person. This question was interested in exploring participants' opinions about whether they thought persons suffering from different forms of distress would be stigmatised, how the community may assist with these forms of distress, and what sort of traditional and/or mainstream interventions would be employed to treat the distress.

The third-subsection of 'Part 2' was included to gain an understanding of whether the participants held similar ideas about concepts of depression, PTSD and psychosis to Western conceptualisations. This sub-section investigated participants'

beliefs, opinions, and conceptualisations of symptoms commonly associated with the Western psychiatric disorders of depression, psychosis, and PTSD. In this part of the interview schedule, participants were presented with some possible symptoms of each disorder and asked what they thought these behaviours represented or meant. They were also asked about (i) the likely impact of these behaviours on the person's functioning, (ii) other behaviours or feelings that they thought may commonly co-occur with the behaviours presented, (iii) what they considered the key reasons for these behaviours, and, (iv) how the Somali community typically responds to someone who engages in these behaviours (including treatment approaches). For example, one of the questions from this section was: "What do you think is going on for someone who cries all the time, does not want to get out of bed and stops seeing their friends"? Participants were not told that the behaviours in question were often considered core symptoms of major mental illnesses in Western countries, nor were they informed about the diagnostic labels typically associated with these symptoms in the West. This interview approach was used to reduce the likelihood of biasing participants' responses by introducing Western descriptions of these psychological states.

The fourth subsection of 'Part 2' was developed to explore the participants' beliefs about and conceptualisations of resilience and factors they considered would protect against suffering and distress. Key questions participants were asked in this section included (i) what they considered were key indicators that a Somali woman is coping well in New Zealand, (ii) what are the important milestones for a Somali woman to achieve in her lifetime, and (iii) what sorts of achievements earn Somali women respect within their community. Participants were also asked in what ways a

Somali woman who is also considered to be suffering serious psychological difficulties (such as walli or jinni) could still be achieving or coping well.

'Part 3' of the interview schedule explored the participants' own experience of psychological distress (as indicated earlier, key informants were not interviewed about their own experience of psychological distress), both since arriving in New Zealand and while still living in Somalia. This section also explored what they have found most difficult about living in New Zealand and the impact of these stressors on their own and their families wellbeing. Finally 'Part 3' explored how the participants managed stressors they have confronted, what (if any) mainstream and traditional assistance they have received, and the effectiveness of this assistance.

Care was taken to explore the issues being investigated during the interviews in an open-ended and non-directive fashion. The interview schedule was not developed to identify all concepts of psychological distress for the participants and, as such, issues brought up which were outside the scope of the interview schedule were also explored when participants spontaneously raised such issues. The interviews followed the style of 'talking around' issues and themes rather than a stimulus (question) and response (answer) type procedure (PePua, 1989).

The interviews were carried out using a conversational approach which meant that the exact questions and issues covered were not necessarily the same for each participant. Although such an approach means the data are not collected in a standardised manner and cannot necessarily be directly compared quantitatively across participants (and indeed between interviewers), this approach is preferable when working with refugees to reduce the likelihood of the participants experiencing

the interview as interrogative. A conversational approach also helps to ensure that participants are relaying their opinions in an unrestricted and open-ended manner, which is more likely to allow them to describe their ideas as a narrative in which they choose what is relevant to discuss rather than such discussion being strictly determined by the interviewer. Researchers who place undue restrictions on the topics of discussion (as well as how the discussion unfolds) in cross-cultural research may seriously compromise the integrity of the data collected and hence may perpetuate the universalist and absolutist assumptions about psychological distress which have typically not been adequately challenged. This assertion is supported by the research of Bäärnhielm and Ekbal (2000), who found that posing direct questions about the perceived aetiology of psychological illness to Turkish migrant women (living in Stockholm) considerably compromised the quality and quantity of data collected. When the authors' questions shifted to a broader narrative form, rich information was obtained and probing questions could be used to clarify answers and obtain more detail.

Procedure

Ethical approval for the current study was obtained from the University of Waikato's Psychology Department Ethics Committee. All participants were given a \$10 supermarket voucher at the end of each one and a half hour session, not contingent on them answering any particular questions or answering in any way.

The Somali co-researcher was not formally trained in interview technique by the principal researcher. As indicated earlier, the co-researcher had six years experience interviewing Somali women for research projects using semi-structured

interview schedules and open-ended questions. The interview schedule was, however, discussed in detail and the importance of using an open-ended and exploratory approach during interviews reiterated prior to the study commencing. Regular discussions following interviews conducted by the co-researcher were held and, on some occasions, the principal researcher suggested further areas for the co-researcher to follow-up with particular participants. Review of the co-researcher's notes and transcriptions by the principal researcher also identified areas for her to follow up with some participants. This approach was taken to try to increase the level of consistency between the principal and co-researcher with respect to topic areas explored as well as the level of detail obtained about certain issues in the interviews.

Participants were interviewed in a location of their choice. Interviews were primarily conducted in the participants' home, however, two participants were interviewed at the primary researcher's office and two participants were interviewed at the homes of co-researchers.

Two participants were interviewed once. One of these participants left the country unexpectedly shortly after the first interview took place and therefore could not be interviewed a second time. The other participant stated that they were too busy to engage in a second interview. As such, the amount of data collected from these two participants was considerably less than that collected from the other Somali interviewed. Of the remaining participants, four were interviewed twice and four were interviewed on three occasions. The number of times each participant was interviewed was determined by how much time each participant had to be interviewed on any one occasion. Generally those who were available for 90 minute

interviews rather than 60 minute interviews were only interviewed twice.

Participants interviewed three times were typically interviewed over three 60 minute interviews. One participant was interviewed both by the Somali co-researcher and the primary researcher. This participant said that she felt uncomfortable talking with the co-researcher about her spiritual beliefs and indicated she would prefer to discuss these with the primary researcher. When this request was explored further with the participant, she indicated that she considered the questions about spiritual beliefs to have obvious answers to a Somali Muslim and hence considered a dialogue about these matters pointless with the Somali co-researcher. She stated she was comfortable however, to describe her beliefs about spiritual forms of distress to the principal researcher.

All participants were asked whether the interviews could be audiotaped and four gave consent for this to occur. The primary researcher interviewed three of these participants, two of whom had completed tertiary level education. Detailed notes were taken in the interviews with those who declined to tape the sessions.

Coding and Analysis

A thematic approach to data analysis was taken in the current thesis. According to Braun and Clarke (2006) “thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data” (p.79). It is a flexible approach to data analysis which is not necessarily tied to pre-existing theoretical frameworks. Part of the flexibility of thematic analysis is that it allows researchers to determine themes in a number of ways. That is, it is not necessarily the case that themes identified in thematic research are based on the most prevalent patterns in the

data. Rather, they may be based on the researcher's judgement about what constitutes a critical theme, even if the prevalence rates of this theme are lower than that of other patterns in the data. Regardless of the manner in which themes are identified in a thematic analytical framework, the critical issue is that the approach taken remains consistent within a particular analysis (Braun & Clarke, 2006).

Rather than focusing on some themes or questions within the analysis while omitting analyses of other themes, it was decided to provide a rich description of the entire data sets in the current thesis. Although taking this approach to thematic data analyses can lead to some depth and complexity of data being lost (Braun & Clarke, 2006), a rich overall description of the data is maintained. This sort of approach to qualitative analyses is recommended by Braun and Clarke when investigating a sparsely researched area, or when interviewing participants whose perspectives on the topics under investigation are not known. As such, it seems particularly appropriate within the current thesis to provide rich descriptions of the data sets in all three studies.

Themes were identified using a theoretical thematic analysis approach (Braun & Clarke, 2006). This approach is primarily driven by the researchers' theoretical interest and relies to an extent on their judgement about what aspects of the data are important to the overall research questions. It is also driven by the findings of previous research in the same area and the results and theories that have been developed based on this research. Hence, the coding of themes was primarily related to specific research questions developed for the purpose of the thesis.

There are two primary levels at which themes can be identified according to Boyatzis (1998) - the semantic and the latent level. Typically thematic analysis focuses exclusively on one of these levels (Braun & Clarke, 2006). Within a semantic approach, themes are identified according to the explicit meaning of the data. That is, the researcher does not attempt to make inferences about the underlying meaning of the raw data (during the coding and analysis processes) beyond the meaning provided by the participant. In contrast, within the latent approach the analysis goes beyond the explicit meaning of the data and attempts to identify ideas, assumptions and ideologies that it is hypothesised the explicit data is based on. In the current thesis themes were identified at the semantic level – that is themes were identified based on the explicit (or surface) meanings of the data. The decision to analyse the data at this level was to try to decrease the amount of researcher bias introduced into the data analysis process. This was considered particularly important given the cultural world view of the researcher was considered in many ways to be vastly different to that of the participants. Interpretation at the latent level (i.e., making assumptions about the underlying meaning of what the participants were saying) was kept to a minimum during the data analysis process.

In the current thesis the audiotaped interviews were transcribed verbatim by an administrative assistant. The transcript data were then checked by the primary researcher for accuracy. In interviews in which permission was not granted to audiotape the sessions, detailed notes were taken and typed up immediately following the interviews. The entire data set was then read to search for patterns. All data items within the set were reviewed in an attempt to reduce the potential of the

principal researcher favouring or focusing on certain aspects of the data while ignoring other aspects. During this process preliminary notes were taken that outlined possible themes for coding. Once the principal researcher was familiar with the data, codes were identified at the semantic level of analysis. Data extracts considered relevant to each code were placed in separate word processing files. With respect to the data which was audiotaped, when themes were identified in participants' statements, the entire statement of that participant was placed within the theme rather than the specific aspects of their statement relevant to the theme. This was done to ensure that the context for which each statement relevant to the theme was maintained during the analysis process. With respect to interview data that was only available based on notes from participant discussion, the entire section of the notes that corresponded to the participants answer to a particular question (or set of related questions) was placed within the theme. Individual extracts of the data were placed into as many different themes as they seemed to fit into. The coded data were then analysed to identify potential themes across the various codes.

In the next phase of analysis themes were reviewed to ensure there was adequate data to support each theme and to also ascertain which themes could be collapsed together due to a very high level of similarity of content as well as which themes needed to be broken down into separate sub themes due to a high degree of divergence of content. Once this process was complete, the entire data set was re-read to ensure the themes extracted reflected the data set and to ensure no themes had been missed in the initial analysis.

Two Western researchers (who were also supervisors of this thesis) experienced in qualitative analysis, refugee and cross-cultural issues (Bernard Guerin/BG and Pauline Guerin/PG) concurrently analysed the transcripts for themes and sub themes. The primary researcher and research supervisors then compared the themes/sub themes they had independently identified and discussed any discrepancies in their findings until agreement about all of the themes/sub themes was achieved. Additionally the Somali co-researcher reviewed drafts of the Results sections (for Studies 1 and 2) and was asked to provide feedback on how accurately she considered the findings represented the perspectives of the woman interviewed. Her feedback related to minor editorial changes and she stated that she considered the results of Studies 1 and 2 to be an accurate representation of the participant interviews. With respect to other means of cross-validating the current findings, some support for various components of the taxonomy relevant to the Somali conception and explanations of distress can be found from other sources (e.g., Carroll, 2004; Guerin et al., 2004b; Rousseau, et al., 1998a; Zarowsky, 2004).

In each of the Results sections of the current thesis, each theme is briefly described and examples from the interview transcripts and field notes are used to provide evidence for each theme. It is important to note that the themes are not discrete or mutually exclusive and are often inter-related. They are however, compartmentalised to make interpretation of the data easier.

Results

As already outlined, the data for this study were drawn from the transcripts of clinical interviews. Some of these were interviews with Somali women who were

currently or had previously received formal assistance from Western mainstream services (including consultation and medication prescriptions from GPs and contact with local mental health services) to treat their psychological distress, while other interviews were conducted with Somali who had family members who had received such treatment. One key informant who had acted as an interpreter at local mental health services did not disclose any personal or family history of contact with mental health services but did discuss her knowledge of distress in her capacity as an interpreter at these services. One other participant also did not describe any personal or family history of assistance from Western services for psychological difficulties. This participant, however, was only interviewed on one occasion and did comment on Somali women in the local community she was aware had had experience with mental illness. Given that so many of the current participants had personal or family involvement with Western services as a consequence of experiencing psychological distress, the themes and issues presented as pertinent by participants may be different from the issues presented if so many of these participants had not had direct involvement with these mainstream services. This is an important issue to remain aware of so that it is not assumed that the views expressed by these participants are representative of all local Somali women.

The results are identified in terms of the key themes identified from the interviews. The thematic analysis identified themes related to participants' views on (i) *jinn* possession (including the aetiology, treatment and prevention of *jinn*), (ii) *jinn* versus Western psychological disorders, (iii) other forms of distress (including social isolation, reduced activity level, grief, war trauma, spells and curses and dishonest

conduct), (iv) Western idioms of distress, (v) mainstream mental health interventions, (vi) the impact of family separation on psychological distress, and (vii) protective factors, resilience and success.

Each participant was assigned a number (from 1 to 10; see Table 1 in the Method section of this chapter). These numbers are provided in brackets at the end of each interview excerpt included in the results section. A ‘P’ (for ‘participant’) precedes each number. This was done to demonstrate that all participants’ perspectives and opinions were included in the analysis. This was not possible however, with field notes taken from participants who did not consent to the interviews being audiotaped.

Jinn

All but one participant spoke about jinn, and most participants spontaneously mentioned jinn without prompting. One participant indicated doubt about the existence of jinn. This interviewee said she and her family did not really believe in jinn but also acknowledged the importance of respecting others’ beliefs about the existence of this spiritual entity. One participant described jinn as “scientific fact” (P8) and another stated that because jinn are stated in the Koran “that actually puts 100% belief that it’s there” (P2). The very out of character and unusual behaviour that jinn sufferers engage in was considered strong evidence to support the existence of this spiritual entity by participants.

I’ve seen lots of... people like that. I mean, why would somebody be possessed with something and not remember whatever he had going on in him and tomorrow he wakes up as a normal person and nothing was wrong with him. It gets you thinking you know, what was going on in his mind? Was he just acting it out and it’s like its impossible no one would act that kind of stuff out. (P2)

One participant indicated that jinn are likely to possess non-Muslims but they may not be known as jinn. Another participant described her frustration that jinn are not recognised by Western health practitioners and suggested that this is likely to impact negatively on the efficacy of treatment with Somali suffering from jinn.

Symptoms of jinn possession

Jinn possession does not seem to be characterised by a uniform cluster of symptoms. Participants' descriptions of the severity of jinn possession ranged from being able to continue functioning adequately but with some relatively minor changes in behaviour and mood, to inability to maintain family, household, social, and occupational responsibilities.

It did not seem that there were clear indicators of less serious and more serious symptoms of jinn possession. The ability to continue functioning adequately in day-to-day responsibilities versus the 'need' for psychiatric hospitalisation seemed to be the clearest way of distinguishing between the two ends of the spectrum. Symptoms such as "moodiness", hearing non-existent voices, "seeing things" that are not actually present, increased physical strength and energy, tearfulness, loss of control over behaviour, unresponsiveness, talking to oneself, screaming, laughing for no apparent reason, physical aggression toward other people, anger, refusal of food, memory loss, life endangering behaviours, requesting unusual food or drinks (such as beer which is generally not consumed by Muslims), disrobing in public, staying in bed, social withdrawal, pulling their own hair out, and generally "not acting normally" were all considered indicators of jinn possession. Aggression and disrobing however were most frequently associated with more severe cases of jinn.

According to participants the other symptoms could be associated with both mild and severe cases of jinn.

Possession was considered the only explanation for visual and auditory hallucinations by one participant.

Researcher:...what else besides jinn might be the reason someone might hear voices that other people can't hear or see things that other people can't see?

P2: That is the only reason. You've got to be possessed to see that kind of stuff. Any normal person who is not possessed wouldn't see it, but if you see it, you've got jinni of some sort, that is actually in you making you see things. Me being normal, I wouldn't see it because I wouldn't be having possessed by any kind of Jinni's. That's the only reason that I can say to talk and act funny and be weird.

Another participant provided the following description of jinn possession which ultimately led to psychiatric hospitalisation.

...like this one lady I know, when she is unwell the jinni's are you know have possessed her she can be working or doing something for 24 hours without getting tired. Like this time we went to a wedding and she was singing and singing you know she couldn't say a word anymore because of the sore throat. And she would be doing multiple activities like she would be singing dancing and drumming at the same time and she wouldn't let anybody else dance and everybody would be saying that she is getting crazy now she is being ah, the jinni's are doing their work. Nobody will, you know there was moment when this older lady attempted to move or do something and she pushed her to the ground which is also out of the ordinary for any person to do that to elderly women as they are classed as the mother whether they are your mother or not. There is so much respect for the elderly that you don't even talk back to them so physically to push her it was a symbol that something was not right. (P5)

Six participants discussed the amnesic state that affects jinn sufferers:

... there's different kind of jinni's that make [people] act very funnily and in different ways but most of them [those experiencing the possession] wouldn't have a memory of that. They only get the memory after

they're back to normal and they're well, but the jinni's gone. They're not doing anything, just like a force that's in them. (P2)

Five respondents also described the apparent lack of insight associated with more severe jinn possession:

...and the people who have got jinni they don't have questions over themselves, they wouldn't even think of going to a doctor because they don't know what they are doing... Any sickness that they know like it hurts me here, it hurts me there, you have your own questions, hasn't anything to do with jinni because you have control over yourself still. (P2)

However, participants reported that with milder jinn possession, insight remains intact and the sufferer may actually know they are possessed. Respondents said those more mildly affected often organise their own Koran readings as treatment for the possession.

Two participants reported that there were benign jinn that may cause no harm and "doesn't do anything to make them go crazy" (P4) and may co-exist within the possessed person who can still live a "perfectly normal life" (P4). Unusual dreams or sleeping experiences were provided as one example of how an individual may become aware they are possessed by a benign jinni.

Maybe she might be seeing things sometimes very normally, but maybe in a dream way, or she might be sleeping and she might be seeing things when she is sleeping and things come and tell her stuff and when you wake up you are just perfectly normal, maybe you have jinni, but just read the Koran and hopefully nothing goes wrong with you. (P2)

Aetiology of jinn possession

Numerous aetiologies for jinn possession were proposed by participants. The following explanations were not common but were reported as there was a reasonable degree of variation in the aetiology of jinn possession proposed by interviewees.

Some participants suggested that jinn may be hereditary. Other aetiologies outlined by one respondent were:

..sometimes they will say, walking under specific trees when the jinn and their families are present will disrupt them, will disrupt the environment/somebody's environment.... or being immersed into something until it takes over your life ... or people in some areas have high incidences of possession of jinni then that area will be known as a place that has more...or somebody can lose a very loved dear one and they totally lose it from then on and then it is thought that person has been possessed. (P5)

Two participants talked about a jinni occasionally possessing someone when another individual has strong feelings toward them (e.g., envy, love, hate). These respondents reported that the individual with these strong feelings would not know however, that they had possessed the jinni sufferer. Four participants said that “only God knows” (P8) who will become possessed.

Additionally, becoming obsessed with a particular activity so that it consumes an individual's life was considered to create vulnerability to jinn. *Walli* was reported by one participant as caused by jinn. Another participant said “someone who doesn't do good deeds” (P8; she suggested alcohol use, homosexuality and prostitution were ‘bad deeds’) may be at greater risk of suffering from jinn possession.

Losing loved ones in the Somali Civil War and not being able to overcome the consequent grieving process was considered by one participant to lead to vulnerability to mental illness and hence, jinn possession. Having a family, occupational or financial problem with no ready solutions was also suggested as contributing to vulnerability to jinn.

Treatment of jinn possession

According to participants, treatment of jinn in New Zealand primarily takes two forms: Koran readings and, occasionally, engagement with mainstream mental health services (and sometimes both). All respondents considered Koran readings the most effective form of intervention and many were concerned for any Somali seen at mental health services for this spiritual state. In particular, three participants voiced concern about the lack of knowledge mainstream service providers have about jinn and the possibility that mainstream clinicians would not adapt their practice even if they were aware that spirit possession was considered the reason for the client's distress. However, three participants reported that they had found family members had improved significantly in their symptomatology after taking psychiatric medication. This medication however, was seen as an adjunct to Koran readings rather than a panacea by two of these respondents.

All participants who talked about jinn possession reported that Koran readings were the primary means of treatment, and said that sufferers generally recover to complete premorbid levels of psychological, occupational, social and domestic functioning following expulsion. The description of Koran readings was relatively consistent across participants. Some participants reported that jinn sufferers may travel from Hamilton to Auckland to receive Koran readings from individuals known to have expelled jinn successfully in the past. One interviewee said that jinn "hate" the Koran and may become physically and verbally aggressive during recitations. Additionally, one participant reported that the jinni often identifies itself during the Koran readings. That is, the jinni will apparently speak via the mouth of the

individual it has possessed (often using a different tone of voice) and may claim to be related to the possessed person (e.g., claiming to be their husband or wife).

According to this participant, the jinni may also describe itself as Christian or Muslim during the recitations.

Participants spoke of numerous Koran readers or Imam being engaged sequentially by jinn sufferers and their families, and that the process of expelling jinn may depend on the knowledge and God given ability of the Koran reader. Koran readings in some cases may occur constantly over a 24 hour period for an entire week. In these cases participants said that various readers or Imam would take turns reciting verses to the sufferer. The time it would take to expel the jinni by reading the Koran was considered variable and was related to the type of jinn possession an individual was suffering.

... it depends on different jinni's that you have. There might be other jinni's that are quite strong and it might not be that easy to get them out, but eventually you can get them out, but there are some of them you can get them out easily, so it is just your luck which type you have been affected with, some of them it takes maybe five years, four years to get them out. Some people it takes a couple of days, some people a couple of months. (P2)

Complete expulsion was not always reported, and four participants said that jinn may repossess an individual. Repossession reportedly occurs if the jinn are not expelled effectively initially and hence, may recur within a few months or as long as a few years after the expulsion. Between possessions, however, an individual's functioning is expected to return to baseline levels.

Four participants said that if the Koran readings did not eventually expel the jinni, and the sufferers' symptoms deteriorated further, then at that point, they may require hospitalisation. The use of psychiatric hospitalisation was considered

necessary by these respondents when an individual sufferer's situation "gets so bad that nobody can handle it" (P2). Participants also spoke of the need, in some cases, to supervise and care for the sufferer constantly during the length of the possession.

The family or community will try Koran readings but if takes long over a month and people are starting to lose their patience with the sick person, as sometimes it involves staying awake and taking turns to take care and guard them 24/7 days a week. So once they realise the Koran reading has been repeated even if it has to be on daily basis and the person's health is declining such as refusing feeds plus hygiene problems or challenges plus the safety of the person, then they are hospitalised in mental institutions. (P7)

One participant indicated concern that mainstream psychiatric inpatient units would not be accepting of Koran readings occurring during admission and believed that Somali may also be reluctant to engage in Koran readings at an inpatient unit as they believed Somali and Muslims would not be well received in the hospital. The impact of severe jinn possession was considered potentially far reaching. Hospitalisation as the extreme intervention when other community interventions failed was considered to have a major impact on the sufferer's livelihood if they are working and needed to send money back to family in refugee camps in Africa. Additionally, the impact of medication prescribed was considered by one participant to lead to severe tiredness and therefore also being unable to work and support family both in New Zealand and in Africa. Although two participants stated that psychiatric medication was valuable in helping to manage jinn (and knew of Somali using such medication), another participant knew of Somali prescribed, but not taking Western medication. Reasons stated for not taking prescribed medication were that the medication was considered redundant, sleepiness and a "heavy" tongue. The

apparent frequent failure of Western medication to expel jinn was seen by another participant as evidence that medication based treatment was not the most efficacious intervention for spirit possession.

The reported inability of Western doctors to diagnose jinn possession when an individual appears psychologically well was also relayed as evidence for the ineffectiveness of the Western system to help identify and extract jinn. Additionally one participant indicated concern that Western clinicians would attempt to reframe the sufferer's condition as depression or schizophrenia.

Even in cases where participants conceded that Western medication may have a role in alleviating jinn possession, they also asserted that they did not believe that Western medication alone was adequate to expel jinn. For participants who did consider that Western psychiatric medication may have a role in healing jinn possession, it was seen as an adjunct to, rather than a replacement for, Koran readings.

One participant spoke of a family member being possessed by a jinni for five years before a combination of Western medication and Koran readings eventually led to a partial recovery of their premorbid functioning. Although the family member continues to report hearing voices, they now apparently know how to control the voices.

Now when she hears the voice she will come... and say ... lately those stuff that talk to me, they're back, they talk to me, and [we] would be like, whenever you hear that, you should go read the Koran... so she would go read it, so she has control over herself. It's not like she misses her medication and she would be going all crazy because she hasn't taken her medication. She does take it perfectly well, but she does know what's happening, she knows this thing that is disturbing her as jinni, so when she knows they are back, they want her distraction,

she'll go read the Koran all day and two days after they're all gone. (P2)

This participant stated that although she recognised the potential value of Western psychiatric medication, she believed that her perspective was not generally shared by other Somali.

...and [the psychiatrist] put her on medication, but at the same time we had the sheiks coming to rid jinni so we had both of them going hand in hand, but now she is better and she is really ok, she's on medication too, so it's now that people are thinking that maybe you guys [Westerners] do have some medicine that can help, you know, it does help, but it's going to take ages before [Somali] figure out that that really works, it does work too and you guys recognise it.

Alongside both mainstream mental health interventions and Koran readings, six participants talked about generally providing the jinn sufferer with an adequate level of social, community, and family support.

If a person has jinni, one thing you always have is your family support there no matter what, this person is possessed, got jinni's, every person, every member of the family, nobody is going to diss them and go like, oh my God. There maybe some people possessed for five, six years but you'd see the mum and dad pay lots and lots of money to make them better, whatever it takes to get them better, they will stick by, not like just let him go, whatever your brother, sister do, always be there for you. (P2)

Prevention of jinn possession

Two participants said there was nothing that could be done to prevent jinn possession as it was predetermined by God who would experience this fate. One of these participants suggested, however, that reading Koran verses prior to going to sleep (that are considered to protect against jinn), and again on waking was a possible strategy to ward against jinn.

Jinn versus Western Forms of Psychological Distress

In some cases participants said that Somali who had attended mainstream health services and were suffering from jinn had been labelled as having ‘depression’, ‘psychosis’ or ‘schizophrenia’ by mainstream health clinicians. Two participants said that “craziness” and jinn were the same underlying state.

Mostly mental problems are associated with jinni, so I can't say mental problem, for us all mental problem has to have either jinni or different types of jinni, all the mental problems are jinni's. It's not like a depression, or stress or whatever. We have, you act funny with something not normal from every other person it's got to be jinni...(P2)

Three other participants stated that jinn may cause someone to become “crazy”.

Researcher: But that is still because of the jinni that they are crazy, even though, mainstream medication works?

P5: [nods]

Researcher: What would they [Somali] attribute that to – the fact that the medication works even though it is a jinni?

P5: They will say the jinni has triggered it [the mental illness] but if the jinni goes with the Koran there was obviously a jinni present - a possession by a jinni, but, then if they have to go to medication then they are crazy...if the Koran doesn't really help at all then they go to hospital, it's not the jinni.

Five participants provided means of differentiating between jinn and “mental illness” or “craziness” (the word “crazy” was frequently used by participants). Some of these respondents said that someone who was “crazy” without having jinn would not experience the jinn talking through them and reacting negatively to the Koran readings (which were considered proof of the jinn possession by a number of participants). One participant stated that differentiating between jinn and mental illness would depend on whether there was a history of mental illness in the sufferer's family. If not, according to this participant, symptoms would automatically be assumed to be due to jinn possession. Generally, however, those participants who did

distinguish between jinn and mental illness considered that if the Koran readings did not return the person to normal functioning, then it was likely they were “crazy”.

... the person who is considered crazy will have all this other stuff and maybe they will say they are the symptoms of a jinni and the Koran will be read but then they are not getting well but once they are admitted [to a psychiatric inpatient unit] and they are being given all these medications and they are sedated they are well. And once they stop the medication they will go crazy again. (P2)

One participant said that an individual could be “crazy” without having jinn. This participant also said that Koran readings would not be effective to treat “craziness”. Symptoms of “craziness” mentioned by her were sleeplessness and hearing voices. Another participant said that socially isolating oneself, becoming non-communicative, being unable to care for dependant children, and being unable to maintain basic activities of daily living (such as dressing and preparing meals) were indicators of “craziness”. These symptoms, however, were also provided as symptoms of jinn by many respondents. It was not clear from the current data how and if the symptoms of “craziness” and jinn were differentiated between by those participants who considered these distinct states.

Participants’ Perspective on Other Somali Conceptions of Distress

As indicated above, participants primarily associated distress and consequent impairment in functioning, with jinn possession. Two participants said they considered Western concepts of depression and psychosis valid explanations of psychological distress and did not attribute these illnesses necessarily to jinn.

It is important to note that Koran readings were the most commonly reported treatment for all aspects of psychological, physical, spiritual, social and

environmental explanations for suffering. All participants described the effectiveness and importance of Koran readings for treating distress. Having Koran recitations did not mean that other interventions could not be initiated, but that this was almost always an aspect of treatment. Additionally, faith in God and prayer were considered critical factors in managing hardship of any kind.

The following sub-section will primarily focus on interview data which provided accounts of psychological distress considered distinct from jinn possession by participants. The term “craziness” was still frequently employed by interviewees to describe these forms of distress.

Aetiology, symptoms, and management of psychological distress

Social Isolation

Social isolation and lack of community support in the new host country was described by one participant as a reason for “craziness”. This participant described the marked change in lifestyles between New Zealand and Somalia. For example, she said in Somalia women would frequently sit out the front of their houses talking, working on domestic chores together, and looking after each other’s children. This participant stated that Somali women do not do this in New Zealand and are often not neighbours. Even when they are neighbours with another Somali family, fences tend to separate properties (which is apparently not the case in Somalia). Five participants also talked of the impact of discrimination, prejudice and violence from non-Somali, (and occasionally other Somali) which led them to be reluctant to engage in any activities outside of their home, including visiting other Somali families. Such changes in lifestyle seem to have led, at least for some Somali women, to a decrease

in social support and increase in isolation. The case of one Somali woman was relayed in which apparently, due to a lack of community support when she first arrived in Hamilton, New Zealand, she began “yelling and screaming”, became confused, and broke windows in her house. The Somali community eventually heard about this woman’s situation and began visiting and conducting Koran readings with her. No mainstream mental health assistance was initiated and this woman’s distress eventually subsided. Now, according to this participant, the local Somali community ensure they visit and support any newcomers to the city so they do not become lonely and isolated.

Grief

Although one participant stated that Muslims are more likely to manage and accept death as the will of God and therefore are less likely to become significantly psychologically affected by the passing of loved ones, other participants disagreed with this assertion. Three respondents suggested grief could lead to significant psychological difficulties for Somali. One participant said that she had a family member who had suffered clinical depression following the death of another close family member. The family member was diagnosed with depression by her GP and although she did not agree with the diagnosis, she complied with taking the prescribed antidepressants. The medication was considered to have a positive effect on alleviating this woman’s mood and wellbeing. The participant interviewed, did consider that this family member suffered from depression and described symptoms such as anger, inactivity and poor sleep that she considered evidence to support this diagnosis. This participant recognised that her support for Western diagnostic

nosologies and interventions was atypical for a Somali who would generally not consider such diagnoses valid.

War Trauma

Two participants spoke of their own experience of distress due to the trauma they had experienced in the civil war. This is the account of one of these respondents.

I had frequent nightmares about my [family], who I left behind in the camp, and at times I will be sleeping on my bed and I could start seeing the people who died in front of me or the pile of dead bodies some of which were familiar that I helped bury or move them from the roads. These experiences will never be erased from my memory, I try to forget by joining Koran reading groups, English classes to occupy myself but it was real experience very traumatic and it will never go away. What I don't like is doctors asking me about this, this makes me re-live the whole war experiences again. (P8)

This participant talked about how she tried to cope with her trauma-related distress and articulated that talking about this trauma to health professionals was not considered a valuable intervention; on the contrary, it was considered atherapeutic. Other participants also acknowledged that women's experiences in the civil war may lead to nightmares and distressing memories. However, this sort of distress was generally not considered to significantly impact on a Somali woman's ability to manage her day-to-day responsibilities.

A relationship between traumatic war experiences and distress was not considered to exist by all participants. Three participants said they had never heard of women becoming distressed by memories of the war. Another participant however, did relay a case of a woman in Somalia who had become "crazy" due to the trauma of war. According to the respondent, this woman lost all six of her sons in the Somali

civil war. Reportedly because of this loss, the woman laughs “all the time”, believes one of her sons is still alive when she sees his clothes, has no enjoyment of life, “just exists”, and requires help with basic daily activities (such as eating and hygiene).

The participant said that there was no cure for this woman’s condition.

Dishonest Conduct

Stealing and dishonesty were also considered by participants to potentially lead to punishment by Allah and pervasive unhappiness for the person who was deceitful. According to one participant, the only remedy for this sort of unhappiness is to return the stolen property to its rightful owner. Another participant gave a detailed account about how dishonesty and failure to fulfil responsibilities to those who have supported you may lead to “craziness”.

... my [cousin] got married to this guy and my whole family, we had stood up for him, like paid expenses for him, treated him like a son, even his plane ticket, he was supposed to go to Europe, and ... my uncle paid everything for him and they’d only been married a couple of months and she was pregnant and he had gone away without seeing the baby. So when he went to Europe to study...and finish his study, after about a year he decided I don’t want to be with you any more after all my family had done everything, basically, even the ticket that he used to go there was paid by my uncle, he was treated like a son, and then he [mailed] a letter and said I divorce you, he didn’t even have the guts to come through face to face... And he went to Africa for a job there and something happened and now he’s back .. .he’s not normal....We haven’t seen him since about two years, the next time we see him he’s not okay, he’s gone like he lost it, he was just like going around and met my [uncle] and he was like, I’m so sorry, but he was not himself, he’s like he went mental... So that’s the kind of thing, whatever you do, you just think you can get away with it, like you might have your punishment and still in this life, but you’re going to die you have another that’s waiting for you, but something like that you’ll be punished while still here. (P2)

All of the other participants agreed that you may be punished by God for wrong doings but generally stated that this punishment may take many forms and others may not be able to recognise a person's hardship or distress as a specific punishment from God.

Somali Perspectives on Western Idioms for Distress

One participant said that she suffered from "stress" which included hearing voices, nightmares, social withdrawal, low energy, "thinking a lot", headaches, forgetfulness, vigilance to danger, and anxiety. This interviewee stated that her house in New Zealand had been robbed on numerous occasions, and she had separated from her husband. She believed that these experiences had contributed to her current "stress". Because this participant had dependent children she reported that she "had to" continue functioning adequately on a day-to-day level. She also received support from close family members, particularly with child care. She described her voices as hearing someone say her name or greeting her, when no one had in fact spoken to her. Although this participant was distressed about her symptoms, she said neither she nor her family considered she was "crazy". She had willingly accepted a referral to the mental health services for treatment of her symptoms and was engaged in psychological therapy. Only her close family knew of her contact with mental health services. This participant also acknowledged making a suicide attempt years earlier following significant familial conflict including reportedly being the victim of domestic violence. Most participants however, said that terms such as "stress", "depression" and "psychosis" were non-existent in Somali culture. Those who were

familiar with these terms indicated they had only become aware of them since living in New Zealand.

Although all participants were aware of extreme episodes of distress in Somali women, a number of participants relayed how their Islamic faith and teachings were the primary reasons for low incidence of “stress” and “worry” in Somali culture. Faith and believing that one’s destiny has already been determined by God, also has been indicated as a protective factor against the development of psychological distress, including worry, by a number of participants.

Stress is a really hard thing to find in Somalis because we all have a strong faith so people don’t have much stress.you’ve got a problem, just pray and God will make it better.... at the end of the day, that’s what [Somali] all believe. You can go crazy, have a mental problem but by going crazy it’s not going to change anything...don’t worry, what ever it is God can make it better....I can sit and listen to you crying for hours on end but at the end of the day I can’t do anything for you, so what’s the point. Stressing out, we don’t have that...Mostly the person who doesn’t believe in anything, that’s the only person going oh my God, it’s unfair, it shouldn’t happen to me, people like that can talk like that because you don’t have faith in anything....whatever happens it’s God up there...everything is for a reason... (P2)

Two participants stated that Somali women are just as likely as women from other ethnicities to experience marked psychological distress. However, they said that due to cultural and religious prohibitions and concern about “gossip”, Somali women would be less inclined to discuss these concerns with other Somali.

Some participants said that for someone to be considered ‘mentally ill’ their behaviour had to be considered extreme and commented on the apparent discrepancy on what is considered ‘mental illness’ by Western standards compared to Somali standards.

I have a New Zealand neighbour who his relatives say is unwell mentally and does wander off sometimes but he cooks for himself and has never had any accidents, so this makes me doubt his mental health status....Plus since coming to New Zealand, I have not come across someone who is sick “crazy” enough to hit people, stop traffic or break shops, I’m sure there are crazy people in New Zealand but are well maintained that they don’t fall into the criteria of madness that I’m familiar with. (P7)

Somali Perspectives on Mainstream Mental Health Interventions

Participants were aware of the use of psychiatric medications to treat Somali experiencing distress. One participant in particular relayed concern that the use of Western medication leads to confusion, communication problems, dependence, inactivity, and weight gain. Additionally, this participant did not think engagement with mainstream mental health services was appropriate or helpful. The interviewee seemed to consider that contact with mental health services could cause “craziness”.

If [the mental health clinicians] visit you, and you are good, then you believe you are crazy. (P3)

Cultural barriers, differences in world views, and mistrust of health professionals’ intentions were described as barriers to actively engaging with mental health services by another participant.

My GP and mental doctors were very helpful but language, cultural and belief barriers made it very difficult for both of us. They tried many times to help but I regarded them not experienced because they have not witnessed the trauma and what I saw and they wanted me to keep talking about it, this upset me but in the end once my child’s process was initiated I trusted the doctor’s intention of wanting to help me get better. (P8)

This excerpt also demonstrates the positive impact of building a trusting therapeutic alliance, in a manner which is meaningful to the client.

Another participant talked about eventual contact with mental health services after numerous Imams had recited Koran verses, with only minimal success. This participant's family member had been demonstrating symptoms indicative of significant distress for a number of months.

...like you had to watch her all the time. You know she will go to the kitchen and if she finds raw meat she will have it. You have to watch her 24 hours a day. She wouldn't comb her hair. She wouldn't do her hair, we had to do all of her hygiene and stuff. If she went to the toilet we had to go with her and watch her otherwise she would put her hands you know in the [toilet] basin and stuff not really knowing exactly what is going on. She wouldn't sleep on the bed she would sleep on the floor. (P5)

The family in this case was supportive of intervention from mental health services. The woman was seen by a psychiatrist and prescribed medication which according to the interviewee seemed to alleviate her symptoms significantly. She is now apparently managing well and is no longer considered to be distressed or "crazy". The participant who relayed this story said that her family were not sure why this woman experienced this level of suffering or what the cause was.

Responses to the use of inpatient psychiatric hospitalisation were variable. As indicated earlier, some participants had never heard of a Somali being admitted to an inpatient psychiatric ward. Other interviewees had, and were concerned with this form of intervention for reasons already mentioned. One participant said that in severe cases of distress, inpatient hospitalisation was appropriate. Only two interviewees described having contact with mental health services of their own volition. None of the other interviewees knew of Somali women voluntarily engaging with such services.

The Impact of Family Separation on Psychological Distress

One of the most frequently reported psychosocial stressors was family separation. Four participants had experienced this first hand, and had been separated from biological children (both very young and adult children). Leaving very young children in Africa was reported by three participants while one participant reported having an adult child still in Africa. One interviewee reported until recently her grandchildren remained in Africa (but they have since commenced living in New Zealand) while another said her husband was in Africa. Separation from these family members was an additional source of distress for the two participants.

Although the overt demonstration of psychological distress was considered unusual for Somali, family separation was a stressor commonly associated with demonstrable distress. Experiencing distress in response to family separation was considered more acceptable by participants than worry about other psychosocial issues which as highlighted earlier is considered unusual, and according to two interviewees, indicative of a lack of faith in God. Family separation was also cited by one participant as the primary reason Somali would attend mental health services.

The stress associated with family separation was said by respondents to be triggered by two key factors. First, concern for the safety of family still residing in refugee camps was commonly cited as a reason for distress. Additionally, most Somali families send money back to other family members still in refugee camps in Kenya and Ethiopia. According to participants, Somali typically send back a minimum of US\$100 per month to family in refugee camps. This money is apparently used to supplement food and other basic needs such as water. The

majority of Somali families in Hamilton are receiving government benefits or are in low skilled/low paid jobs. This means they are supporting two families on meagre incomes which participants said contributes significantly to financial stress.

According to participants, Somali experience a strong sense of responsibility to family still in Africa and both male and female heads of households will send money back to their families. It is considered an obligation for Somali to share their wealth when they are aware other family members have less financial resources than they do.

One participant said the strain of trying to support family both in Africa and New Zealand can become so great that it leads to marriages dissolving. This dissolution was attributed to lack of agreement between a husband and wife, about how much money to send to Africa. Additionally, marriage dissolution was considered especially likely if it seemed that the female head of the household was more concerned about the well-being of family in Africa than her family living with her in New Zealand.

Distress caused by family separation was also suggested to impact significantly on a mother's relationships with children living with her in New Zealand.

It will impact on their family and whoever they are responsible for, it will impact on their children, if they come and find their mother in bed when kids come from school expecting moral support and encouragement, they come home and hear mum saying "cover me cover me" while all the time the pillow is wet as a result of crying. The children become very disappointed and they start crying like you. (P10)

Additionally, one participant commented that sending money to Africa meant that children living in New Zealand often missed out on opportunities (such as joining sports teams because the family could not afford to pay the fees) which also placed a strain on family relationships.

Three participants said it was considered unusual for Somali women to become tearful in the company of others. One participant said that the primary reason they thought a Somali woman would become tearful was if they were missing family members. Inactivity, anger and social withdrawal were associated with the distress of family separation by participants. Interviewees said that concentration lapses and forgetfulness were the most common idioms of the distress of family separation. Failing to stop at red traffic lights when driving, forgetting to put shoes on when going out, and forgetting how to get home from a familiar location, were some of the more often cited indicators of poor concentration and memory. Additionally, according to participants, guilt about leaving family behind is also common, as is chronic rumination and worry about the wellbeing of family in camps. Phone calls from family in Africa were thought to trigger nightmares and distressing memories of war experiences for some.

...when those people in Somalia ring their family members here, then that is when these nightmares and the experiences come rushing, and because Somali when we communicate we communicate very straight-forward, those people will normally use phrases like, 'We are where you've left us', you know, 'we are experiencing the things you have left your country for and it has gotten worse since you left', and they will start (re)counting so and so had died, so and so maybe their legs have been amputated, and all the horror stories have come along with that phone call which are constant. That's what triggers and reminds them and people feel so guilty, especially when they are told we are in the same spot you have left us, the danger you have left your own country for is where we are still there and this will have an impact on how they experience or how they feel and it can be very stressing. (P5)

Family separation was also considered by one participant to be the most common reason Somali women would experience 'mental illness'. Another participant stated that she knew of an instance in which the stress of family separation

had led a woman to go “crazy”. This was a woman who apparently had no history of ‘mental illness’ who started disrobing in public, and also experienced impaired sleep, physical aggression and social withdrawal and was eventually hospitalised in a psychiatric unit. Other participants also described themselves as “crazy” while they were waiting to be reunited with family members. None of the participants who had been separated from family members and considered themselves ‘crazy’ were admitted to inpatient psychiatric units, and, hence all of them were functioning on a day-to-day level, albeit they reported, with considerable community and family support. These women were also often receiving psychiatric medication from their GPs or psychiatrists. Frequently however, participants said the medications were not taken as prescribed and often they were not taken at all. The psychological impact of family separation was articulated by a number of participants who had experienced this personally.

It affects [your] whole health lets say someone like me, I’m separated from family, I know of occasions whereby I will be walking, cars in the streets but for me it will appear like a wall as I will be talking to myself and will realise or find myself in the middle of the road. There were times where food will be next to me until its cold or will take to the bin. I know of times that I undressed my kids for a shower but dressed them back with the same dirty clothes that I took off with no shower and my kids will tell me, “Mum you have not showered me yet. (P 10)

Participants mentioned numerous ways of dealing with and trying to achieve family reunification. Frequently they said Somali women will lobby local Ministers of Parliament to write supporting letters for immigration applications. GPs and mental health clinicians may also be asked to write such letters. One participant said that the primary reason Somali women engaged with mental health services was to

obtain a report about their level of psychological distress caused by family separation (which is typically forwarded to the New Zealand Immigration authorities).

According to interviewees women who were engaged with mental health services were not typically seeking a cure for their distress – whether medication or psychotherapy – but assistance in reuniting with family members.

With respect to how the distress associated with family separation is managed or treated, one participant stated the following:

Relocation for me was good at first because I had shelter, food, medicine but once I settled, the reality of leaving my family behind was overwhelming and I started to re-live my past experiences. My life has changed significantly since my family joined me, I could finally sleep without medication, I could enjoy. (P8)

This participant said she had been treated at mainstream mental health services for her distress, but did not consider any medication was appropriate to help manage the acute concern and anxiety associated with having family members in dangerous and vulnerable predicaments. She reported all of her anxiety subsiding once her family members received their New Zealand Visas and she said she required no more medication after learning of this news. Participants generally stated the only way to alleviate the distress associated with family separation was reunification. Another participant provided the following account of her distress and attempts to treat this distress both employing traditional methods and engaging with mainstream services.

The hardest part was when the phones at night and I hear my son's voice, I never used to sleep, enjoy life, food nothing was meaning anything to me, this meant my daughters had to grow up quickly/mature and be independent. Sleeping [medication] did help for a while but then it did not help anymore and I started taking more and more but after telling the doctor he gave me another one which was going to help with nerve and it had sleeping effect as well but it made me more crazy, like I

couldn't sleep, I felt that my head was spinning and was full of stuff like insects, my head was sore, dry mouth, put more weight on, loss of memory. Like this time, I was looking for my headscarf for six hours at night and later my daughter told me it was on my head!! I think I was really mad but because I was still dressed people thought I was normal, some were gossiping saying that I was unwell because I was concerned that my husband was going to remarry as I left him with a baby and that my worries weren't for my baby. This hurt me but again it's these same people who were helping me with my children, Koran arrangements and reading, transport so they helped me a lot. And perhaps my state of mind I did not allow me to resent or confront them because I was in a different world and I use to wonder why can't these people feel what I'm going through but then this also made me believe I was truly crazy and everyone else was fine. That's why they were wondering what's wrong with me, even the doctors, I will go and complain of headache or jaw pain and this is when he started taking one tooth [out] after another. (P7)

This participant describes the significant impact her distress had on her physical wellbeing in addition to her psychological wellbeing. Again this woman reported that her physical pain and psychological distress completely and immediately subsided once she was reunited with her family members.

Although three participants acknowledged being prescribed and taking Western psychiatric medication to assist in alleviating the anguish associated with family separation, these participants also stated that such medication did not provide relief from their emotional distress.

Yes they said I had problems with my mind and gave medications to help forget my problems but what medicine will make you forget your own child and husband? (P10)

Protective Factors, Resilience, and Success

Participants identified few factors which they considered protect Somali women from suffering from jinn, "craziness" or general psychological distress. Most of the factors that were identified are already mentioned earlier in this Results section (e.g.,

having strong faith, following Islamic principals and prayer). However, even these factors were not always considered adequate protection from significant distress. Generally, given the Islamic belief in ‘God’s will’ and pre-determined life trajectories, a number of participants said that there was nothing that could be done to prevent major distress if it was ‘God’s will’ that they experience this ordeal. Two participants stated that having formal support networks and a physical location where Somali women could meet or “drop in”, and where they could also obtain practical (e.g., bill paying) and more specific forms of support (from health professionals) would encourage women who did require some level of support to seek this prior to their situation deteriorating too much. Currently, in Hamilton, New Zealand there is no such ‘drop in’ or formal support centre for refugees and migrants although three other major cities have them.

A number of indicators of success were identified by participants. These were not necessarily valued by all participants, although general themes did emerge from the data. The ability to learn English was considered one of the most important signs that a Somali woman had become successful since arriving in New Zealand. Learning English enables women to cope independently with every day issues such as bill paying, obtaining employment, being aware of how her children are managing school, and interacting with government agencies (such as Work and Income New Zealand, the Inland Revenue Department and the Immigration Department). Marriage and children were also frequently cited indicators of success as was having siblings and parents in close proximity.

...let’s say a woman is here and her mother and her siblings are in the camp and then she has to support them, she is always incomplete and she will never ever do

anything for herself because she has this as a priority.
(P5)

Ingredients cited that were considered important to a successful marriage were complying with the husband's request, and not having to involve external agencies (such as the police) in marital problems. According to participants, a woman's success may also be measured by the conduct of her children. Children who have not got into any difficulties at school, who embrace Somali culture and religion, and teenagers still living at home were three common indicators provided that a woman has raised her children successfully. Being able to bear children is considered very important in Somali culture as children are considered "wealth". Hence, a woman who has no children but does have a 'successful' marriage (as defined above), is educated and has a career would often not be considered successful to other Somali women.

One participant stated that although she appreciated the importance of marriage and children within Somali culture, she did not necessarily consider these factors indicators of success in her own life. Rather, this participant considered having tertiary education and a career as strong indicators of success. Six other participants also discussed the importance of Western education, and although this was frequently cited by participants as a sign of success, four participants did not mention education and career in relation to success. One participant stated that employment was important particularly prior to having children, but indicated being employed may diminish in value once child rearing begins. Having a strong Islamic faith, was frequently mentioned as an indicator of success as was taking Koran lessons and being well-educated on the Koran.

Strong social support and meaningful activities outside of the home for married Somali women with children was considered important by one participant. This participant noted that life roles had changed markedly for Somali women in New Zealand and believed that not having meaningful roles outside of the home may place some women at risk of distress and unhappiness.

Two participants believed that a Somali woman could be taking psychiatric medication and still be considered successful. Both interviewees suggested that in these cases such women would be considered successful only if she was not actively exhibiting any symptomatology.

Yes, it doesn't matter whether if she is on anti-psychotic tablets, so long as nothing is visual. She is coping and is doing really, really well and she has integrated and adapted to this country. (P5)

The participant who made this statement also suggested that a woman on anti-psychotic medication, who had been managing her responsibilities well, would probably be considered to have been "misdiagnosed" by her doctors. Although this woman would be considered to be psychologically well if she was not demonstrating any overt symptoms, the participant commented that there is always likely to be a stigma associated with the period when she was considered acutely unwell.

P5: Yes, they would consider her successful but there would always be a big but. She is very successful, but... she has episodes where she goes crazy.

Researcher: So she could still be successful?

P5: But there would always be that connotation of, 'But'.

This participant also said that even if a woman is exhibiting some symptoms of distress, that as long as she is able to maintain important daily responsibilities, she would be considered to be coping adequately in at least some realms of her life.

So she might be doing some of these things throughout the week such as saying unusual things to people or walking around not properly clothed but if she's able to raise her family, keep her house clean, able to generally socially be okay, she would still be seen to be doing okay in some of the areas of her life.

Summary of Results

The findings of Study 1 identified spirit possession as a form of distress known by at least some members of the local Somali community. Jinn appeared to be a common explanation for both milder forms of distress akin to depression and anxiety as well as more severe forms of distress similar to psychosis. Some participants acknowledged the similarity between jinn and psychosis although considered psychosis to be in fact spirit possession. Treatment for jinn possession tended to focus on Koran readings in conjunction with family and community-based support. Generally participants considered there was a very limited role for mental health professionals and Western psychiatric medication in the extraction of jinn.

Some participants described a form of "craziness" which was distinct from jinn. It was unclear based on the current data how these two states are differentiated. Faith in God and prayer were considered by a number of interviewees as critical to protect against experiencing significant psychological distress. A number of stressors however, were identified that participants suggested would increase vulnerability to distress; social isolation, reduced activity level, grief, and dishonest conduct. Additionally, war trauma was acknowledged to have an adverse impact on the psychological functioning of Somali women by a number of interviewees. Such trauma was not considered to impact on a woman's ability to manage her day-to-day responsibilities, however. Some interviewees said that they had not heard of a Somali woman describing war trauma related distress. The impact of having family in

refugee camps in Africa was identified as a common and very distressing issue impacting on many Somali women. The only way of alleviating the distress associated with this stressor according to participants is reunification.

Generally Western idioms for distress were considered to be very uncommon amongst Somali. Faith was considered a key protective factor against experiencing stress, worry, anxiety and depression. A few participants suggested that psychological distress does impact on Somali women, although cultural prohibitions (including such distress being considered a sign of lack of faith) make it unlikely that emotional difficulties would be overtly acknowledged.

Although a number of interviewees acknowledged receiving assistance from Western mental health services, generally this was not considered useful in alleviating their distress. Psychiatric medication as a common form of intervention within mental health settings was also not considered efficacious by many participants although some acknowledged a role for such medication in some instances.

In addition to faith in God, learning English, marriage, children and having family in New Zealand were also considered protective factors against experiencing psychological distress. Primarily, however, interviewees said that life trajectories were predetermined by God and as such, if it was God's will that you experience psychological distress then there was little that could be done to prevent this from occurring.

Discussion

The following paragraphs will summarise the key issues identified in the Results section of Study 1.

Jinn Possession

The current findings suggest that spiritual explanations for distress may be common within the local Somali culture. These results are consistent with previous research which has found that spiritual forms of suffering are common in other Somali communities throughout the world (Carroll, 2004; Guerin, et al., 2004b; Rousseau et al., 1998a; Tiilikainen, 1998; Whittaker, et al., 2005). The various symptoms of *jinn* possession can be likened to an array of psychiatric diagnoses from the less severe disorders such as anxiety and mild depression to the more severe disorders such as schizophrenia. From the participants' perspective, there appears to be some symptoms which more clearly indicate jinn as the aetiology (such as hearing voices, public nudity, aggression) but even in less severe cases of possession, 'out of the ordinary' behaviour may be ascribed to jinn (such as increased physical strength). From most accounts, it would also seem that the clearest way of determining jinn possession if there is ambiguity is during the Koran readings. Interviewees said it is during these readings that jinn let their presence be known, and this phenomenon does not occur with other conditions. Loss of memory during the time of the possession and loss of insight also appear to be key indicators of (more severe) jinn possession.

The current findings are similar to those of Guerin et al. (2004), Rousseau et al. (1998a), Tiilikainen (1998), and Whittaker et al. (2005) in that severe psychological

distress and spirit possession were not necessarily considered distinct states. In contrast to the results of these studies the majority of Carroll's (2004) participants considered jinn and 'mental illness' to be distinct conditions. Interestingly, in Carroll's study, participants' description of *walli* (e.g., public nudity, unpredictable physical and verbal aggression, "talking nonsense") was similar to the description of severe jinn possession provided by participants in the current research. Carroll's participants, however, reportedly suggested that extreme trauma was the primary explanation for these symptoms. Trauma was seldom mentioned as a reason for significant psychological distress in the current study.

Although it is not clear why this difference in findings has occurred, one possibility (alluded to in Chapter 4) is that these apparent differences are due to semantic differences or issues of interpretation, rather than actual differences in categorisation of distress. It is important to recognise that words and their meanings are often not interchangeable between languages (Tribe, 1999). Hence, both interpreters and bilingual participants in research projects such as this (and the previously cited studies) are at best delivering an approximation to the thoughts and ideas they actually want to convey. As such, language in itself becomes a methodological issue and one which may explain the apparent divergent results of studies exploring Somali conceptions of psychological distress.

Of note, one participant in the current study and some Somali participants in other studies have challenged the validity of jinn possession and asserted that this phenomenon is a sign of mental illness and not a spiritual matter (e.g., Carroll, 2004, Tiilikainen, 1998). As Somali continue to become acculturated into their new host

cultures, the need for a more integrated approach to understanding distress which identifies the validity in both the Somali and Western perspectives is critical to ensuring that Somali presenting to mainstream mental health services engage in efficacious interventions.

Non-spiritual Forms of Distress

Notwithstanding the difficulty disentangling symptoms of jinn from other forms of psychological distress; social isolation and in particular, family separation, were described as triggers for non-jinn related suffering. These findings suggest that there may be some triggers to psychological distress that are readily acknowledged and identified by the Somali community and, if occurring in an individual's life, may be considered the aetiology for their difficulties rather than jinn possession.

Family separation

It is possible, even if the symptoms of general psychological distress and jinn possession are difficult to disentangle, that identifying a culturally sanctioned reason for the distress may be less likely to lead to the symptomatology being attributed to jinn. Family separation and social isolation may be culturally sanctioned reasons for experiencing distress due to the collectivist nature of Somali society and the importance placed on family and living interdependently. Additionally, limited social support may be particularly likely to trigger distress given that strong social and familial support are frequently considered key protective factors against experiencing distress (Ryff & Singer, 2000; Weine, Vojvoda, Hartman, & Hyman, 1997). Hence, women separated from family or women who do not perceive they have adequate

social support, may be at greater risk of experiencing significant psychological distress.

Post-traumatic stress disorder

The current findings although limited in scope, add to the growing body of literature which is questioning the assertion made in some research studies that post-traumatic stress disorder (PTSD) is of epidemic proportions in refugee groups. Although symptoms characteristic of PTSD were acknowledged as causing difficulties for some Somali women, there was limited evidence that such symptoms caused *significant* distress. No participants reported receiving Western interventions for trauma-related distress, nor did any participant mention that they knew of any other Somali who had received such assistance. Hence, accepting hardship as God's will, and believing that one's life course has been predetermined by God, may act in some circumstances as protective factors against trauma-related psychopathology. This assertion is supported by research conducted by Ryff, Singer and Palmersheim (2005) who found that spiritual beliefs are a protective factor against experiencing psychopathology. Further, Ramsay and Gorst-Unsworth (2003) suggest that the psychological reaction of refugees to their war experiences in many cases may actually be an adaptive rather than maladaptive psychological response. There is no doubt, however, that refugees in exile can present with symptoms of distress or problems in functioning which may relate to different etiological factors including war trauma (Summerfield, 1995; 1996).

One potential barrier for Somali to admitting trauma-related psychological distress may be that there appears to be a degree of shame or stigma attached to

acknowledging such distress. That is, participants who had had personal experiences with trauma-related symptomatology may have been disinclined to describe this to the researchers undertaking the current study. Notwithstanding this possibility, given that other members of the present research group (who have had long term involvement with the local Somali community), have seldom heard of PTSD symptomatology significantly impacting on the lives of local Somali (either a specific symptom or a cluster of symptoms), it is conceivable that Hamilton-based Somali may have low rates of trauma-related pathology. Given also that some participants were reporting other events that could be considered shameful (such as an attempted suicide), it might be unlikely that they were intentionally under-reporting trauma-related psycho-pathology.

Western idioms for distress

Given the entwinement of Somali culture and Islamic teaching, it is not surprising that Western psychological disorders were often considered by participants to be non-existent within the local Somali community. This perspective was not held by all participants, however, as two respondents did consider disorders such as depression to exist in Somali culture. Nevertheless, these participants stated that the validity of these disorders would generally be rejected by Somali if presented within a Western paradigm.

Regardless of the explanatory model used, constructs similar to anxiety and depression were identified in the narratives of the participants in the current study. Again, given the apparent stigma attached to admitting that one is suffering from acute psychological distress, and the suggestion that such difficulties are an indication

that the sufferer has “lost their faith”, it is understandable that Somali may be less likely to acknowledge intense emotional distress. This stigma may be so great that it prohibits women from seeking support for this distress from their friends, family and professional agencies. As one participant asserted, failure to request such support may in fact exacerbate the symptoms.

Physical suffering

Participants described physical distress seemingly in response to psychosocial stressors – particularly family separation. In an extreme case teeth were extracted possibly unnecessarily in an effort to alleviate physical pain that reportedly subsided once the participant was reunited with family members. Most participants considered physical illnesses to be distinct from spiritual and psychological difficulties. Interviewees also considered Western medical interventions to be an acceptable treatment for physical health problems. Given that physical distress does not seem to have the same stigma attached to it as psychological distress, it may follow that distress in response to significant psychosocial stressors manifests as physical ill-health. The impact of psychosocial stressors on psychological and physical wellbeing is not unique to non-Western cultures. One need only review key theories and models of psychological disorders such as anxiety and depression within the Western world (e.g., Andrews, Creamer, Crino, Hunt, Lampe & Page., 2004, Hawton, Salkoskis, Kirk, & Clark, 1986) and it is clear that these Western idioms of distress have a significant impact on physical wellbeing also.

Of concern is the use of such extreme forms of intervention (such as tooth extraction) when they may not be necessary. If, however, health practitioners

(particularly specialist health practitioners) are not aware of the context within which the pain is being experienced, unnecessary forms of medical intervention are likely to ensue. Such interventions may also reflect health practitioners' desire to be therapeutic, particularly if clients present to them in overt distress and pain.

Developing a health setting that takes an holistic approach to health and wellbeing may help to ensure that unnecessary and invasive treatments are not performed when the aetiology of the pain is psychosocial in nature.

Barriers to Mainstream Service Use

There are numerous hypotheses for local Somalis' apparent disinclination to engage with mainstream mental health services. These hypotheses are outlined below.

There was evidence from the interviews, that participants equate "mental illness" with extreme forms of distress akin to psychosis. This conceptualisation of mental illness is somewhat narrower in definition than the definition typically applied in New Zealand mainstream mental health services. The local Waikato District Health Board's criteria for mental illness is consistent with the *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition* (American Psychiatric Association, 1994) and *The International Classification of Diseases – Tenth Edition* (World Health Organization, 1990) categories of mental disorders which range from anxiety, depression, and eating disorders, to severe dissociative and psychotic states. If, however, Somali consider that engaging with the local adult mental health service equates with being "crazy", it is understandable that (i) they may be reluctant to attend such a service given the apparent stigma attached to being considered

'mentally ill' within Somali culture, and (ii) they may not consider their psychological difficulties (if in the form of depression or anxiety, for example) as relevant foci for such services. Hence, the services title 'Adult Mental Health' may prohibit some Somali from even contemplating accessing this form of assistance.

There are of course many other reasons why Somali may be reluctant to seek help from mainstream Western services. Guerin et al.'s (2004b) finding that all but one of the Somali participants in their study described negative experiences with the Hamilton (New Zealand) based mental health service may also mean that the reputation of the service based on these (and other Somalis) women's experiences has been relayed widely throughout the community. Concern raised by Guerin et al.'s (2004b) participants that they perceived that clinicians wanted them to recall traumatic war experiences which they [the participants] generally did not consider beneficial, could highlight a major difference between how trauma is often dealt with by Western clinicians and how Somali would prefer to manage trauma.

Concern about confidentiality, mistrust of government agencies, inability for Somali with limited command of English to present their stories in their own words, reluctance to use interpreters, limited understanding of the operating principles (e.g., understanding why client files are kept, who has access to file information and the premium placed on attending appointments as scheduled) of mental health services and reluctance to disclose intimate personal details to a stranger are likely all barriers to engaging with local mainstream services. Additionally, practical issues such as lack of childcare and transport, and the distance between women's homes and local services may be prohibitive factors even for women who are motivated to attend such

agencies. Women may also be concerned about the perceived limited appreciation of cultural differences between themselves and their clinicians.

Within inpatient mental health settings, there is some evidence that Somali do not feel comfortable engaging in Koran recitations on site. These Koran recitations may involve a medium or large group of Somali spending lengthy periods at psychiatric inpatient units conducting readings with an individual considered to have a jinni. Their perception of being evaluated negatively by inpatient staff and not feeling welcome is difficult to validate without obtaining the perspective of inpatient staff also. It is, however, their perception which seems to be contributing to reluctance to integrate their traditional treatment with Western treatments whether accurate or not. Given the importance of matching an individual's world view and beliefs with a complimentary treatment approach (Draguns, Gielen, & Fish, 2004), Somali in mainstream mental health services who do not have access to or (for whatever reason), cannot access their own traditional forms of intervention, may be at risk of suffering more significant and longer episodes of distress.

Resilience

Although participants generally proscribed a fatalistic perspective on wellness and protection from suffering, the data suggested that some factors were more likely to foster resilience than others. Learning the language of the host country has been identified as a key protective factor in previous research both with immigrant groups generally (e.g., Colic-Peisker., & Tilbury, 2003; Ho, Au, Bedford, & Cooper, 2003) as well as with Somali refugees (e.g., Halcón Robertson, Savik, Johnson, Spring, Butcher, Westermeyer, & Jaranson, 2004; Jaranson, Butcher, Halcón, Johnson,

Robertson, Savik, Spring, & Westermeyer, 2004). English proficiency was also considered important to general wellbeing in the current study. A command of English allows Somali women to manage their day-to-day responsibilities independently and also enables them to communicate directly with health professionals about their concerns without relying on an interpreter or family member to accompany them to appointments. Hence, having a greater level of mastery over their new environment by being able to speak the local language is understandably going to reduce the stress associated with adapting to a new country.

Factors predictive of resilience in previous research such as family cohesion, social support, and the presence of caring relationships in the family and in the community (Cowen & Work, 1988; Resnick, Bearman, Blum, et al., 1997) also seemed to be important predictive factors in the current research. As already indicated, it is understandable that separation from family, particularly in a collectivist culture, may lead to significant psychological distress. This may explain why a fatalistic perspective with strong religious underpinnings may not act as an adequate protective factor against experiencing major psychological distress caused by family separation. That is, in these circumstances, one of the key corner stones (i.e., family support) to ensuring psychological wellbeing is lacking. Additionally, stressors such as (i) the financial burden of supporting family both in New Zealand and Africa, (ii) pressure from relatives in refugee camps to bring them to New Zealand, and (iii) attempting to negotiate the complex process of applying for visas for family, are also likely to contribute to the psychological distress described by many participants in the current study.

Belonging to a collectivist society with close family and kin relationships in which religious and cultural norms are enmeshed, may be a key reason why Somali infrequently engage with mental health services. That is, it is possible that their need is not greater than that of individuals from Western cultures for psychological and psychiatric intervention. Factors shown in previous research to be predictive of resilience (namely strong religious beliefs and family networks) could be contributing to less incidence of significant psychological distress in Somali culture compared to mainstream New Zealand society. This is not to suggest that Somali do not have any need for such services, but rather, that ‘denial’ of difficulties and ‘lack of psychological mindedness’ (e.g., Kinzie, Boehnlein, Leung, Moore, Riley & Smith, 1990; Silveira & Ebrahim, 1998; Somasundaram, 1996) are not necessarily the most likely hypotheses as to why some non-Western groups do not seek psychological assistance.

Additionally, as suggested by Guerin et al. (2004b), it is possible that other life stressors (such as family reunification, learning to adapt to a new country, financial hardship) are more pressing issues for Somali to address than receiving assistance for psychological distress. Such stressors are likely to contribute to an individual’s general emotional state regardless of their cultural background. That is, in Western cultures it is also unlikely that psychological therapy and psychiatric medication are going to have a significant impact on an individual’s emotional state if they are not able to also ameliorate such major stressors as financial hardship, unemployment, and poor housing conditions. Nevertheless, within mental health services, refugee clients’ traumatic experiences (e.g., starvation, torture, rape) may be seen as such salient

factors to Western practitioners (in whose culture the same experiences would most likely be considered extraordinary) that they overshadow other stressors possibly considered more pressing by their clients.

Within a Western trauma paradigm it may be very difficult to comprehend how such experiences would not have a chronic and pervasive impact on refugees. However, failure, to consider the entire context within which a refugee's distress is manifesting, and failure to understand the unique cultural factors which may mediate the expression of psychological distress, could be major shortcomings of current mainstream approaches to working with refugees.

Summary

The Somali participants identified a wide range of symptoms indicative of distress. Stigma was associated with psychological distress but was not associated with distress that manifested as spirit possession. From a Western perspective, the cultural and spiritual sanctions against experiencing significant psychological distress, may mean that spirit possession becomes an explanation for an individual's suffering that is accepted and supported by the local community.

Physical distress was generally considered a 'medical' matter and treated as such with no stigma attached to this form of suffering or to receiving mainstream medical treatment. In some cases it seemed that psychological distress was manifesting as physical illness and being treated as such. Forms of psychological suffering were acknowledged to exist by some participants but were often considered a consequence of lack or loss of faith in Allah. Family separation was described as a significant stressor by many participants, and one which was also thought to lead to

intense psychological distress. This form of distress was considered distinct from jinn possession and did not seem to have the same level of stigma attached as ‘worry’ (about other stressors) and ‘depression’ did to participants.

Traditional treatment involving Koran readings and social support were a common form of intervention mentioned for all aspects of suffering. The therapeutic power of such interventions cannot be underestimated. Given the significant change in life roles of Somali women in New Zealand, and the reported increase in social isolation, these traditional interventions act to acknowledge, validate and increase support networks for the sufferer. The current findings also suggest that there may be a role for mainstream mental health services, although it is possible that the present service model is not adequate to meet the needs of diverse groups such as Somali.

The results of the current study suggested that spirit possession is a common explanation for suffering but identified very limited information about other Somali-specific forms of distress. Additionally, based on the findings of this study it was not possible to ascertain whether spirit possession could be disentangled from other forms of distress, particularly walli (“craziness”). Therefore the second study of this thesis explored in more depth Somali-specific idioms of distress and attempted to more clearly disentangle jinn from walli. This study is presented in the following chapter.

CHAPTER 7

Study 2:

A Focus Group Approach to Exploring Somali Women's Conceptions of Psychological Distress and Approaches to Treatment

Overview

Given Jacobsen and Landau's (2001) concern that the applicability of refugee research is frequently compromised by very small sample sizes and that such research is often then used to make policy and far reaching decisions for a considerably larger and diverse group of refugees, the intention of Study 2 was to explore, in more depth with more participants, the specific Somali idioms of distress as well as possible antecedents and maintaining factors contributing to psychological distress and jinn possession in Somali women. In particular, Study 1 did not clearly disentangle *jinn* from other states of distress so the current study aimed to identify if and how jinn was unique from other psychological states, especially the state of *walli* ("craziness"). Additionally, since there is evidence that the Somali communities residing in various cities in New Zealand are at various stages of acculturation and cultural adaptation (P. Guerin, personal communication, December 2005), the objective of Study 2 was to ascertain how valid the results from Study 1 were considered to be by women from other Somali communities around New Zealand. These communities were based in

Auckland and Wellington. In addition a new sample of Hamilton-based Somali women were also interviewed in Study 2.

Focus group interviews were used to gather data for both Studies 2 and 3. The focus group approach is an efficient qualitative data collection technique as the amount and range of data is increased by interviewing several people simultaneously. This interview style also allows participants to respond to thoughts and comments of other group members about issues that are of primary interest yet nonetheless may not have been spontaneously mentioned in a one-to-one interview. Hence it was hoped this approach may lead to a greater depth of interview data being collected than is possible with one-to-one interviews.

Method

Recruitment

Even though reasonable efforts were made in Study 1 to recruit a wide and heterogenous sample of Somali participants (i.e., by attempting to recruit through the Refugee and Migrant Service, Adult Mental Health Services and local general practitioners surgeries), all of the participants in that study were recruited via the Somali co-researcher. Given that some recruitment methods did not yield any participants, it was therefore decided that the Somali co-researcher would be responsible for recruiting participants for Study 2. The Somali co-researcher initially approached potential Hamilton-based participants and explained the current research to them, outlining the ethical considerations and what would be involved in taking part. She also provided potential participants with an information sheet about the study (see Appendix E). The co-researcher informed those who indicated interest in

participating that the interview would be conducted in a group format and negotiated a date and time with them for the interview to be carried out.

With respect to participants recruited from Auckland and Wellington, the Somali co-researcher made contact with one Somali colleague in each of these cities, provided them with information about the study and ascertained their willingness to recruit women for the current study. Both of these women also took part in the focus groups.

Participants

Participants were required to be at least 18 years old. No other exclusion criteria (with the exception of gender) were applied in the current study. Participants were not required to speak English. The Somali co-researcher was present at all focus group interviews and translated interview questions for those participants who were not fluent in English. A total of 27 Somali women participated in the current study. Six focus groups were conducted. The number of participants in each group ranged from two to ten.

Due to the acculturation process (and hence younger women's likely greater exposure to Western education systems and culture), it was hypothesised that younger and older female participants may have somewhat different opinions on some of the issues raised in this research. Additionally, given the expectation that younger women respect and defer to the wishes and opinions of older Somali women, the initial intention of the research was for the focus groups to be divided into 'younger' (between 18 and 29 years) and 'older' (30 years and above) Somali women. Such an

approach was hoped to enhance the likelihood that younger women would provide an honest account of their opinions if these did differ from those of older women.

In Auckland, however, only one group could be organised, which comprised women who ranged in age from 20 to 53 years. Additionally one of the groups run in Wellington also comprised women ranging in age from approximately 18 years to 55 years. Ages were sometimes given as estimates (or as age ranges) by participants as birthdates are apparently not typically remembered or celebrated in traditional Somali communities (Elmi, 2006). Furthermore, birth certificates are often not issued in Somalia so there was often no formal means the participants could employ to accurately state their age. The Somali co-researcher informed me that it was difficult for her Somali colleagues in Auckland and Wellington to recruit participants for two separate focus groups based on age characteristics and hence the reason provided for the mixed age groups in these cities. The Somali co-researcher was however able to recruit participants for two separate groups based on age in Hamilton.

Hamilton participants

Ten Hamilton-based Somali women participated in Study 2. Three focus groups were conducted in Hamilton. One focus group comprising five participants was conducted with 'older' Somali women. Two of the younger participants could not make it to the initial 'younger' focus group and an alternative interview time was arranged to meet with these two participants. Consequently the Hamilton-based younger participants were interviewed in two groups – one group comprised three participants and the other two participants.

'Older' participants

Of those participants aged 30 years or older, one had a tertiary level qualification, one had completed secondary school, one had completed primary school and two reported no formal education. The age range of these participants was approximately 30 to 65 years. Average length of time spent in New Zealand was 6.6 years with a range between 5 and 8 years. One participant was engaged in paid employment. Two reported being students at the English Language Institute. One participant described herself as a volunteer Koran teacher and another as a homemaker. Average number of children each participant had was 6.8 with a range from 0 to 11 children. Three of the participants were married while two were widowed. All five 'older' participants reported spending time prior to arriving in New Zealand in refugee camps. Time spent in camps ranged from three to five years. Two of the women in this focus group arrived one hour late and therefore were only able to take part in the second half of the interview.

'Younger' participants

Of the five younger participants, one had a tertiary level qualification, one had completed secondary school, two had completed primary school and one reported no formal education. The age range of these participants was approximately 22 to 25 years. Average length of time spent in New Zealand was nine years with a range between 8 and 12 years. One participant was engaged in paid employment, one reported being an English language student, two described themselves as homemakers and one as a seasonal fruit picker. Average number of children each participant had was 2.6 with a range from 0 to 7 children. Two of the participants

were married, two were separated, and one was single. All of these participants reported spending time prior to arriving in New Zealand in refugee camps. Time spent in camps ranged from one to three years.

Auckland participants

Seven participants took part in the Auckland focus group. Five of these participants were 30 years or over and two were under 30 years. Given that only two participants in the younger age group were recruited from Auckland, only one focus group was run in Auckland which comprised all seven participants. Practical and financial considerations meant that the researchers were not able to return to Auckland on a later occasion to interview the younger participants separately.

Two of the Auckland participants had tertiary level qualifications while another two women were currently enrolled in tertiary level studies. Two participants had completed secondary school while one reported no formal education. The age range of these women was approximately 20 and 53 years. Average length of time spent in New Zealand was 5 years with a range between 2 and 10 years. Two participants were engaged in paid employment, one participant was engaged in full time tertiary studies, two described themselves as house wives while two reported being unemployed. Average number of children each participant had was 5.1 with a range between 0 and 13 children. Five of the participants were married. Only two participants reported spending time in refugee camps prior to arriving in New Zealand. One of these participants lived in a camp for five years while the other was in a camp for six months. One of the participants arrived an hour late for the focus group and therefore could only take part in the second half of the interview.

Additionally, another participant only remained in the interview for approximately half an hour. This was apparently due to her feeling “bored” by the nature of the discussion. The participant that left was the youngest interviewee in this group.

Wellington participants

Mixed group ('younger' and 'older' participants)

Of the eight participants in the mixed Wellington focus group, one had a tertiary level qualification, three had completed secondary school, two had completed primary school and two reported no formal education. The age range of these participants was approximately 18 and 55 years. Average length of time spent in New Zealand was 6.1 years with a range between 2 and 11 years. None of the participants reported being engaged in paid employment, one reported being retired, four described themselves as students, and three as homemakers. Average number of children each participant had was 1.8 with a range between 0 and 6 children. The fact that five of the participants in this group were under 25 years of age may help explain why the average number of children per participant seems considerably lower in this focus group compared to the other focus groups. Only one of the participants under 25 years had any children. Four participants were married, and four were single. Six participants reported spending time in refugee camps prior to arriving in New Zealand. The average length of time these 6 participants spent in camps was 3.8 years. Time spent in camps ranged from zero to six years.

'Younger' participants

The two younger participants were studying toward tertiary level qualifications. They were 18 and 19 years old respectively. Both had spent three years in New

Zealand and both had spent ten years in refugee camps. Neither of these participants was married nor had children.

The Interview Schedule

The interview questions were developed to provide a more in-depth understanding of some of the key psychological and spiritual states of distress identified in Study 1. In particular, questions focused on gaining a greater comprehension of the aetiology, symptoms, and intervention approaches related to these states of distress. All questions were designed to be asked in an open-ended and non-leading manner. The thesis supervisors and the Somali co-researcher reviewed the original questions. Items were revised based on feedback from these sources.

The interview schedule was divided into three sections (see Appendix G). The first section included questions designed to explore participants' beliefs about Somali-specific idioms of distress identified both in the literature (Carroll, 2004; Guerin et al., 2004b; Rousseau et al., 1998a; Tiilikainen, 1998; Zarowsky, 2004) and from the results of Study 1. Jinn, *qalbijab/niyadjab*, *murug* and *welwel ama walaac* were the spiritual and psychological states focused on in the first section of the interview schedule. Questions focused on the aetiology, symptoms, and treatment approaches employed to treat or manage these states. Questions in this section were also developed to try to gain a greater understanding of how Somali women differentiate between these states, in particular how they differentiate between jinn possession and other forms of distress, particularly walli. Finally, section 1 focused on obtaining an understanding of participants' attitudes toward mainstream mental

health services, under what circumstances Somali would engage with such services, as well as why they may choose not to use such services. The specific questions asked in this section of the interview schedule are outlined below.

1. What are your thoughts about jinn possession?
2. What do you consider key signs of jinn possession?
3. What are the consequences of jinn possession
 - for the person with the jinn?
 - for their family?
4. What helps get rid of jinn?
5. Why do you think jinn possess some people?
6. What other forms of distress do Somali women experience?
 - Qalbijab or niyadjab
 - Murug
 - Welwel ama walaac
 - walli
 - Antecedents, consequences, symptoms and treatment approaches to be explored for each state as relevant
7. How do you know the difference between jinn possession and other forms of distress?
 - Ask this question in relation to walli if it is not mentioned
8. What other sorts of assistance (both traditional and Western) would Somali woman suffering from distress access?
9. What do Somali generally think about other Somali who get these sorts of assistance?
10. What do you think about Western mental health services?
11. What do you think of Somali using these services?
12. What would be reasons Somali would use these services?
13. What would be reasons Somali would not use these services?

Section 2 of the interview schedule was developed to seek feedback from participants about three Vignettes (see Appendix F). The reason that Vignettes were included in this study was so that all participants would have the opportunity of being presented with same material for feedback. That is, using Vignettes allowed for direct comparison of findings across all focus groups with respect to one aspect of the interview schedule. In particular, the primary researcher was interested in exploring how participants interpreted the behaviour and symptoms of the women in each Vignette and how consistently this was done between groups. These Vignettes outlined examples of psychological and spiritual distress described by participants in Study 1. Transcript data from Study 1 were modified in the Vignettes to ensure the anonymity of those whose spiritual and/or psychological distress was described to the researchers. Questions in this section were designed to explore participants' beliefs about the aetiology, antecedents and intervention approaches they considered relevant to each of the three Vignettes. Questions also asked about participants' attitudes to Western services potentially becoming involved in the type of difficulties outlined in each Vignette. Additionally this section asked participants what they thought clinicians based in Western services would and/or could do to treat the state of distress described in the Vignettes. Participants in Study 2 were not told what the participants in Study 1 (who provided the data the Vignettes were based on), considered the aetiology and antecedents of the states described in each Vignette. Additionally participants in Study 2 were not told what type of intervention (if any) was employed to treat each of the states outlined in the Vignettes. This information

was omitted to reduce the likelihood of biasing participants' responses. The three Vignettes as well as the questions asked about these Vignettes are outlined below.

Vignette 1

“There is a Somali woman who can be working or doing something for 24 hours without getting tired. Sometimes she walks all day and all night and she is not even going anywhere. She also talks to someone other people can't see, she will talk, and laugh and she doesn't care about showering or cleaning herself. Sometimes she gets really violent. There was this time when this older Somali lady was standing in her way and she pushed her to the ground. Sometimes when the voices go away and she is not being violent and starts looking after herself again she says that she can't remember doing any of these things once she stopped”.

Vignette 2

“Another Somali woman has frequent nightmares about her family who she left behind in a refugee camp. At times she says that she will be sleeping on her bed and she will start seeing the people who died in front of her or the pile of bodies, some of which were familiar, that she helped bury or move from the roads. This woman said that these experiences will never be erased from her memory even though she tries to forget them by occupying herself with other things. She also said that she drops to the ground if she hears a siren as that reminds her of the war back home too”.

Vignette 3

“Another Somali woman has started staying in bed a lot and has stopped looking after her house. She only leaves her house to drop her children at school and pick them up. Some of this woman's friends say that they have seen her crying. Often when you talk directly to her she doesn't even seem to notice. Her husband is concerned that she has become very forgetful and might leave something on the stovetop and burn their house down. This Somali woman said that when she was asleep she would experience dreaming and think that someone called her name but there is no one there”.

Following each Vignette being read, participants were asked the following questions.

1. What do you think is going on for this person?
2. Why do you think the person is acting this way?
3. What causes this sort of behaviour?
4. What sort of help would this person receive from the Somali community?
5. If this person was to go to a Western mental health service, what sorts of things do you think would be done to try to help them there?
6. What do you think about Western treatment approaches being used with this person?

Section 3 of the interview was designed to seek further understanding about the impact on Somali women of family separation and war experiences. Family separation was focused on due to evidence from Study 1 as well as previous studies (e.g., Carroll, 2004; Guerin et al., 2004b, Zarowsky, 2004) that this is a major psychosocial stressor and cause of psychological distress according to Somali women. War experiences were explored due to the substantial body of Western research which suggests that war trauma is a major cause of psychological distress for refugees (e.g., Geltman, Augustyn, Barnett, Klass, & McAlister-Groves, 2000; Hodes, 2002; Kinzie, Boehnlein, Leung, Moore, Riely, & Smith, 1990; Kinzie & Jaranson, 2001; Paunovic & Öst, 2001; Riding-Malon, 2004; Weine, Kuc, Dzudza, Razzano, & Pavkovic, 2001). Questions focused on how a woman who had experienced these stressors was likely to feel and behave as well the potential consequences of these stressors for herself and her family. Additional questions in

this section explored how Somali women might manage the distress associated with these stressors and what (if any) traditional or Western intervention approaches would be employed.

Section 3 was also designed to explore the concept of walli in greater depth. Questions focused on symptoms of walli, particularly behaviours and emotional indicators as well as the impact of walli on the individual and their family. Additionally, questions were included about the aetiology of walli as well as participants' beliefs about the effectiveness of various treatment approaches (both traditional and Western).

The sections were prioritised, with sections 1 and 2 being considered high priority areas to explore in every focus group. Questions in section 3 were also considered of importance; however, it was hypothesised that these three areas would be spontaneously raised by participants in earlier parts of the interview. This assumption was based on the results from Study 1 in which these themes were threaded throughout the interview data and typically spontaneously raised by participants without prompting from the interviewers. Hence, these areas were only explored in focus groups in which the issues of family separation, war experiences and walli were not spontaneously mentioned by participants, and if time permitted.

As with Study 1, the interviews were carried out using a conversational approach, which meant that the questions were not necessarily asked in exactly the same manner in each interview (see the rationale for this approach in the Method section of Chapter 6).

Procedure

Ethical approval for the current study was obtained from the University of Waikato's Psychology Departments Ethics Committee. All participants were given a \$10 supermarket voucher at the end of each focus group. The voucher was not contingent on participants' responses.

Focus groups

Focus group interviews were employed in Study 2 rather than individual interviews. The focus group technique involved a discussion on a specific topic in a group setting. This approach allowed researchers to access participants' accounts in a way that was flexible enough to explore various points of view (Kamberelis & Dimitriadis, 2005; Krueger & Casey, 2000). The rationale for employing a focus group approach largely relates to the assumption that group interview formats tend to stimulate thoughts and comments of others in the group (Robson, 2002). As such, participants in a group format may have the opportunity to respond to important opinions or issues that may not be spontaneously thought of by these participants in one-to-one interviews. Furthermore, each of the focus groups was relatively homogenous in nature (i.e., each group comprised Somali women living in the same geographical location), which may also act to facilitate communication, promote exchange of ideas and give a greater sense of safety in expressing conflicts or concerns about the questions posed and issues explored (Robson, 2002). That is, it was thought that some Somali women may be more inclined to spontaneously relay their perspectives on the issues under discussion if in a situation with other familiar or known Somali women compared to discussing issues of a potentially stigmatizing

nature with a relatively unknown interviewer (in a face to face format) from a different cultural background.

Although it could have been considered preferably to run focus groups that specifically targeted Somali women who had had experienced significant psychological distress (rather than inviting any Somali women in the relevant geographical areas to participate), there were a number of reasons why this approach was not undertaken. First, the Hamilton-based women known by the co-researchers to have experienced significant psychological distress had either i) already participated in Study 1, ii) already participated in the study conducted by Yates (2003), or iii) declined to participate in one or both of the aforementioned studies. Hence, in the Hamilton region it was considered unlikely that Somali women with a history of significant psychological distress who had not already been recruited or contacted about the current or Yates previous research could be easily identified for this study. Second, it seemed unlikely given the stigma reportedly associated with having experienced significant psychological distress or being engaged with mainstream mental health services (as identified in Study 1 as well as in the previous research reviewed in Chapter 5) that women would volunteer for a study that wanted to discuss these experiences – particularly in a group situation involving other women from their community. Finally, the primary researcher was interested in Somali women's ideas about Somali forms of psychological distress generally. Discussing these issues with lay informants was still considered a relevant and fruitful endeavor particularly as there were no identified Somali female experts to recruit and explore these matters with.

The research project tried to recruit five to ten participants for each of the group discussions (Krueger & Casey, 2000; Morgan 1997). Based on feedback from the Somali co-researcher, the Hamilton-based focus groups were held at the primary researcher's place of work (The Psychology Centre). This decision was made as it was a quiet and spacious location, free from the distraction of domestic responsibilities that may have made carrying out the interviews in one of the woman's homes more difficult. The Somali co-researcher checked with each participant that they were comfortable coming to this location. The Auckland focus group was carried out in the home of the woman who had recruited on our behalf. Given the practical difficulties organising a location to meet in Auckland, this was considered an adequate venue. Additionally there was a large and private room that we were able to use in this woman's home for the purpose of the interview. The Wellington focus group was carried out at a Somali drop-in centre situated in the suburb of Wellington in which the participants lived. A large room was available to meet in the drop-in centre.

At the outset of the focus groups participants were again informed of the rationale behind the research and the types of issues which would be explored. It was explicitly stated that the purpose of the research was to obtain participants perspectives and understandings of Somali idioms of distress in general terms and that we would not be asking about nor exploring participants personal experiences of distress. It was considered particularly important to make this point given the apparent stigma associated with psychological distress identified in Study 1. Additionally, the primary researcher provided participants with some information

about her background (e.g., profession, previous contact with Somali both personally and professionally) and how she became involved in this area of research. Basic ground-rules were then outlined which were designed to allow the conversation to run smoothly (see Appendix F).

In some instances participants spontaneously relayed information about their own personal experiences of psychological distress and/or contact with Western mental health services. Again, due to the potentially sensitive nature of these communications, and the possibility that the information disclosed may not remain confidential (i.e., there was no way of the researcher knowing which other group members were aware of this information and whether they may discuss the information outside of the focus group), this data was not explicitly followed up by the primary researcher. Although no specific processes were put in place to debrief women who became distressed following disclosure of their experiences of significant psychological difficulties, only two participants in this study made such disclosures. Additionally, these participants did not demonstrate any overt signs of distress indicating the need for further follow-up or support following the group interviews.

Including participants with and without a history of significant psychological distress within the same focus group may have led to a degree of self-censorship. That is, women with a history of psychological difficulties could have been less likely to disclose such personal information due to the sensitive and potentially stigmatising nature of the focus group topics. Hence richer data on the experiences of individual group members may not have been obtained for fear of this information being

ridiculed or disseminated outside of the group. Irrespective of this, as the interest was in Somali women's ideas generally, it was hoped that the data obtained from focus group discussions (irrespective of women possibly opting not to disclose their personal experiences) would be even richer than that obtained from individual interviews.

In all of the focus groups there were participants who had only a limited understanding of English. Given this, the interview questions were initially asked by the primary researcher in English and then translated into Somali by the co-researcher. Those who were fluent in English tended to provide responses in both English and Somali. For those who provided responses in Somali, the co-researcher would then translate information spoken in Somali back into English so the primary researcher could ask follow-up questions. In all focus groups with the exception of the 'younger' participants from Hamilton, the majority of the interview content was spoken in Somali. Four of the 'younger' Hamilton participants primarily spoke in English. For those who responded to questions in English, further follow-up questions were often asked directly to these participants in English.

Only one of the groups gave consent for the interview to be audiotaped. In the interviews in which participants were not willing to be audiotaped, the primary researcher took detailed notes. In the case of interview material presented in the Somali language, the Somali co-researcher interpreted this data into English during the interview so that the primary researcher could write down as much as possible of the conversation being interpreted. All notes were typed up as soon as possible after each interview. The Somali co-researcher was provided with a copy of these notes.

She added any further information not already contained but mentioned within the focus groups and also checked and gave feedback on how accurately she considered the written documentation to reflect the content of the interviews.

Coding and Analysis

The audiotaped focus group interview was transcribed. The transcript data were then checked for accuracy. Both the audiotaped and non-audiotaped data were initially analysed by the primary researcher and two of the supervisors (Bernard Guerin and Pauline Guerin) independently reviewing the data and identifying key themes. During the initial analysis the primary researcher and supervisors discussed the themes they had identified from the data. Once consensus had been reached about the key themes a coding framework was created. For a comprehensive description of the analytical approach taken please see the 'Coding and Analysis' Method section of Chapter 6.

With respect to the current study, from a theoretical perspective, the objective was not to make between-group comparisons, but rather to extract themes which were common across groups. These themes are presented in the following Results section.

Results

The following chapter outlines the findings of the data analysis conducted in Study 2. The data for this study were drawn from the transcript and field notes of the focus group discussions. A total of six focus groups were run. One group was run in Auckland, three in Hamilton ('older', larger 'younger' and smaller 'younger' groups) and two in Wellington (a 'mixed' and a 'younger' group).

The focus group facilitators did not directly ask about participants' contact with mainstream mental health services and other formal interventions that participants may have engaged in to treat psychological distress. This was considered too sensitive an issue to explore with focus group participants in the group context, given the apparent stigma associated with attending mental health services. Although some participants did disclose contact with mental health services and others reported experiencing jinn possession, it was not possible to ascertain what proportion of participants had such experiences. It is also important to mention that the women recruited for the focus groups in the various locations typically knew each other and often either attended Koran groups together and/or were related. Hence, this was a highly selective sample. This is an important issue to remember, so that it is not assumed that the views expressed by these participants are representative of other Somali women living in these three centres.

Not all focus group interviews covered the same issues or questions. This was largely related to time constraints as it was not always possible to run the focus groups for the two hours originally anticipated. The primary reason participants stated that they could not meet for this long was family commitments, in particular they were anxious to return home to young children.

The themes/sub themes that were independently identified (by the primary researcher, BG and PG) were compared and agreement about these themes/sub themes was achieved. As with Study 1, the Somali co-researcher reviewed an earlier draft of the current results section and was asked to provide feedback on how accurately she considered the findings reflected the perspectives of the women

interviewed. This feedback related to editorial issues rather than amendments to the findings proper. With respect to other means of cross-validating the current findings, some support for various components of the taxonomy relevant to Somali conceptions and explanations of distress can be found from other sources (e.g., Carroll, 2004; Guerin et al., 2004b; Rousseau et al., 1998a; Tiilikainen, 1998; 2003; Zarowsky, 2004).

The data from the three different locations were initially analysed separately. This was done to ascertain whether participants in the three cities held differing perspectives on psychological distress. Although focus groups were conducted in Auckland and Wellington, Hamilton was the only location in which it was possible to divide participants into focus groups consisting of ‘older’ and ‘younger’ interviewees. The Auckland focus group primarily consisted of ‘older’ participants, the Wellington focus groups both mainly consisted of ‘younger’ participants. However, given that the larger Wellington and Auckland groups had a mixture of older and younger participants, analysing the data based on aged groups was considered inappropriate. The initial data analysis based on geographical location found the data from all focus groups to be moderately consistent. As such, in some of the following sections the results are reported as general themes identified across all groups. Where there was discrepancy in the responses of participants based on geographical location or group type, these are reported separately. Again, it must be remembered that reporting a general theme across all groups does not mean that every individual subscribed to those views.

It is important to mention that as only one group interview was audiotaped, it was difficult to monitor and record individual group participants' responses to specific issues or questions. Consequently, even though a particular group member may have voiced an opinion or perspective, it was not always possible to collate how many other group members shared or agreed with this perspective. Furthermore, given that often participants spoke in Somali rather than English, there was no way of the primary researcher knowing the precise nature of discussions taking place. The primary researcher typically relied on the Somali co-researcher to interpret these data. This is an inherent limitation of the focus group approach taken in this study. Hence the findings represent comments that emerged from the group discussions and are not necessarily representative of the opinions of the entire group.

The results are presented in terms of the key themes identified from the interviews. The analysis identified a number of Somali-specific idioms of distress and these idioms fell into the following categories; (i) *jinn* possession, (ii) *jinn* versus psychosis, (iii) *jinn* versus *walli*, and (iv) other Somali idioms of distress (*qalbijab*, *boofis*, *murug*, *welwel*). The analysis also identified themes relating to Somali women's opinions and perspectives about (v) the psychological impact of war and having family in Africa, (vi) mainstream mental health services, (vii) GPs responses to Somali women's distress and, (viii) the protective role of faith. The final section of the current chapter provides participants' responses to the three Vignettes.

The quotations used to support some of the thematic findings are all from the interview transcript of the younger Hamilton focus group as this was the only focus group which was audiotaped.

Jinn Possession

All focus groups were asked about jinn (as stated in Chapter 3, 'jinn' is plural, and 'jinni' is singular) and no participant in any of the groups questioned the validity of jinn as a state of possession. Although it was not always clear from participants what the symptoms of jinn possession were, two different types of possession tended to be conveyed by interviewees.

The first of these experienced states was described as primarily somatic in nature and was considered a less severe form of jinn possession. In particular, headaches, vomiting, fever, lethargy/fatigue, and back and stomach aches for which no physical aetiology can be identified, were provided as examples of this form of jinn. Participants said that the sufferer of this form of jinn is not aware that spirit possession is causing their physical distress until Koran recitations are initiated. The following extract from a younger Hamilton participant provides an example of this form of possession.

Participant: I was sick and had pain here [points to stomach], then I vomit a lot, then I feel sick, I can't move. I went several times to the doctor, he told me maybe I don't know what's going on with you but I am going to send you to Hospital...then I went to Dr. [name omitted] and he put me on [medication] and then I went to CT scan and a lot of blood tests and X rays and every month I used to see him once, I...and then I went to Koran reading then I went to Koran, Koran Koran ...

Researcher: Then it came right?

Participant: [Nods]

This participant said she believed the Koran readings had directly led to her physical symptoms (and hence the jinni) dissipating.

The second form of jinn possession was considered more serious. Symptoms such as "voices in your head", inability to control behaviour, amnesia for the period

of possession (once the jinni had been extricated), tearfulness, social withdrawal, physical aggression (e.g., strangling children), increased physical strength, “screaming and yelling”, labile mood, incomprehensible talk (according to some participants talking in a language unknown to the sufferer or their family), excessive talk, talking to oneself, remaining in bed, weight loss, removing clothes in public, insomnia, constant pacing/walking, swearing, singing (at times considered inappropriate), “running away” from family, and decreased activity, were provided as examples of this form of possession. Crying was also considered a sign of jinn, as tearfulness was stated to be very unusual within Somali culture. These symptoms would not necessarily be experienced by each individual possessed by a jinni and participants said that the symptom profile and severity would vary from person to person.

Participants said those who tend to suffer the most are the family members of the person who is possessed by this more serious form of jinni. They stated this is because it is the family who has to constantly monitor the safety of the possessed individual, which often includes remaining awake throughout the night to ensure they do not harm themselves or others.

Somatic symptoms were also reported as indicators of more severe jinn possession. The important difference between the more and less severe forms of possession according to participants is that those with primarily somatic/physical symptoms are still able to generally manage day-to-day responsibilities (such as childcare, domestic duties and paid employment), whereas those with the more severe form of possession are not considered capable of maintaining such responsibilities.

From participants' accounts, jinn often have a relapsing and remitting cycle. When free of jinni, interviewees said that an individual would be able to resume their everyday roles and responsibilities (if these roles had been interrupted). One of the younger Hamilton participants commented, however, that the unpredictability of the possession often meant that family would still often remain constantly vigilant of the sufferer's behaviour for fear that the jinn was "tricking them" into believing it was extricated when in fact it was still controlling the individual's behaviour.

When asked how a Western health professional could ascertain that a Somali was experiencing jinn, the participants in the younger Hamilton focus group stated that they may not be able to. These women stated that the sufferer is not aware they are possessed by jinni and therefore cannot communicate this directly to health professionals. These interviewees suggested that friends and family would most likely be aware that jinni was the aetiology of the sufferer's difficulties and that involving friends and family in GP consultations may be helpful for this purpose.

Aetiology of jinn possession

Numerous aetiologies for jinn possession were proposed by participants. The following explanations were not universally reported and there was variation across the focus groups with respect to aetiological explanations provided. There were no aetiologies that were consistent across all or even most of the focus groups.

Participants in the older Hamilton group said that jinn may be inherited. Interviewees in the younger Hamilton focus group asserted that if God had predestined an individual to suffer from a jinni then there was nothing they could do to prevent this from occurring.

Because we believe that whatever happens to a person it's like from the time you are born to the time you are dead, everything has already been written down for you so it [jinni] affects some person and not another person so it's just how it's been written down, so it's not like all of us have to get it [jinni], it's just what is written for you and if you are going to get it [jinni], you are going to get it.

Participants in the younger Hamilton and the larger Wellington focus groups said that a jinni may possess someone if they reject a potential or actual romantic partner. Additional factors that may increase vulnerability to jinn identified by the younger Hamilton participants included, being outside at sunset, walking under trees at sunset (as jinn are believed to live in trees), watching too much television, and “partying”. What is more, praying during menstruation is discouraged according to some of the younger Hamilton participants as this is a time of higher vulnerability to jinn possession. Interviewees in the Auckland focus group said that jinn could be caused by a ‘witch’ or by a curse. They stated however, that they had never heard of these factors causing jinn possession in New Zealand. They said they were unsure why this was.

Participants in the larger Wellington group said that not having a strong faith would increase vulnerability to jinn possession. On the other hand, according to the participants in the larger Wellington, Auckland, and younger Hamilton focus groups, having a strong faith and following the lore of Islam acts as a protective factor against jinn. Interviewees in the smaller Wellington focus group said that going to rubbish dumps and wearing strong smelling perfumes were additional factors which may increase vulnerability to jinn.

Treatment of jinn possession

The efficacy of Koran recitations as the primary means of extricating jinn was unanimously voiced in all focus groups. The causes and treatment for jinn were considered interlinked – that is according to participants the former leads logically to the latter. The older Hamilton focus group participants stated that Koran readings were the only effective means of extricating jinn. However, interviewees in each focus group stated that an individual possessed would have an adverse reaction to the Koran reading which could include shaking and acting afraid of the Imam/elder conducting the reading. Additionally, participants said the sufferer may attempt to refuse to listen to the readings and may need to be physically restrained by family members. Interviewees stated such adverse reactions to Koran readings was very unusual as typically Somali considered these recitations healing and beneficial to their wellbeing rather than threatening. As such, this adverse reaction was reported as evidence of jinn. Hence, the Koran readings themselves were described as a means of identifying possession in ambiguous cases.

Another frequently reported phenomenon during Koran recitation given as affirmative evidence of jinn possession was the observation of the jinni identifying itself during the readings. According to participants the jinni may identify itself as human or as a spirit. Often interviewees said the jinni would speak in a different voice to that of the person possessed.

The length of time Koran recitations would last for was not held constant according to participants and varied considerably depending on both the individual conducting the recitation and the nature of the jinn. Some participants described

cases of jinn possession in which the sufferer had been taken to Australia or Africa to have Koran readings conducted by an Imam/reader who has a reputation as an effective jinn extractor. Interviewees said that it was often unclear which Imams/reader would effectively rid the sufferer of their jinni, so multiple different Imams/readers may be involved over a period of time in attempting to extricate the spirit. From participants' accounts there was no specific time line with respect to the course of jinn possession or how quickly jinn could be removed by Koran recitations. The period of possession reportedly varies from person to person. One participant said it could take three weeks for Koran recitations to effectively rid someone of a jinni, while another participant said it could take three to four months. Yet another interviewee said that it may take one to two years to cure the sufferer of jinn.

Less frequently, participants in some focus groups described other means that were used to extricate jinn usually in conjunction with Koran readings. For example, one participant in the younger Hamilton focus group said that she was aware of instances in which canes are employed (although infrequently in New Zealand) to hit the individual suffering from jinni.

Sometimes they will recite Koran and use canes, even though it is not very common here [in New Zealand] but it was very common in Somalia, they will use sticks to hit the individual in the sense of chasing the jinn away,.....

Another strategy to extricate jinn, reported by some of the participants in the younger Hamilton and the Auckland focus groups, was animal sacrifices. Some jinn are apparently believed to request such sacrifices be made before they will leave the sufferer alone. Interviewees stated however, that they had never heard of this strategy

being used in New Zealand. Additionally, participants said they considered this approach anti-Islamic.

I don't know how religion wise or Islamic way, [animal sacrifice is] not accepted, it doesn't have a place, because it is more blasphemy...

Social and in particular family support during the time of the possession was considered important to monitor the safety of the sufferer (in the more severe forms of possession). However, family and social support were not considered a cure for jinn.

Participants did not think GPs or mental health practitioners would have any knowledge of jinn and hence stated that misdiagnosis would be common for jinn sufferers presenting to mainstream services. A number of respondents said that jinn may be misinterpreted as “craziness” by mental health professionals and GPs. None of the interviewees considered psychiatric medication effective in the management of jinn, although they anticipated that this would be the treatment of choice by GPs and mental health services. It is important to note, however, that participants in all but one focus group said they had never heard of Somali attending mental health services for assistance with jinn possession.

One participant did report admissions to inpatient psychiatric wards and follow up by mental health services due to suffering from what she reported was severe jinn possession. This woman described a recent admission during which time she started to listen to audiotapes of Koran recitations increasingly more frequently over the course of the admission. This woman also said that typically when not possessed by jinn she dresses in a very conservative Muslim manner, wearing both a *hijāb* (a

Muslim woman's traditional head, hair, and body covering) and *niqāb* (a veil which covers the face leaving only the eyes showing) when in public. At times when she is possessed, however, she said she frequently fails to cover her head at all. She said that during her most recent inpatient admission she did not have her hijāb or niqāb with her in hospital and so, as the state of possession began to lift, she used a hospital sheet to cover her hair and face. This participant and the other women in the focus group agreed that her aforementioned behaviour was an indication she was overcoming the jinn possession (i.e., by being able to tolerate Koran recitations and dressing in her more traditional conservative Islamic manner). In contrast, however, this participant (and other participants who knew her) said that mental health clinicians considered her behaviour as evidence she was becoming increasingly psychotic.

Jinn versus Psychosis

A participant in the younger Hamilton focus group was the only interviewee to spontaneously mention the word 'psychosis'. Participants in this group differentiated jinn from psychosis, not by symptom profile (which they reported to be similar), but by aetiology and treatment approaches. Some of these respondents suggested that recreational drug and alcohol use commonly causes auditory hallucinations and suicidal and homicidal ideation in Westerners. In contrast, the younger Hamilton participants said that Somali do not typically use recreational drugs and hence the same symptoms experienced by a Somali are unlikely to be due to drug use. Consequently, they believed that jinn were the most plausible explanation for symptoms akin to psychosis experienced by Somali. These participants said that

Somali who do present to mainstream mental health services and are diagnosed with psychosis are in most cases being misdiagnosed (with the most likely explanation in these cases being jinn). They said the fact that these Somali do not respond to Western psychiatric medication is typically the strongest evidence of this misdiagnosis.

Jinn versus Walli

Participants in all focus groups stated that walli and jinn presented in a very similar fashion. In fact, all of the symptoms of jinn described above were reported to also be symptoms of walli (as with jinn not all symptoms listed would be evident in an individual with walli and participants stated it was often very difficult to differentiate between the two states. The only symptom of jinn not also associated with walli was amnesia. Additionally walli was considered a state of “craziness”, whereas jinn possession was not. Interviewees in the younger Hamilton focus group stated that if an individual was suffering from walli there was no hope that they would recover unless it was Allah’s Will. Additionally, these participants said that walli is a chronic and unremitting state, whereas jinn is not. That is, although a jinni may return to possess an individual following expulsion, while free of the jinni the individual is able to function adequately in all their day-to-day responsibilities. According to participants, this is not the case for those with walli, who would reportedly not be able to fulfil any major adult expectations.

Participants in the younger Hamilton group said that jinn possession can lead to walli. These women also said that jinn possession is a more accepted state within Somali culture – a state that God has brought on and that can be treated. Interviewees

in the younger Hamilton and both of the Wellington focus groups said individuals who suffer from walli, however, are feared by the community and participants said this fear was due to concern that the sufferer may seriously harm someone else due to their inability to control their behaviour. The women in these three focus groups also stated that walli would affect your ability to find a marriage partner. With jinn, however, participants said you would be able to find a marriage partner.

Interviewees in the younger Hamilton, larger Wellington and Auckland focus groups said the only reliable means of identifying both jinn and walli was during Koran readings. As indicated above, individuals suffering from jinn will often respond with an adverse reaction and the jinn may identify itself during the recitations. According to participants, this would not occur if an individual was suffering from walli. What is more, participants in the Auckland focus group said that those with jinn would experience an immediate (although sometimes short lived) improvement in symptoms following Koran recitations. This also would reportedly not occur if an individual was suffering from walli. Additionally, if after a period of about one year of frequent Koran readings an individual who was suspected to have jinn did not have a therapeutic response to the recitations, family and others close to the sufferer may then consider it a possibility that their symptoms are actually due to walli rather than jinn. Hence, the chronicity of the symptoms was also mentioned as a means to differentiate between the two states.

Participants in the younger Hamilton and smaller Wellington focus groups said that in the case of walli, Western mainstream treatments may be considered by the family of the sufferer. Medications were considered to be potentially helpful for

specific symptoms (such as insomnia) but were not considered to cure walli.

Inpatient psychiatric admission was also considered a useful approach for managing walli by the larger Wellington focus group participants. Interviewees in the younger Hamilton and Auckland groups also said, however, that Koran readings would still be implemented with an individual suffering from walli as there was always the possibility that these recitations may help in alleviating symptoms to some degree.

Aetiology of walli

Trauma and other negative childhood experiences were suggested as possible aetiological factors in the onset of walli by some of the younger Hamilton participants. They also said, however, that some individuals seem to be born with walli and environmental/childhood factors make no difference in these cases.

Interviewees in the Auckland focus group suggested that not praying and a lack of strong religious values could lead to walli. Additionally the Auckland focus group interviewees said that an individual may “have everything going for them” (e.g., financially, spiritually, within their marital and other relationships) yet still suffer from walli if it was God’s will. Other factors that may lead to walli identified in this focus group included sustaining a head injury, and excessive cognitive rumination about life difficulties. Auckland participants also suggested there was sometimes a genetic predisposition to suffer from walli.

Other Somali Idioms for Distress

Given the extensive discussion of jinn and walli conducted with the younger Hamilton participants, insufficient time was left available to discuss other Somali idioms of distress in the two hour interview with this group. Hence qalbijab, boofis,

welwel, and murug were explored to some degree in all but the younger Hamilton focus group. These psychological states as described by participants are outlined below.

Qalbijab

Participants in the older Hamilton and both of the Wellington focus groups said that qalbijab means “broken heart”. Hopelessness was another description provided by these women for qalbijab. The older Hamilton focus group participants said qalbijab may be caused by a loved one passing away, and excessive rumination about an objective that cannot be achieved (such as unsuccessfully applying to New Zealand Immigration for family in Africa to join them in New Zealand). The larger Wellington focus group and the Auckland interviewees also likened qalbijab to jealousy. Both groups said that a husband taking a second wife could lead to qalbijab. Traumatic experiences (e.g., during war) were also described as a potential cause of qalbijab. Other stressors, such as temporarily losing a small child/infant or being intentionally frightened by someone else, were also suggested as triggers for qalbijab in some cases. Auckland participants said that such experiences may lead to qalbijab if an individual cannot stop ruminating about these experiences.

The older Hamilton interviewees said that if a family member or friend was suffering from qalbijab their response would be to try to distract the sufferer from their distress by visiting with them and trying to identify activities for them to engage in to refocus their attention. The women said that, in the case of someone losing a loved one and suffering from qalbijab, the Somali community response would often be to try to take on the role or responsibilities of the person who has passed away for

a period of time. These participants said they would gradually reduce this level of support as the sufferer's psychological state began to improve and eventually reduce this sort of support completely. Koran readings and prayer were also considered effective interventions for qalbijab by both the Hamilton and Auckland participants. Older Hamilton and younger Wellington participants said that if qalbijab is not overcome it could lead to walli.

None of the participants had heard of cases in which Somali women had gone to see their GPs due to suffering from qalbijab. Interviewees generally said that although qalbijab could, in its most severe form, impact significantly on an individual's day-to-day responsibilities, often in less severe cases it would not be obvious to others that someone was experiencing qalbijab (although this condition may still impact on day-to-day functioning to some degree).

Boofis

The older Hamilton focus group participants said that boofis is a condition that affects young Somali who use recreational drugs, particularly *qat* (an amphetamine-like substance). Symptoms that were provided as indicative of boofis were restlessness, diminished appetite, excessive rumination, and insomnia.

Auckland participants stated that boofis could be caused by very negative life events such as traumatic war experiences (due to being victims/witnesses of rapes, robberies, assaults, murders, etc.). They said such experiences may seriously diminish an individual's capacity to trust others and lead to a "loss of confidence in the human condition". Auckland participants also said that individuals suffering from boofis are typically socially isolated and suspicious of others' intentions. They stated that

someone with boofis caused by war trauma may be sensitive to noises during the night and may attribute such noises to someone (unknown) intending to harm them. These participants said that in order to assist someone overcome boofis the primary approach is befriending the sufferer and showing them kindness so they regain their faith in other people. They also reported that Koran readings and prayer would help to treat boofis. Auckland focus group interviewees said that those experiencing boofis could recognise that this is the condition they are suffering from and may spontaneously engage in Koran readings, although, this would not be the case for all individuals who had boofis.

The smaller Wellington group did not consider boofis a state of major psychological significance and likened it to general every day worry. These participants said that no formal treatment would be sought for this state.

Murug

The larger and smaller Wellington focus group participants' said that murug was a term for "worry". For example, an interviewee in the larger Wellington group said that if someone promises to buy something for someone else but cannot actually afford to, they may worry about having made this promise. Participants said this was not a major state of distress and would not require any formal intervention.

In contrast, the older Hamilton participants said that murug was similar to qalbijab although typically did not cause as severe psychological distress.

Nightmares, distressing dreams, concern about family left in Africa and "seeing things" others cannot see were provided as symptoms of murug by this group of interviewees. These participants said that if murug was not effectively managed or

treated it could lead to qalbijab. Hamilton interviewees said the same interventions would be used for murug as are used to treat qalbijab.

Welwel

Only participants in the older Hamilton and smaller Wellington focus groups were asked about welwel. Participants in all three of these groups described this as a state of worry. The state was considered a temporary and understandable response to an acute stressor by women in the Hamilton focus group. For example, these women said that welwel could be triggered by learning that there had been a fire at your children's school. Once your children are home safely, however, you would stop worrying.

In contrast, the participants in the smaller Wellington focus group considered welwel a potentially serious form of distress and stated it could impact significantly on an individual's ability to maintain domestic or employment responsibilities competently. Two participants in this focus group suggested that psychiatric medication may be helpful in alleviating this state. Additionally these participants said that attending appointments with a psychiatrist to talk about the cause of welwel could be efficacious. The interviewees in this focus group, however, stated that they had never heard of a Somali woman attending psychiatric appointments for this purpose. Rather, these participants said Somali are more likely to discuss the cause of the welwel with family and friends, although they acknowledged this may be of variable effectiveness. The interviewees also said Koran readings may also help overcome welwel.

The Psychological Impact of War and Having Family in Africa

The psychological impact of war and having family in Africa have already been illustrated to some degree given that these two stressors were commonly described by participants as explanations for psychological states of distress. Additional data gathered about these two states in the current studies suggests they merit further consideration.

The psychological impact of war

Participants in the younger Hamilton focus group said that a woman who had escaped from Africa and was now living in New Zealand was likely to feel happy and relieved that she was now out of danger. These interviewees also stated, however, that the woman's relief and happiness may be eclipsed if they had family members still in danger or missing in Africa. Participants in this focus group said the worry that a woman in this situation may experience could lead to "depression".

One participant in the younger Hamilton group reported difficulty sleeping when she first arrived in New Zealand as she said she would still "hear" the gun shots when she was dreaming. The participant said to stop herself from experiencing the gun shots, she stopped sleeping. She stated however, that after two years her sleep patterns returned to normal. She did not seek any formal intervention (either Somali or via mainstream services) to assist her with these issues. Participants in this focus group acknowledged that war experiences could impact on different people in different ways and that although some may have minimal ongoing psychological difficulties due to these experiences, others may have considerable difficulties. Participants associated greater distress with having relatives in Africa. They said that

women who are frequently contacted by relatives still in danger in Africa are less likely to be able to prevent rumination about the chaotic state of Somalia and their experiences in the civil war. These women will also be concerned about the wellbeing of their family members and hence may ruminate chronically about this.

Some participants in the younger Hamilton group said that unexpected loud noises may lead to an exaggerated startle response for some Somali women (e.g., falling to the ground when a siren sounds). Participants in the smaller Wellington focus group said that erosion of trust in other people and poor concentration may be key indicators of distress for woman experiencing suffering based on their war experiences. Seeing war on the television news was also considered by this group to exacerbate a woman's distress and may lead to her changing the channel to avoid further distress. Both participants in the younger Hamilton and smaller Wellington focus groups said they considered that war experiences could cause psychological distress for some Somali. None of the participants however, were aware of any Somali who had been significantly psychologically affected by such experiences. The Wellington participants said this could be due to Somali's general reluctance to demonstrate their distress even to close family and friends.

The participants in the younger Hamilton and smaller Wellington focus groups did not consider consultation with GPs to be a useful approach for women experiencing distress associated with war memories. The Hamilton interviewees believed that GPs would primarily prescribe sleeping medication and asserted this could lead to further difficulties due to the side effect profile of such medications. The Wellington interviewees, however, said that medication may be beneficial in

helping to alleviate specific symptoms associated with their suffering (such as sleep deprivation). These participants did not think Somali would attend mental health services for assistance with their distress.

Koran readings were considered to be a useful approach to overcoming distress associated with war trauma. Participants in the younger Hamilton group said that women's Koran reading groups helped to build a stronger sense of spirituality and that having a strong sense of faith and strong belief in God would reduce distress about previous war trauma. Furthermore, considering traumatic experiences as part of God's plan for one's life was also thought to assist in overcoming distress associated with such war experiences.

The psychological impact of having family in Africa

As already stated, participants said that leaving family behind in Africa is typically very worrying for Somali women and can have a significant impact on their day-to-day lives. Women in the younger Hamilton focus group said the stress of family separation is exacerbated by the financial strain this places on the woman and her family in New Zealand. These interviewees said that women in this situation may work long hours to send money to relatives in Africa, are likely to worry about their wellbeing constantly and may also neglect their own health. The participants in this focus group stated worrying too much about the wellbeing of family in Africa could lead to walli in some cases.

The loneliness and distress associated with being separated from family was considered one of the most significant problems a Somali woman could face, according to participants in the larger Wellington group. Constant headaches, guilt

(e.g., “Why am I eating when my children [in Africa] are not?”) and worry (particularly about the welfare of family in Africa and the constant pressure of sending money back to these family members) were identified as very common complaints for these women. They asserted that family is the most important factor in a Somali’s life and hence it is difficult for them to feel content unless they are with their family. Interviewees in both the older Hamilton and larger Wellington focus groups stated that once reunited with family in Africa, symptoms of emotional distress spontaneously subside.

Perspectives on Mainstream Mental Health Interventions

All focus groups except the smaller Wellington group stated that they considered there was a very limited role for mainstream mental health services in assisting Somali experiencing distress. A participant in the younger Hamilton group made the following statement about the use of mainstream mental health services,

It’s better for the Western [people]. The cause of the mental problem is not the same for every community, people are different.... The diagnosis they get, it’s not the same.

This participant said she did not think that Western psychiatric diagnoses were relevant to Somali and provided her assessment of why this was,

Reseracher: So those diagnoses you might get in Western mental health services wouldn’t work [for Somali]?

Participant: No, and most Somali end up having jinn because they never had drugs or anything else.

Participants voiced concern about the use of psychiatric medications which they perceived was the primary intervention employed in mainstream mental health

services. Women in the younger Hamilton group said that psychiatric medication “makes people very fat”.

Yes, I think most of the medications of the people under mental health are anti-depressant and you take that and all you want to do is sit and keep eating, and that's one way that the medication makes you put on weight....

Concern that medication would lead someone into a zombie-like state was also reported by participants in some of the focus groups. None of the participants in the focus groups stated that they were aware of Somali voluntarily attending mental health services. One of the Auckland participants, who also works as an interpreter, said she was aware of referrals being made for Somali women to attend mental health services. She said these referrals were often made by GPs when no physical aetiology could be identified for women's physical complaints. The interviewee stated that the women reporting the complaints would not be aware that they had been referred to this service until they arrived at the appointment. This participant said women refused to engage with mental health services once they became aware that this was where they had been referred. Participants in the larger Wellington group also said that GPs may make referrals to mental health services. These interviewees however, stated that such referrals were most common when women were experiencing distress due to family separation. Participants in this focus group said women may attend such services but would terminate their engagement once they had been reunited with their family (and hence their psychological distress has subsided). In contrast to the perspectives of the women in the other focus groups, the participants in the smaller Wellington focus group did consider that “talking with a psychiatrist” may be helpful.

The primary reasons for a Somali woman to be involuntary admitted to an inpatient psychiatric unit according to many of the participants was the presence of jinn or walli.

Researcher: ...are there times you can think of when Somali would choose to go to mental health services?

Participant: I've never heard of it. Mostly it's not like they choose to go there it's an end result, the medication is not working and you end up in mental health but as an individual I think it's a .. you find someone saying I'm really sick, put me in a mental [hospital], it doesn't work.

Participants in the younger Hamilton group also said it was unlikely that Somali would refer themselves for psychotherapy.

It's a very Western thing, psychologists and psychiatrists. Personally I wouldn't go to a person like that and cry and that, from a Western point of view when you talk it out you feel better, but we want more of an action thing. It's not like I don't want to cry and feel better but at the end of the day I'm still me and what ever problem I've got it's still here, but from the Western point it's not like that, you let it out and you feel much better because you let it out and you can walk out and feel a bit better than before.

A participant in the Auckland focus group, however, reported a positive experience with a psychotherapist in New Zealand. She said she met with a psychotherapist when one of her sons was in a coma following a serious accident. The woman said that it had been recommended by the therapist that she talk to her son while he was in his coma. Although this interviewee initially dismissed this advice she did eventually begin talking to her son who informed her once out of his coma that he was aware of her speaking to him during this period. The participant said she now has a "very small appreciation" for psychotherapy.

The women in the Auckland focus group said that Somali have their own form of psychotherapy in the form of Koran reading groups and family support (emotionally

and practically). They considered these interventions served the same function for Somali as psychotherapy does for Westerners.

Participants in the younger Hamilton focus group said that New Zealand born mental health professionals may be more likely to have difficulty understanding the cultural differences between themselves and Somali and that this lack of understanding may actually lead to iatrogenic outcomes for Somali clients.

Perspectives on GPs Responses to Somali Women's Distress

Participants in the younger Hamilton group commented that GPs tend to assume that physical distress has a psychological aetiology if they cannot identify a medical cause for the symptoms a Somali woman may present with. Additionally, this group suggested that regular visits to GPs due to physical complaints were often seen by their doctors as evidence for psychological distress/disorder.

I've seen people who go for headaches [to their GP] all the time. Classic example, I got a headache and couldn't sleep and went to the doctor two or three times and he said are you depressed? I said no, and he just gave me big tablets.

Participants in the older Hamilton group voiced their frustration that they were typically not referred to specialists and for more comprehensive assessments (such as X-rays) when they present to their GPs with physical complaints. Routine blood and urine tests were not considered adequate assessments by these interviewees, particularly if they did not identify a medical aetiology for their physical distress. The women in this group said that their physical complaints seem to be attributed to post-traumatic stress disorder. These interviewees said they were typically prescribed Panadol and Voltaren to help them deal with their pain but found these medications of minimal effectiveness.

Participants in the younger Hamilton group reported that it was very common for Somali women to be taking anti-depressant medication, without knowing it was psychiatric medication, for physical complaints. Interviewees in the Auckland focus group also said this was common. Additionally these participants stated that Somali women would frequently share their antidepressant medication with family and friends, assuming it was for headaches or other physical complaints rather than depression. The younger Hamilton participants said as soon as Somali became aware the medication they were prescribed by their GP was an antidepressant they would discontinue taking it.

And when they find out they're on them [antidepressants] they go off them because they don't agree that is what's going on – it's not depression, it's headache, or toothache...

The participants in this focus group also said that Somali may be reluctant to return to the GP who had prescribed this medication. They reported this is because they lose trust in their GP for “classifying them as mentally ill”. Concern was also raised by the younger Hamilton participants about the stigma within the Somali community that was attached to being considered “mental” or crazy”. Taking antidepressant medication was seen as evidence of severe psychiatric distress by these interviewees.

...plus once the people [Somali community/family] are told that you are using anti-depressants that in itself can be scary because we share a lot of our issues and our problems. Somebody who knows somebody that you don't talk to hears you are on anti-depressants they will straight put into the town that she's mental, she's on anti-depressants, you start being singled out. .. Gossiping and rumours about the wrong thing and it affects you later because people start to think oh my God she's going crazy, she's not normal, but you're not like that, but maybe anti-depressants they take it as you are going crazy.

One of the Auckland participants acknowledged being prescribed medication for “stress and worry” due to having family still living in refugee camps in Africa. She said, however, that while taking this medication she fell out of bed, broke a tooth, and nearly broke her leg. She attributed this accident to lethargy and poor concentration caused by side effects of the medication she had been prescribed (i.e., “acting like a zombie”). The participant reported discontinuing the medication on the advice of a different GP. Participants in the larger Wellington group also said that GPs frequently prescribed psychiatric medication to women experiencing the distress of family separation. Interviewees in the Auckland and larger Wellington focus groups voiced concern that GPs seem to prescribe these women medications (particularly anti-depressants and sleeping medications), as participants did not consider this an effective means of alleviating this form of distress. Wellington participants said that when prescribing psychiatric medications to Somali patients, GPs will often not ask about the patient’s general life circumstances or stressors that may be impacting on them. Hence, participants suggested GPs frequently do not identify alternative psychosocial reasons for their distress and physical symptoms (particularly headaches and poor sleep).

The Protective Role of Faith

Faith as a protective factor against experiencing major psychological distress was discussed by the younger Hamilton and Auckland participants. Interviewees in the younger Hamilton group said that having a strong faith in God and believing that your fate has been predetermined by Him were protective factors against distress. Accepting your fate was considered to be accepting the will of God, and hence

challenging your circumstances by making statements such as, “It’s not fair” or, “Why me” was considered to be indicative that you were not a believer in God (as you were questioning His wisdom/choices).

The Auckland participants also discussed the importance of assuming trauma and life difficulties were the Will of God. For example, one of these interviewees said two of her young children died unexpectedly within days of each other. She said that she relied on her faith in God and belief that her children were not meant to remain alive (as this was considered by her to be the will of God) to manage the loss she had suffered. The woman believed that her faith in God protected her from significant psychological distress and enabled her to continue to cope adequately with her familial responsibilities.

The Vignettes

Participants were asked a number of questions about the most likely explanation for the behaviour of the women in the Vignettes and treatments or interventions that would typically be employed in each case. Interviewees in all six focus groups were presented with the Vignettes. The three Vignettes and participants’ responses to each are outlined below.

Vignette 1

“There is a Somali woman who can be working or doing something for 24 hours without getting tired. Sometimes she walks all day and all night and she is not even going anywhere. She also talks to someone other people can’t see, she will talk, and laugh and she doesn’t care about showering or cleaning herself. Sometimes she gets really violent. There was this time when this older Somali lady was standing in her

way and she pushed her to the ground. Sometimes when the voices go away and she is not being violent and starts looking after herself again she says that she can't remember doing any of these things once she stopped."

Participants' responses to Vignette 1

Participants in all focus groups stated that the most likely explanation for the woman's behaviour in Vignette 1 was jinni. Interviewees described this as a "classical" and "typical" case of spirit possession. Crying and laughing for no apparent reason were described by the older Hamilton participants as key indicators that this was a case of jinn. The Auckland participants, however, stated that the woman's reluctance to remain clean was the strongest indicator that she was suffering from jinni. Both the Wellington groups said that the woman's tendency toward violence was the clearest indicator of spirit possession. The smaller Wellington group also suggested that the woman's heightened energy levels was a clear sign of jinni.

Support from family and friends as well as Koran recitations were suggested as the most likely approaches taken to rid the woman of the jinni. Participants said that mainstream mental health services may become involved in a case like this if the woman became violent. They considered inpatient psychiatric admission may be useful to assist in restraining aggressive jinn sufferers and preventing them from harming others. Psychiatric medication was also considered potentially helpful if it assisted in sedating the woman in Vignette 1 and reducing her propensity to become violent.

Vignette 2

“Another Somali woman has frequent nightmares about her family who she left behind in a refugee camp. At times she says that she will be sleeping on her bed and she will start seeing the people who died in front of her or the pile of bodies, some of which were familiar, that she helped bury or move from the roads. This woman said that these experiences will never be erased from her memory even though she tries to forget them by occupying herself with other things. She also said that she drops to the ground if she hears a siren as that reminds her of the war back home too.”

Participants’ responses to Vignette 2

There was less agreement between the groups with respect to explaining the nature of the woman’s behaviour in Vignette 2. None of the participants, however, considered jinn an explanation for this behaviour. The younger Hamilton and smaller Wellington focus group participants did not provide a particular name for this woman’s behaviour. The younger Hamilton participants said the woman’s distress was due to experiences she has had in the past and has difficulty forgetting. The smaller Wellington group suggested the woman was probably missing family still in Africa and experiencing “stress” because she was separated from them.

The older Hamilton participants said this was a case of murug. They stated that the signs of murug evident in the Vignette were nightmares, memories of the war and deceased family, and having visions others cannot see. The Auckland and larger Wellington focus group participants said this appeared to be a case of qalbijab. The participants in the larger Wellington group said the woman’s experience of watching family members die in front of her was one of the reasons they had considered she

was suffering from qalbijab. The Auckland participants said this would only be considered a case of qalbijab if the woman was unable to stop ruminating about the distressing memories. Women in both focus groups said many Somali have had these sorts of experiences and they are able to distract themselves from the memories. In these instances, they would not be considered to have qalbijab.

The interviewees all said the woman would benefit from Koran readings. The younger Hamilton, larger Wellington, and Auckland focus group participants also said when experiencing this form of distress it was important to maintain your faith in God, to increase your worship of God and to believe everything is predetermined by God. These women also stated that praying to God more regularly than usual and asking for some relief from the nightmares would probably help the woman in Vignette 2 rid herself of these distressing dreams. Additionally, both the younger and older Hamilton participants said increasing the activity level of the woman experiencing the nightmares and trying to keep her distracted from thinking about her war memories would help her to overcome her distress.

Interventions from GPs or mental health services were generally not considered an effective approach by the participants. The younger Hamilton participants said that GPs may assume the woman was going crazy, which they did not think was the case. These interviewees did, however, state that it may be helpful for the woman to take medication (particularly sleeping medication) to help her forget the past trauma (especially the nightmares) she had experienced. None of the participants said they had heard of a Somali woman going to see her GP due to the impact of distressing war memories or dreams. The participants in the smaller Wellington group were the

only interviewees to assert that seeing a psychiatrist to help with this type of distress may be beneficial.

Vignette 3

“Another Somali woman has started staying in bed a lot and has stopped looking after her house. She only leaves her house to drop her children at school and pick them up. Some of this woman’s friends say that they have seen her crying. Often when you talk directly to her she doesn’t even seem to notice. Her husband is concerned that she has become very forgetful and might leave something on the stovetop and burn their house down. This Somali woman said that when she was asleep she would experience dreaming and think that someone called her name but there is no one there.”

Participants’ responses to Vignette 3

As with Vignette 2, there was some difference of opinion as to what the nature of the distress outlined in Vignette 3 was considered to be. Some of the younger Hamilton participants suggested this was a case of jinni possession as the woman was hearing voices (considered a strong sign of jinn). Other participants in this group suggested the woman may be “a bit depressed”. The interviewees said that when a Somali is separated from family members still in Africa, this is often how she will behave. The younger Hamilton participants suggested that if the woman had all her family here with her in New Zealand then this was most likely a case of jinni; if she did not, they would consider that she may be suffering from stress due to family separation. The Auckland and Wellington participants considered this to be a case of jinni and stated the woman’s tearfulness and voice hearing experiences were key

indicators she was possessed. The Auckland interviewees, however, suggested that this seemed to be a milder form of jinni in which the sufferer may be able to maintain many of their daily responsibilities. The smaller Wellington group also said that the woman's behaviour may be due to "stress". They said it was possible that a jinni could cause her to experience stress and therefore she could be suffering from both jinni and stress concurrently. The older Hamilton participants said this was a case of murug and stated that they would intervene in the manner outlined above when an individual is suffering from murug.

Approaches to assisting this woman were consistent with earlier data presented with respect to jinn possession and family separation. Participants did not think there was a role for psychiatric medication in this case.

Summary of Results

The findings of Study 2 identified numerous culturally specific forms of distress although here was not always a clear distinction between these states. Jinn possession seemed to be a well known and accepted form of distress within all of the focus groups. Treatment for jinn possession and the other states of suffering tended to focus on Koran readings and family/community support. Generally, participants considered there was a very limited role for GPs and mental health professionals in assisting Somali to deal with these idioms of distress. Most interviewees did not consider that psychiatric medication would be beneficial and often suggested such medication may actually be harmful due to the side effect profile. Some, however, asserted that there could be a therapeutic role for medication in some instances. Participants were unanimous in stating that they were not aware of a Somali

voluntarily choosing to engage with mainstream mental health services. Only one participant reported personal involvement with such services and this was involuntary. Faith was considered the most important protective factor against suffering from major forms of distress, although it was not mentioned as a protective factor in all focus groups. The impact of having family in refugee camps in Africa was identified as a key psychosocial stressor impacting on the wellbeing of Somali women in New Zealand. War related trauma was considered to impact on wellbeing but generally participants suggested that this was only likely to cause significant distress if the sufferer was also lacking social support and/or had family still in Africa.

Discussion

The following sections summarise the key issues identified in the results of Study 2.

Jinn Possession

The current findings suggest that *jinn* possession is considered a common explanation for distress and suffering within some New Zealand Somali communities. In this study participants tended to identify two distinct forms of jinn. The more extreme form of spirit possession could be likened to a psychotic illness such as schizophrenia. According to one group of participants, however, jinn and psychosis were distinguishable according to their aetiology (i.e., jinn being due to spirit possession, psychosis being due to drug and alcohol use) and treatment responsiveness (i.e., jinn was considered to be only effectively extricated by Koran readings, psychosis was considered to respond to psychiatric medication). The less

severe form of jinn seemed akin to Western somatoform disorders. Both states cause numerous physical complaints that appear to have no medical aetiology.

Additionally, it would seem that both this form of jinn and somatoform disorders are characterised by the complainant's frequent visits to medical professionals.

There were some symptoms that seemed to be more consistently associated with jinn. With respect to the more severe state of possession, aggression, communication impairments, disrobing in public and amnesia (for the period of possession) were the most frequently reported indicators. Headaches, and back and stomach aches were most consistently associated with the somatic presentation of jinn. Tearfulness and hearing voices were also reported as indicators of both forms of jinn.

From participants' accounts, jinn possession can often be definitively identified during the Koran readings. This appears to be due to the unique manner in which a jinni sufferer typically responds to the readings. Attempting to flee from the recitations and the jinni apparently identifying its presence and speaking in a different voice to that of the person it has possessed were presented as unequivocal signs of possession. According to participants, a Muslim not possessed by jinni would not respond adversely to Koran readings, nor would a foreign entity speak 'via the mouth' of an individual suffering from some other form of distress.

The efficacy of Koran readings for treating jinn

The apparent efficacy of Koran recitations in treating severe forms of jinn possession could seem at odds with Western biomedical explanations of similar psychotic illnesses. Given the apparent similarity in symptom profile of severe jinn possession and psychosis it could be considered somewhat perplexing that a spiritual

intervention apparently has such a high success rate for the treatment of jinn. There are, however, a number of possible explanations for the reported effectiveness of Koran readings which are discussed in depth in Chapter 9.

Non-spiritual Forms of Distress

The key issues relevant to the non-spiritual states of distress identified in the current study are outlined below. It is important to mention that it not assumed that the list of psychological states described by participants and outlined in the results section is exhaustive. It is likely that other states of distress were not mentioned by participants, and not known to the principal researcher.

Walli

The findings of the current study suggest that the Somali participants considered jinn and walli to be distinct forms of distress. The distinction, however, was not based on symptom profile (which many participants said was indistinguishable), but rather the sufferer's response to Koran recitations, and chronicity of the conditions. Interviewees said that individuals suffering from walli would not respond therapeutically to Koran readings nor would any spiritual entities identify themselves during the recitations. It was not only the response (or lack of response) to the Koran readings but also the course of this illness, which participants said differentiated walli from jinn possession. Walli was generally considered incurable, chronic and unremitting. Jinn in some cases could also have a chronic course, however, interviewees said that there would be intermittent periods of remission. An additional point of difference discussed by participants was the stigma attached to the state of

walli (impacting on marriage prospects and the sufferer's ability to be accepted as a contributing member of Somali society), which was not attached to jinn.

Walli, as the most severe and stigmatised form of distress identified by participants, may not respond to Koran readings due to a biological aetiology similar to Western forms of psychosis. Participants' accounts of the heritability of this state suggest some notion of biological processes playing a role in the manifestation of walli. If this condition is indeed a state similar to psychosis, this may explain why some participants said that psychiatric medication has been helpful in its treatment.

The symptoms of walli identified in Carroll's (2004) study and the current study were similar (e.g., shouting, aggression, talking incessantly). Carroll was also the only other researcher who suggested walli and jinn were unique idioms of distress. As with the current findings, she concluded that causation rather than symptom profile was the primary means of differentiating between these states.

Other non-spiritual states of distress

Qalbijab

The description of qalbijab in the current study was consistent with the description conveyed by Tiilikainen's (1998) and Zarowsky's (2004) interviewees. This condition seems to be a state of excessive sadness akin to depression. Descriptions of qalbijab as meaning "broken heart" (Tiilikainen, 1998), and hopelessness (Zarowsky, 2004) were the precise terms used to define this state by some participants in the current study. Reasons provided for developing qalbijab were also consistent between the current and previous studies. "Jealousy" (e.g., due to a husband taking a second wife), death of a loved one, traumatic war experiences,

excessive rumination and unfulfilled desires (such as being unable to reunite with family members overseas) were cited as triggers for qalbijab in all three studies.

With respect to treatment approaches for qalbijab, Zarowsky (2004) and Tiilikainen (1998) both stated that it was necessary to find a means to fulfil the unfulfilled desires to overcome this state. This may equate with participants' comments in the current research that the only means to overcome the distress associated with family separation (one reason provided for qalbijab) was to be reunited with family. As with Tiilikainen's participants some of the current interviewees reported that if qalbijab could not be ameliorated this could lead to "madness" or "craziness". Prayer, Koran readings, and maintaining a strong faith were identified in the present study as means of overcoming qalbijab.

Murug

Not all participants considered murug a state of psychological distress but those that did reported that traumatic war experiences could trigger murug. Nightmares, memories of the war and deceased family and having visions other people could not see were provided as symptoms of this form of distress. Consequently, in some instances, murug may be likened to post-traumatic stress disorder (PTSD). No known research to date, however, has explored the apparent similarity of this Somali state of distress with PTSD. Nonetheless it is conceivable that certain forms of murug and PTSD are two different conceptualisations of the same underlying phenomena (i.e., an extreme anxiety response to trauma).

Welwel

In the two focus groups in which *welwel* was discussed, it was described as akin to worry or stress. This finding was consistent with those of Tiilikainen (1998) and Zarowsky (2004). As with *murug*, however, discrepant opinions about the severity of this state were identified between the focus groups. Participants in the older Hamilton group considered *welwel* a temporary state of worry that occurred in response to understandable stressors (such as concern for their children if they were involved in a house fire). This description was similar to Zarowsky's description of '*wilwil*' being a state of "ordinary worry". Participants in the smaller Wellington focus group, however, considered *welwel* a potentially serious state that could significantly impact on an individual's ability to fulfil major role obligations. This description of *welwel* seems consistent with the description provided by Tiilikainen who also suggested that this state could have a major impact on a Somali woman's day-to-day functioning. Both Tiilikainen's participants and the participants in the smaller Wellington focus group asserted that the primary means of alleviating *welwel* was via support from significant others.

Boofis

Participants in the older Hamilton focus group said that restlessness, diminished appetite, excessive rumination and insomnia were symptoms of *boofis*. Recreational drug use (including the use of *qat*) was provided as the reason for *boofis* by members of this focus group while negative life events such as war trauma was suggested as a reason for *boofis* by the Auckland participants.

Some of the symptoms of boofis indicated by participants were consistent with amphetamine intoxication. Research suggests that qat can lead to psychotic states in Somali who ingest this substance (Hohenwald, Neuter, Schafer et al., 2005). Given qat is an amphetamine-like substance this is not a surprising outcome. Most research however, suggests it is primarily used by male Somali rather than female (see Bhui, Abdi, Abdi et al., 2003; Elmi, 1999; Guerin et al., 2004b). Hence, even though qat may be a possible trigger for symptoms akin to psychosis it is arguably a less likely aetiology in female boofis sufferers. The impact of war trauma, however, may be a more likely aetiology for the presentation of boofis in female Somali. This hypothesis is elaborated in the following section.

The Psychological Impact of War and Family Separation

The Auckland participants' description of boofis was consistent with some symptoms of PTSD (e.g., estrangement from others, hypervigilance). Although not diagnostic indicators, hostility, social withdrawal, impaired relationships with others, and feeling constantly threatened are also factors associated with PTSD (APA, 1994). These symptoms were also provided by participants as possible indicators of boofis. It is possible then that some presentations of boofis are culturally unique psychological responses to war (and other) trauma as PTSD is in Western countries. As with most other Somali idioms of distress, participants said treatment of this form of boofis would consist of Koran readings and social support.

In contrast to participants in Study 1, who suggested that war-related experiences were unlikely to cause significant distress and interruption in women's day-to-day lives, some participants in this study did consider the distress associated

with war trauma to be potentially serious. One possible explanation for this apparent discrepancy in findings could be that exploring specific psychological states familiar to Somali (i.e., murug, qalbijab, boofis) in Study 2 prompted participants to consider more specifically under what circumstances these states may be triggered. It was not asked in the current study how common were each of the idioms for distress, and it is still possible that the actual incidence of significant distress associated with war related trauma is considered very low.

Participants reported that there were numerous psychological responses that Somali women may have as a consequence of war-related trauma, which were not necessarily related to boofis or murug. Many of the symptoms were similar to those that make up the diagnostic criteria for PTSD (e.g., exaggerated startle responses, difficulty sleeping, vivid distressing dreams). Participants generally did not, however, ascribe a label or name to these symptoms. It is not surprising that anxiety conditions similar to PTSD may exist in Somali culture. The fear response is fundamentally an evolutionary response which allows humans to biologically prepare for threatening situations (Debiec & LeDoux, 2004). The ability to acquire a conditioned fear response to dangerous stimuli is adaptive and often necessary to an individual's survival. Hence, some of the primary features of the conditioned fear response, including hypervigilance to danger and heightened autonomic arousal would be expected to be demonstrated cross-culturally.

Generally interviewees said that war-related distress was worse for those who had left family behind in Africa. This makes sense in light of these individuals often being reminded of the plight of family in Africa due to the very frequent phone calls

with those still in refugee camps. Additionally, participants reported that family in refugee camps will remind their New Zealand-based sponsor of the dire circumstances in which they exist. These constant reminders understandably make psychological adjustment to a new country difficult to achieve in addition to such factors as: the financial burden of attempting to support family in both New Zealand and Africa, the uncertainty of not knowing whether family will be able to immigrate to New Zealand, and dealing with immigration services.

The stress of family separation was considered to contribute to numerous psychological difficulties including headaches, worry, guilt and insomnia. The only effective means mentioned to overcome the stress associated with family separation was reunification. The findings of Study 2 are generally consistent with the findings of Study 1. That is, family separation was reported as a major cause of psychological distress for Somali women in both studies. The results of Study 2, however, help to more clearly elucidate in what ways this distress may manifest and also highlight the possible moderating role that social support plays in decreasing the stress of war memories and experiences.

Perspectives on Mainstream Mental Health Interventions

The findings of Study 2 suggest that Somali have their own culturally distinct and efficacious approaches to treating spiritual and psychological suffering. The approach most often employed is Koran recitations, often conducted in conjunction with prayer. Family and community support was also frequently described as a common means of assisting someone suffering from distress. The majority of participants did not consider that there was a role for mental health services in

providing intervention for Somali. The findings of this study are consistent with the results of Study 1 and other research demonstrating that ethnic minority groups typically opt to employ their own traditional means of intervention rather than engage with Western mental health services (e.g., Geltman, Augustyn, Barnette, Klass, & McAlister-Groves, 2000; Guerin, et al., 2004b; Littlewood & Lipsedge, 1997).

The findings of Study 1 suggested that one of the primary reasons that Somali may choose not to use mainstream mental health services was their perception that attending such services equated with extreme forms of distress akin to psychosis. Participants in Study 2 did not describe this as a rationale for the apparent low numbers of Somali attending mental health services. Perceived inappropriate and overuse of psychiatric medication, perceived lack of efficacy of this medication, as well as the perceived lack of efficacy of psychotherapy, were provided as reasons for not engaging with such services by participants in Study 2.

Perspectives on GP Interventions for Psychological Distress

Interviewees often said that their physical complaints were not appropriately investigated by their GPs. They considered the attribution of physical ailments or pain to psychological causes as a misdiagnosis and indicated further concern that some GPs are prescribing psychiatric medication without Somali patients being aware of the nature of the medication they are taking. Lack of understanding of the rationale behind taking particular medications is likely to lead to poor compliance and may in fact be dangerous to the patient if not used in the prescribed manner. Additionally, learning that the medication is a 'psychiatric' medication appears to

lead to some Somali women abruptly discontinuing the medication which in itself could lead to dangerous and unwanted side effects.

Although in some instances Somali may consider psychosocial stressors to be causal in the manifestation of their physical complaints, it is possible given their perception that psychiatric medication is for “craziness”, that they misattribute the intent of GPs who suggest they take such medication. Somali may assume the GP does not believe that their physical complaints are causing real physical distress and hence may contribute to an erosion of trust between Somali women and their GPs.

The Role of Protective Factors

As with the participants in Study 1, the participants in the current study tended to demonstrate a fatalistic perspective on wellness. Additionally, the present results highlighted that having a strong faith in God was considered an important protective factor against experiencing significant psychological distress. As asserted in Study 1, however, strong religious faith often appears to be insufficient in protecting Somali women from suffering major psychological distress if they are separated from close family members (particularly if those family members are living in refugee camps).

Although it was suggested in Study 1 that belonging to a collectivist society with close family and kin relationships in which cultural and religious norms are enmeshed could be a key reason why Somali under-utilise mental health services, the current findings suggest that lack of ‘cultural fit’ may also at least partly explain this apparent under-utilisation. That is, the Somali women in this study described numerous states of distress, some of which they considered could have a significant impact on the sufferer’s life. They also described traditional treatment approaches

that they said were employed to alleviate these states. From participants accounts it seemed that traditional treatments were readily available and easy to access in New Zealand. Hence, it may not be that Somali are necessarily any more resilient against experiencing psychological distress, but rather the manner in which the distress manifests and the treatments they employ may be considered incompatible with Western interventions.

Summary

The Somali participants in the current research identified a number of culturally distinct idioms of distress and demonstrated a relatively sophisticated approach to the assessment and aetiology of these states. Stigma seemed to be primarily associated with the most severe and apparently incurable form of suffering identified as walli or “craziness”. Other forms of distress, including jinn possession, were not described as having a sense of shame or stigma associated with them. Psychosocial stressors (particularly family separation) were acknowledged by some participants to lead to physical symptoms of distress (such as headaches, toothache, back pain). Physical symptoms were also associated with less severe forms of jinn possession.

It is unclear why the current study yielded discrepant results with respect to the meaning of some of the key idioms for distress identified and why these results appear divergent with some other research findings. One possible explanation relates to Somali exposure to mental health concerns in public discourse. Within Somali culture there appears to be no textbook outlining idioms of psychological distress, very few Somali mental health professionals to clarify the types of mental distress known within Somali culture, and limited evidence that mental health concerns are a

pressing social priority to Somali. It is unsurprising then that there is some inconsistency with respect to the explanations given for some idioms of distress in the current and previous research.

Family separation was commonly identified as a significant psychosocial stressor in all geographical locations. War trauma was also acknowledged by many participants as having a significant impact on psychological wellbeing. Lack of adequate family support, however, seemed to be a moderator in this regard, with those women who were separated from close family members more likely to have difficulty overcoming the distress associated with war experiences.

Treatment approaches to assisting a Somali woman overcome psychological distress were primarily traditional interventions. The therapeutic power of such interventions cannot be underestimated. Given the significant change in life roles of Somali women in New Zealand, and the reported decrease in social support, these traditional interventions act to acknowledge, validate and increase support networks for the sufferer.

Generally participants did not consider a role for mainstream health services in assisting Somali experiencing distress. An apparent poor cultural fit between Western means of treating distress and those of Somali was voiced by some participants. Possibly too, however, minimal knowledge about the nature of mainstream services and the scope of difficulties such services can assist with may also act as a barrier to engaging in such services. That is, participants seemed to consider only the most severe cases of distress (i.e., those individuals considered “crazy”) were relevant to mental health services. They also held some erroneous understandings of the role of

psychotherapy (i.e., believing that this was a process of ‘just talking to someone’ without engaging in any active intervention approaches), which may also act to prevent them from considering such options.

If there is a role for mainstream mental health services, further research is required to elucidate what that role may be. Certainly Somali in the current research identified their own efficacious means of managing and overcoming psychological distress. These approaches were considered to be effective in the New Zealand context. They also, however, demonstrated some inaccurate assumptions about mainstream services and concern about the manner in which clinicians in these services as well as GPs approach treatment with Somali. Without also consulting with Western practitioners and GPs who have been involved in the treatment of Somali suffering from psychological distress it is difficult to ascertain how we can currently work toward improving the services offered to this group. The third and final study of this thesis explores these issues from the perspective of clinicians and GPs working with Somali.

CHAPTER 8

Study 3:

Western Practitioners' Perspectives on Somali Idioms for Distress and their Approaches to Treatment with Somali Clients

Overview

The methodology of Study 3 is based on the interactive model of learning developed by Proctor (2003). Proctor employed this model to gain a greater understanding of the perspective of Australian migrants about their mental health needs as well as health practitioners' opinions about the needs of migrant groups (see Chapter 5 for a description of the interactive model). The interactive model is somewhat unique in refugee research, as typically studies which have focused on the mental health needs of refugees have based their conclusions about barriers to mainstream services on the perspectives of these immigrant groups and have not interviewed mainstream service providers. Although in many cases the barriers identified in these studies are likely to reflect real and tangible shortcomings of mainstream services, there is also the possibility that some of these concerns are at least in part limited. Also, where such barriers are considered to exist by mainstream practitioners, these practitioners may be able to readily contribute to identifying means to overcome these barriers. Hence, in the present research this approach helps to ensure that

the information obtained from Somali women about mainstream mental health treatment approaches is complemented by also exploring the opinions of mainstream practitioners. Obtaining a greater understanding of both Somali conceptions about distress and the management of this, as well as mental health clinicians' perspectives, is also likely to provide a basis for reciprocation of information and learning (Proctor, 2003). That is, information provided by Somali in the previous two studies can be relayed to mental health clinicians to enhance their knowledge and ability to work with this group, while information provided by mental health clinicians may enhance Somalis' understanding and willingness to engage in mainstream services.

Method

Recruitment

Initially for the purpose of Study 3, the intention was to run three focus groups involving health professionals. The focus group composition was planned to vary along the following dimensions (i) mainstream mental health clinicians working in a government-funded outpatient setting, (ii) practitioners working at a specialist service for which the primary focus is assessment and treatment of psychological distress in refugees, and (iii) general practitioners (GPs). The region participants were recruited from and the agencies that they worked for will not be identified in the current study to protect the confidentiality of both the agencies and the participants.

In order to recruit participants from a mainstream outpatient mental health service (which did not specialise in working with refugee or non-Western

clients), permission was initially obtained from the mental health services' research committee and the services' mental health managerial staff. After obtaining this permission, information sheets (see Appendix G) outlining the nature of the current study were distributed to practitioners working in this setting. A total of 80 mental health (MH) clinicians working in a North Island outpatient setting were provided with an information sheet. Four mental health clinicians initially volunteered to participate. One of these clinicians, however, was unable to be interviewed due to unexpected health concerns. Due to the low response rate, the three mental health clinicians who were interviewed were asked if they were aware of other mental health clinicians who may have had refugee clients and may be willing to participate in the current study. Based on their responses, six other mental health clinicians were contacted directly by telephone by the primary researcher. Four of these clinicians agreed to participate in the current study. Only three of these clinicians however were actually interviewed, as the third was on annual leave at the time the interviews were being organised. The two participants who declined to participate stated that they had had no contact with Somali refugees and therefore did not wish to be interviewed.

In order to recruit practitioners working at a specialist refugee mental health service, permission was initially obtained from the team leader of this service. After obtaining this permission, information sheets (see Appendix H) outlining the nature of the study were disseminated to all team members. A time to meet for the purpose of conducting the focus group was then negotiated

with interested team members via the team leader. The specialist mental health team comprised 13 employees. Six of these employees participated in the current study.

In order to recruit GPs, all Hamilton-based GPs were initially sent information sheets (see Appendix I) about the current study which invited interested parties to contact the primary researcher. A total of 108 GPs were contacted in this manner. Three agreed to participate in the current study. Given this low response rate, local GPs identified by the co-researchers as having experience working with the Somali community were contacted directly by telephone by the primary researcher. Five additional GPs were identified. All of these GPs declined to participate in the current study. Not all provided a rationale as to why they were unwilling to participate, but those that did cited their busy work schedule as the primary reason. In addition to making contact with these five GPs, telephone contact was also made with the administrators at two medical surgeries located in areas of Hamilton in which there was a high density of Somali living. A total of 21 GPs worked in these two settings. The administrator at both of these agencies agreed to remind the GPs about the study and identify if any of them would be willing to take part however, all GPs at these surgeries declined to participate in this research.

Given the low recruitment rate from the Hamilton region, it was decided to attempt to recruit GPs from Auckland and Wellington. Rather than send information flyers to all GPs in these two cities, GPs working in areas in which there was a high density of Somali living were targeted. In order to

identify these areas, one refugee agency in Wellington and one refugee agency in Auckland were contacted to enquire what suburbs had the highest proportion of Somali refugees. Once these suburbs had been identified, internet website searches were conducted to identify medical surgeries located in these areas. The 'New Zealand Yellow pages' (<http://yellow.pages.co/nz>), the 'Hutt Valley District Health Board' (<http://www.huttvalleydhb.org.nz>) and the 'Finda – Business Search' (<http://www.finda.co.nz>) websites were then searched in order to find medical surgeries located in these areas. Additionally, both refugee agencies contacted to identify suburbs to target for recruitment provided names of GPs or medical surgeries that were considered to have experience working with the Somali community.

A total of 63 Auckland and 9 Wellington GPs were sent information flyers. One Auckland GP volunteered to participate in the current study. None of the Wellington GPs responded to the information flyer. One nurse-practitioner from the Wellington region did, however, contact me to indicate interest in participating in the research. Given the very low number of GPs recruited, it was decided to also include this nurse-practitioner in the current study. The nurse-practitioner provided the contact details of two other nurse-practitioners she recommended be invited to participate in the current study. Attempts were made to contact both of these nurse-practitioners. One was successfully contacted and agreed to be interviewed.

In total four GPs and two nurse-practitioners (from hereon this group of participants is described as general health practitioners) were recruited to

participate in this aspect of the current study. Three of these participants were from Hamilton, two were from Wellington and one was from Auckland.

Given that the six general health practitioners were recruited from three different geographical locations it was not considered feasible to attempt to conduct a focus group with these participants. Hence face-to-face and telephone interviews were conducted with all six of these interviewees. What is more, work commitments of the mainstream mental health participants meant it was not possible to identify a time that suited all of them to meet for one focus group interview, therefore individual interviews were conducted with these practitioners also.

Participants

The three different groups of health professionals that the participants were recruited from were (i) mainstream mental health practitioners, (ii) specialist refugee mental health practitioners, and (iii) general health (comprised of both GPs and nurse-practitioners) practitioners. The composition of these three groups is outlined in more detail below.

Group 1: Mainstream mental health practitioners

Three clinical psychologists, one social worker and two nurses from the outpatient mental health services participated in the current study. Of the six mental health clinician participants, five were from Western ethnic backgrounds and the sixth was of Māori ethnicity. The average length of time participants reported working in their current profession was 19 years. The average length (in years) that participants reported working with refugees as mental health

clinicians was one year. The number of years experience working with refugees ranged from zero to three years. Only two of the participants reported that they had worked formally with Somali female clients. Neither of these participants currently had any Somali clients on their caseloads.

Group 2: Specialist refugee mental health practitioners

The participants involved in the specialist refugee mental health (SRMH) focus group were three psychologists, one body therapist (body therapy was described as incorporating various types of massage, and traditional pacific island forms of physical therapy), the community co-ordinator and an interpreter. According to the team leader, these were the only staff members available and motivated to participate in the current study.

Of the six SRMH focus group participants, two were from Western ethnic backgrounds. The other four participants described themselves as of Persian, Afghani, Indian and Pacific Island ethnicity respectively. One participant said he had arrived in New Zealand as a refugee. The average length of time participants reported working in their current professions was 20 years. Two participants, however, did not provide data on how long they had been working in their current profession. The average length of time that participants reported working with refugees as mental health workers was 4.3 years, ranging from 2 months to 10 years. Only two of the participants reported that they had ever worked formally with Somali clients (although most of the participants reported involvement at some point with the local Somali community). Neither

of these interviewees had any Somali clients on their caseloads currently. Two of the six participants were female.

Group 3: Primary health practitioners

Of the six primary health practitioners, four were from Western ethnic backgrounds and the fifth was from a mixed Asian and Western ethnic background. The average length (in years) that these participants reported working as primary health practitioners was 15 years. The average length (in years) that participants reported having professional contact with refugees was 9.2 years. The numbers of years experience working with refugees ranged from 4 years to 20 years. Five of the participants had worked with Somali refugees. The range of Somali clients currently on caseloads was estimated to be between 0 and 277. Three participants reported having 100 or more Somali clients currently on their caseload, one participant reported having 30 Somali clients while another reported having 13. The estimated average number of Somali women on these practitioners' caseloads was 57. The range of Somali women on these caseloads was estimated to be between 0 and 136. Three of the six participants were female. Table 2 provides demographic comparisons across the three groups of participants.

Table 2

Participant Demographic Information

| Group | Western / Non-Western ethnicity | Females/ Males | Length of time in current profession (average) | Estimated current number of Somali clients (average) | Estimated current number of Somali female clients (average) |
|---------------------------------------|--|---------------------------|---|---|--|
| Mental Health Clinicians | 5/1 | 4/2 | 19 years | 0 | 0 |
| Refugee Specialists | 2/ 4 | 2/4 | 20 years | 0 | 0 |
| Primary Care Practitioners | 5/1 | 3/3 | 15 years | 70 | 57 |

Statistical comparisons were not conducted on the data due to the small sample sizes. However, these data demonstrate some marked differences in contact rates between the three groups. In particular, primary care practitioners interviewed had considerably more contact with Somali clients than both mental health clinicians and specialist refugee professionals interviewed. The demographic differences between the three groups of professionals, particularly with respect to contact with Somali refugees, meant that it was appropriate to initially explore between-group difference to ascertain whether there were other meaningful disparities in the data that may have related to the divergent demographic status of the participants.

The Interview Schedule

The first section (‘Part 1’) of the interview schedule (see appendix J to review the entire interview schedule) focused on gaining an understanding of the types of difficulties Somali women typically present to mainstream services, what participants considered the likely aetiology of these difficulties, what sort of treatment is generally

provided/recommended, and how (if at all) practice is modified when working with Somali. Questions in this section were also designed to gain an understanding of participants' knowledge of traditional Somali healing approaches and how mainstream services could better meet the needs of Somali. For those participants who had not had any contact with Somali clients, the word 'Somali' was replaced in the interview schedule with 'refugee'. For those participants who had not had any contact with refugee clients, the word 'Somali' was replaced with 'non-Western clients'. Although these adaptations to the interview schedule may have changed the focus of the interview, it was considered worthwhile to explore the perspectives and attitudes of clinicians who had not had contact with Somali or other refugee groups. It was thought that these clinicians' approaches to working with other non-Western groups might provide some indications of how they may choose to work with Somali clients they come in contact with in the future. Below is a list of the questions asked in Part 1 of the interview schedule:

1. What are the most common complaints/difficulties Somali women you have worked with have described to you?
2. What is the most common form of treatment you provide for Somali women?
 - How effective do you consider this treatment to be for them?
3. Have you had any difficulties/ concerns in working effectively with Somali women?
 - If so, why do you think that might be?
4. Do you adapt/modify your practice when working with Somali women? How?
5. How often do family members accompany your Somali clients to their appointments?

6. How often do paid interpreters accompany your Somali clients (those that require interpreters)?
 - If infrequently, why?
7. Have you ever had a Somali female patient who has chosen (or requested) to engage in specialist mental health services?
 - Under what circumstances?
8. Have you ever referred Somali women to specialist MH services? How did that go?
 - Was it effective?
9. In what ways do you think mental health services currently cater for the needs of Somali clients?
10. How do you think services could be improved to meet the needs of Somali clients?
11. What do you think is important information for Somali to be aware/educated about with respect to Western services?
12. What agencies/professionals would you most commonly refer your Somali clients to?
13. Do you deal with MH issues with your Somali women clients yourself?
 - In what ways?
14. What is your understanding of traditional Somali conceptions of wellbeing and distress?

Given that an open-ended and conversational interview style was employed, follow-up questions were often used to seek clarification of responses and to obtain a greater depth of understanding of the issues raised by participants.

The second section of the interview schedule ('Part 2') was developed to seek feedback from participants about three written Vignettes (see Appendix J). The Vignettes outlined examples of psychological and/or spiritual forms of distress

described to me by participants in Study 1. Information was modified, however, to ensure anonymity of the participants in that study as well as the individuals they were referring to when describing these forms of distress. Questions in this section were designed to explore participants' beliefs about the aetiology, antecedents and intervention approaches they considered relevant to each of the three Vignettes. Questions also asked about participants' attitudes to traditional Somali methods of healing as well as their reaction to spirit possession being presented by Somali as an explanation for their distress.

The Vignettes in study 3 were identical to the Vignettes presented to participants in Study 2. Employing the same Vignettes in both Study 2 and Study 3 allowed a direct comparison between the Somali women's responses and those of the mainstream health practitioners. It was thought this comparison would provide some degree of understanding of the ways in which mainstream practitioners and Somali women may have convergent and divergent perspectives on Somali idioms of distress and treatment approaches. Participants in Study 3 were not told what the participants in Study 1 and Study 2 considered the antecedents and aetiology of the states described in each Vignette. What is more, participants in Study 3 were not told what type of intervention (if any) was recommended by participants in the former studies to treat these states. This information was omitted to reduce the likelihood of biasing participants' responses.

Section 3 ('Part 3') was designed to seek further understanding about what clinicians considered the impact of family separation and war experiences are for Somali women. It was thought to be particularly important to explore this issue with

practitioners given that many of the Somali participants in Studies 1 and 2 suggested that mainstream practitioners' primary response to this form of distress is medication-based therapy (which was considered inappropriate by many of the respondents; see the Results and Discussion sections of Chapter 7 for further information). In section 3, the same questions that were used in Study 2 were also explored with the health practitioners in Study 3. Again, it was anticipated that direct comparisons between the perceived significance, and approaches to addressing these psychosocial stressors could be made between participants in Study 2 and Study 3.

The final section of the interview schedule was developed to gain basic demographic information from participants (see Appendix K). As with the previous two studies, the interviews were carried out using a conversational approach, which meant that the questions were not necessarily asked in the same manner in each interview.

The thesis supervisors reviewed the original questions which were then revised based on feedback from these sources. Changes recommended and implemented included restructuring of the interview protocol so that questions were prioritised in terms of importance (i.e., to ensure those questions considered most critical were put to all practitioners), modifying some questions to ensure they that were phrased in an open-ended and non-leading manner, and developing additional questions to try to obtain an adequate depth of understanding of the issues being explored.

Procedure

Ethical approval for the current study was obtained from the University of Waikato's Psychology Department Ethics Committee.

Although it had been intended to run a GP and mainstream mental health focus group, this was not possible. Two of the three local GP participants indicated a preference for individual interviews, hence, all three GPs engaged in face-to-face interviews with the primary researcher. The three health practitioners living in other cities were interviewed by telephone. Individual face-to-face interviews were conducted with all of the mental health clinicians. The specialist refugee mental health workers were interviewed at their place of work using a focus group format.

At the outset of each interview participants were again informed of the rationale behind the research and the types of issues which would be explored. In all interviews consent was provided for the interview to be audiotaped.

Coding and Analysis

As with Studies 1 and 2, a thematic approach to data analysis was taken in the current study. The rationale for employing a thematic approach, the specific thematic techniques employed, and the analytical process undertaken is comprehensively outlined in the Method section of Chapter 6. However, a brief overview of how the thematic analysis was conducted with the results of the current study is provided below.

The audiotaped interviews were transcribed verbatim by an administrative assistant. The transcript data were then checked by the primary researcher for accuracy. The entire data set was then read to search for patterns. All data items

within the set were reviewed in an attempt to reduce the potential of the principal researcher favouring or focusing on certain aspects of the data while ignoring other aspects. During this process preliminary notes were taken that outlined possible themes for coding. Once the principal researcher was familiar with the data, codes were identified at the semantic level of analysis. Data extracts considered relevant to each code were placed in separate word processing files. When themes were identified in participants' statements, the entire statement of that participant was placed within the theme rather than the specific aspects of their statement relevant to the theme. This was done to ensure that the context for each statement relevant to the theme was maintained during the analysis process. Individual extracts of the data were placed into as many different themes as they seemed to fit into. The coded data were then analysed to identify potential themes across the various codes. In the next phase of analysis themes were reviewed to ensure there was adequate data to support each theme and to also ascertain which themes could be collapsed together due to a very high level of similarity of content as well as which themes needed to be broken down into separate sub-themes due to a high degree of divergence of content. Once this process was complete, the entire data set was re-read to ensure the themes extracted reflected the data set and to ensure no themes had been missed in the initial analysis.

Two Western researchers (who were also supervisors of this thesis) experienced in qualitative analysis, refugee and cross-cultural issues (BG and PG) concurrently analysed the transcripts for themes and sub themes. The primary researcher and research supervisors then compared the themes and sub themes they had

independently identified and discussed any discrepancies in their findings until agreement about all of the themes and sub themes was achieved.

In the following Results section, each theme is briefly described and examples from the interview transcripts are used to provide evidence for each theme. It is important to note that the themes are not discrete or mutually exclusive and are often inter-related. They are however, compartmentalised to make interpretation of the data easier.

Results

The following chapter outlines the findings of the thematic data analysis conducted as part of Study 3. It is important to mention that the participants in this study were a highly selective sample. Three of the participants in the health practitioners' group were recruited from practices located in areas where a high proportion of Somali refugees reside. Three of the participants from the mental health clinicians' group were invited to participate directly by the principal researcher given that they were considered by their colleagues to have a high level of professional contact with refugees or non-Western clients. All of the specialist refugee mental health clinicians had a high level of professional contact with refugees. It is important to remember this selective nature of the current sample of participants so that it is not assumed that the views expressed by the respondents are representative of all general and mental health professionals.

It was not always possible to present all of the interview questions to all of the participants. With some respondents time constraints meant that they were not

available to meet for a full hour. In other cases, participants spontaneously provided relevant information without probing.

The first theme identified as part of the thematic analysis was: (i) general (i.e., GPs and nurse-practitioners) and mental health practitioners' perspectives on Somali forms of distress and treatment approaches. A number of sub themes were identified as part of this overarching theme. These were participants perspectives on (a) psychological manifestations of distress for Somali clients, (b) GPs use of psychiatric medication with Somali female clients, and (c) Somali women's contact with mainstream mental health services. The other two primary themes identified were (ii) general and mental health practitioners' views on the effectiveness of current New Zealand services established to assist refugees experiencing psychological distress, and (iii) practitioners' professional practice when working with refugee clients. The second and third themes do not necessarily relate specifically to Somali refugees. However, these data are still considered relevant to the current thesis as they provide an understanding of what the participants considered to be critical issues for refugees generally and also provided an indication of how they view and respond to refugees presenting to their services.

The practitioners' responses to the three Vignettes are also presented at the end of this Results section. The Vignettes are presented independently of the other data so that direct comparisons can be made between the practitioners' responses in this study and those of the Somali female participants in Study 2.

In brackets at the end of each interview extract, information is provided to identify whether the respondent was from the specialist refugee mental health

(SMRH) group (n = 6), the general health practitioner (GHP) group (n = 6), or the mainstream mental health practitioners (MHP) group (n = 6). Each participant in each group was assigned a number (from 1 to 6) and these numbers are also provided in the brackets so that comments from the same participant can be cross-referenced. In each section, the data from the three groups of participants are presented separately because often their perspectives on the themes derived from the transcripts were divergent.

General and Mental Health Practitioners' Perspectives on Somali Forms of Distress and Treatment Approaches

None of the SRMH practitioners had worked with Somali clients. They therefore were not asked directly about their understanding of Somali idioms of distress and no data from this focus group are presented as part of this theme.

Three of the six participants in the general health practitioners' group had considerable experience with Somali women. Although the other three participants had consulted with Somali clients on occasion, their contact with this group was infrequent. One of these three general health practitioners had only met briefly with one Somali woman in an emergency consultation and hence data from his transcript are not included in this section. As a result, most of the general health practitioner transcript extracts and data are derived from the interviews with the three participants who had reported a high level of contact with Somali clients. These general health practitioners reported that somatic presentations of distress were the most common form of psychological distress presented by their Somali clients.

All six of the MHPs said that Somali are very seldom clients at mental health services. All of the MHPs also stated their knowledge of Somali forms of psychological distress was minimal. Only two of the mental health practitioners had worked with Somali clients. As such, only the data from these two MHP participants are presented. The data from the general health practitioners and the two MHP respondents who had contact with Somali clients are presented below.

Perspectives on Somali psychological manifestations of distress

General health practitioners

Within the general health practitioners' group five of the six participants described somatic symptoms as the most common complaint that Somali women presented to them.

So more of what you see is either more minor illness, colds, flu, etc., and some of the psychosomatic illness. One of the doctors... [a specialist] refugee [doctor]... had a wonderful term that he used that I often use in my diagnostic list now which was 'miss', multiple ill-defined somatic symptoms, and that is a very good acronym, you literally do get people coming in with aches, pain, headaches, dizziness, it's clear that this is not something serious and that is a nice, tidy little acronym which I think often does describe it well (GHP 6)

Three general health practitioners said that frequent attendance at GPs surgeries for somatic complaints that had no clear medical aetiology was often an indication that the complaint was more likely to be due to psychological rather than medical factors.

...I think in our stats we see them [Somali women presenting with physical symptoms with no identifiable physical aetiology] three times more often than we see our average white patient... (GHP 2)

Four of the general health practitioners said that regardless of suspecting that some of their Somali female clients' difficulties may be due to a psychological rather than physical aetiology, they would still invariably conduct medical investigations to be confident there was no physical cause for the distress. These general health practitioners said that specialist referrals were often at the insistence of their Somali clients. However, two of these respondents indicated reluctance to refer to specialists when they suspected the aetiology was psychosomatic in nature. These two interviewees stated that this reluctance was due to their belief that such referrals were unnecessary and irrelevant to the suspected psychological basis of the clients' difficulties.

The problem is that quite a number of times the patient really wants a referral to the specialist and their issue is not a referable issue, you know, I've got a pain here or a thing on my skin and I want to go and see a specialist, so it often takes quite a lot of energy to dissuade people of a need to go and be seen by a specialist or to have an X-ray or MRI scan or whatever. I think a lot of times Somali women are expressing their... I suspect they're expressing their depression, anxiety-type, mental health issues in this physical model. (GHP 3)

Psychosocial stressors such as paying bills, finding suitable accommodation, and adapting to the New Zealand way of life, were often considered by general health practitioners as the primary aetiology of Somali women's physical distress. Family separation was considered by three of these respondents to be a particularly major stressor impacting on psychological wellbeing.

A lot of sadness, grief and guilt and this may be behind some of the [physical] symptoms that people are experiencing. I know [specialist refugee mental health service] deal a lot with family reunification issues because people have come here and once the honeymoon period is over, it's like; "I'm here now, Africa is so far away, my family is there and I can't see them and don't know if they can come here, and if they can, well how am I going to get the money?" Those sorts of things, so that

can lead to a lot of stress and potentially mental health issues which could manifest in all the ways...PTSD, depression, feeling sad and miserable. (GHP 5)

In cases where family reunification was not necessarily the primary psychosocial stressor, one general health practitioner suggested that for some Somali women, their psychosomatic distress could at least partly be a means of eliciting support from family members.

... They get a lot of attention when they say the pain is really bad, I mean this is somebody who has been shot through the face and has got some problems, but every month or so it seems to get to a crescendo and the husband brings her in, nothing has changed and I go to the house and they've still got all these medications and haven't started taking them, so what is her secondary gain?...I'm thinking this woman has got a huge family and she most likely has to cope and eventually it gets too much and so she has a sick day, and he [her husband] doesn't know how to cope so he brings her here wanting a cure...I'm wondering if she is getting more attention from him at that stage and he's doing maybe a little bit more around the house...I think he spends a lot of time helping his brother and his sister, and so of course the wife is at home with her very large brood and maybe missing out a bit. (GHP 2)

Three of the general health practitioners asserted that psychosocial stressors seemed to underlie the somatic distress of many Somali women who presented to their agencies. However, these respondents stated that even when attempts were made to try to highlight the possible relationship between psychosocial stressors and physical symptoms, most Somali women would not agree that there was a causal relationship between these factors.

The doctors have tried to actually say, "Often when you are worried about things it makes your headache worse. It would be really good if we could get you to talk to someone about your worries", but there seems to be resistance to that or to accepting that could even be the case. It's only two or three people who have obviously got that. (GHP 2)

Not all Somali women were considered to reject the possibility that their physical distress was due to a psychological aetiology. However, Somali women were considered to present very rarely to general health practitioners with overt concerns about psychological forms of distress.

Anxiety and depression were mentioned by four general health practitioners as psychological forms of distress they believed some of their Somali female clients were experiencing. These respondents said that invariably Somali clients presenting with symptoms indicative of anxiety or depression would not consider their difficulties to be psychological in nature.

Post-traumatic stress disorder (PTSD) was not spontaneously raised by any of the general health practitioners as a common presenting issue for Somali refugees. Two participants were prompted specifically about the impact of war trauma on Somali women however, and they both acknowledged this could be a major source of distress.

PTSD, flashbacks, depression, it doesn't take much for things like a broken window to trigger off those traumas from overseas, a car back firing will cause them panic attacks. (GHP 2)

Trauma-related distress was not raised as a common presenting complaint amongst Somali clients. One general health practitioner suggested that this may be because this form of distress is masked by psychosomatic symptoms.

I guess it's because you observe that sometimes they appear stoical, they don't complain but maybe [trauma-related distress] comes through in other ways by the headaches, body aches, that sort of stuff which probably GPs might see.... (GHP 5)

Only one general health practitioner reported working with a Somali woman diagnosed with psychosis. This respondent said that the woman attributed her psychotic symptoms to leaving a son in Africa.

Mainstream mental health practitioners

The only mainstream mental health practitioner who had worked with a Somali woman in her role at the mental health services said that the client suffered from paranoid schizophrenia. This participant reported however, that there were other psychosocial stressors most likely impacting on this woman's presenting difficulties.

I think she does have a type of mental illness but I also think the challenge for this woman is that she knows nobody. She doesn't have any family here. She has Somali friends but she has almost been isolated by the Somali community because of her unusual behaviours. Really she has nobody. (MHP 1)

The mental health practitioner said she had never seen this Somali woman acting "peculiarly" but had heard reports from members of the Somali community that she did engage in "unusual" behaviours.

This participant also referred to family separation as an issue with this client. The participant said the mental health services attempted to provide some assistance for this, in particular by writing letters to New Zealand Immigration Services on her behalf.

Another participant who had had professional contact with Somali said that the most common cause of distress for women she had worked with, was family separation. This participant had made referrals for Somali women she had worked with to obtain assistance from specialist refugee mental health services. The reason for the referrals tended to vary somewhat, but she said distress about family separation was a common component of most of her referrals. This participant stated she would

primarily refer Somali women for massage therapy, which was apparently a common form of intervention in the particular specialist refugee mental health service she had been associated with.

General health practitioners' use of psychiatric medication with Somali

Two of the general health practitioners who routinely prescribed psychiatric medication to Somali reported that they would discuss how the medication may work to reduce particular vegetative symptoms (e.g., sleep problems and physical pain) rather than overtly state that the medication is for 'depression' or 'anxiety'. These practitioners said their decision not to disclose that the medication was a psychiatric agent was based on their experience that Somali women would not accept psychological explanations for their physical symptoms of distress.

I don't always present it in exactly those terms of saying I think you are depressed and this is an antidepressant medication...I'll often just put it to them as a treatment for their headache. I understand, well I won't be saying this to them, I will understand they have all this stress going on, worry, family back home, they have problems here, they're obviously having psychological distress and that is being manifest by them coming and complaining about these symptoms including headache and pain, so I will put this to them as "let's try this medication, I think it will help with the headaches", and I think it has been a reasonably well accepted thing to do, not always but certainly sometimes it has been quite helpful. (GHP 6)

One general health practitioner suggested that psychiatric medication, even if prescribed and complied with, was unlikely to have a significant therapeutic effect when the Somali client was burdened by major psychosocial stressors.

We've got at least two [Somali] women who keep coming in, and it doesn't matter how many tablets we give them, they are continuing to have the same pain and one lady we just found out recently that she has two young children that she had to leave over in Somalia and we didn't know about that. Her many presentations for

headaches, not sleeping, head pain...we kept trying to work out what the problem was because you could sense that there was a problem but her English was so poor. (GHP 2)

Additionally, compliance issues and failure to attend follow-up appointments were considered major impediments to effective treatment outcomes.

Perspectives on Somali women's contact with mainstream mental health services

General health practitioners

None of the general health practitioners had ever had a Somali client request a referral to a mental health service. Some participants said that they had attempted to refer Somali women to specialist mental health services but invariably the referral was rejected by the client. One participant provided a number of possible reasons that may prevent Somali from accessing these services:

I would think that because of the stigma in the community about mental illness, a lot of people don't come forward. From their belief system they may not even understand that it is something that can be helped with some sort of clinical intervention. There would be a lot of not understanding mental health or mental illness. There would be issues around male consultants, female seeing a male... In our [specialist refugee mental health] service here there is a female psychiatrist and all the therapists are female, which could be a problem for the male [client]. (GHP 5)

Difficulty getting to the physical location of mental health services (due to services being located a considerable distance from suburbs more highly populated with Somali) was also raised by one participant as a factor prohibiting Somali from engaging with such services. The general health practitioners said, however, that it was not just Somali women who were reluctant to engage with mainstream mental health services but also they (i.e., GPs and nurse-practitioners) were reluctant to refer

them to such services. For example, one participant said that they had found it very difficult to attempt to broach the topic of what mental illness actually is with Somali clients due to language and translation problems. Additionally, this general health practitioner reported being concerned that Somali would consider the suggestion that their symptoms were psychological as invalidating their physical distress.

I have certainly suggested it [a referral to mental health services], and interestingly, the whole concept of mental illness, depression in particular, is very difficult. With a kiwi woman if you say “do you think you might be depressed?” she knows immediately what I am talking about and I know immediately what I’m asking her and they can normally say yes or no. But to introduce that whole concept of depression, I’m never really sure, apart from those with very good English, if I raise that as a possible diagnosis that they quite understand what it is that I’m asking them. So that is difficult to raise. And again, you’ve got to be very careful in that not to give the impression when you are steering down that path that you are thinking to yourself that there is nothing physical here, this is all psychological, you have to be very careful not to let the patient have the impression that you think it is in their head because they will often take that the wrong way meaning that you think that they’re making it up or imagining it. (GHP 6)

One general health practitioner said she was aware of some Somali women who had engaged with specialist refugee mental health services in the past but had reportedly not found these services to be helpful. This participant stated she was therefore reluctant to refer other Somali to the same service. Another participant said that he did not think mainstream mental health services had the expertise or knowledge to work with Somali clients and consequently he was therefore reluctant to refer Somali to such services. According to two other participants, one of the primary reasons Somali would accept referrals to mainstream mental health services was to seek assistance with family reunification.

Researcher: So they're often requesting [assistance with family reunification] from your service?

GHP 2: From our service, from mental health services, from [emergency departments], [specialist refugee mental health services] Refugee and Migrant Service. One lady frequently comes in [to the GP practice] extremely distressed and the basis of it all is she wants her mother to come out here and can we please write a letter. Her fits or headaches tend to stop once we get her focused on the mother.

Mainstream mental health practitioners

As already stated none of the MHPs were currently working with Somali clients and only two reported professional contact with Somali women. The participant who had worked with a Somali women diagnosed with paranoid schizophrenia voiced concern that the women's involvement with mental health services may have served, in itself, to alienate her from the rest of the Somali community (as she was apparently very socially isolated). Additionally, the participant described how input from mental health services, although focused on administering antipsychotic medication, nevertheless seemed to become increasingly more focused on addressing psychosocial issues. It was the psychosocial interventions which were also considered by this MHP to be the most critical to the client's wellbeing.

The most effective intervention for her was the psychosocial stuff, because she had nobody. We could get the symptoms of her mental illness under control, no problem, but it was all the other stuff. She didn't have anybody to walk with her through that process of being in a totally foreign country, doesn't speak the language, doesn't know the area at all, and it all became too overwhelming for her... [An occupational therapist] spent a lot of time doing simple things like the bus timetable and actually physically getting on a bus and going for a bus ride with her, those types of things. [A social worker] was involved in the schooling for her child, I think. Really practical-based stuff and making sure it was on a really simple level that she understood what we were doing and why we were doing it. (MHP 1)

Practitioners' Perspectives on the Effectiveness of Current New Zealand Services that Cater to Refugee Clients

The following section outlines practitioners' perspectives on the effectiveness of mainstream services with respect to meeting the needs of refugees generally and is not specifically focused on the needs of Somali. These data were still considered applicable to the current thesis, as it was considered likely that some of the issues raised would be relevant to Somali living in New Zealand. The three groups of practitioners tended to have somewhat divergent perspectives on what were effective and ineffective services and hence the data from the three groups are presented separately below.

Specialist refugee mental health practitioners

The specialist refugee mental health workers voiced concern about the ability of mainstream mental health services to provide effective intervention for refugee clients. This was due to their perception that clinicians in mainstream services did not have adequate knowledge of cross-cultural psychological issues.

Unfortunately, the mental health system hasn't really worked to understanding the different systems, therefore the therapists outside [specialist refugee mental health services], they try to use the same [approaches] that they use for Kiwi people and it really doesn't work. Most of the people, almost all of the people that I have [advocated] for in the mental health setting outside, they dropped out of the therapy after even one year, because they all think it's not helping them, it's not going to work for them, they don't understand them... (SRMH 6)

The integration of both traditional and mainstream Western approaches was also raised as an issue that SRMH participants said made working cross-culturally potentially very difficult for some mainstream practitioners.

... [Refugees] have traditional healing systems which are very different from the Western systems. One of my clients said she didn't know if she should be saying this, but she went to a fortune teller. I said "you don't have to feel bad about saying you want to see a fortune teller"...that belief needs to be respected and I said "do you know any fortune teller here?", she said "no", she asked the interpreter and the interpreter said "yes I know", so I said "maybe after the session you could tell her about the fortune teller". Sometimes there are limits. Okay, maybe they are used to going to a fakir or a healing person or a wise man. Whatever be the system but the Western model cannot reach that. There are similarities between both the models as well but on the surface there are differences which cannot be bridged and which have to be accepted. (SRMH 2)

Another SRMH indicated concern that legislation and ethical guidelines in New Zealand were often inconsistent with the cultural values of many non-Western refugee groups. This SRMH suggested New Zealand's approach to working with clients with mental illness may actually lead to greater rather than less psychological distress for some non-Western clients.

Sometimes in New Zealand law and rules are not working for us as a refugee, for instance, it's too soft. Back home if you know someone who needs medication she or he has to take the medication. The family members will make the person take the medication, make sure the person has got their medication all of the time, but here if someone says I don't want medication, the law does not allow you to give the person the medication. Sometimes we need something from the cultural advisor or some respected people in the community and this gives what would you do back home, especially when the young generation has been growing up here and they know all their rights. If I say I don't want medication, I'm entitled not to receive it. But if in the community or the family and also the professionals know this medication will help the person culturally there are ways to make the person use the medication. New Zealand's flexibility and softness may actually work against people's wellbeing. (SRMH 3)

General health practitioners

The general health practitioners were also critical of mainstream mental health services' ability to cater for the needs of refugees. Some of these interviewees said that

they tended to treat psychological distress in their refugee clients with medication-based therapy and cited lack of resources, lack of expertise and long waiting lists in public agencies as reasons why they tended not to refer to these services.

Two of the general health practitioners said that a difficulty that they faced in ensuring refugee clients received adequate follow-up care for psychological distress, was the limited time they had available to conduct comprehensive assessments in their consultations with these clients.

We don't have the timeframe in a GP consultation to go into too much detail. You certainly can if you can plan ahead, but in the short term by the time you have got through the initial presentation, the introduction, the hellos and worked out what the protocol is in the room with the people involved, you don't get much time for this. (GHP 4)

Even in cases in which psychological distress was identified to be a key issue for refugee clients, one general health practitioner held the opinion that only people experiencing very severe psychiatric disorders (such as psychotic illnesses) were eligible to be seen at mental health services. This participant said this was one of the primary reasons he did not refer many of his clients to mental health agencies.

Another general health practitioner stated that even if a non-Western client was presenting with severe psychological distress such as a psychotic disorder, she would still be reluctant to involve mainstream mental health services.

It's possible that somebody like this may actually need to go through [the local psychiatric inpatient ward], but on the whole I would suspect that that would not be the best for them. Where they need to be is in the home environment on the grounds that going to a completely foreign place like [the local psychiatric inpatient ward] is likely to imbalance further. That would be my concern so I have to think maybe the mental health services in that context may not necessarily be the best place for a foreigner, especially when they can't go with anybody else, can't have any of their family stay with them. (GHP 3)

Another general health practitioner considered language a barrier to effective engagement with mental health services for refugee clients who did not speak English fluently.

... I guess again it's language, it is very hard to engage someone in deep and meaningful, in depth, worthwhile, psychological counselling when you are not speaking the same language. (GHP 6)

Only three of the general health practitioners lived in areas in which specialist refugee mental health services were located. One of these participants said that she did refer refugee clients suffering from psychological distress to specialist refugee mental health services although she said she had never had a Somali client request such a referral. The two other general health practitioners however said that although specialist refugee mental health services were available in the cities they lived in, there were still difficulties for many refugees in accessing these services.

[The specialist refugee mental health services] focus is very much on people who have experienced trauma and they don't see themselves as just a refugee counselling service. They are very under-funded and they've only got the equivalent of two full-time staff for the whole of the region. So, if we refer someone there, it's three or four months [before they will be seen], and they keep saying if there is anything urgent send them to the mental health team, so at the moment I'm finding they're more stressed than the clients. (GHP 2)

One of these practitioners indicated concern about the quality of the local specialist refugee mental health services (in particular, its apparent lack of therapeutic effectiveness) and as such stated he did not refer his refugee clients to this agency.

General health practitioners' perspectives about improving mental health services for refugees

With respect to general health practitioners' opinions about how mental health based interventions could be improved to better meet the needs of refugee clients, greater access to psychologists was mentioned as an important aspect of this process by two interviewees:

One way it could be improved is greater access to psychology in particular. Often when we refer these patients or want to be able to refer on for some other help, it's often not to see a doctor. We don't often refer for a diagnosis but we are often referring for someone to spend the time talking about ways that the patient can change their whole mindset towards life, illness and learn new skills to deal with anxiety and stressors, and that is stuff you don't need a psychiatrist for, you need a good psychologist. (GHP 6)

One general health practitioner also suggested that an increase in cross-cultural workers who not only spoke the same language as refugee clients but also shared an understanding of the world view would increase the accessibility of mental health services to many non-Western clients. Another participant provided a number of ideas with respect to how mental health service access could be improved for Somali women.

Firstly, you would probably have to work through the key community groups and having information that was delivered in a way that was appropriate, probably oral because many of the older women may not read. Presenting information in a variety of ways, oral, written, or with pictures. Talking to the women themselves and finding out what they know about feeling depressed or blue, they must have words in their language for those things. Getting a bit more of a perspective from their point of view. I don't think mainstream services will be able to cater for their needs unless they understand where they are coming from in terms of those issues. It's going back to the people and finding out from them. (GHP 5)

Psychosocial interventions primarily focusing on increasing social support networks outside of the home were also suggested as critical to enhancing psychological wellbeing by one general health practitioner.

Mental health practitioners

The MHPs reported divergent perspectives on the efficacy and accessibility of mainstream mental health services for non-Western clients. Two MHPs said that mental health services' apparent immersion in the medical model was a major impediment to effective intervention for many clients (not just non-Western clients) and considered that there were a large number of clients who would benefit more from addressing the psychosocial reasons for their difficulties rather than utilising medication-based interventions. However, one of these MHPs suggested that non-Western clients had a tendency to defer to the advice of psychiatrists and hence were more likely than Western clients to accept psychiatric medication as the treatment of choice.

MHP 2: ...It worries me that the first port of call is always medication, that's what the service does, they all get medication.

Researcher: What is their response to the medications?...

MHP 2: All the [non-Western clients] I talked to were concerned about the effects it had on them. They noticed it was slowing them down, they felt very much affected by it and were worried about it but they also thought the doctor knows best so I have to do what the doctor tells me.

Another MHP considered that the mainstream mental health services they were employed by had worked hard to ensure that interpreters were accessible to non-English speaking clients. Two MHPs from this service stated, however, that all their non-Western clients who were not fluent in English had declined to have an interpreter attend therapy sessions with them. Fear of being labelled within their own

communities as having a mental illness was the primary reason suggested by one MHP for reluctance of these clients to use interpreters. Only one MHP stated that they considered interpreters a key component to ensuring mental health services efficaciously met the needs of non-English speaking clients.

... I really believe to have depth in it you need the interpreter, so you can ask at a level in which to get that real depth and guts into what you are doing. (MHP 3)

Two other participants indicated their reluctance to work via interpreters due to concern about how interpreters may subtly change the nature of what the client is saying and hence suggested the true meaning of clients' communications may be distorted. One of these MHPs said that it was for this reason that she was very reluctant to work with non-English speaking clients.

Mental health practitioners' perspectives about improving mental health services for refugees

With respect to MHPs opinions on how to improve service efficacy and accessibility, numerous ideas were put forward by participants. One interviewee suggested that increased focus on hiring cross-cultural workers was critical to service improvement.

Have a [cross-cultural facilitator] there all the time so that when these people come through the service that they're there to say look, can you come with us and walk with us through this journey, rather than having to organise an interpreter, because as soon as you have to organise an interpreter to understand somebody they're automatically different. Having more resources available in terms of people... Why not employ someone or a couple of people that could do that and see them in the hospital through the process and see them again in the community in their homes (MHP 1).

One participant discussed how she thought mainstream mental health services could be made more accessible for refugees. She also described her intentions to work towards this outcome:

... so what you are needing to do is that grass roots stuff again, getting it into places like the Migrant Resource Centre, the GPs needing to know the processes, but you know going to a GP, when you talk about going to the GP and you haven't got one that speaks your language as well so you can't get that in-depth stuff. Sometimes people think you can just walk through the door but you actually need referrals, so you need to inform them in their own language. If you've got a pamphlet, have it in that language, identify people like GPs or identify services that can support different cultures more.... and that's how I plan to do what I am doing, once I have done the base stuff, is a letter to the community leaders and the community groups and then going in and developing a presentation talking about mental illness... It's about breaking down those barriers slowly ... (MHP 3)

On the other hand, another MHP said that it was hard from an economic perspective to justify increasing resources for working with non-Western clients as there were so few engaging in mainstream mental health services. Additionally, one MHP stated that although mental health services were not necessarily well equipped to work with culturally diverse groups, a lack of human resources within such services meant that increasing accessibility for refugee clients was not realistic:

I don't know if I want to increase the number [of refugee clients] because we still have more [clients] than we could poke a stick at. (MHP 6)

One MHP located in an area where there was not a specialist refugee mental health service, considered that it was important to have such services available to support and enhance the well-being of refugees entering New Zealand. This MHP asserted that all refugees are likely to be suffering from some form of psychological distress that would benefit from formal intervention. She suggested that a 'drop-in

centre' that could cater for the psychiatric, psychological and practical needs (such as housing, electricity, employment) was likely to be a more effective approach than attempting to modify existing mental health services.

In one centre where the current study was conducted, participants were aware of a number of research projects that were attempting to develop a better understanding of the psychological issues refugees were dealing with and how services may better meet the needs of this group.

They are doing some research to see what is happening. One of the nurses is doing a Masters research and feeding back some information at meetings which is good. At least people are getting more aware. I think the [district health board] itself is doing a research project next year looking into the multi-cultural aspects of health delivery. It means that people are aware. (MHP 2)

Practitioners' approaches to working with refugee clients generally

The interview data related to practitioners' approaches to working with refugees generally are outlined below. The data from the three participant groups are presented separately below.

Specialist refugee mental health practitioners

Within the SRMH focus group, the importance of using empathic interviewing and assessment strategies was considered a critical aspect of working with refugees by one practitioner.

It's an art of doing an assessment without asking questions... then the whole thing is conducting an assessment but without making them feel this is an interrogation because they have been exposed to places where the doctor also could be somebody who could be interrogating them to gain information that will be used against them. (SRMH 1)

Rapport building and focusing on developing a strong therapeutic alliance were also considered key components of therapy by members of the SRMH focus group.

I think basic psychotherapy skills, listening, empathy, very basic skills make the foundation of the relationship because they've been struggling for so long in their lives and their families and especially the women. Nobody has asked them how have you been feeling, there's nobody to take care, here is this person listening to you for one hour, she's giving that exclusive attention to you and you are talking about yourself and who wants your welfare. (SRMH 2)

The SRMH practitioners stated that generally family separation was a major form of psychological distress for most refugee groups that they worked with. These participants commented that the nature and extent of therapy would depend on the cultural background of the client. Interviewees in the SRMH focus group stated that education about what therapy entails was a key aspect of orientating clients who had not been exposed to psychotherapy in their country of origin to the potential effectiveness of such an approach.

Although participants accepted that refugees have traumatic histories, the SRMH practitioners said that they would not necessarily focus on past trauma as part of therapy with these clients. Rather, they stated that they tended to place a greater emphasis on assisting refugees to orient to their host country and new environment and establish skills for negotiating this environment effectively.

The SRMH participants reported using cognitive-behavioural, narrative, and psychodynamic psychotherapy approaches. From one of the SRMH psychologists' accounts, such interventions would be applied to assist with practical problems of everyday living as well as to assist in alleviating psychological distress related to

states such as anxiety and depression. These practitioners also said that a common aspect of their work was to act as an advocate for their refugee clients:

... Also something I've begun to do is goal planning, think into the future. "What are your goals in the next 6 months, between 6 months and 12 months, what are your goals? Supposing one of your goals is to get your family members, now how will that happen? What resources do you have? Maybe before that you need to learn English." There will be other priorities. The children are there, they have to go to school, so work out how... they might need to collect a lot of money before they can get a family member, so go through the stages and then help them to get through in telling it to Immigration if need be, Red Cross if need be, so telling them information. (SRMH 1)

Only one participant from the SRMH group said that they would sometimes refer clients with depression to psychiatrists for medication-based therapy. On the other hand, these participants reported commonly referring clients for (or engaging clients in) massage therapy. These practitioners said that massage therapy was not necessarily a treatment for chronic pain, but rather was often utilised to assist in relieving stress and as a way of building trust with clients to increase the likelihood they would be willing to be referred for specialist psychological intervention.

In the beginning it's a relaxation, a very soft, caring touch just to relieve them of stress because a lot of these people haven't had that personal touch... so in the beginning it's just a soft massage to establish that trust and to get their body used to that, and then by the second treatment you can go a bit further and can actually start treating them, and often you will find some dysfunction in the body somewhere and immediately you start working on that, that's when you start to build up a trusting relationship, especially once you start getting results...you've built up this trust with them, so next time when you start talking to them about anything they really start to open up and then if they want to talk more about something you can refer them to a psychologist (SRMH 5).

The SRMH participants said that massage therapy was the most popular intervention offered by their service.

General health practitioners

The general health practitioners reported that their approach to treating non-Somali refugees was the same as that when working with Somali – primarily medication-based therapy and occasionally referral to secondary services. Consequently, these data do not require further elaboration.

Mental health practitioners

Although one of the MHPs said he did not think he adapted his practice in a significant way when working with non-Western clients, he stated that he did tend to take a “gentler” and more careful approach to exploring issues to decrease the likelihood he would cause offence. Another MHP said he attempted to decrease the possible client-practitioner power imbalance when he worked with non-Western clients by “walking alongside” the client and attempted to establish a relationship based on equality. The one MHP who had worked regularly with interpreters said that she would often consult with interpreters prior to meeting with clients from particular backgrounds. She said this was to try to ensure that she was familiar with basic cultural practices and to decrease the likelihood that she would offend the person she was intending to meet with.

All of the mental health practitioners reported that family were involved in therapy at some point with non-Western clients. Participants said family members often acted as interpreters but were also a key form of support for their client during consultations.

With respect to intervention approaches, two of the psychologists interviewed reported primarily using a combination of cognitive-behavioural strategies (e.g.,

activity scheduling, relaxation training), and practical interventions (e.g., encouraging exercise and healthy eating, assistance with developing curriculum vita) to improve wellbeing. The third psychologist considered cognitive-behavioural therapy to be “too simplistic” an approach and reported using a more systemic intervention that focused on the context of interpersonal relationships in her client work. All of the MHPs said that advocacy and assistance negotiating processes with government agencies were common approaches they employed with refugee clients.

The MHP participants said that referrals to occupational therapists and social workers were the most common types of referrals they made for non-Western clients. Assistance from these two professional groups was considered very effective for such clients. Although the MHPs said the use of psychiatric medication was prevalent amongst non-Western mental health clients, only one of the MHPs said that they would make a referral for psychiatric intervention.

The Vignettes

As stated in the Method section of this chapter, the primary researcher asked participants a number of questions about the most likely explanation for the behaviour of the women in the Vignettes as well as their perspectives about interventions that may be efficacious in each case. Outlined below are the three Vignettes followed by the participants’ responses to each Vignette.

Vignette 1

“There is a Somali woman who can be working or doing something for 24 hours without getting tired. Sometimes she walks all day and all night and she is not even going anywhere. She also talks to someone other people can’t see, she will talk, and

laugh and she doesn't care about showering or cleaning herself. Sometimes she gets really violent. There was this time when this older Somali lady was standing in her way and she pushed her to the ground. Sometimes when the voices go away and she is not being violent and starts looking after herself again she says that she can't remember doing any of these things once she stopped."

Findings based on Vignette 1

Participants in the SRMH focus group as well as all six general health practitioners and all six of the MHPs said they would consider psychosis as a possible explanation for the woman in Vignette 1's distress. Three general health practitioners also queried whether depression would be the most likely hypothesis for this presentation and one suggested that anxiety may be the reason for her symptoms.

Regardless of many of the participants stating they would consider Western psychiatric disorders as likely explanations for the woman in Vignette 1's distress, the SRMH participants, three of the general health practitioners and four MHPs said that traditional cultural explanations would also be worthy of exploration. One SRMH participant said that within rural Indian culture this presentation may be attributed to spirit possession and hence, queried spirit possession as an explanation for the woman in Vignette 1's distress.

One general health practitioner, four MHPs as well as the SMRH focus group participants stated they would attempt to seek appropriate cultural consultation to advise and assist with the difficulties this client is experiencing.

The one thing I would like to see is an authentic cultural opinion of these presenting symptoms. What is the significance within the Somali cultural context and what would the cultural perspective be on the factors likely to be causing these particular behaviours and if

these behaviours occur within the Somali cultural context how would they be regarded and how would they be addressed? (SRMH 4)

Two of the MHPs said, however, that regardless of whether the woman in Vignette 1 and/or her family and community interpreted her behaviour as problematic (or not), many aspects of this behaviour could still be considered ‘abnormal’. They said that this assertion was irrespective of the cultural background of the client.

What I’m saying is happening here is out of the norm, and we haven’t got a history yet, I haven’t got any background yet. It is still out of the norm to do something for 24 hours without getting tired, so there’s something happening there. She walks all day and all night, that’s out of the normal behaviour for any culture, the self care is down, the violence, and she talks about voices....I’d put it to somebody to make a decision around what is going on. I’m looking at things that are out of the ordinary and they need to be tended to, she’s not stable and we need to get her to a place of stability. (MHP 5)

Members of the SRMH focus group, three of the general health practitioners and three of the MHPs reported that collateral information from the referrer and family members was important to understanding the nature of this woman’s distress. Additionally, the SRMH focus group participants, four of the general health practitioners, and four of the MHPs said that they would want to conduct a comprehensive assessment of contextual stressors such as family, spiritual and social factors that may have contributed to the manifestation of the woman’s symptoms.

And I would be looking at financial, physical, emotional and spiritual stuff. You can’t not look at the whole package of what’s happening; grief, loss. Because we know that even just by leaving her country all those things are happening. What fears are involved, how we can support her practically on a day-to-day basis until she is stabilised. (MHP 5)

Two of the six general health practitioners reported that a comprehensive assessment of the woman’s medical history was important to rule out a medical illness

in the aetiology of her difficulties. None of the SRMH participants or the MHP participants said they would explore potential medical aetiologies. Additionally, four members of the general health practitioners' group said they would initially consult with psychiatrists or specialist psychiatric services if the woman in Vignette 1 presented to their agency.

I'm sure the first thing our doctors would do would be to call for [an urgent assessment by the psychiatric crisis assessment team] or mental health assessment before they did anything else. (GHP 2)

Three of the MHPs said it would be important to employ an interpreter to assist with the assessment.

The first thing I would do is make sure we had an interpreter because you wouldn't get anywhere without one, unless there was a Somali person who was able to interpret for you. (MHP 1)

None of the participants in the other two groups said they would consider the use of an interpreter in this case.

The SRMH focus group participants, four general health practitioners, and all six of MHPs said the potential of risk of serious harm to self or others was as an issue which would need to be carefully explored with the woman in Vignette 1. Three of the six participants in the MHP group acknowledged that the woman's difficulties may become more difficult to adequately manage from a Western perspective if she did not wish to pursue mainstream mental health interventions. These MHPs discussed the potential dilemma of attempting to adequately monitor the potential serious risk to herself and others while on the other hand not impinging on cultural beliefs.

[Resistance to Western intervention] presents a dilemma. There's a risk to the person and the others around them and I'm obliged to do something more. If they're completely resistant then I'd have to use legal

means to ensure safety and that's not going to work well culturally at all. (MHP 2)

All of the MHP participants said, however, that identification of serious safety issues would warrant an increase in the level of intervention provided by the mainstream mental health services irrespective of whether the woman in Vignette 1 consented to such interventions.

When asked about their response if the client or their family were to state that the explanation for the distress was due to spirit possession, the four general health practitioners who were specifically asked about this reported that they would be at least overtly accepting of this assertion. These interviewees also said they would support the use of traditional treatment approaches to extract the spirit. The five MHPs who were asked about their likely response if the woman or her family said her difficulties were due to spirit possession said they would attempt to understand and incorporate this explanation into their way of working with the client. Participants in the SRMH group, one general health practitioner and the aforementioned five MHPs said they would encourage the woman in Vignette 1 to take an integrated approach to treatment that comprised both Western (i.e., primarily psychiatric medication and/or psychological treatment) and traditional interventions.

With respect to intervention approaches, three MHP participants and four general health practitioners said that psychiatric medication would be the primary treatment they would recommend for the woman in Vignette 1. One MHP participant and one general health practitioner stated however, that medication would only be one aspect of the intervention and highlighted the importance of exploring psychosocial factors that could also be addressed to help alleviate distress.

Four of the general health practitioners were asked about their possible reaction if this woman or her family were to inform them that they were going to exclusively treat her presentation with Koran readings. These interviewees (two of whom said that they did not accept spirit possession as a possible explanation for the distress) said they would be overtly supportive of this intervention.

I'd think that was fine. I think you'd say that's okay, let's watch and wait to see what happens. I don't need to interfere here, so long as she is no risk to herself or others then we could negotiate a timeframe for how she expects that form of input therapy to show any signs of working and then it's a case of where we go from there if there is no resolution. (GHP 4)

If the potential of risk of harm to self or others was high, however, the four aforementioned general health practitioners said they may take a more active role in the client's care.

I wouldn't have a problem with [Koran recitations] provided I didn't feel they were a danger to themselves or anyone else. Again, you have an obligation to act if you felt that was the case. There's obviously many ways to skin a cat and it's not as if we've got the monopoly on every answer in western medicine so we clearly don't always have the cure. So I would be quite happy for someone to try that if I felt they were safe. (GHP 6)

All of the MHPs were also supportive of Koran recitations being an aspect of the intervention employed with this woman. These participants said however, that in this case, they would still attempt to remain involved with the woman to monitor her progress.

I would say "if that's what you would like [to conduct Koran readings], then it's important to continue that, but I also think it would be helpful for you to come and talk with the doctor and see what other options are available so that you can work hand in hand". I would tell them she doesn't have to take the medication but may find it helps. I wouldn't say you have to stop the readings. You can't do that. (MHP 1)

Vignette 2

“Another Somali woman has frequent nightmares about her family who she left behind in a refugee camp. At times she says that she will be sleeping on her bed and she will start seeing the people who died in front of her or the pile of bodies, some of which were familiar, that she helped bury or move from the roads. This woman said that these experiences will never be erased from her memory even though she tries to forget them by occupying herself with other things. She also said that she drops to the ground if she hears a siren as that reminds her of the war back home too.”

Findings based on Vignette 2

Participants in the SRMH group as well as four of the six general health practitioners and three of the six MHPs said that PTSD was a possible explanation for the woman in Vignette 2’s distress. One of the general health practitioners also suggested the woman could be suffering from comorbid depression. Two other general health practitioners and three MHPs stated that her distress seemed trauma-related but did not suggest a diagnostic label. One MHP stated that although he considered the woman in Vignette 2’s behaviour to be consistent with PTSD, it was also important to normalise rather than pathologise her anxiety response.

We have PTSD here. That’s our interpretation of what we’re hearing here. When we have a person who collapses in a heap on the ground as soon as she hears a siren, that is a fairly automatic response to imminent danger, and usually in her life this is going to be death, because anyone who is standing is a threat. Her response in some ways is very self preserving, and you can’t take that from her, so it’s a case of trying to get a person to look at in terms of, this is no longer appropriate in this kind of setting, so it’s looking at behaviour whether it actually fits the changed circumstances. (MHP 5)

One of the general health practitioners and one of the MHPs said that they would attempt to consult with the woman in Vignette 2's family to get a comprehensive understanding of the family context. Two of the general health practitioners stated that assessing the role of cultural and spiritual factors impacting on this woman's distress was important. Seeking appropriate cultural consultation was mentioned by one participant. This interviewee was an MHP and said such consultation was an important aspect of determining how to proceed with therapy and how therapy may need to be adapted to best suit the needs of this woman.

Two of the general health practitioners said their decision to suggest formal mainstream assistance to the woman in Vignette 2 would depend partly on how much she considered her distress was impacting on her everyday life and to what extent support systems within her own community were effectively in place.

I suppose the big question is how much does it affect her life. The next bit is, if it does affect her life, dealing with it in terms of verbalising it to other people, be it friends, family, religious people, counsellors and that sort of stuff, can be therapeutic... It's better to tell people so you can run through your emotions with them rather than bottling it up.... The next bit would be exploring, is that something that she would be comfortable doing, will she be comfortable doing it in her own social network. No doubt the friends, female friends in particular, or elder females that she could talk to about or we could specifically involve someone that's trained to be able to, psychologists, counsellors, that sort of thing...(GHP 4)

With respect to Western-based treatment approaches, the SRMH focus group participants as well as three of the general health practitioners and one MHP said that psychotherapy, (primarily exposure based interventions) would likely be the treatment of choice for the woman in Vignette 2. They said, however, that there may be many Somali clients who would choose not to engage in this form of intervention. Being

particularly sensitive to the client's emotional state and willingness to engage in exposure therapy was considered important by SRMH interviewees. Additionally, the SRMH participants as well as three general health practitioners said it was important to consider involving a GP or psychiatrist for medication-based therapy if the trauma symptoms were significantly interfering with the woman in Vignette 2's life.

Again it will depend on the severity and when we read [the Vignette] it looks gruesome but some clients do have the capability to talk about it and it is important for them to go through exactly what happened. Every time it is a different story, horrible stories about the trauma or torture that they have experienced, but at the same time there are many of them who would not like to talk about it as well which needs to be respected. I would right in the beginning, especially for the clients who might be very sensitive, I would say if I say something or put a question to you that you don't like, please let me know. Let me know if I'm going into an area which is not comfortable for them and if the thoughts are very intrusive, it's really disturbing their life activity and patterns, yes, then a psychiatrist needs to be involved, follow up referrals to a mental health centre or through the GP to take place. (SRMH 2)

One MHP said, however, she was doubtful that medication would be useful for this woman.

Is there medication for this? I don't know if there is medication for a memory and the experience and the pain. I totally believe there is something in this that she needs the supporting networks and the expertise of a psychologist to be able to work through these things ... (MHP 3)

Although three general health practitioners said they considered psychological and psychiatric-medication based intervention appropriate for the woman in Vignette 2, only one of these interviewees said he would probably refer this woman to mainstream mental health services. Another general health practitioner stated she would refer the woman to specialist refugee mental health services. On the other

hand, two general health practitioner interviewees said they would be unlikely to refer this woman to mental health services. One of these participants thought that the woman would benefit from psychological treatment but did not think mainstream services would be able to provide this effectively (for reasons outlined earlier). The other interviewee said she did not believe that Western interventions were likely to be efficacious or necessary. Rather, she suggested the woman's symptoms were a normal and understandable response to her traumatic experiences. This interviewee as well as one MHP said that orienting refugees to their new host country and developing community-based supports, would likely be the most effective means of reducing their levels of trauma-related anxiety.

I think one of the key things is again community relationship, having support people who take people around in the community, explain to them what's happening here, the local police station, what they're likely to hear, what the sirens are... so it's all part of awareness stuff of a really new community. If you have ever lived cross culturally in a community, there are all sorts of things that happen, and unexpected noises and events that actually can be quite worrying, and to have someone say that just happens once a year, this is whatever, is really helpful. (GHP 3)

Vignette 3

“Another Somali woman has started staying in bed a lot and has stopped looking after her house. She only leaves her house to drop her children at school and pick them up. Some of this woman's friends say that they have seen her crying. Often when you talk directly to her she doesn't even seem to notice. Her husband is concerned that she has become very forgetful and might leave something on the stovetop and burn their house down. This Somali woman said that when she was asleep she would

experience dreaming and think that someone called her name but there is no one there.”

Findings based on Vignette 3

The SRMH participants as well as all of the general health and mental health practitioners stated that depression was the primary Western psychiatric hypothesis they would explore with the woman in Vignette 3. The SRMH participants also suggested that dementia may be an explanation for the woman’s presentation. Additionally, one of the MHPs said that psychosis or anxiety were possible explanations. Four MHPs stated that exploring the meaning of the symptoms from the client’s perspective and whether the woman in Vignette 3 considered her presentation to be problematic or abnormal was as an important aspect of assessment.

Additionally, one of the general health practitioners as well as one of the MHPs said they would also consider cultural or spiritual explanations for this woman’s presenting distress.

Again there is the spiritual side of things. Is she being possessed by a spirit or has she had some of her spirit energy sapped from her, whether there is a cultural explanation for that. Otherwise, is she showing signs of overt depression? (GHP 4)

The SRMH participants said that they would engage in cultural consultation as part of their standard assessment approach with the woman in Vignette 3. Two MHPs said that they would want to learn more about how depression manifests and is typically dealt with in Somali culture. Additionally, one of the MHPs and one of the general health practitioners, as well as the participants in the SRMH focus group said that psychosocial factors that may be contributing to this woman’s distress were important issues to investigate.

Her husband might be beating her up, she might be socially isolated, she might not speak the language at all and be feeling culturally isolated because her children have gone to school and she is alone at home. (MHP 4)

Four of the general health practitioners and one of the MHPs said they would be interested in obtaining information about how the woman in Vignette 3's symptoms were impacting on her day-to-day life as well as her current life circumstances. Willingness to accommodate the wishes of the Somali woman were mentioned by three MHPs – whether this meant seeing her at home, having a numerous family present during the assessment and intervention, or having young family members act as interpreters at the woman's request.

The SRMH participants as well as one general health practitioner stated that they would be interested in trying to facilitate a Somali community-based response to assisting the woman in Vignette 3. With respect to Western-based interventions, the focus group participants said that non-directive psychotherapies (such as psychodynamic approaches) would most likely be employed by their psychologists with this woman. Three general health practitioners said they would consider referring the woman in Vignette 3 to a counsellor or psychologist. Three MHPs stated that basic cognitive-behavioural strategies that focused on increasing the woman in Vignette 3's activity level, helped her address resettlement issues, and increased her interaction with her family and community were likely to be the most efficacious approaches to treatment.

... starting to look at a gradual reactivation programme with some support from her husband. Maybe that they start looking at cooking together rather than her doing it on her own, making sure she is getting adequate sleep, adequate food, maybe also adequate time without the kids and maybe that she is able to socialise with people from within her culture and without. Seeing whether she is doing something about getting to know and feel more

familiar and comfortable with New Zealand itself, the language, the people. (MHP 6)

Three of the MHPs, five of the general health practitioners and the participants in the SRMH focus group said that medication-based interventions were a likely treatment option for the woman in Vignette 3. Two of the MHP interviewees, however, discussed potential difficulties with taking this approach.

...and that probably would necessitate from a medical viewpoint perhaps, some antidepressant medication, probably something to help a person sleep better...and we all know from a Western medicine point of view can mean that sedatives can make dream states worse, because you don't wake up when things get bad where in normal sleep cycles if it gets really bad sometimes people wake up and survive it that way, as it were. (MHP 5)

Summary of Results

In summary, the general health practitioners reported a considerably greater level of contact with Somali women than either the SRMH practitioners or the MHPs. The general health practitioners described psychosomatic distress as the most common presentation of psychological distress amongst Somali clients. Although these interviewees generally suspected that anxiety or depressive states were the underlying aetiology of this distress, they reported that often Somali would fail to accept a psychological explanation.

The psychosocial stressors identified as contributing to psychological distress for Somali women were relatively consistent across the three groups of health professionals and also consistent with the stressors identified by the participants in Studies 1 and 2. Although trauma was considered a typical aspect of the history of Somali women by the current interviewees, PTSD was not considered a common

psychological response to this trauma. Rather, participants considered stressors impacting on Somali refugees' quality of life more pressing issues to address.

Medication-based interventions were generally the treatment of choice for general health practitioners working with Somali women. A number of these participants, however, acknowledged that medication was of limited value, particularly when the key reason for the distress of their Somali clients was due to psychosocial factors. Both the SRMH and MH participants primarily suggested that psychotherapy would be the treatment of choice for Somali women experiencing psychological distress, albeit adapted somewhat to more adequately respond to their cultural needs. Many of the participants said they would be motivated to assist their Somali clients through advocacy work and assistance with day-to-day concerns. Concern about the efficacy and accessibility of both mainstream mental health services as well as specialist refugee mental health services was raised by numerous participants. Some of these participants' concerns were so strong that they indicated they would not refer clients to such services even when they may be clearly eligible for assistance from secondary health services.

Generally, participants were supportive of traditional forms of healing being used as the treatment of choice by their Somali clients. This support seemed to be primarily based on participants' desire to demonstrate acceptance, tolerance, and respect for the cultural beliefs of their clients. Most of the interviewees, however, said that they would encourage their clients to also engage in Western-based interventions as well. Unless there were major safety issues that the practitioners felt compelled to monitor or respond to, they generally said that if a client was adamant

that he or she did not wish to pursue mainstream intervention, they would accept this decision.

All of the participants (who were asked about this) said they would be overtly supportive of a Somali client who asserted that spirit possession was the basis of their presenting difficulties. Some of the participants, however, considered such a belief system “primitive”, while others seemed to have a greater acceptance of the validity of spiritual explanations for suffering. Again, participants were supportive of traditional approaches being undertaken but also said they would attempt to remain involved in the client’s care.

Participants’ perception of the role of interpreters varied. Some considered interpreters invaluable and a necessity, while other participants stated that they were concerned interpreters may subtly change the client’s meaning in such a way that the information relayed to them would become inaccurate. Regardless of interviewees’ perspectives on interpreters, it appears from the data that they were infrequently used with Somali clients due to (i) lack of time and resources in primary health care to employ interpreters, and (ii) Somali not wanting to work via an interpreter due to fear that confidentiality may be compromised.

The following Discussion section will interpret and discuss the possible meaning of the results of Study 3.

Discussion

The original objectives of Study 3 were to gauge non-Somali health professionals’ understanding of: (i) the nature of distress and suffering experienced by Somali women, and (ii) effective Western and traditional treatment modalities to

ameliorate this distress. Given, however, that so few of the mental health practitioners and in fact none of the specialist refugee mental health practitioners had worked with Somali, these practitioners' approaches to working with refugees and non-Western clients generally were explored. The Vignettes provided the opportunity to theoretically explore how practitioners may approach the assessment and treatment process with Somali. The following sections summarise the key issues identified in the results.

Psychosomatic Presentations of Distress

The general health practitioners described psychosomatic complaints as a common means by which psychological distress manifested for Somali women. Additionally, these practitioners said that psychosocial stressors commonly co-occurred with psychosomatic complaints. According to the general health practitioners, Somali women were often resistant to the possibility that their physical complaints had a psychological aetiology. This finding is consistent with the results of Study 2. Furthermore, some of the women in Study 2 considered the suggestion to trial psychiatric medication invalidating which could lead to an erosion of trust in the general health practitioner. Consequently, in the current study, the general health practitioners' reluctance to suggest a psychological explanation for physical distress to many Somali clients due to fear of negative reactions and ruining rapport, is supported by the findings of Study 2.

The question of why some Somali may continue to attend consultations with their primary health care providers for non-specific physical symptoms of distress if both they, and in some cases the general health practitioners too, find that these

consultations are of little benefit, requires some consideration. One possible explanation for Somali clients' apparent tendency to consult with their GPs for non-specific physical symptoms of distress (rather than attend mental health services for assistance) could be that this avenue is more salient to Somali. That is, GP surgeries are often in relatively close proximity to suburbs in which a high proportion of Somali live. They are therefore visible to Somali on a day-to-day basis. Mental health services, however, are typically centralised to one or a small number of locations within cities. Somali may therefore not be exposed to such services to the same extent as they are exposed to available medical services. Hence, Somali may be more inclined to access services that they are familiar with and for which they have some understanding of the basic operating principles.

Another explanation as suggested in Study 1, is that these visits may function to allow Somali experiencing a high degree of psychosocial stressors to seek support both from health professionals as well as from their community without fear of being considered "crazy". Furthermore, attending frequent consultations with primary health care providers and seeking specialist referrals represents to the family and social support network of the Somali client, the potential seriousness of their distress. Consequently, the function of attending consultations with general health practitioners may have less to do with seeking medical assistance and more to do with enhancing community and family support.

Depression in Western society may serve a similar function for many sufferers – that is, depression can be a form of communication to those in the sufferers' environment that they require additional support at a time of high psychosocial stress.

This does not suggest that the psychological distress is fabricated by the individual in question, or that the communication of distress is a conscious attempt to obtain social reinforcement. It does, however, seem an adaptive response for someone experiencing significant psychological distress to intentionally attempt to obtain social support at times of high stress. Hence, psychosomatic presentations may be an adaptive means of actively eliciting support from one's environment without fear of being stigmatised with the diagnosis of a mental disorder.

Western explanatory models of psychosomatic disorders, suggest that sufferers are not intentionally acting to elicit community and social support. Rather, the sufferer is often convinced that there is an underlying physical aetiology that medical specialists are yet to diagnose (Hawton, Salvkoskis, & Dobson, 1986). This Western formulation of somatoform disorders seems to be consistent with the formulation held by some Somali women with respect to the distinction made between psychosocial stressors and physical symptoms of distress. The current findings however, could not identify whether Somali are any more likely than their Western counterparts to present to their GP with psychosomatic complaints. Even if there is a higher rate of somatoform presentations in Somali than Western primary health care clients (who are experiencing similar levels of psychosocial stressors), it is possible that this presentation is made more salient for Somali given their apparent reluctance to consult with their GPs about any other form of psychological distress (see Studies 1 and 2). Consequently, the prevalence of somatoform presentations may be no higher for Somali than Western clients.

Psychosomatic Distress versus Jinn Possession

Participants in Study 2 described frequent visits to medical professionals, ongoing requests for further medical investigations, and numerous physical complaints with no clear physical aetiology as indicators of jinn. Interestingly, the general health practitioners in Study 3 considered the same symptoms as indicators of psychosomatic distress. None of the participants in the current study, however, said that jinn were suggested as the primary explanation for the physical distress by their Somali clients. This may be because Somali often do not initially consider that it is jinn causing their physical symptoms (as suggested in Study 2) and therefore are not likely to pass such information on to their general health practitioners. It is also possible that Somali are reluctant to inform their general health practitioners about their belief that their symptoms are due to jinn because of concern about how a non-Muslim practitioner (who works primarily within a scientific rather than spiritual/religious paradigm) may react to this information. The evidence from the current research suggests that Somali are more accepting of a spiritual explanation for physical symptoms of unknown aetiology than they are of a psychological explanation. It seems critical then, that general health practitioners are aware that some Somali may consider their physical distress as caused by jinn. Awareness of this explanatory model may help speed recovery from symptoms if an integrated and culturally appropriate intervention is developed. It is important however, that practitioners do not employ jinn as a default diagnosis in circumstances where no clear explanation can be identified for physical symptoms. Such an approach would

not only be stigmatising for Somali but may also prevent other possible explanations for the physical symptoms being explored.

General Health Practitioners' Use of Medication with Somali Women

The finding that GPs do not always disclose to Somali women that they are prescribing them a psychiatric medication is of considerable concern. Lack of understanding of the rationale behind taking particular medications is likely to lead to poor compliance in some cases and in other cases may in fact be dangerous to the patient if not used in the prescribed manner. That is, Somali may over or under use psychiatric medications which, based on the side effect profile of the medication may lead to numerous outcomes including impairment to driving skills (due to sedation or drowsiness), impaired ability to adequately care for dependent children (again potentially due to sedation or drowsiness), psychotic reactions and major medical problems (e.g., hypotension, hypertenstion, arrhythmias, strokes; MediMedia, 2004).

The potential risks associated with such prescribing practices stretch beyond the actual client as it is possible that Somali receiving medication in this manner may also use their prescribed 'pain' medication (i.e., antidepressant or anxiolytic) as an analgesic with other family members (including children). Additionally, learning that the medication is for 'psychiatric' conditions appears to lead to some Somali women discontinuing the medication (see Studies 1 and 2) which in itself could lead to dangerous and unwanted side effects, particularly if cessation is abrupt and unmonitored. Within a model of reciprocal learning it is imperative that the data obtained about Somali women's use of such medication and their reaction to learning that it is for psychiatric conditions, is relayed back to general health practitioners.

Such information may lead to an adaptation in prescribing practices which is critical to reduce the risk associated with misuse of such medications.

Somali Engagement with Mainstream Mental Health Practitioners

The MHPs reported only knowing of one Somali woman currently engaged in mainstream mental health services. Although this woman was being treated for psychosis, the one participant who had worked with her, said that she had suspected that psychosocial issues (family separation, social isolation, financial concerns) were a more salient aspect of the woman's distress than psychosis. Cultural consultation had been a critical aspect of the MHPs approach to assessing and treating the woman's distress. Additionally, considerable effort was made to consider the issues impacting on this client from a psychosocial rather than a primarily biomedical perspective. Psychosocial interventions were considered more effective and relevant to the Somali woman's difficulties than medication-based treatments by the participant who had worked with her. Given the client's apparent level of isolation from her own cultural community, she may have been more willing to engage with mainstream mental health services (as this provided her with some level of support) than other Somali similar psychological difficulties would be.

Only limited conclusions about the meaning of these data for other Somali who may become involved in mainstream mental health services can be drawn from this single case study. However, it does provide one example of mental health practitioners attempting to accommodate and understand the cultural context and unique needs of Somali clients.

The Role of the Interpreter

Only the SRMH participants routinely employed the services of interpreters. The general health practitioners reported rarely employing interpreters and this seemed primarily to be a funding issue – that is, not having the financial resources in general practice to hire interpreters. The MHPs said that generally the clients they had worked with who were not fluent in English chose not to use interpreters due to fear of their health information being passed on (via the interpreter) to others. Some of the MHPs also voiced concern that the integrity of the information obtained via an interpreter may be compromised.

The issue of protecting the integrity of interview data when employing interpreters is a difficult matter to rectify. Regardless of how accurately the interpreter attempts to relay the concerns of clients, key information is often likely to be lost or modified in this process. A literal translation may lose the fundamental essence of the client and therapist's interpretation whereas attempting to interpret the fundamental meaning rather than making a literal translation is likely to lead to the omission of key information that both parties had intended to convey. This does not mean, however, that employing interpreters is an inefficacious exercise. In circumstances in which non-English speaking clients are willing to both engage in formal intervention for psychological issues and also employ the services of interpreters, an approximation to the intended message may be far more desirable than no therapy at all.

As suggested by Raval and Smith (2003), bi-lingual therapy assistants (in the absence of trained Somali mental health professionals) whose role includes but

extends beyond that of being exclusively an interpreter may be an efficacious means of working with Somali and other non-Western clients. Bi-lingual therapy assistants who share the same world view as the client and who are not only able to assist the client overcome their psychological distress but also have an educative role with health professionals, may contribute to greater service use by non-Western clients in need of specialist mental health interventions. In the absence of high numbers of Somali utilising mental health services, however, the funding for both educating Somali about such services and training bi-lingual therapy assistants would likely be hard to justify.

The Psychological Impact of War

As already indicated most participants considered psychosocial stressors impacting on Somali refugees' present life circumstances more pressing issues to address than psychological responses to historical trauma experiences. Furthermore, numerous participants said that even when symptoms of PTSD were evident, psychosocial interventions (such as educating Somali about the meaning of various sirens so they are not misattributed as a signal of imminent danger) and advocacy work (e.g., assisting with family reunification) were more frequently employed than medication and psychotherapy. Hence, it appears that even when a diagnosis of PTSD is made or considered by health practitioners, they do not necessarily act to treat this disorder in a conventional Western manner (i.e., via medication and psychotherapy). These findings suggest that the perspectives, experiences, and practices of some New Zealand health and mental health professionals are at odds with that of researchers who have asserted that PTSD is of epidemic proportions in

refugees (e.g., Hodes, 2002; Jamil, Hakim-Larson, Lakako, Diqi, & Jamil, 2002; Mollica, McInnes, Sarajli, Lavelle, Sarajli, & Massagli, 1999; Riding-Malon, 2004; Sue, Sue, Sue, & Takeuchi, 1998)

Family Separation

The participants in the current study shared the same perspective as the Somali women in Studies 1 and 2, that family separation is a major psychosocial stressor impacting on wellbeing. This was the most frequently cited stressor that SRMH and MHP participants in this study said refugees present with. It was also a commonly reported stressor cited by general health practitioners who worked with Somali. The findings from all three studies provide support for the hypothesis that limited or lack of family support is a key risk factor for experiencing major psychological distress. Family separation seemed to be a pervasive underlying issue for many of the Somali women whose stories were described by practitioners in the current study.

Approaches to Working with Somali Suffering from Psychological Distress

Given that so few of the MHPs and none of the SRMH participants had had contact with Somali clients, the Vignettes were a valuable means of identifying how these practitioners may approach assessment and intervention with Somali. The three groups of participants provided reasonably similar responses to how they would conceptualise the presenting difficulties of the Somali women in the three Vignettes. Exploring both Western diagnostic explanations and cultural explanations of the behaviour of the women in the Vignettes was considered important to obtaining an understanding of how the distress was impacting. Cultural consultation and

interviewing family members were often raised as important aspects of the interview process. Interestingly, a number of participants stated that they would want to learn if the presentation of the women in the Vignettes was considered normal from a Somali cultural perspective. Hence, it appears that the participants in this study may be cautious not to apply Western standards of psychological ‘normality’ or wellbeing to non-Western groups without careful consideration and appropriate consultation.

Some participants in all three groups stated that psychosocial stressors were likely to be a major contributor to the women’s distress in each Vignette. Consequently, the findings suggest that even those practitioners in the current study who had very little (if any) contact with Somali women were cognisant of the importance of the overall context within which their psychological distress could manifest.

Typically, psychological, rather than medical and spiritual explanations were suggested as the most likely explanation for the women’s distress in each Vignette. This is not surprising given participants were aware that the current thesis was primarily focused on exploring the psychological distress of Somali women. It is possible that a greater number of non-psychological explanations would have been offered if the participants remained blind to the overall focus and objectives of the current research.

Attempting to integrate both cultural models of distress and treatment approaches with mainstream Western interventions was generally suggested as the ideal approach to working with Somali experiencing psychological distress.

Participants in all three groups considered advocacy and community-based assistance an important aspect of intervention.

The responses to the Vignettes in Study 3 were similar to the responses of the Somali women in Study 2. Although the current participants did not typically identify specific spiritual or cultural explanations for the distress they did often acknowledge that these were important issues to explore with Somali women. Hence, although the participants in Study 3 may have lacked specific cultural knowledge of Somali idioms of distress they reported motivation to explore and obtain an understanding of any possible culturally-specific explanations. Traditional approaches to treating the distress outlined in all three Vignettes were the primary forms of intervention suggested by the participants in Study 2. Interestingly however, these participants also suggested that if in the context of such distress a Somali woman became violent, this would most likely lead to involvement by mainstream services, particularly mental health services. It seems that both the Somali women and the health professionals who participated in this research agree that when the physical safety of an individual or others is at risk, this may necessitate the involvement of Western services.

Summary

The findings of the current study are consistent with the findings of Studies 1 and 2 and other research that has suggested that Somali are infrequent users of Western mental health services (e.g., Bhui et al., 2003; Guerin et al., 2004b; Jaranson et al., 2004; McCrone et al., 2005). Although the findings of Studies 1 and 2 indicate that the Somali who took part in these studies consider that they already have

effective traditional means of ameliorating psychological distress, the findings of Study 3 provide a number of other possible reasons for low mental health service use. Long waiting lists, mental health practitioners' lack of expertise working cross-culturally, and poor treatment outcomes were three of the common rationales provided by general health practitioners for frequently not referring Somali experiencing psychological distress to mental health services. Additionally, Somali clients' apparent rejection of the notion that psychosocial stressors and physical distress may be causally related was provided as a reason for not referring to secondary services. The stigma attached to having a mental illness was also considered a barrier to engaging with mental health services.

The general health practitioners were the group of participants who had the most experience working with Somali women. This group described psychosomatic concerns as typically the most common form of psychological distress that Somali women tended to present with. Interestingly, what general health practitioners described as psychosomatic distress was similar to the description of the milder form of jinn provided by participants in Study 2. Of concern in the current results was some of the general health practitioners' reports that they did not properly disclose the nature of medication they prescribed to Somali when they suspected the underlying issues were psychological (i.e., anxiety or depression) in nature. The motivation behind this non-disclosure seemed to be to retain rapport while providing what the general health practitioner considered the most effective intervention for their clients' psychological distress. This practice however, is arguably unethical,

potentially dangerous and in cases in where Somali discover the true nature of the medication, may contribute to an erosion of trust in their general health practitioner.

Given that both the mainstream and specialist refugee mental health practitioners reported very low rates of professional contact with Somali, it was not possible to ascertain what sort of common concerns those Somali who do attend mental health services present with. A number of participants in these two groups however, were aware that spiritual and cultural explanations for distress and suffering were important to explore with Somali clients. The general health practitioners were also aware of the importance of exploring cultural explanations for psychological distress.

The findings of this study suggest that psychosocial stressors, particularly family reunification issues and social isolation, may have a moderating influence on Somali women's propensity to experience significant psychological or physical distress. Most participants acknowledged the impact of such stressors on the wellbeing of Somali. Additionally, many participants said that interventions aimed to address psychosocial stressors were likely to be the most efficacious means of ameliorating distress and frequently considered advocacy and other practical based interventions more important than medication or psychotherapy. Post-traumatic stress disorder was not mentioned by participants as a disorder they considered common to Somali. This finding seems consistent with the findings of other qualitative research studies conducted with Somali (reviewed in Chapter 5), as well as the findings of Studies 1 and 2. This does not suggest that Somali are not substantially affected by their war experiences, but it is likely that the distress

associated with this trauma manifests in different ways to those commonly known in the West as PTSD.

The findings of the current study taken together with the findings of Studies 1 and 2, provide interesting insight into how very similar symptoms of distress and help-seeking behaviour can be conceptualised (i.e., psychosomatic distress versus jinn possession) and treated in markedly different ways depending on the world view of the client or health practitioner. Developing a greater understanding of the Somali perspective on illness and wellbeing is likely to enhance health professionals' ability to respond efficaciously to indicators of psychological distress in a manner that complements the world view of Somali clients.

The final chapter of this thesis (Chapter 9) outlines a rudimentary perspective that is anticipated to provide an initial understanding of how Western health and mental health professionals may conceptualise, understand and consider responding to the psychological distress of Somali clients they encounter. This chapter also outlines the strengths and limitations of the current thesis as well as some concluding comments and areas for future research to pursue.

CHAPTER 9

General Discussion

This chapter begins by summarising the primary findings of the three studies of this thesis. Following this, a preliminary perspective of Somali psychopathology based on the current and previous Western research literature is presented.

Implications of the research are outlined, as are some suggestions for future research. The chapter ends with a discussion of the strengths and limitations of this thesis and some concluding comments which relate to how the research findings could be employed to enhance the efficacy of Western mental health interventions for Somali.

Summary of the Main Research Findings

The results of the current thesis add to the small yet growing body of literature that suggests Somali have their own sophisticated and complex nosologies to describe distress and suffering. Some of these idioms have strong parallels to Western forms of psychopathology (e.g., more severe forms of *jinn* possession are akin to psychosis, some forms of *qalbijab* seem similar to depression). In some cases the symptom profile seems so similar between Western and Somali forms of psychopathology (such as *jinn* and psychosis) that it is not clear, based on the current findings, how these states could be differentiated. One of the primary objectives of this discussion, however, is to demonstrate that it is the cultural explanation and understanding of these symptoms that is critical for Western health professionals to appreciate and not whether or not these symptoms map neatly onto Western psychiatric nosologies. The

Somali idioms of distress identified in the current thesis as well as some of the main implications of the findings are discussed below.

Jinn possession

Spirit possession seems to be a common explanation within Somali culture for a range of uncharacteristic behaviours and symptoms. Jinn possession seems to exist on a continuum, with symptoms akin to psychosis at the severe end, while symptoms which may be considered similar to anxiety, depression or psychosomatic presentations are at the mild end. Although there appears to be a small number of symptoms which are unambiguously interpreted by Somali as indicators of jinn (e.g., amnesia during the period of possession, the jinni identifying itself during Koran recitations), most of the indicators of this state are also observed in other Somali idioms of distress (particularly walli). There seems to be no or very little stigma associated with jinn possession and the sufferer is afforded a high degree of support.

The psychosomatic presentation of jinn appears to be a common form of distress for which Somali visit their GPs. Although the current findings suggest that physical distress caused by jinn and Western psychosomatic disorders reflect the same underlying condition, the aetiological explanation for these two conditions is different. An individual's belief in the validity of aetiologies suggested to them, as well as his/her belief in the treatment approaches recommended, is critical to ensuring a positive therapeutic outcome (Hirsch, 2004). This may explain why medication-based interventions for psychosomatic distress are often rejected, particularly when the Somali sufferer discovers the medication is psychiatric.

Walli

Walli seems to share many of the features of severe jinn possession.

Aggression, nudity, hearing voices, shouting, and talking incessantly are common to both states. Hence, in the current research walli and (severe) jinn could not be clearly disentangled on the basis of symptom profile. The chronic, unremitting, and apparent incurable nature of most cases of walli seems to be the most reliable means of differentiating this state from jinn. Hence, an individual suffering from walli may initially be assumed to be possessed by a jinni and sometimes, only after a substantial period of time (in some cases years), with the sufferer failing to respond to Koran recitations, would walli be considered the most likely explanation for the distress. Walli was one of the few states of distress for which the Somali women considered was sometimes appropriate to seek mainstream mental health assistance for, particularly if there were concerns about the individual's risk of harm to self or others.

Although severe jinn possession shares common features of Western psychotic disorders, walli seems to be even more similar to psychosis. That is, the current research findings indicate that walli sufferers typically do not benefit from psychosocial and spiritual interventions. Although tentative, the results of this project suggest walli has a biological basis. Stigma seems to be associated with walli to the point that the sufferer may not be considered eligible for marriage or employment. Walli seemed to be the only Somali idiom of distress associated with stigma and fear.

Qalbijab, murug, welwel, and boofis

Within Somali culture there appear to be a number of other idioms for psychological distress. According to participants in the current research, *qalbijab* seems to be a state of excessive sadness akin to depression, *murug* appears to bear some similarity to a post-traumatic anxiety response, *welwel* is a type of ordinary worry or stress and *boofis* seems to be similar to both a state of amphetamine intoxication and post-traumatic anxiety (with the aetiology determined by whether the sufferer has been exposed to recreational drugs or war trauma). To reiterate, however, participants did not always agree on the meaning of these states and hence, the description provided in the current research may only be an approximation to what these terms actually mean. Regardless of this, the current findings were similar to those of Carroll (2004), Tiilikainen (1998), and Zarowsky (2004).

Clear psychological, environmental and social antecedents (e.g., war memories, family separation) were provided as the cause of these states. None were suggested to have a spiritual aetiology. The idioms were not considered indicators of ‘craziness’, although if unresponsive to traditional interventions the risk of becoming ‘crazy’ or walli is apparently heightened (particularly *qalbijab* and *murug*). Mainstream Western interventions were not considered relevant or useful as treatment approaches for these psychological states. Koran recitations and social support were cited as the most frequently employed and most effective interventions.

Resilience

The current research endeavored to identify factors which may decrease vulnerability to psychopathology regardless of the experience of adverse

circumstances. Factors shown in previous research with Western participants to be predictive of resilience (see Ryff & Singer, 2000; Ryff, Singer & Palmersheim, 2005) were also identified in the current thesis. It seems that supportive and physically close family networks and unwavering religious faith are the main protective factors within Somali culture to maintain a psychologically healthy state.

One of the key means by which religious faith may act as a protective factor irrespective of an individual's culture, may be due to the promise of a rewarding and eternal 'after life'. This promise may foster resilience in as much as religious followers may be able to sustain higher levels of stress or trauma (compared to those with no religious faith) as they are able to consider their current circumstances as temporary and perhaps less significant when considered alongside the eternal rewards of their faith in the 'after life'. Additionally, the belief in a supreme deity that has the power to alleviate this suffering, particularly if religious based rituals are adhered to (such as prayer), may also act to protect those with a religious faith. That is, such individuals may consider that they are employing the most powerful means to overcome their current distress and this belief in itself may have a strong therapeutic impact (refer to the section below on the apparent efficacy of Koran readings for a comprehensive discussion of how 'expectancy theory' may explain the apparent efficacy of spiritual forms of intervention). They may also accept that their current suffering is a trial or test from God (or other deity) which may motivate individuals to demonstrate their ability to cope with this challenge to the deity they worship. These possible explanations for the psychological mechanisms by which religious faith may

act as a protective factor are arguably applicable to Western and non-Western cultural groups, including Somali.

The psychological mechanisms by which social support serves as a protective factor against significant emotional distress is arguably largely due to individuals having access to additional social resources at times when their own resources are being taxed due to stress or trauma. Such social resources are likely to act as buffers against distress for multiple reasons. These reasons may include having other people to take over or assist with key responsibilities (e.g., at work or home), having others to engage in activities that may act as relief/distraction from the issues causing the distress, and significant others providing support with respect to identifying possible solutions or means of addressing the cause of the distress. It is likely that these explanations for the important role that social support plays as a protective factor against suffering from significant emotional difficulties is applicable universally.

It is important to acknowledge that Somali who manage to find their way out of the hostile environment of Somalia into safer host countries are likely to be a unique subset of the overall Somali population. That is, it is possible, by virtue of their experiences and ability to move to safety, that these refugees may be more resilient in the face of adversity than those who do not manage to flee Somalia. This may explain their apparently low engagement rate with mainstream mental health services.

The use of Western interventions to treat Somali idioms for distress

Both general health (GPs and practice-based nurses) and mental health practitioners acknowledged the importance of attempting to address the psychosocial stressors which commonly co-exist with psychological forms of distress for all of

their refugee clients. A number of the mental health practitioners suggested that identifying means of ameliorating the psychosocial stressors was the most critical and efficacious intervention to employ with refugees. The general health practitioners were concerned with the efficacy of mainstream mental health services for two primary reasons, (i) the perceived lack of expertise of mainstream mental health practitioners to work with refugees, and (ii) the very long waiting lists at mainstream mental health services (particularly for psychological services) making such services seem inaccessible. A number of the general health practitioners stated that due to their concerns about mainstream mental health services they opted for medication-based treatments for their refugee clients – even in circumstances in which they were aware such treatment was less than optimal. The implications of this intervention approach are potentially far-reaching for Somali (and other refugees) who are not accessing the best standard of Western care to assist them to ameliorate their distress.

Somali women's perspectives about GP-based interventions

Somali participants voiced concerns about the manner in which they perceived general health practitioners manage their distress. Their perception that physical ailments were misattributed to a psychological cause (particularly depression) was one such concern. Additionally, participants said that some GPs prescribe psychiatric medication without informing the Somali of this. Some of the GPs also acknowledged that they often did not fully disclose to Somali women that they were prescribing them psychiatric medication. These GPs stated they were concerned Somali would not take the medication if they were aware it was for psychiatric conditions. The findings of Studies 1 and 2 suggest that this is an accurate

assumption. However, failing to inform Somali clients about the nature of prescribed medication is an ethically questionable practice. Furthermore, learning that the medication is 'psychiatric' appears to lead to some Somali women abruptly discontinuing the medication, which in itself could lead to dangerous side effects.

Somali women's perspectives about Western mental health services

The majority of Somali participants did not consider that there was a role for mainstream mental health services in providing intervention for Somali. Additionally, only one of the 12 mental health professionals who participated in this research had had professional contact with Somali (although those who took part were likely to be more interested in working with Somali and other refugee groups). Hence, the findings of the current thesis are consistent with previous research which has identified that Somali infrequently engage with mental health services (Bhui, Abdi, Abdi, et al., 2003; Jaranson, Butcher, Halcón, et al., 2004; McCrone, Bhui, Craig, et al., 2005).

Besides the Somali participants describing having their own efficacious means of ameliorating psychological and spiritual distress, they also described numerous other reasons why they would typically not engage with mental health agencies. Perceived inappropriate and over use of psychiatric medication, the apparent lack of efficacy of this medication, as well as the lack of efficacy of psychotherapy, were provided as reasons for not engaging with such services. Additionally, the assumption that mental health services catered only for individuals at the most severe end of the spectrum who were considered "crazy" was also outlined as a reason these services were rarely used by Somali. According to the Somali participants,

miscommunication and misunderstandings between Somali patients and non-Somali health professionals in inpatient psychiatric settings leads to the perpetuation of the view of mainstream mental health services as unhelpful and potentially harmful.

A Preliminary Perspective on Somali Psychopathology

The following paragraphs provide a preliminary perspective of how Western health and mental health practitioners could begin to conceptualise and formulate the psychological distress of Somali refugee women. This perspective is depicted diagrammatically in Figure 1. It is recognised that the small sample of participants in the current research means that caution needs to be applied when considering the inferences and implications of the results. When the results of the three studies are compared, however, there is a considerable amount of consistency in the findings. Additionally, many of the primary findings are generally consistent with previously cited studies. Even where the data of the Somali women and practitioners seemed divergent, they still provide interesting insights into the different manner in which similar symptom clusters are interpreted within Somali and Western cultures.

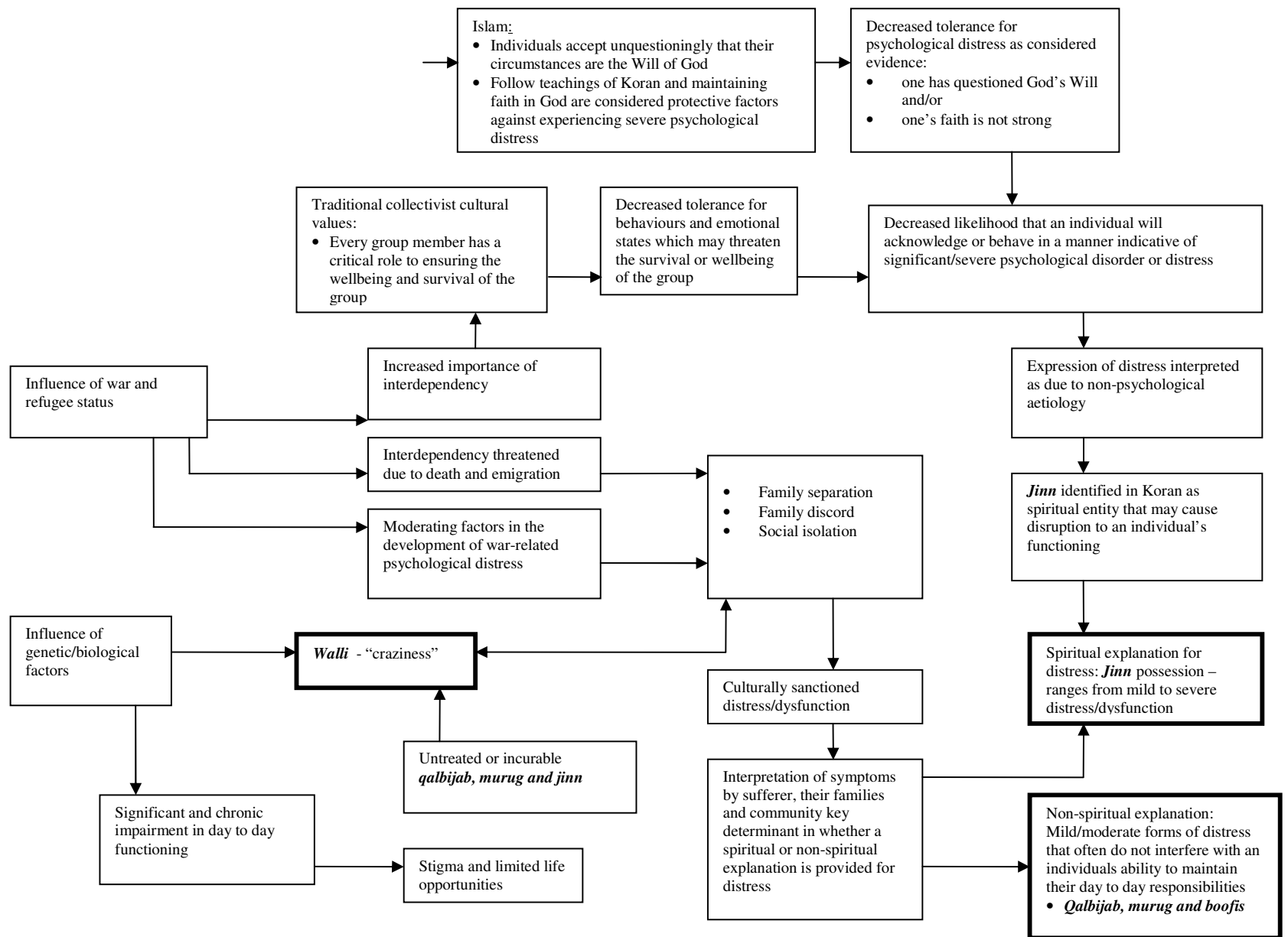


Figure 1. Diagrammatic representation of a preliminary perspective of Somali psychopathology.

The impact of historical and cultural factors on Somali perspectives of psychological distress

Traditionally, in an environment in which every member of the group holds a critical role for the groups' wellbeing, emotional states such as anxiety and depression could be considered a burden and a danger to the livelihood of collectivist societies. There may be little tolerance for psychological forms of distress within a culture where basic survival has traditionally been the most critical focus of everyday life. The expectation of each individual to contribute to the overall livelihood of the family and community group in traditional collectivist societies may therefore have acted as a protective factor against suffering (at least overtly) from serious psychiatric illness. Hence, Somali experiencing acute psychological distress may be actively discouraged from expressing this distress for fear of the implications of this for themselves and their families. That is, having a psychological disorder that prevented one from contributing to the wellbeing of the group may have jeopardised an individual's safety and role within the group as they may have been seen as a liability. Assuming these assertions hold some validity, this perspective on the apparent danger attached to having a mental illness may still underpin the world view of Somali living in Western countries. With this framework in mind, jinn are explored as an accepted explanatory model for out-of-character or physically distressing symptoms.

Jinn

The findings of the current thesis coupled with the findings of previous research articles and academic writings (e.g., Abdullahi, 2001; Carroll, 2004; Guerin, Guerin,

Diiriye, & Yates, 2004b; Kapteijns, 2000; Lewis, 1989; Rousseau, Said, Gagné, & Bibeau, 1998a; Tiilikainen, 1998, Whittaker et al., 2005) suggest that jinn as an explanatory model for distress is readily accepted and tolerated within Somali culture. This is likely to be at least in part due do jinn being described in the Koran and the apparently strong adherence to Islamic lore within Somali culture. Hence, although the findings of the current thesis indicate that (Western) psychological disorders appear to be rare amongst Somali women in New Zealand, jinn possession is a well-known phenomenon within Somali culture. It seems plausible then that jinn possession is a culturally sanctioned means of expressing psychological distress which also affords the sufferer a high degree of familial and social support.

In a culture in which life trajectories are considered predetermined by God, and in which individuals are expected to accept suffering as a test, challenge, or punishment from God (see Tiilikainen , 2000 and Silveira & Allebeck, 2001 for a more comprehensive discussion of these issues), jinn possession may provide an outlet to express and seek support for distress without compromising religious values. This is not to suggest that Somali typically feign spirit possession, but rather that the psychological distress of such factors as social isolation and the burden of domestic responsibilities may be interpreted by the sufferer and their support network as the signs of jinn. This hypothesis may explain both the most severe and milder states of jinn experienced by Somali. It is important to note, however, that given most of the Somali participants in the current research reported an unwavering belief in the existence of jinn, and also considered there was little that could be done to prevent

spirit possession, evidence to support the relationship between psychosocial stressors and the onset of jinn possession is currently speculative.

Non-spiritual forms of psychological distress were identified by Somali participants in the current research. Only one of these states (walli) seemed to have a high degree of stigma associated with it. With respect to the other psychological states identified (particularly qalbijab and murug), participants often provided culturally-sanctioned explanations for the suffering which also reportedly allows the sufferer a high degree of familial and community support. Stigma did not appear to be attached to psychological conditions which did not impede an individual's ability to contribute in a meaningful way to their family and communities. The psychological states identified in the current research as well as a discussion of what factors seem to contribute to the onset and maintenance of these conditions is outlined below.

Psychological idioms for distress

It is unclear from the current findings why the psychological states of qalbijab, murug, welwel, and boofis do not seem to have stigma attached to them in the same manner as walli. It is plausible that since individuals are still likely to be able to function and fulfil major role obligations (such as domestic, child care and employment responsibilities), they are not considered "crazy". If these states do not threaten the wellbeing of family or community groups, it may be less likely that the sufferer is stigmatised. It may also be in the best interest of the family and community to assist the sufferer to return to optimal functioning again as a means of maintaining the wellbeing of the group as a whole. Consequently these states,

although acknowledged as forms of distress, are tolerated more than walli and afforded support by the wider community. Further research, however, is required to understand how these psychological states are understood and accepted within Somali culture and why there is less stigma attached to these states than walli.

Causal factors in the manifestation of psychological distress

Family separation, social isolation, and family discord in particular seem to be causal and maintaining factors in the manifestation of psychological distress (both with respect to jinn and other states such as qalbijab and murug). These stressors are arguably universal causes of emotional suffering and hence, it is understandable that such stressors would contribute to marked psychological distress irrespective of an individual's cultural background.

Family separation, social isolation and family discord seem to be salient both to Somali women and health and mental health practitioners as factors impacting adversely on wellbeing (although Somali do not necessarily associate the impact of psychosocial stressors on their experience of psychological/physical distress). Family separation and social isolation may be culturally sanctioned reasons for experiencing distress due to the collectivist nature of Somali society and the importance placed on family and living interdependently. Additionally, limited social support may be particularly likely to trigger distress given that strong social and familial support, as well as ensuring the safety of the family, are frequently considered key protective factors against experiencing distress (Ryff & Singer, 2000; Weine, Vojvoda, Hartman, & Hyman, 1997). Hence, women separated from family and/or who do not

perceive they have adequate social or community support, may be at greater risk of experiencing significant psychological distress.

Family separation also seems to be a causal and maintaining factor in the manifestation of war-related distress for Somali women (including qalbijab and murug). This makes sense in light of these women often being reminded of the plight of family in Africa due to the very frequent phone calls with those still in refugee camps. The constant reminders of their own traumatic war experiences coupled with the financial burden of attempting to support family in both New Zealand and Africa would understandably make adjustment to a new country difficult to achieve. Hence, it seems likely that those women who have intact family units living with them in New Zealand are less likely to experience significant negative psychological sequelae of war as this family support appears to act as a buffer against such distress.

The efficacy of Koran readings

The apparent efficacy of Koran recitations for severe forms of jinn possession could seem at odds with Western biomedical explanations of similar psychotic illnesses. Within a Western medical model, spiritual healing would be primarily used as an adjunct to psychiatric interventions, if used at all. Given the apparent similarity in symptom profile of severe jinn possession and psychosis it could be considered somewhat perplexing that a spiritual intervention apparently has such a high success rate (according to participants in this study) for the extraction of jinn. Five possible explanations for the reported effectiveness of Koran readings are outlined below. These explanations are not necessarily mutually exclusive.

First, the apparent efficacy of Koran recitations for severe jinn possession could be due to an expectation within Somali culture that the sufferer will recover and will resume being a contributing member of the local society. This assertion is supported by the findings of a World Health Organization (1979) study that found that developing countries seemed to have a better recovery rate from psychosis (even though they often did not have access to psychotropic medication) than developed countries. The authors of this research suggested that the expectation of each individual to contribute to the overall wellbeing and livelihood of the family and community group in traditional collectivist societies may act as a protective factor against suffering from chronic and serious psychiatric illness. That is, in some developing countries those suffering from psychotic phenomena (unless largely incapacitated by the illness) may still be expected to contribute meaningfully to the group's wellbeing. This expectation in itself may act as a catalyst for recovery (at least to some extent) to occur. Consequently the Koran readings, although an important aspect of the therapy approach, may not be as critical in some circumstances as the community expectations of recovery.

Another hypothesis born out of the WHO research to explain apparently faster recovery rates from psychotic illnesses in developing countries was the premise that psychosis is qualitatively different in Western compared to non-Western countries. In a sub-study of the WHO project Day, Nielson, Korten, et al. (1987) found that stressful life events were more likely to precede the onset of psychosis in non-Western countries. Consequently these researchers suggested that psychosis may be

more likely to manifest in non-Western countries as a brief reactive psychosis (with stressful life events primary aetiological factors) rather than as schizophrenia (the most common and arguably most chronic and unremitting form of psychosis in Western countries). The implication based on Day et al.'s findings is that the divergent recovery rates from psychosis between Western and non-Western countries may be due to differences in aetiological factors leading to differing forms of psychotic illness. Hence, if what has been identified as jinn in the current research is in fact a parallel form of brief reactive psychosis it is possible that recovery from this psychosis is more likely related to amelioration of the initial psychosocial aetiological factors than to the Koran readings. However, given that Koran recitations seem to serve numerous functions (e.g., prayer, and social support) their role in assisting to ameliorate psychosocial stressors must be considered of critical therapeutic importance by Western health professionals.

A third possible explanation for the apparent effectiveness of Koran recitations for jinn possession (whether 'severe' or 'mild'), as well as the apparent ineffectiveness of psychiatric medication, is likely to be related to the sufferer's belief in or expectations about the efficacy of these interventions – that is 'expectancy theory'. As Sussman (2004) asserts, beliefs about the cause of an illness and its natural progression largely determine expected outcomes of treatment. Hence, if it is believed that certain behaviours, experiences or difficulties are the result of spirit possession, expectations that biomedical treatment will be effective are likely to be very low and in fact medical treatments will have minimal therapeutic impact. In

contrast, spiritual approaches to healing may have considerable efficacy in these circumstances.

The power of an individual's beliefs and expectancies about the efficacy of particular interventions have been demonstrated in numerous placebo-controlled drug studies. In these studies, sugar pills (the placebo) have consistently been shown to produce health enhancing outcomes (see Hirsch, 2004 for a more comprehensive discussion of the placebo effect). It is theorised that the consumer's belief that they are taking a health-enhancing substance, coupled with his or her belief that this substance will have a positive therapeutic impact on them, determines the effectiveness of a placebo. Such research arguably suggests that the placebo effect is a real component in healing and that the healing process is much more complicated than simply a cause and effect relationship between treatment approach and psychological outcome.

Hirsh (2004) asserts that it is the relationship between the healer and patient (the 'therapeutic alliance'), and their shared culture and world view, that gives the placebo the ability to produce its effects. Kleinman, Eisenberg, and Good (1978) suggest that a shared world view may contribute to more efficacious treatment outcomes due to smaller class differentials between patient and practitioners and greater concordance between the explanatory systems of healer and patient. The importance of the therapeutic alliance to treatment outcome has been highlighted in a review written by Orlinsky, Grawe and Parks (1994) who found that positive therapeutic alliance was a strong predictor of efficacious treatment outcomes regardless of the type of treatment being conducted. As such, having a high expectancy in the efficacy

of the practitioner (healer) and their therapeutic prescription is likely to have a powerful therapeutic impact regardless of the ‘scientific’ support for the intervention. The apparently unwavering belief in spirit possession held by many Somali, as well as their belief that Koran recitations are the primary (and often only effective) means of extracting jinn, may therefore be at least partly understood in relation to their strong adherence to this explanatory model.

Another equally important potential explanation for the effectiveness of Koran recitations could be related to the social and supportive functions that are a part of the Koran rituals themselves. That is, Koran recitations often occur in a group setting with close family and friends involved in organising and being involved in this form of spiritual healing. That significant others have taken the individual’s distress and suffering seriously and consider this distress an issue requiring formal spiritual intervention may not only serve to validate the suffering but may also provide a level of social support (practically, spiritually and emotionally) that may have otherwise been lacking or limited. Additionally, if an individual’s distress is causally related to conflict with family or wider social support networks, meeting for Koran readings may provide the opportunity to work to resolve this conflict. Hence, the social aspect of Koran recitations might be a very powerful therapeutic intervention in itself.

Implications for Mainstream Services: New Directions for Refugee Mental Health Care

Both practitioners and Somali women who participated in this research were generally concerned about the nature and effectiveness of mainstream health services that worked with Somali. It appears that it is often only when a Somali woman’s

level of distress can no longer be adequately managed by the Somali community that referrals to mainstream mental health services are initiated (typically by family and community members rather than the sufferer). Additionally, the results suggest that Somali often reject GPs psychiatric medication-based interventions.

Given that respondents described advocacy as a fundamental aspect of intervention with refugees, and, given that the data from Studies 1 and 2 suggest that major psychosocial stressors are often affecting the lives of Somali experiencing psychological distress, an intermediate service that operates at the interface between primary and secondary health services for non-Western refugee clients may be a fruitful approach to consider within the New Zealand context. Such a service could be developed to assist refugees orient to the new cultural context they live in, as well as providing educative information about how to manage day-to-day issues such as bill payments, setting up bank accounts, and organising schooling for children. Difficulty with managing these sorts of day-to-day tasks is likely to increase an individual's stress levels which in turn may make them more vulnerable to experiencing significant psychological distress. Hence, ensuring there is a service to help assist refugee clients to deal with these everyday concerns may decrease this vulnerability.

Given that there is evidence that difficulties competently managing these psychosocial stressors contribute to psychological distress for refugees (e.g., Bhui, et al., 2003; Bhui, Craig, Mohamud, et al., 2006; Silveira & Allebeck, 2000; Silveira & Ebrahim, 1998; Whittaker, Hardy, Lewis, & Buchan, 2005), an intermediate service could also provide advice on immigration, employment, housing, training, budgeting,

and legal issues. If the service is independent of mental health agencies it may increase the likelihood that refugee clients will attend for assistance with psychosocial stressors (as attendees are unlikely to be stigmatised or perceived negatively within their communities for seeking assistance with psychosocial issues). In turn, obtaining effective assistance rapidly as psychosocial stressors arise may decrease the level of psychological distress and consequent suffering associated with attempting to deal with these stressors. In these cases, Somali and other refugees may be less inclined to present to their GPs with multiple somatic symptoms, as they are receiving the support they require to address the aetiology of their distress from this intermediate agency.

If an intermediate agency were to be established in some New Zealand centres, it is critical that refugees are part of the development and implementation of this agency. This will ensure that the needs of refugees are being met in a way that is meaningful to them and complements their world view. This model of intermediate level intervention may enhance refugees' sense of self-efficacy while simultaneously reducing the impact of stressors that would contribute to psychological distress. From a financial perspective, visits to primary health care agencies and unnecessary specialist referrals for Somali clients may be reduced considerably, making this a potentially cost-effective service to establish. Consequently, the opportunity for refugees to be contributing members of New Zealand society would be enhanced.

The importance of primary and secondary mental health services is not overlooked when considering an intermediate agency approach to refugee health. Such services would still be critical for some refugee clients whose difficulties could

not be addressed by taking a psychosocial approach to intervention – particularly those with clear medical or psychiatric concerns. Having mental health and general health professionals attached to an intermediate service who were available to be consulted with by other staff members and refugee clients may increase the likelihood that mental health interventions would be utilised by refugees. It would be critical, however, to remain mindful that refugees have their own valued means of ameliorating psychological distress and the role of mainstream services may be as an adjunct to such traditional approaches rather than the treatment of focus

It will be unavoidable in some circumstances for Somali (and members of other refugee and migrant groups) to be admitted as inpatients to psychiatric units. Within inpatient settings, however, miscommunication and misunderstandings between Somali patients and non-Somali health professionals may perpetuate the view of mainstream mental health services as unhelpful and potentially harmful. Given that there are currently no known Somali working in New Zealand mental health services in clinical roles, it is conceivable that the misattributions and miscommunications identified in the current thesis will continue to remain problematic. It is imperative that a culturally appropriate consultation process be developed to reduce the frequency of such miscommunications and ensure more efficacious and less distressing inpatient experiences for Somali (and other refugee groups) who are required to be involuntarily admitted.

A reciprocal learning approach (Proctor, 2003) may also help to reduce some of the erroneous perceptions held by both Somali and mental health professionals about each other. Within this approach (i) the Somali community is informed about the

nature and purpose of mental health services, and (ii) health professionals are educated about the basic premises of Somali culture and idioms of psychological and spiritual distress. Additionally, ensuring that Somali who are involved in mental health services are also able to access their own traditional forms of intervention may reduce the length and severity of the distress they are experiencing.

Refugee and migrant services exist in a number of cities throughout New Zealand (e.g., Christchurch, Hamilton, Auckland, Wellington) and many of these services offer similar types of assistance to those outlined above (i.e., support orienting to their new environment, assistance with immigration issues, English language classes). These services, however, do not typically have refugees and migrants involved in managerial or governance roles nor do these services employ GPs and mental health practitioners as core staff. Hence, the current intermediate service model proposes to further enhance refugee and migrant services by developing a more holistic approach to wellbeing that is fundamentally based on the needs and direction of key refugee and migrant groups.

There would be numerous obstacles that would need to be overcome before setting up an intermediate agency. Staffing such services may be one of the greatest obstacles with respect to setting up an intermediate agency. Agency developers would need to ensure an appropriate balance between Western-trained health professionals and non-Western health specialists. Additionally, it is critical that training not just be conducted by Western 'experts' in cross-cultural and refugee issues. Refugee and immigrant health professionals and other esteemed members of

the immigrant and refugee communities would also need to be intricately involved in staff training.

Ensuring that an intermediate agency is considered a valuable and effective means of addressing psychosocial and psychological concerns by external agencies and professionals would also be a critical issue. If such an agency is not perceived as valuable and efficacious by such external professionals, referrals to the service may remain very low. Hence, ensuring that staff are well trained, disseminating information about the service (in various languages) to GPs and mainstream mental health agencies, and involving general and mental health practitioners in ongoing consultation about the service may enhance referral rates and contribute to reciprocal positive regard between primary, intermediate and tertiary health agencies.

Effective management of waiting lists is an ongoing issue for many health agencies, particularly those in the public health sector. To ensure that lengthy waiting lists are not a major impediment to receiving effective assistance in an intermediate agency, care would need to be taken so that intake referrals (particularly those to specialist mental health staff such as psychologists and psychiatrists) were processed in a manner that did not over tax a small number of available services (such as psychological therapy). Taking a multi-disciplinary team approach in which all referrals are discussed amongst the larger team as well as screening all clients initially to ensure that there are not clear psychosocial issues that can be addressed initially may help reduce the burden of large waiting lists. That is, for many clients significant psychological distress may be effectively dealt with by obtaining formal assistance for psychosocial stressors (e.g., financial, housing, immigration concerns)

impacting on quality of life. Hence, the need for psychological or psychiatric intervention is likely to be unnecessary in such cases. In circumstances in which the amelioration of psychosocial stressors does not lead to a consequent reduction in psychological distress an internal referral for more specialist assistance could be made. Such an approach may decrease considerably the number of clients who are referred for and receive (potentially unnecessary) psychological therapy. This would, of course, also have important implications for ensuring waiting lists did not become too long.

Regardless of the potential obstacles to developing an intermediate health agency, the findings of the current research suggest that an alternative model of health care that takes an holistic approach to healing may be a more efficacious means of assisting refugees in New Zealand than the primarily Western models of health currently available.

Methodological Implications

The following paragraphs discuss some general methodological implications of the current thesis. Specific limitations and strengths of the research are discussed later in this chapter.

It was hoped that the methodology of this research could be extrapolated for use with other refugee groups in New Zealand. Given, however, the considerable difficulties with respect to recruitment of participants (especially in Studies 1 and 2) this objective was only partially attained. That is, it is unlikely that other researchers would be willing to undertake the same largely unfruitful process of recruitment as was carried out in the current thesis. In Study 1, considerable energy was expended

attempting to recruit Somali women from a wide range of sources. This approach to recruitment was undertaken to try to attain the greatest degree of applicability and generalisability with respect to the findings of the study. The only successful means of recruitment in Study 1, however, was via the co-researchers who recruited Somali women known to them. In Study 3 irrespective the effort put into recruiting specialist mental health, mainstream mental health and general health practitioners who had worked with Somali women, only three participants (all general health practitioners) had current Somali female patients. Additionally, in relation to Study 3 the response rate from GPs was very low (in fact only 3 of 180 GPs invited to take part in the research did so). These recruitment issues are elaborated on in the Limitations section below.

Irrespective of the considerable difficulties with recruiting participants for the current research, there are some strengths to the design of this thesis that may be worthy of consideration by other Western researchers interested in exploring psychological distress in non-Western cultures. The implications of these methodological approaches are outlined in the following two paragraphs.

The methodological approach used in this thesis allowed the Somali participants to provide their perspectives on the issues explored without the constraints of Western psychometric instruments or nosologies being imposed. The findings reinforce the importance of employing qualitative methods when conducting cross-cultural research with non-Western groups, particularly groups for which very little is known about their psychological idioms for distress (Guerin & Guerin, 2007). The approach taken in the current thesis allowed the researcher to gain a richer

understanding of the Somali culture by direct observation and involvement. This approach helped to put the participants' interview data into a wider cultural context, rather than assessing psychological distress in a 'vacuum' devoid of other important contextual information. Becoming involved with the local Somali community also helped to build trust with many of the participants, thereby increasing the likelihood that participants would provide a frank and honest opinion about the matters discussed. Attempting to have more than one interview with each (Somali) participant also meant that there was opportunity to explore ambiguous or seemingly contradictory points of view. The findings of the current thesis suggest that in order to obtain a rich understanding of non-Western participants' perspectives and attitudes about topics of a potentially sensitive psychological nature, developing trust and rapport may be critical prerequisites.

The findings of the current research reinforce the importance of taking a reciprocal approach to understanding the psychological issues affecting non-Western refugees and how these are managed within mainstream services. As stated in Chapter 5, this method of research-based learning allows for a reciprocal relationship of information sharing between the particular cultural group under study and the mental health practitioners who treat these community members (Proctor, 2003). Some of the assumptions which could have been made by the primary researcher on the basis of Somali participants' perspectives alone may have been partly erroneous or misguided (although many of their perspectives were also accurate as reflected in the data collected from health professionals). Consequently the findings highlight the importance of consulting with multiple relevant sources when exploring the efficacy

of mainstream services used by refugee groups. Using a reciprocal approach arguably assists in identifying more accurately the strengths and weakness of current Western services. Such an approach is largely lacking from refugee psychopathology research and seems fundamental research methodology to help improve existing general and specialist services.

Strengths and Limitations of the Research

Outlined below are the primary strengths and limitations of the current thesis.

Strengths of the research

Involvement with the Hamilton-based Somali community was a strength of the current thesis. Engaging in voluntary work and obtaining a greater understanding of the Somali culture by direct observation and involvement was considered a particular strength of the research. This approach helped to put the participants' interview data into a wider cultural context, rather than assessing psychological distress in a 'vacuum' devoid of other important contextual information. Becoming involved with the local Somali community also helped to build trust with many of the Hamilton-based participants, thereby increasing the likelihood that they would provide a frank and honest opinion about the matters discussed. Although volunteer work was not undertaken with Somali in Wellington or Auckland, the primary research was able to inform participants at the outset of the focus groups of her involvement with women in the Hamilton-based Somali community. Based on this involvement the primary researcher was able to use and understand a very small number of Somali words and terms employed throughout the interviews. It is possible that this association and voluntary work with Hamilton-based Somali women increased the Auckland and

Wellington participants' trust and willingness to participate in the research. What is more, the Somali co-researcher was known to many of the participants in the focus groups (in all three geographical locations) and had also conducted volunteer work for some of the family members of participants in Hamilton, Wellington, and Auckland. The Somali co-researcher stated that her prior involvement with some of the participants was likely to increase rapport and participants' trust in her intentions as a researcher and may have therefore assisted in facilitating more open and frank discussions of the issues explored than would have otherwise happened.

A particular strength of Studies 2 and 3 was the use of focus group interviews to gather data. The focus group approach is an efficient qualitative data collection technique as the amount and range of data is increased by interviewing several people simultaneously. This interview style also allows participants to respond to thoughts and comments of other group members about issues that are of primary interest yet nonetheless may not have been spontaneously mentioned in a one-to-one interview. What is more, participants may have been more inclined to discuss their points of view on the issues raised within a group setting of individuals of similar cultural (Study 2) or professional (Study 3) backgrounds. Hence the richness of data obtained may have been enhanced by using a focus group format.

Study 3 was the first known study that has attempted to explore Western practitioners' approaches and attitudes towards working with Somali female refugees. Prior to this study, the primary data that conclusions about the effectiveness of Western services were based on was that obtained from Somali research participants. This study therefore, helped to begin to identify what perspectives and approaches are

taken (or theoretically considered) by some New Zealand-based practitioners who work with Somali. Hence, the approach taken in this research helped to ensure that the information obtained from Somali women (in previous research) about their perspectives and experiences with mainstream agencies is not assumed to be accurate, but is validated by also exploring the opinions and perceptions of mainstream professionals. The research then provides a platform for the reciprocal exchange of information to occur between Western health professionals and Somali who may engage with these professionals.

Although interviewing practitioners with varying levels of experience with Somali, may have limited the amount of data collected that was directly applicable to Somali, this approach can also be considered a strength of Study 3. That is, given that clients in mainstream services are not necessarily matched to particular mental or general health professionals, it is likely that many professionals with no contact to date with Somali clients will in the future work with members of this cultural group. Consequently, it is important to gauge the perspectives and potential responses of practitioners who have not, but may in the future engage with Somali clients.

Audiotaping all of the interviews conducted as part of Study 3 helped to maintain the integrity of the data and reduced experimenter bias impacting on the manner in which the data was collated. The findings presented in the Results sections of each study are based primarily on direct transcript excerpts. This is a particular strength of the current study as it means that the data can be presented in an unadulterated form, less likely to be affected by experimenter interpretation of the comments and statements made by participants.

The open-ended interview style employed in all three studies was designed to allow the participants to provide their opinions and ideas using their own terminology and to try to ensure that the focus of the interviews was not anchored to Western diagnostic categories. This style was also used to facilitate discussion and to allow participants to spontaneously identify issues they considered important. The primary researcher employed Pe-Pua's (1989) 'talking around the issue' interviewing style and avoided the use of leading but potentially ambiguous terms such as "mental illness", "craziness" and "mental problems". This interview style helped to decrease the level of experimenter bias so that the possibility of searching for confirmation of the researcher's hypotheses was decreased.

Physical and psychosomatic explanations of distress were explored in the current thesis due to findings from previous research which suggests that somatisation is a common expression of psychological distress in non-Western cultures. Spiritual conceptions of distress were also intentionally explored to ensure the research was not constrained to a Western perspective of psychological distress. Taking this broad approach to suffering seemed fruitful, as much of the current data may not have been obtained if a strict DSM-IV approach was taken to exploring psychological distress. What is more, exploring psychosomatic and spiritual manifestations of distress arguably provided the most interesting and relevant data in the current thesis.

A clear and transparent description of the methodology was outlined in the Method section of each study. This was done to allow other researchers to form their own judgements about the validity of the findings and the robustness of the method

employed. The manner in which the findings are presented is intended to reflect the diverse perceptions of the participants, with minimal interpretation of the data in the results sections. This should help the reader differentiate the participant data from the inferences and conclusions drawn by the primary researcher. Although a clear description of methodology is a necessary aspect of any research project, this has often been lacking from research (particularly qualitative studies) exploring Somali psychopathology (see Chapter 5 for a review and critique of this literature). Consequently, to enable other researchers to replicate and extend the present research, a comprehensive description of the methodology is provided.

Recruitment of participants took place in a number of geographical locations which may increase the applicability and generalisability of the findings of the current thesis. Attempting to recruit Somali participants of various ages, and practitioners of various levels of experience and professional backgrounds, hopefully helped to reduce the homogeneity of the perspectives and attitudes obtained. Although the sample sizes in each study were relatively small, recruiting from various geographical locations may have helped identify which themes were more pervasive and therefore more relevant at a national level when considering service provision issues.

Jacobsen and Landau's (2003) concern that research with small and non-representative samples may be used to erroneously develop guidelines for entire communities is an important issue to consider (the issue of the small sample sizes in all three of the current studies is discussed in the next section of this chapter). Given

the highly selective nature of the current participants, one needs to be very cautious about the conclusions drawn and how these may relate to Somali generally.

Although the participants in each study were highly selective, the findings of all three studies serve as a means of cross-validating the results. For example, the therapeutic approach that the general health practitioners reported frequently taking with Somali clients was similar to the approach the Somali women in Studies 1 and 2 stated that general health practitioners take. Additionally, mental health and specialist mental health practitioners concerns about the apparent overuse of psychiatric medication were also shared by some of the Somali participants. Hence, the corroborating data from the first two studies suggest some of the primary themes identified in the third study may reflect a more pervasive perspective/approach taken by health practitioners working with Somali women rather than being merely the perspectives and approaches taken by the selected sample of such practitioners in this study. Furthermore, the current findings, combined with previous research findings that have used similar methodological approaches (e.g., Carroll, 2004; Guerin, Guerin, Diiriye, & Yates, 2004b; Tiilikainen, 1998; Zarowsky, 2004), identify some similar themes, which suggests that the present results may have implications which reach beyond the participants who took part in each of the present studies. The research therefore provides a platform for reciprocal exchange of information and learning to occur between Western health and mental health professionals and Somali who may engage with these professionals.

In all three studies reasonable effort was made to accommodate participants with respect to the time and place in which interviews took place. This approach was

taken to increase rapport and also increase potential participants' willingness to contribute to the research. Placing restrictions on the location and timing of the interviews may have decreased the already small sample of participants.

Limitations of the research

One of the primary limitations of the current research was that the participants interviewed were a highly selective sample. Almost all of the participants in Studies 1 and 2 were known to the Somali co-researcher. Consequently it is likely that these participants share similar conceptions of distress (due to belonging to similar social networks). Somali women not known to the co-researcher may have had very different conceptualisations of psychological distress than those who were. Although reasonable effort was made in Study 1 to recruit participants from various sources to try to increase representativeness, this approach was not fruitful. Other researchers who have attempted to recruit Somali participants have also found that using pre-existing networks known to the researchers is the most effective recruitment method (e.g., Carroll, 2004; Silveira & Ebriham, 1998). Although lack of representativeness has been criticised as a key weakness of previous research (Jacobsen & Landau, 2003), the intention of the current thesis was not to obtain a representative sample but rather to (i) identify a process by which Somali could describe their perceptions of distress in an open and frank manner, and (ii) develop a basic and general understanding of conceptions of distress that could be followed up in future research.

The considerable difficulties recruiting specialist mental health, mainstream mental health, and general health practitioners who had experience working with Somali women can also be considered a particular limitation of the current thesis.

Significant energy was expended attempting to recruit practitioners for Study 3, however, only three of the participants (all general health practitioners) actually had Somali clients they were actively working with at the time of the research interviews. Additionally, out of the 180 GPs invited to take part in this research, only 3 did so. There is a history of GPs being difficult to recruit for research studies (e.g., Fitzgerald & Clarkson, unpublished manuscript; Pearl, Wright, Gamble, Doughty & Sharpe, 2003; Silagy & Carson, 1989). Time pressures and forgetfulness have been identified as primary explanations for the often low levels of GPs recruited for research studies (e.g., Peto, Coulter, & Bond, 1993; van der Windt, Koes, van Aarst et al., 2000; Ward, King, Lloyd et al., 1999) and there was some evidence that time pressure was also a barrier for GPs in the current research. Although previous research has suggested that GP participation is enhanced when the research is considered of clinical relevance to them (e.g., Bell-Syer, & Moffett, 2000; van der Windt, Koes, van Aarst et al., 2000), targeting GPs working in urban areas known to house a high density of Somali did not seem to aid recruitment in the current study. Consequently, the current findings provide only very limited data on how GPs may work with Somali patients enrolled at their surgeries. This is a particular limitation of the current research given that the data from the GPs who were recruited, coupled with the research conducted by Yates (2003), suggests that GPs are the primary source of mainstream assistance sought by Somali women experiencing psychological distress.

Low recruitment rates of mental health practitioners who had experience working with Somali was possibly due to the apparently low rate of Somali attending mental health services and therefore the research study having limited relevance to

many mental health practitioners. However, even though so few specialist and mental health practitioners had experience working with Somali women, it was still considered important and relevant to explore how practitioners who did not have contact with Somali may approach assessment and treatment with this group. That is, it is possible within the NZ government funded sector that Somali and practitioners have little power to screen each other due to long waiting lists and limited resources. Nevertheless this approach did not provide the same level of insight into the actual practices of Western mental health practitioners working with Somali women as would have been the case if more experienced practitioners in this area had been recruited.

The small and highly selective sample of participants recruited for Study 3 could also be considered a limitation of this thesis. The data from these interviews cannot be generalised to reflect the perspectives of other general and mental health professionals. Participants in Study 3 cannot be considered representative of the wider national professional groups and agencies to which they belong. As already stated this was a highly selective sample of participants, some of whom were directly contacted to take part due to their apparent experience working with non-Western clients. Those recruited from Wellington and Auckland were recruited from areas of these cities known to be highly populated by Somali refugees. What is more, by virtue of their place of work, all the specialist refugee mental health practitioners had considerable experience working with refugees, although in this case, none had professional contact with Somali. Even those participants who were not directly targeted for participation in this study may arguably be more interested in cross-

cultural mental health issues than their counterparts who did not participate.

Given the likelihood that sampling bias and small sample sizes impacted on the findings of the three studies of this thesis the interviewees cannot be considered representative of either (i) other Somali who did not participate in the current research, or (ii) other general and mental health practitioners who did not participate in the current research. Regardless, the findings of the three studies were often similar suggesting that there was a degree of internal consistency across the studies. For example, the general health practitioners' perspective that Somali women tend to reject psychological explanations for their physical distress was supported by some of the data from Study 2. Mental health and specialist refugee mental health practitioners concerns about the apparent overuse of psychiatric medication were also shared by some of the women in Study 2. Furthermore, the findings of Studies 1 and 2 were generally consistent with both previous national and international qualitative research which has explored Somali idioms of distress (e.g., Carroll, 2004; Guerin et al., 2004b; Tiilikainen, 1998; Whittaker, et al., 2005; Zarowsky, 2004). Consequently, the themes identified in all three studies suggest the findings may have applicability that extends beyond the participants who were interviewed.

As stated earlier conducting volunteer work with the local Somali community may be considered a particular strength of the current thesis, however, becoming involved with potential research participants in this manner has been criticised for compromising researcher objectivity (Jacobsen & Landau, 2003). That is, by becoming involved with the community under study, it is possible that the primary researcher was not able to maintain impartiality when developing the methodology,

conducting the interviews and analysing the findings. Steps were taken to reduce the impact of experimenter bias however. The open-ended interview style as well as the cross-validation process (i.e., two co-researchers independently analysing the data for themes, the Somali co-researcher providing feedback about the perceived accuracy of the analyses) undertaken as part of the data analysis procedure were employed to reduce such bias. These steps do not necessarily rule out experimenter bias from the current research, hence it is important to mention that this may have inadvertently impacted on the results.

Although employing two of the research supervisors to cross-validate the results may have helped reduce experimenter bias, the decision not to employ analysts' naïve to the objectives and nature of this thesis could also be considered a limitation of the methodology. The two researchers involved in cross-validating the results were intricately involved in the establishment and development of the research. This may have meant that the supervisors (and primary researcher) were influenced in their analyses of the results by their own hypotheses and assumptions. Careful consideration was given to the most appropriate means of cross-validating the current findings. Although it is typical to employ research-naïve coders for this purpose, given the specialist nature of this research area it was thought that coders naïve to the area of research may in fact introduce another form of bias due to their lack of expertise and knowledge of cross-cultural research issues. That is, coders who had limited knowledge or experience in the area of cross-cultural psychology may be at risk of analysing the findings in a manner consistent with their own world view. It was considered possible that naïve coders would identify themes which are

very 'Western' in nature (e.g., reinterpreting Somali idioms of distress in line with major DSM-IV criteria). As such, the employment of Western experts who had a high level of knowledge of cross-cultural psychology and the Somali world view was thought to be less problematic than utilising inexperienced coders. In an effort to reduce any bias introduced due to the form of cross-validation employed, all three coders initially reviewed and developed their preliminary themes independently. Only after this process had been completed did they compare and discuss their proposed thematic frameworks. The final themes presented in this research were unanimously agreed on by the primary researcher and two coders. Furthermore, with respect to the findings of the first two studies, the Somali co-researcher reviewed the proposed thematic framework and entire results sections (of Studies 1 and 2) to ensure that it reflected what she considered were the perspectives and opinions of the Somali participants interviewed. The careful and rigorous approach taken to cross-validate the results hopefully helped to reduce the bias introduced by employing the research supervisors to be involved in this aspect of the study. This process, however, does not necessarily rule out bias from impacting on the current findings.

Irrespective of the rigorous and careful approach employed in this thesis to analyse the data, two primary limitations were identified with respect to employing thematic analytical techniques. First, unlike other qualitative analytic methods (particularly narrative approaches), employing thematic analysis means the researcher is unable to retain a sense of continuity (i.e., assessing a participant's interview data for more than one datum point supporting a certain theme or sub-theme) or contradiction (i.e., instances in which participants provide apparently differing and

incongruent perspectives in relation to a certain theme or sub-theme) with respect to the interview data (Braun & Clarke, 2006). Although the primary researcher was mindful and alert to apparent contradictions in the data provided by individual participants or groups, given there is not a particular emphasis within thematic approaches to analysing the data for such inconsistencies, it is possible that such potentially critical data were overlooked in the current analyses.

It is also important to mention that thematic analysis does not seem to hold the same level of credibility as other qualitative analytic methods such as grounded theory, interpretative phenomenological analysis, and discourse analysis. Braun and Clarke (2006) argue that this is apparently due to researchers often citing their use of thematic techniques yet failing to clearly describe their analytical approach as well as often failing to clearly differentiate their approach from other qualitative methods. The current research, however, clearly outlined a rigorous thematic approach that was chosen due to its apparent ability to help answer the research questions. Hence, thematic analysis was not employed as an ad hoc and poorly thought out approach to the current analyses (see the Method section of Chapter 6 for the rationale behind selecting thematic analysis). It is hoped that by clearly justifying the rationale behind using thematic analysis and clearly outlining the analytical procedures, the current thesis enhances rather than impedes the credibility of taking this approach.

Only one of the participants interviewed by the Somali co-researcher in Study 1 consented to have their interviews audiotaped. This meant that the cross-validation of interview approaches (i.e., comparing the findings of the primary researcher and the Somali co-researcher) and ensuring the accuracy of translated material could not be

properly conducted. It is important to note, however, that the Somali co-researcher is an experienced researcher, translator and qualified health professional. Additionally the material obtained from the interviews she conducted was generally consistent with the information obtained by the primary researcher. This finding therefore provides support for the internal consistency of the results.

In Study 2, only one group of participants consented to the interview being audiotaped. This meant for all but one group, the data analysed was based on handwritten notes taken during, and typed up immediately following the interviews. Although the Somali co-researcher reviewed and added to the notes to ensure the greatest level of accuracy and volume of data, a considerable amount of rich data was lost through this process.

Throughout the interviews conducted as part of Study 2, the majority of the participants spoke Somali. This introduces another potential limitation in as much as the primary researcher was reliant on the Somali co-researcher to accurately translate these data during the interviews so that further follow-up questions could be explored. The process of translation and how this may impact on the meaning originally ascribed by participants is difficult to quantify but nonetheless is likely to have impacted on the results. Both the inability to audiotape interviews and the primary researcher's inability to understand a large amount of the content of the interviews affected the methodological rigour of the design of Study 2. It was considered preferable, however, to conduct the interviews under these conditions as it may have been very difficult to find Somali women who were both willing to be audiotaped (in a group context) and could speak English fluently enough to converse

directly with the primary researcher. Additionally, excluding women who were unwilling to be audiotaped or could not speak English would have been omitting a large and significant number of women from the Somali community whose perspectives are important to the objectives of this research.

The focus group approach taken in Studies 2 and 3 although considered a key strength could also be considered a key weakness of this research. Focus group results cannot be easily generalised as participants cannot be considered representative of the wider communities to which they belong. Given, however, the findings of these two studies converged in many ways and were also consistent with the findings of Study 1 as well as previous research the results may have implications that are relevant beyond the small number of participants who contributed to the study.

Another potential concern with using a focus group approach is that the social psychology phenomenon of 'group think' (Janis, 1972) is more likely to occur in a group interview forum (particularly homogenous focus groups). That is, focus group participants may have had a tendency to conform to dominant opinions in the group even though they may not have uniformly agreed with this position. This is a common phenomena observed in social psychology experiments which has been found to be robust across diverse and various contexts (e.g., Asch, 1955; Brown, 1988; Forsyth, 1983; Sherif, 1935). Again, however, given the relative consistency of the focus group findings with those of Study 1 as well as previous research, the 'group think' process, although potentially exerting an influence in the focus group interviews, does not seem to have significantly impacted on the validity of the

findings.

In Study 3 the volume of data varied considerably between the specialist refugee mental health practitioners' focus group and the individual interviews conducted for the participants in the other two groups. This meant that depth of data obtained from the SRMH practitioners is not as comprehensive as the data collected from the other participants, given that only one two-hour group interview was conducted with the SRMH participants. It was not possible, however, to meet with general health practitioners and mental health practitioners in a group setting as a suitable time to meet could not be identified and additionally, a number of the general health practitioners specifically stated they preferred to be interviewed individually. Given that the specialist refugee mental health focus group was the first to be organised and conducted, the primary researcher was not aware until after this interview had been completed that it would not be possible to run focus groups with the other participants. Consequently, however, the use of different data collection methods also meant that less data could be reported from the SRMH group and therefore their perspectives and approaches may be under-represented in the analysis.

Future Research

The current thesis findings provide a number of ideas to explore for future research in this area.

Further research is needed to gain a better understanding of factors promoting resilience in Somali women. Case studies of women who are considered successful within Somali culture, as well as women considered to be suffering significant psychological distress, in which a comprehensive investigation is conducted into the

psychological, cognitive, spiritual, familial, and environmental, factors operating in these women's lives, may help identify specific factors that promote resilience.

The findings of the current thesis provide some evidence to suggest that PTSD triggered by war-related experiences may not be common in some New Zealand-based Somali communities and that Western intervention approaches may not be appropriate for Somali who do suffer war-related psychological distress. The research also suggests that Somali have their own distinct psychological idioms that are considered consequences of war (and other) trauma. Given the small and selective sample of respondents who took part in this thesis, however, these conclusions are speculative at best and further research is necessary to provide a clearer picture of the psychological consequences of war trauma for this and other refugee groups. It is important that such research desists from employing Western-based assessment approaches to ensure that the non-Western groups under study are able to articulate their perspectives in a manner consistent with their own world views.

Although Somali-specific idioms of distress were identified and explored in the current study, the prevalence rates of these conditions were not. Hence, epidemiological research may help elucidate how common these idioms are for Somali living in Western countries. What is more, although psychosomatic disorders seem to be a common psychological presenting problem of Somali attending GP consultations, these results could not identify whether Somali are any more likely than their Western counterparts to present to their GP's surgery with psychosomatic complaints. Even if there is a higher rate of somatoform presentations in Somali than

Western primary health care clients, it is possible that this presentation is made more salient for Somali given their apparent reluctance to consult with their GPs about any other form of psychological distress. It is uncertain from a Western perspective how frequently psychological forms of distress actually affect Somali women. It is important that future research attempts to explore the prevalence rates of Somali idioms of distress as well as apparent psychosomatic presentations. Such data are likely to be useful to mainstream services as they may help to ensure resources are focused to assisting with ameliorating psychological states most frequently impacting on the functioning and wellbeing of Somali.

It is unclear why diverse definitions were obtained in the current thesis with respect to the meaning of murug and welwel and why some of these definitions appear divergent with other research findings (e.g., Carroll, 2004; Zarowsky, 1998). This may be partly due to the small sample of participants in the current and previous studies which have attempted to explore these concepts with Somali women. This in itself does not explain the discrepancy as other states such as jinn, walli, and qalbijab were described with a high degree of consistency across Somali participants in the current study. Alternatively, it is possible that murug and welwel are relatively lesser known psychological states within Somali culture and hence a shared and pervasive cultural understanding of murug and welwel has not been well established. Another possibility is that the current research identified natural variations in individual definitions and understandings of these Somali states. It was not expected nor considered likely that every interviewee would share the same opinion on the meaning of the aforementioned states. However, further research is required to

explore these psychological constructs to obtain a more coherent and consistent understanding of their aetiology, symptom profile (if they are in fact considered states of distress) and means of ameliorating any associated distress or dysfunction.

Future research is needed to explore mainstream mental health practitioners and general health practitioners' practices when working with Somali (or other refugee) clients. Approaches to recruitment will need to be carefully considered to increase the likelihood of engaging practitioners with knowledge and experience working with this client group. With respect to enhancing GP recruitment, strategies such as the researcher making direct contact with GPs known to have experience working with Somali, providing GPs with the opportunity to attend workshops or educative forums (so that there is a clear perceived benefit from engaging with the research team), and providing financial reimbursement have all been identified as effective approaches in previous research (e.g., Bell-Seyer, & Moffett, 2000; Murphy, Spiegel, & Kinmonth, 1992; Ward, King, Lloyed et al., 1999). Such recruitment procedures are arguably necessary for any future research in this area to be successful. Additionally, recruitment of GPs may have been more successful if there had been a degree of interaction with GPs working with refugees over a longer period of time. That is, disseminating brief yet informative flyers to GPs about therapeutic issues relevant to the refugee groups they work with (for a number of months prior to attempting to recruit for the research proper) may increase interest in research such as this and therefore increase recruitment rates. Such a strategy is recommended for future researchers in this area to consider utilising.

With respect to recruiting specialist refugee and mental health practitioners, future research that attempts to recruit on a national level rather than in predefined geographical regions may help identify practitioners who have experience working with Somali women. Additionally, recruiting practitioners working in psychiatric inpatient settings (where practitioners may have had a higher degree of contact with Somali experiencing severe forms of psychological distress) rather than in community based mental health settings may also enhance the likelihood of researchers recruiting professionals with a greater degree of knowledge and experience working with Somali than was the case in the current research.

Most of the practitioners in Study 3 said they do (or would) attempt to accommodate the unique needs of clients from culturally diverse backgrounds and also often adapt their practice in an effort to develop rapport and improve therapeutic outcomes. These findings cannot, however, be generalised to general and mental health practitioners who did not participate in the current study and who may not invest the same level of energy and resources into assisting non-Western clients. Given, however, that in many Western secondary health settings practitioners and clients are not matched on any particular characteristics (and therefore non-Western clients may be randomly assigned to a practitioner in mental health services), it is important that future research attempts to obtain a greater understanding of the attitudes, perspectives and approaches of practitioners who do not have a particular interest in working cross-culturally.

Conclusions

Somali who participated in the current thesis described having their own culturally distinct and efficacious approaches to treating spiritual and psychological suffering. Stigma seemed to be primarily associated with the most severe and apparently incurable form of suffering, identified as walli or “craziness”. Other forms of distress, including jinn possession, were not described as having a sense of shame or stigma associated with them. Psychosomatic distress was identified as a common presenting problem of Somali women by general health practitioners, however, Somali seem to reject the possibility that there is a psychological aetiology to their physical ailments. On the other hand, spiritual explanations are typically accepted as an explanation for physical concerns.

Family separation was commonly identified as a significant psychosocial stressor by participants in all three studies. War trauma was also acknowledged by many Somali participants to significantly impact on psychological wellbeing. This distress seems to typically manifest in culturally distinct ways (e.g., as boofis, qalbijab, or murug) rather than in a manner consistent with the Western trauma diagnosis of PTSD. Lack of adequate family support seems to moderate the impact of war-related distress, with those women who were separated from close family more likely to have difficulty overcoming their distress associated with war experiences.

The approach most frequently cited to ameliorate both spiritual and psychological distress was Koran recitations, often conducted in conjunction with prayer. Family and community support was also often described as a common means

of assisting someone suffering from distress. The therapeutic power of such interventions cannot be underestimated. Given the significant change in life roles of Somali women in New Zealand, and the reported increase in social isolation, these traditional interventions act to acknowledge, validate, and increase support networks for the sufferer.

There seem to be clear parallels between Somali idioms of distress and those of Western cultures. The current research has avoided taking a reductionist approach in which these culturally distinct states are simply reassigned a Western diagnostic label. The findings of the thesis suggest that this approach would be rejected by Somali as, regardless of the similarity of symptom profile of some of the Somali states to Western states, the manner in which these states are conceptualised, understood and treated is markedly different. Consequently, the findings provide strong evidence in support of expectancy theory. Expectancy theory is based on the supposition that an individual's belief alone in the omnipotence of a particular healer or particular therapeutic intervention may be sufficient for healing to occur. Hence, the findings reinforce the importance of matching the world view of the client and healer to enhance the likelihood of an efficacious therapeutic outcome.

The findings of the current and previous research (e.g., Bhui et al., 2003; Guerin et al., 2004b; Jaranson, Butcher, Halcón, et al., 2004; McCrone, Bhui, Craig, et al., 2005) suggest that Somali do not tend to present to Western mental health services. Although the findings of Studies 1 and 2 indicate that the Somali participants consider that they already have effective traditional means of ameliorating psychological distress, the findings of Study 3 provide a number of

other possible reasons for this low service use. Long waiting lists, mental health practitioners' lack of expertise working cross-culturally, and poor treatment outcomes were three of the common rationales provided by general health practitioners for deciding not to refer Somali to mental health services. Additionally, Somali clients' apparent rejection of the notion that their psychosocial stressors and physical distress may be causally related was provided as a reason for not referring to secondary services. The stigma attached to having a mental illness was also considered a barrier to engaging with mental health services.

With respect to improving service provision for non-Western clients, an intermediate service that sits between primary and secondary health care agencies may be an effective means of meeting the needs of non-Western clients experiencing psychosocial stressors and mild to moderate psychological distress. It is imperative, however, that any such service involves key stake holders from the community groups it would serve in the design, development and implementation.

The importance of conceptualising health and wellbeing holistically for many non-Western refugees groups is critical to contributing to therapeutic, health-enhancing outcomes. Researchers, refugee communities, and practitioners alike must work together to improve the wellbeing and ameliorate the distress and suffering of these refugee groups living in New Zealand.

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Appendices

Appendix A

Semi-structured Interview Schedule

Interview Schedule for New Zealand Somali Women Identifying Somali Women's Conceptions of Mental Illness

Dates of Interviews: _____

PART 1: DEMOGRAPHIC INFORMATION

Age (or approximation): _____

Length of Time in NZ (approximate number of years): _____

Education:

- None
- Primary School
- Secondary School
- Tertiary

Notes:

Background (if applicable):

- Rural
- Urban Somali

Notes:

Country and Place of Residence prior to moving to New Zealand: _____

Notes:

Time Spent (approximate in years) in refugee camps: _____

Notes:

Current Job/Occupation: _____

Notes:

Employment Status/Job held in Somalia: _____

Notes:

Number of Children: _____

Notes:

Relationship Status:

- Married
- Divorced
- Widowed
- Single
- Other

Notes:

Number of People living in your household: _____

Notes:

Languages Spoken: _____

Notes:

Level of Literacy: _____

Notes:

Loss/death of, and/or missing family members _____

Notes:

Physical Health Status (e.g., current illnesses, diseases injuries etc): _____

Notes:

Medications (both traditional Somali medicines and Western medicines):

Notes:

**PART 2: SOMALI WOMEN'S CONCEPTIONS OF MENTAL ILLNESS
AND RESILIENCE**

Section A.

What sorts of difficulties are treated with:

Koran readings

Last time someone had Koran readings, what was the person doing/saying? Who else/what other agencies etc., were involved. What were you doing/thinking (if relevant)?

Herbal/traditional Somali medicines (specify if possible)

Obtain similar detail as indicated above for each treatment

Modern western medicines

Preparation of special foods (specify)

Emotional support

- Prayer

- Consultation with church leaders

- Consultation with divine healers – to exorcise/appease spirits

- Engagement with mainstream western mental health services

- Consultation with GP

- Family reunification

- Hospitalisation

- Physical Therapy (e.g., massage, exercise, etc.)

Notes: -

Section B.

What sorts of things would a person be doing and/or saying which would suggest that they had been possessed by evil (e.g., jinni) spirits? (request an example if possible)

What sort of impact does possession have on someone/their family/their responsibilities?

What is the person's/family/community response to this (may indicate whether follow-up about treatment approaches is necessary)?

What would you say to someone else about this person's behaviour?

How is this person likely to be feeling?

What would make you think this person's behaviour was out of the ordinary or unusual?

How would you know that someone was receiving a punishment from Allah (e.g., for sins, broken taboos, forgotten rituals)? (request an example if possible)

What would this person be doing or saying?

What sort of impact would this have on someone/their family/their responsibilities?

What is the person's/family/community response to this (may indicate whether follow-up about treatment approaches is necessary)?

What sorts of things would you say to someone else about this person's behaviour?

How is this person likely to be feeling?

What would make you think this person's behaviour was out of the ordinary or unusual?

What sorts of things would a person be doing and/or saying if they had a curse/spell placed on them? (obtain example if possible)

What sort of impact would this have on someone/their family/their responsibilities?

What is the person's/family/community response to this (may indicate whether follow-up about treatment approaches is necessary)?

What would you say to someone else about this person's behaviour?

How is this person likely to be feeling?

What would make you think this person's behaviour was out of the ordinary or unusual?

What sorts of things would a person be doing/saying if they worried too much? (obtain example if possible)

What sort of impact does worrying too much have on someone/their family/their responsibilities?

What is the person's/family/community response to this (may indicate whether follow-up about treatment approaches is necessary)?

What would you say to someone else about this person's behaviour?

How is this person likely to be feeling?

What would make you think this person's behaviour was out of the ordinary or unusual?

How would you know someone had tuberculosis (TB) if no one told you – i.e., what would the person be doing and saying that would suggest that they had TB?

What sort of impact does TB have on someone/their family/their responsibilities?

What is the person's/family/community response to this (may indicate whether follow-up about treatment approaches is necessary)?

What would you say to someone else about this person?

How is this person likely to be feeling?

What would make you think this person's behaviour was out of the ordinary or unusual?

What would you think about this person?

How would you know someone had AIDS/HIV if no one told you – i.e., what would the person be doing and/or saying which would suggest that they had AIDS/HIV?

What sort of impact does AIDS/HIV have on someone/their family/their responsibilities?

What is the person's/family/community response to this (may indicate whether follow-up about treatment approaches is necessary)?

What would you say to someone else about this person?

What would you think about this person?

What would make you think this person's behaviour was out of the ordinary or unusual?

How is this person likely to be feeling?

How would you know someone had epilepsy if no one told you – i.e., what would the person be doing and/or saying which would suggest they had epilepsy?

What sort of impact does polio have on someone/their family/their responsibilities?

What is the person's/family/community response to this (may indicate whether follow-up about treatment approaches is necessary)?

What would you say to someone else about this person?

What would you think about this person?

What would make you think this person's behaviour was out of the ordinary or unusual?

How is this person likely to be feeling?

How would you know someone had poliomyelitic paralysis if no one told you – i.e., what would the person be doing and/or saying which would suggest that they had polio?

What sort of impact does polio have on someone/their family/their responsibilities?

What is the person's/family/community response to this (may indicate whether follow-up about treatment approaches is necessary)?

What would you say to someone else about this person?

What would you think about this person?

What would make you think this person's behaviour was out of the ordinary or unusual?

How is this person likely to be feeling?

What are some of the outcomes for someone who lives in poverty?

What sort of impact does poverty have on someone/their family/their responsibilities?

What is the person's/family/community response to this (may indicate whether follow-up about treatment approaches is necessary)?

What would you say to someone else about this person?

What would you think about this person?

How is this person likely to be feeling?

What sort of changes might you notice in a person when a family member dies/is separated from them?

What effect might this have overall on a person?

What is the person's/family/community response to this (may indicate whether follow-up about treatment approaches is necessary)?

What is the impact/effect on someone who does not have strong support from his or her family/community?

What is the person's/family/community response to this (may indicate whether follow-up about treatment approaches is necessary)?

What might you say to someone else about this person?

How is this person likely to be feeling?

Section C

What do you think is going on with someone who:

- (i) **Cries all the time, does not want to get out of bed and stops seeing their friends?**

What sort of impact does this have on someone/their family/their responsibilities?

What is the person's/family/community response to this (may indicate whether follow-up about treatment approaches is necessary)?

What would you say to someone else about this person's behaviour?

How is this person likely to be feeling?

What if anything, about this person's behaviour would you think is out of the ordinary or unusual?

What do you think causes this type of thing to happen?

(ii) hears voices that other people can't hear or sees things that other people can't see?

What sort of impact does this have on someone/their family/their responsibilities?

What is the person's/family/community response to this (may indicate whether follow-up about treatment approaches is necessary)?

What would you say to someone else about this person's behaviour?

How is this person likely to be feeling?

What if anything, about this person's behaviour would you think is out of the ordinary or unusual?

What do you think causes this type of thing to happen?

(iii) has frequent nightmares about terrible war experiences they have had, and become very distressed really when reminded of these experiences (even months/years afterwards)

What sort of impact would this have on someone/their family/their responsibilities?

What is the person's/family/community response to this (may indicate whether follow-up about treatment approaches is necessary)?

What would you say to someone else about this person's behaviour?

How is this person likely to be feeling?

What if anything, about this person's behaviour would you think is out of the ordinary or unusual?

What do you think causes this type of thing to happen?

Section D

Resilience and Somali Women

1. What are the indicators that a Somali woman is coping/doing well in New Zealand?¹

- Marriage
- Children (if yes, how many)
- Employment
- Education (if so how much)
- Ability to speak English
- Strong sense of spirituality/reliance on God
- Having adequate family support
- Being able to successfully reunite family members
- Owning and/or driving a car
- Having female Somali friends
- Having female New Zealand friends
- Individual strengths/coping abilities (if so, what factors are considered important)
- Able to manage financial commitments (e.g., bills, automatic payments, rent, etc.)
- Physical well-being
- Feeling “content”/happy/satisfied
- Other

Notes:

2. What sorts of things may protect Somali women from suffering from becoming crazy/walli?

(This may include all or some of the factors outlined above as well as others)

¹ Phibbs Witmer and Culver (2001) suggest that absence of psychopathology is not a necessary or sufficient indicator of resilience and should not be considered the benchmark for assessing this concept.

Further Possible Interview Topics

The following are issues that previous literature has indicated may be considered indicative of mental illness for Somali. These topics may also be explored with participants

- **Alcohol use**
- **Recreational drug use (e.g., cannabis/speed)**
- **Homosexual relationships**
- **Prostitution**
- **Inability/decision not to have children**
- **Rejecting/turning away from Islamic Faith**
- **'Zar'**
- **Qat use**
- **Aggression (e.g., stone throwing, yelling, hitting others)**
- **Chronic pain**
- **Out of the ordinary behaviour (e.g., public nudity, eating from rubbish bins)**

Appendix B

Information Sheet for Health Professionals and Voluntary Agency Workers



The Psychology Centre
2 Von Tempsky Street
HAMILTON
07 834 1520



University of Waikato
Psychology Department

10/02/05

PhD Research Project: An Investigation into Somali Women's Understanding of Concepts of Psychological Distress and Resilience

| |
|--|
| INFORMATION SHEET FOR HEALTH PROFESSIONALS AND VOLUNTARY AGENCY WORKERS |
|--|

Why is this research of interest?

There is growing evidence from the international literature that non-western countries view mental illness, and the treatment of mental illness very differently to how this concept is viewed in the west. Additionally, recent literature suggests that illnesses such as post-traumatic stress disorder (PTSD) are actually not that common in refugee populations and may not even exist in the home country of many refugees. Regardless of such research, many professionals who work with refugees still consider PTSD to be the primary psychological disturbance their clients are experiencing. This may mean that, even with the best of intentions, misdiagnosis and failure to identify the real cause of psychological disturbance (and therefore the opportunity to address the real cause) are possible outcomes for refugee/immigrant clients. The current research is therefore a preliminary attempt to begin understanding psychological distress from the unique cultural perspective of the Somali women who participate in the study. It is hoped that the information obtained from the study will be useful to health professionals working with the Somali clients presenting with psychological distress.

Why Somali Women?

There are more Somali refugees in Hamilton than anywhere else in New Zealand. Somali could be considered to be different from New Zealanders in many ways (e.g., religion, food, dress, appearance, family issues) which

suggests that their health needs (particularly their psychological/emotional health) may also be somewhat different/unique compared to the average New Zealander. With very little research in this area, however, it is difficult to determine how best to work with Somali who may request assistance with psychological difficulties. The primary reason that women rather than men are being recruited, is simply due to the fact that as a female researcher, it is likely to be considered inappropriate from the perspective of many Somali, for me to interview men about these issues. There is the possibility of future research exploring similar issues with Somali males.

What will participation involve?

Involvement in the study is likely to involve two to three initial meetings with potential Somali participants in which they are told about the study and given the opportunity to ask questions, as well as discuss the information sheets and informed consent procedure. The formal interviews for the study will take place over approximately three 1 ½ hour sessions. An interpreter will be available (at no cost to the participant or agency they may be engaged with) for every meeting/interview that takes place.

Who may take part in the research?

Up to 20 Somali women will participate in this study. It is intended that the study participants will consist of ten women who are considered to be suffering from some form of mental illness/psychological distress by their general practitioner (GPs) and/or mental health clinician/s. The other 10 women will be considered to have never suffered from mental health difficulties (i.e., have not previously been, and are not currently, engaged in treatment for mental health problems). This mix of participants will help provide a reasonably balanced perspective on how psychological distress is perceived by Somali women in Hamilton.

I am currently recruiting for this study. Participants are required to be aged 18 years or over. There are **no exclusion criteria** based on type or number of mental illnesses, medications, current treatments, or additional physical illness participants may have. There is no expectation that participants can speak English – the interpreter is a Somali female. **I am interested in speaking with any Somali women who may like to participate** in my study (i.e., both women who have had formal treatment for 'mental illness'/psychological distress and those who have not).

How you can help

I would be grateful if you could distribute the attached information sheets (there is both a copy written in English and Somali enclosed) to any of your Somali female clients who may be interested in taking part in this study. Potential participants can contact myself, or one of my co-researchers (Dr. Pauline Guerin, Fatuma Hussein Elmi; whose contact details are on the enclosed information sheet) to discuss their interest in the study further. Anybody that is interested in taking part is free to contact one of us to learn more about the study without feeling obliged to participate in any way.

Should anyone from your service have any queries about the project or wish to discuss any aspects of the research with me further, please feel free to contact me.

Yours sincerely

Juanita Ryan
Doctoral Student
Senior Clinical Psychologist
The Psychology Centre
PO Box 4423
HAMILTON

Appendix C

Participant Information Sheet – English Version



Juanita Ryan
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Dr Pauline Guerin
Psychology Department
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Fatuma H. Elmi
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If you are a Somali Woman - You are invited to participate in this research project about:
Somali women and their views about distress and resilience

What this research is about.

This research is interested in Somali women's views on psychological/physical and spiritual factors that may cause them distress (for example, walli, worry, pain, jinni) and how this distress is understood in Somali culture. This research is also interested in what you think are the kinds of things that may protect Somali women from suffering in these ways. Additionally, this research will ask you about your own experiences of distress. The purpose of the study is to get a better understanding of how Somali women think about psychological/spiritual and physical suffering so that we can hopefully improve the health services available to Somali women in the Hamilton area.

Your Participation

Participation in this study is completely voluntary, which means, you can choose whether or not you would like to take part. If you do initially decide to take part in the study, you can change your mind and pull out of the study at any point. Also, at any time in the study, you can change your mind and not answer the questions or not participate. You can have friends and family present for any part of the study if you want. If you decide not to participate, or decide to pull out of

the study at any time, this will not affect any future treatment you might receive from mental health services.

All the information you tell us will remain confidential and anonymous. This information will not be shown to mental health providers or your GP and it will not affect the mental health services that you may currently be receiving. This research will not have any impact on your present immigration status.

Individual transcripts of the interviews you take part in will be available for you to review or will be translated for you, to ensure the information recorded is accurate.

Inconveniences and Benefits of the Study

It will take some of your time to be in this study. We expect that the interviews will take up a few hours of your time and you will be interviewed more than once (maybe two to three times). We don't think that there are any risks to you to take part in the study. The benefit is that you will get to express your own views and ideas about physical/psychological/spiritual distress which might help increase the understanding and knowledge of the mental health professionals that you or your family/friends may visit.

The interviewer is trained, so if you need any help relating to the issues addressed in this study, please ask the interviewer for help.

Confidentiality and Privacy

Your name will not be on any of the information for the study. Nobody will be able to find out who you are from the information we get for this study. Only the person who interviews you and the translator (who will be present if you do not speak English) will know what you say and they are not permitted to tell anyone else, even in the Somali community. We think that it is very important that no one will be able to identify you through anything that we write about this study. To make sure, we will disguise or modify information slightly. We wish to warn you though that with very close communities, such as the Somali community, there is always a small chance someone might guess your identity from information given, even though we will try and disguise such information.

We also want to assure you that this project has nothing to do with any government organisation or group and will not affect your status in New Zealand, immigration, benefits you may receive or anything else.

No information will be given to any organisation or group unless it can be seen as a benefit to the community. We are not going to report information about individuals, only about the research as a whole. We will not report anything about individual people or families.

Results of the Study

We will make some presentations to the community about this project when it is finished. You will be invited to attend. We will also make reports about this project available, in Somali and in English, when it is finished.

Approval

The University of Waikato Faculty of Arts and Social Sciences Ethics Committee have approved this project. We are required to have any project approved by this Ethics Committee before we can do the research. The Ethics Committee looks at what we are doing and thinks about all the ways that the research could be harmful to people and does not approve the research until we show them that we have done everything possible to make sure that people will not be harmed in any way as a result of our research. This even means that we do everything we can to make sure that the reputation of the community is protected.

How to contact us

Juanita Ryan: 834-1520, juanita@tpc.org.nz

Fatuma H. Elmi: 856-9425, 0211370315, elimif@hotmail.com

Any complaints or concerns can be directed to Professor Mary Foster at the University of Waikato Psychology Department: 838-4466 extension 8302.

Who is paying for this?

The Faculty of Arts and Social Sciences of the University of Waikato have funded this project.

Sample Questions

- What sorts of difficulties are treated with Koran readings?
- What do you think is going on for someone who hears voices other people can't hear?
- What are the main indicators a Somali woman is doing well in New Zealand?
- What sorts of things may protect a Somali woman from walli?
- What has the relocation to New Zealand been like for you?
- What has been easy/hard about relocating to New Zealand?

Appendix D

Participant Information Sheet – Somali Version



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Haddii aad tahay qof dumar ah oo Soomaali ah – waxaa lagugu martiqaaday inaad ka qayb qaadato mashruucan cilmi-baarista oo ku saabsan: Dumarka Soomaalida iyo fikradaha ay ka qabaan wel-welka iyo habka looga moodo.

Waxa cilmi-baaristani ay tahay.

Cilmi-baaristani waxay danaynaysaa aragtida dumarka Soomaaliyeed ee ku aadan arimaha cilmi-nafsiga, jirka iyo aaminaada ee keeni kara wel-wel (tusaale, waali, wel-wel, xanuun, jin) iyo sida dhaqan ahaan Soomaalidu u fahansan tahay wel-welkan. Cilmi-baaristani waxa kale oo ay danaynaysaa waxa aad u malaynayso in ay yihiin nocyada waxyaabaha ka difaaci kara dumarka Soomaaliyeed cuduradan. Intaa waxaa dheer, cilmi-baaristani waxay ku su'aalaysaa wax ku saabsan khibradahaaga xagga wel-welka. Ujeedada cilmi-baaristani waxay tahay inaynu si wacan u fahano fikradaha dumarka Soomaaliyeed ay ka qabaan ku dhacitaanka cudurada nafsiga ama maskaxda iyo jirka si aanu isugu dayno inaanu wanaajino adeegyada caafimaad ee ay heli karaan dumarka Soomaaliyeed ee ku nool Hamilton.

Ka qayb galkaaga

Ka qayb qaadashada cilmi-baaristani ma aha khasab, taasoo ah inaad akhtiyaar u leedahay inaad ka qayb qaadato. Haddii aad marka hore go'aansato inaad ka qayb qaadato cilmi-baaristan, waad ka noqon kartaa oo waad ka bixi kartaa cilmi-

baarista marka aad doontid. Sidoo kale, waqti kasta inta lagu jiro cilmi-baarista waad ka noqon kartaa inaad ka jaawaabto su'aalaha ama aadan ka qayb qaadan. Way kula joogi karaa qoyskaaga iyo asxaabtaada goobta cilmi-baarista. Haddii aad go'aanasto inaad ka qayb qaadan, marnaba ma saamaynayso dawadaada mustaqbalka oo ka heli lahayd adeegyada caafimaadka maskaxda.

Warbixinta aad noo sheegto waxay ahaanaysaa sir adag iyo magac la'aan. Warbixintan la tusi mayo hay'adaha caafimaadka maskaxda ama dhakhtarkaaga, mana saamayn doonto adeegyada caafimaadka maskaxda ee aad hadda qaadatid. Cilmi-baaristani ma saamayn doonto degenaanshadaada ama sharcigaaga New Zealand.

Waraysiga lagaa qaado waad eegi kartaa ama waa lagu turjumi karaa si loo habsado in warbixin sax ah la qoray.

Carqaladaha iyo faa'iidooyinka cilmi-baaristan

Waxay qaadanaysaa qaar ka mid ah waqtigaaga. Waxaan filaynaa in waraysiyadu qaataan ila saacado oo waqtigaaga ah, waxaana lagu waraysanayaa in ka badan mar (laga yaabo laba ilaa saddex goor). Isma lihin inay jiraan wax halis ah oo kaaga imanaya ka qayb galka cilmi-baaristan. Faa'iidooyinka waxay yihiin adiga oo dhiibanaya fikradahaaga iyo aragtidaada ku saabsan wel-welka jirka, nafsigu iyo niyadda taasoo caawinaysa inay kordhiso fahanka iyo aqoonta dhakhaatiirta caafimaadka maskaxda ee aad la kulantid adiga ama qoyskaaga/asxaabtaada.

Qofka ku waraysanaya waa qof tababaran, marka haddii aad u baahato wax caawimo ah oo ku saabsan cilmi-baaristan, fadlan waydiiso qofka ku waraysanaya.

Sir xajinta

Magacaaga marnaba laguma qorayo warbixinta cilmi-baarista. Qofna kama ogaan doono warbixinta cilmi-baaristan qofkaad tahay. Qofka kaa qaaday warbixinta iyo turjumaanka kuu turjumaya haddii aadan Ingiriiska ku hadal, uunbaa ogaan kara warbixintaada, loomana ogola inay u sheegaan cid kale, xittaa bulshada Soomaaliyeed. Waxaan u malaynaynaa inay muhiim tahay inuusan qofna kaa ogaan karin waxaanu ka qorno cilmi-baaristan. Si aan u habsanno xijinta warbixintaada, waanu qarinayna ama yara badelaynaa waxaad ku hadashay. Waxaanu jecel nahay inaan kuu digno maadaama bulsho yar oo isku xiran la yahay sida bulshada Soomaaliyeed, waxaa jiri kara fursad yar oo qof ku malayn karo qofka aad tahay inkastoo aanu ka taxadarayno inayan dhicin sidaa.

Waxaanu kaloo kuu cadaynaynaa in mashruucan in uusan wax shuqul ah ku lahayn hay'ada dowlad ama ururo, mana saamayn doonto sharcigaaga iyo dhaqaalahaaga New Zealand.

Warbixin lama siinayo hay'ad ama urur ilaa loo arko inay waxtar u tahay bulshada. Kama warbixinayno shaqsi ahaan ama qoys ahaan waxaad ku hadashay.

Natiijada cilmi-baaristan

Waxaanu u bandhigi doonaa bulshada mashruucan marka uu dhamaado. Waa lagugu marti qaadi doonaa inaad ka soo qaybgasho. Waxaa kale oo aanu ka samayn doonaa mashruucan warbixinno taasoo lagu qori doono Af-Soomaali iyo Ingiriis, marka la dhameeyo.

Ogolaansho

Guddiga ansixinta/ogolaashaha kuliyadda farshaxanta iyo cilmiga bulshada ee Jaamacadda Waikato way ogolaadeen mashruucan. Waxaa nalaga doonayaa in mashruuc kasta ay soo ansixiso guddiga ansixinta ka hor inta aynaan samayn cilmi-baarista. Guddiga ansixinta wuxuu eegayaa waxaanu samaynayno, waxayna ka fikirayaan sida cilmi-baaristu ay bulshadu wax u yeelaynayso, mana ansixinayso cilmi-baarista ilaa aanu caddaynu inaanu samaynay wax kasto oo suurta gal ah oo aanu ku habsanayno in dadka aan wax loogu dhimayn cilmi-baaristan.

Sida aad noola soo xiriiri kartid

Juanita Ryan: 834-1520, juanita@tpc.org.nz
Fatuma H. Elmi: 855 0487, elmif@hotmail.com

Wixii cabasho ama walaac ah waxaad kala xiriiri kartaa borofesar Mary Foster laga helo Jaamacadda Waikato, qaybta cilmi-nafsiga: 838-4466 ext. 8302.

Yaa maal-geliyey cilmi-baaristan?

Kuliyadda Farshaxanka iyo Cilmiga bulshada ee Jaamacadda Waikato ayaa maal geliyey mashruucan.

Nooca su'aalooyinka?

- Dhibaatooyinke ayaa lagu daweyyaa aqriska quraanka?
- Maxaad u malaynaysaa inuu hayo qof maqlaya codad aanay maqlayn dadka kale?
- Waa maxay waxyaalaha muhiimka ah ee tilmaamaya in qofka dumarka ah ee Soomaaliyeed ay horumar ka gaadhay deganaashada New Zealand?
- Maxaa ka ilaalin kara dumarka Soomaaliyeed waallida?
- Sideebay kuu saamaysay dib u dejintaadii New Zealand?
- Maxaa kuugu sahlanaa/ama kugu adkaa xagga dib u dejintaada New Zealand?

Appendix E

Participant Information Sheet



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**If You Are A Somali Woman - You Are Invited To
Participate In This Group Discussion About:
Somali Women's Views On Psychological Distress
And Jinn Possession**

What this research is about

Recently in Hamilton, some Somali women were interviewed about opinions with regard to psychological, physical and spiritual forms of distress and how such distress is managed and/or treated in Somali culture. Many of the women interviewed talked about jinn possession and usually said that Koran readings were the most effective way of being rid Jinn with only a few suggesting that using Western treatments in addition to Koran readings was helpful. Often the Somali women said that they could not see a role for Western mental health services in assisting Somali. Generally the women interviewed reported that Western forms of distress such as “depression”, “worry” and “stress” were very uncommon in Somali culture. The current research is interested in determining whether other Somali women also share these perspectives, or have different opinions about these issues. The research will take place in a group format – with up to ten Somali women taking part in each group. This research will be carried out in Hamilton, Auckland, Wellington and Christchurch. The purpose of the study is to get a better understanding of how Somali women think about psychological/spiritual and physical suffering so that we can hopefully improve the health services available to Somali women in New Zealand.

Your Participation

Participation in this study is completely voluntary, which means, you can choose whether or not you would like to take part. If you do initially decide to take part in the study, you can change your mind and pull out of the study at any point. Also, at any time in the study, you can change your mind and not answer the questions or not participate in the group discussions.

Summaries of the group interviews will be available for you to review to ensure the information recorded is accurate. We expect that the group interviews will take two hours of your time. There will be a Somali female co-researcher present in all of the group interviews who will be able to conduct all, or part of the interviews in Somali if that is necessary.

Confidentiality and Privacy

Everyone who takes part in the group discussion will agree to maintain the confidentiality of all other members of the group. This means everyone will agree not to discuss information which may identify a group participant with anyone who did not participate in the group discussion. Juanita Ryan and Fatuma H. Elmi are not permitted to tell anyone else who took part in the group discussions. We think that it is very important that no one will be able to identify you through anything that we write about this study. To make sure, we will disguise or modify information slightly. We wish to warn you though that with very close communities, such as the Somali community, there is always a small chance someone might guess your identity from information given, even though we will try and disguise such information. Also, even though all group participants will agree to keep information confidential as a condition for being involved in the discussion, the researchers cannot guarantee that this will happen.

No information will be given to any organisation or group unless it can be seen as a benefit to the community. We are not going to report information about individuals, only about the research as a whole.

Results of the Study

We will make some presentations to the community about this project when it is finished. You will be invited to attend. We will also make reports about this project available, in Somali and in English, when it is finished.

Approval

The University of Waikato Psychology Departments Ethics Committee have approved this project. The Ethics Committee looks at what we are doing and thinks about all the ways that the research could be harmful to people and does not approve the research until we show them that we have done everything possible to make sure that people will not be harmed in any way as a result of our research.

How to contact us

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Fatuma H. Elmi: 856-9425, 0211370315, elimif@hotmail.com

Any complaints or concerns can be directed to Professor Mike O'Driscoll at the University of Waikato Psychology Department: 838-4466 extension 8302.

Who is paying for this?

The Faculty of Arts and Social Sciences of the University of Waikato have funded this project.

Appendix F

FOCUS GROUP DISCUSSION PROTOCOL – STUDY 2

Below is a semi-structured interview protocol, which will guide the facilitators in conducting the focus group conversation. The facilitators will actively engage with the participants and ensure they use the terms used by participants in their conversation. The protocol however, ensures core themes will be covered in the focus group discussion.

Introduction

Recently in Hamilton, some Somali women were interviewed about their opinions with regard to psychological, physical and spiritual forms of distress and how such distress is managed and/or treated in Somali culture. I am interested in talking to more Somali women about these matters to get an even better idea of the types of distress common to Somali women, the signs or symptoms of this distress and how it is dealt with/managed within the Somali community. I am also interested in Somali women's thoughts on using Western mental health services. This research will hopefully help us get a better understanding of how Somali women think about psychological/spiritual and physical suffering. Consequently, this information might contribute to improvements in the health services available to Somali women in New Zealand.

We would like to be able to audiotape this discussion so we get the most accurate account of what everybody has to say. This will also mean that we can concentrate on what you are saying rather than focusing also on taking notes. What are people's thoughts about that [*obtain feedback and if appropriate turn on recorder*]?

Before we begin we would like to discuss the following guidelines, which are designed to allow our discussion to run smoothly:

1. We are interested in your opinions. From our perspective there are no right or wrong answers.
2. We would like everyone to feel free to express their views.

3. Feel free to respond to other people's comments and opinions but try not to interrupt.
4. Feel free to disagree with what other people are saying but please be respectful of their views.
5. If there is something you think is important to tell us but we don't ask about that issue directly, feel free to tell us about it anyway.
6. If you have any questions or are unclear about any of the issues raised, feel free to ask for things to be explained more clearly.
7. It is important that what we discuss in the group today is not repeated to anyone outside of the group. This means that you don't tell other people outside of the group who was here today, and also, any information talked about which might identify a particular person is not repeated outside of the group. Has anybody got any questions about this [*will discuss further if necessary*]

Part 1²

The appropriateness and relevance of some of the following questions will be determined based on participants' responses. Some questions may not be asked and some may be modified.

.....

1. What are your thoughts about jinn possession?
2. What do you consider key signs of jinn possession?
 - a. What are the consequences of jinn possession
 - i. for the person with the jinn?
 - ii. for their family?
 - b. What helps get rid of jinn?
 - c. Why do you think jinn possess some people?
3. What other forms of distress do Somali woman experience?
 - a. **Qalbijab or Niyadjab**
 - b. **Murug/Murugo**
 - c. **Welwel ama walaac**
 - d. *Will explore antecedents, consequences, symptoms and treatment approaches as relevant.*

² Parts 1 and 2 of the interview protocol are considered 'high priority' areas to explore and questions in these parts will be asked in all focus groups.

4. How do you know the difference between Jinn possession and other forms of distress?
5. What other sorts of assistance (both traditional and Western) would Somali woman suffering from distress access?
 - a. What do Somali generally think about other Somali who get these sorts of assistance?
6. What do you think about Western mental health services?
 - a. What do you think of Somali using these services?
 - b. What would be reasons Somali would use these services?
 - c. What would be reasons Somali would not use these services?

.....

Part 2

In the second half of the focus groups, participants will be presented with three Vignettes. They will be asked the following questions about each Vignette:

1. What do you think is going on for this person?
2. Why do you think the person is acting this way?
3. What causes this sort of behaviour?
4. What sort of help would this person receive from the Somali community?
5. If this person was to go to a Western mental health service, what sorts of things do you think would be done to try to help them there?
6. What do you think about Western treatment approaches being used with this person?

Vignette 1

There is a Somali woman who can be working or doing something for 24 hours without getting tired. Sometimes she walks all day and all night and she is not even going anywhere. She also talks to someone other people can't see, she will talk, and laugh and she doesn't care about showering or cleaning herself. Sometimes she gets really violent. There was this time when this older Somali lady was standing in her way and she pushed her to

the ground. Sometimes when the voices go away and she is not being violent and starts looking after herself again she says that she can't remember doing any of these things once she stopped.

Vignette 2

Another Somali woman has frequent nightmares about her family who she left behind in a refugee camp. At times she says that she will be sleeping on her bed and she will start seeing the people who died in front of her or the pile of bodies, some of which were familiar, that she helped bury or move from the roads. This woman said that these experiences will never be erased from her memory even though she tries to forget them by occupying herself with other things. She also said that she drops to the ground if she hears a siren as that reminds her of the war back home too.

Vignette 3

Another Somali woman has started staying in bed a lot and has stopped looking after her house. She only leaves her house to drop her children at school and pick them up. Some of this woman's friends say that they have seen her crying. Often when you talk directly to her she doesn't even seem to notice. Her husband is concerned that she has become very forgetful and might leave something on the stovetop and burn their house down. This Somali woman said that when she was asleep she would experience dreaming and think that someone called her name but there is no one there

.....

Part 3³

1. What is the impact on a Somali woman –
 - a. If she has family still in Africa?
 - i. How is she likely to be feeling?
 - ii. How is she likely to be acting?

³ Part 3 is considered questions of moderate importance. If time does not permit, these questions will not be asked in all focus groups.

- iii. What are the consequences for her?
- iv. What are the consequences for her family?
- v. How is she likely to deal with/manage distress associated with this?
 - 1. Traditional methods?
 - 2. Western methods?
- b. Of experiencing war in Africa?
 - i. How is she likely to be feeling?
 - ii. How is she likely to be acting?
 - iii. What are the consequences for her?
 - iv. What are the consequences for her family?
 - v. How is she likely to deal with/manage distress associated with this?
 - 1. Traditional methods?
 - 2. Western methods?
- c. If she is walli?
 - i. How would you know someone was walli?
 - ii. How is the person who is walli likely to be feeling?
 - iii. How is she likely to be acting?
 - iv. What are the consequences for her?
 - v. What are the consequences for her family?
 - vi. How is she likely to deal with/manage this?
 - 1. Traditional methods?
 - 2. Western methods?
 - vii. What causes walli?

Appendix G

Mental Health Practitioners' Participant Information Sheet



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Information Sheet

Going 'Walli' and Having 'Jinn'.
Non-Somali Practitioners' Approaches to Working
with Somali Women Experiencing Psychological

Taking part in this research is completely voluntary. This means that you are free to choose whether you take part or not. You are also free to change your mind about taking part at any time.

What this research is about

Findings from previous research conducted in Hamilton, New Zealand suggests that Somali women's conceptions of psychological distress and the manner that they and/or their Somali support network may chose to manage/treat this distress, may often be at odds with Western idioms of distress and Western psychological/psychiatric interventions. Local and international literature also suggests that Somali are typically infrequent and reluctant users of Western mental health services. Research that explores barriers to mainstream mental health use, however, tends to focus solely on the perspectives of Somali (and other non-Western migrant groups) and frequently fails to seek the opinions and perspectives of practitioners in

mainstream services. Such research is also often problem-focused rather than solution-focused. Based on a model of reciprocal learning developed by Proctor (2003), the current study is interested in health practitioners' understanding of Somali conceptions of distress as well as practitioners' approaches to treatment with this group. This research is also interested in practitioners' perspectives on how mainstream mental health services may benefit Somali and, in what ways clinicians consider barriers to the use of such services could be overcome.

You do not have to have treated/worked with Somali to participate in this research, however, we are especially interested in talking with clinicians who have done so.

What Will Taking Part Involve?

The study will be conducted using a focus group format. No more than ten mental health practitioners (who will all be recruited from the three Hamilton-based community mental health teams) will take part in the focus group. In the focus group, participants will be provided with a number of Vignettes outlining examples of the types of psychological difficulties Somali have described in earlier locally based research. Participants will be asked a number of questions based on each Vignette. Participants will be free to decline to respond to any of the questions asked during the focus group. The focus group will be audio taped with permission.

All participants in the focus group will be expected to maintain group confidentiality and this will be a condition attached to participating in the research. It is important to mention however, that it cannot be guaranteed, that all group members will uphold this confidential agreement. No information will be reported that will identify individual clinicians.

If you **are interested in participating but** do not wish to be involved in a group interview, a one-to-one interview with the primary investigator can be organised. **As with group interviews, individual interviews will be audiotaped.**

What will happen to the audiotapes?

All audiotape data will be transcribed. The audiotapes and transcriptions will be stored securely for five years and then destroyed.

A summary report outlining the results will be given to all clinicians who were involved in the study once the study has been completed.

Approval

The University of Waikato Psychology Departments Ethics Committee has approved this project.

What should you do if you want to participate in this study?

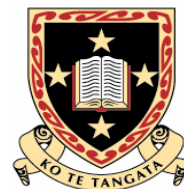
You can contact me directly to indicate your interest in taking part or to discuss any concerns/questions you might have about the focus group. My contact details are:

Juanita Ryan: 834-1520, juanita@tpc.org.nz

Any complaints or concerns can be directed to
Professor Michael O'Driscoll at the University of Waikato
Psychology Department:
838-4466 extension 8302.

Appendix H

Specialist Refugee Mental Health Practitioners Information Sheet



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Information Sheet

Going 'Walli' and Having 'Jinn'.
Non-Somali Practitioners' Approaches to Working with
Somali Women Experiencing Psychological Distress

Taking part in this research is completely voluntary. This means that you are free to choose whether you take part or not. You are also free to change your mind about taking part at any time.

What this research is about

Findings from previous research conducted in Hamilton, New Zealand suggests that Somali women's conceptions of psychological distress and the manner that they and/or their Somali support network may choose to manage/treat this distress, may often be at odds with Western idioms of distress and Western psychological/psychiatric interventions. Local and international literature also suggests that Somali are typically infrequent and reluctant users of Western mental health services. Research that explores barriers to mental health use, however, tends to focus solely on the perspectives of Somali (and other non-Western migrant groups). This research frequently fails to seek the opinions and perspectives of practitioners in mainstream services or practitioners who have expertise in working with refugee and/or migrant groups. Such research is also often problem-focused rather than solution-focused. Based on a model of reciprocal learning developed by Proctor (2003), the current study is interested in

health practitioners' understanding of Somali conceptions of distress as well as practitioners' approaches to treatment with this group. In particular, this aspect of my research is interested in interviewing mental health practitioners with specialist training and/or experience working with refugees/migrants. This research is also interested in practitioners' perspectives on how mental health services may benefit Somali (and potentially other similarly vulnerable groups) and, in what ways clinicians consider barriers to the use of such services could be overcome.

You do not have to have treated/worked with Somali to participate in this research, however, we are very interested in talking with practitioners who have done so.

What will taking part involve?

The study will be conducted using a focus group format. The focus group participants in this part of the study will all have specialist training/expertise in working with refugee and/or migrant clients. No more than ten specialist mental health practitioners will take part in the focus group. In the focus group, participants will be provided with a number of Vignettes outlining examples of the types of psychological difficulties Somali have described in earlier locally-based research. Participants will be asked a number of questions based on each Vignette. Participants will be free to decline to respond to any of the questions asked during the focus group. The focus group will be audio taped.

All participants in the focus group will be expected to maintain group confidentiality and this will be a condition attached to participating in the research. It is important to mention however, that it cannot be guaranteed that all group members will uphold this confidential agreement. No information will be reported that will identify individual clinicians.

If you **are interested in participating but** do not wish to be involved in a group interview, a one-to-one interview with the primary investigator can be organised. **As with group interviews, individual interviews will be audiotaped.**

What will happen to the audiotapes?

All audiotape data will be transcribed. The audiotapes and transcriptions will be stored securely for five years and then destroyed.

A summary report outlining the results will be given to all clinicians who were involved in the study once the study has been completed.

Approval

The University of Waikato Psychology Departments Ethics Committee has approved this project.

What should you do if you want to participate in this study?

You can contact me directly to indicate your interest in taking part or to discuss any concerns/questions you might have about the focus group. My contact details are:

Juanita Ryan: 834-1520, juanita@tpc.org.nz

Any complaints or concerns can be directed to
Professor Michael O'Driscoll at the University of Waikato
Psychology Department:
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Appendix I

General Health Practitioners Information Sheet



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Information Sheet

Going 'Walli' and Having 'Jinn'.
Non-Somali Practitioners' Approaches to Working
with Somali Women Experiencing Psychological
Distress

Taking part in this research is completely voluntary. This means that you are free to choose whether you take part or not. You are also free to change your mind about taking part at any time.

What this research is about

Findings from previous research conducted in Hamilton, New Zealand suggests that Somali women's conceptions of psychological distress and the manner that they and/or their Somali support network may chose to manage/treat this distress, may often be at odds with Western idioms of distress and Western based treatment approaches. Local and international literature also suggests that Somali are typically infrequent and reluctant users of Western mental health services. Research that explores barriers to mainstream mental health use, however, tends to focus solely on the perspectives of Somali (and other non-Western migrant groups) and frequently fails to seek the opinions and perspectives of health practitioners

who work with refugee and migrant groups. Local research has found that general practitioners (GPs) are generally well respected and trusted by the Hamilton-based Somali community, and, are often the only point of contact these women have with mainstream health professionals. Hence, based on a model of reciprocal learning developed by Proctor (2003), this aspect of the current study is interested in GPs' understanding of Somali conceptions of distress as well as GPs' approaches to treatment with this group. This research is also interested in GPs' perspectives on how mainstream mental health services may benefit Somali (and possibly other refugee/migrant groups) and, in what ways GPs think that barriers to the use of such services could be overcome.

You do not have to have treated/worked with Somali to participate in this research, however, we are very interested in talking with GPs who have done so.

What Will Taking Part Involve?

The interview will be conducted over the telephone. Participants will be provided with a number of Vignettes outlining examples of the types of psychological difficulties Somali have described in earlier locally-based research. Participants will be asked a number of questions based on each Vignette. Participants will be free to decline to respond to any of the questions asked during the interview. The telephone interview will be audio taped with permission.

What will happen to the audiotapes?

All audiotape data will be transcribed. The audiotapes and transcriptions will be stored securely for five years and then destroyed.

A summary report outlining the results will be given to all GPs who were involved in the study once the study has been completed.

Approval

The University of Waikato Faculty of Arts and Social Sciences Ethics Committee have approved this project.

What should you do if you want to participate in this study?

You can contact me directly to indicate your interest in taking part or to discuss any concerns/questions you might have about the focus group. My contact details are:

Juanita Ryan: 834-1520, juanita@tpc.org.nz

Any complaints or concerns can be directed to
Professor Michael O'Driscoll at the University of Waikato
Psychology Department: 838-4466 extension 8302.

Appendix J

Interview Protocol: Study 3

Going “Walli” and Having “Jinni”: Research Interview Questions

Part 1⁴

The appropriateness and relevance of some of the following questions will be determined based on participants' responses. Some questions may not be asked and some may be modified.

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1. What are the most common complaints/difficulties Somali women you have worked with have described to you⁵?
2. What is the most common form of treatment you provide for Somali women?
 - a. How effective do you consider this treatment to be for them?
3. Have you had any difficulties/ concerns in working effectively with Somali women?
 - a. If so, why do you think that might be?
4. Do you adapt/modify your practice when working with Somali women?
How?
5. How often do family members accompany your Somali clients to their appointments?
6. How often do paid interpreters accompany your Somali clients (those that require interpreters)?
 - a. If infrequently, why?
7. Have you ever had a Somali female patient who has chosen (or requested) to engage in specialist mental health services?
 - a. Under what circumstances?

⁴ Parts 1 and 2 of the interview protocol are considered ‘high priority’ areas to explore and questions in these parts will be asked in all focus groups.

⁵ Some of these questions can only be asked of those participants who have actually worked with Somali women

8. Have you ever referred Somali women to specialist MH services? How did that go?
 - a. Was it effective?
9. In what ways do you think mental health services currently cater for the needs of Somali clients?
10. How do you think services could be improved to meet the needs of Somali clients?
11. What do you think is important information for Somali to be aware/educated about with respect to Western services?
12. What agencies/professionals would you most commonly refer your Somali clients to?
13. Do you deal with MH issues with your Somali women clients yourself?
 - a. In what ways?
14. What is your understanding of traditional Somali conceptions of wellbeing and distress?

.....

Part 2

In the second half of the focus groups, participants will be presented with three Vignettes. They will be asked the following questions about each Vignette:

1. What do you think is going on for this person?
2. Why do you think the person is acting this way? What causes this sort of behaviour?
3. If this person presented to your agency, what else would you want to know to be able to determine what sort of help to provide?
4. How would you approach the assessment with this person?
 - a. What other considerations might you make?
5. How would you approach treatment with this person?
 - a. What other considerations might you make?

6. What sort of Somali approaches do you think might be employed with this person?
7. What would you think if Somali interventions, such as Koran recitations, were used to help this person?
8. What would you think if the client and/or their family member informed you that their problems were all related to spirit possession?
 - a. How would you respond to this?

Vignette 1

There is a Somali woman who can be working or doing something for 24 hours without getting tired. Sometimes she walks all day and all night and she is not even going anywhere. She also talks to someone other people can't see, she will talk, and laugh and she doesn't care about showering or cleaning herself. Sometimes she gets really violent. There was this time when this older Somali lady was standing in her way and she pushed her to the ground. Sometimes when the voices go away and she is not being violent and starts looking after herself again she says that she can't remember doing any of these things once she stopped.

Vignette 2

Another Somali woman has frequent nightmares about her family who she left behind in a refugee camp. At times she says that she will be sleeping on her bed and she will start seeing the people who died in front of her or the pile of bodies, some of which were familiar, that she helped bury or move from the roads. This woman said that these experiences will never be erased from her memory even though she tries to forget them by occupying herself with other things. She also said that she drops to the ground if she hears a siren as that reminds her of the war back home too.

Vignette 3

Another Somali woman has started staying in bed a lot and has stopped looking after her house. She only leaves her house to drop her children at school and pick them up. Some of this woman's friends say that they have seen her crying. Often when you talk directly to her she doesn't even seem to notice. Her husband is concerned that she has become very forgetful and might leave something on the stovetop and burn their house down. This Somali woman said that when she was asleep she would experience dreaming and think that someone called her name but there is no one there

.....

Part 3⁶

1. What is the impact on a Somali woman –
 - a. If she has family still in Africa?
 - i. How is she likely to be feeling?
 - ii. How is she likely to be acting?
 - iii. What are the consequences for her?
 - iv. What are the consequences for her family?
 - v. How is she likely to deal with/manage distress associated with this?
 1. Traditional methods?
 2. Western methods?
 - b. Of experiencing war in Africa?
 - i. How is she likely to be feeling?
 - ii. How is she likely to be acting?
 - iii. What are the consequences for her?
 - iv. What are the consequences for her family?
 - v. How is she likely to deal with/manage distress associated with this?
 1. Traditional methods?
 2. Western methods?

⁶ Part 3 is considered questions of moderate importance. If time does not permit, these questions will not be asked in all focus groups.

APPENDIX K

PARTICIPANT DEMOGRAPHICS SHEET – STUDY 3

Length of Time as GP/mental health clinician

.....

Ethnicity.....

How long have you worked with refugees (in years)?

How long have you worked with Somali refugees?.....

What percentage of your caseload is made up of Somali refugees?

.....%

What percentage of your caseload is made up of Somali women?

.....%