41 Exploring a Social-Ecological Systems Approach to Assessment through a Composite Somali Refugee Case

Jacob A. Bentley, Mohammed Alsubaie, Kimi Hashimoto, Mansha Mirza, and Farhiya Mohamed

Section I: Background Information

Terminology and Perspective
The people, culture, and language of Somalia are described by using the noun Somali. This chapter integrates a range of perspectives: a Caucasian, European-American rehabilitation psychologist with 15 years of experience working with people internationally displaced by socio-political conflict (JB), a Saudi Arabian clinical psychology doctoral student with interest in trauma psychology (MA), an Asian American clinical psychology doctoral student with interest in cross-cultural neuropsychology (KH), an Asian Indian American occupational therapist with expertise in Disability Studies and factors salient to refugees with disabilities (MM), and a US-based Somali community leader and organizer with a background as a social worker (FM).

Geography
Somalia is a long, narrow country located in Eastern Africa that wraps around the Horn of Africa. Somalia has a long coast bordering the Red Sea and the Indian Ocean. It occupies an important geopolitical position for trading zones, with cross-border trade and international import and exports through various ports. Somalia has a harsh, desert climate overall with seasonal monsoons in some parts. Somalia is prone to recurrent droughts, frequent dust storms in the Eastern Plains, and flooding during the rainy seasons. Famine, deforestation, overgrazing, soil erosion, and desertification have become significant issues in recent decades. Following the Civil War of 1991, the country consists of three zones: the northwest (known as Somaliland), the northeast (known as Puntland), and south/central Somalia.

History
Colonial rule of Somalia by France, Britain, Italy, and Ethiopia began in the mid-1800s, dividing the land inhabited by ethnic Somalis into several territories. In July 1960, British Somaliland and Italian Somaliland peacefully obtained their independence and united to form the current borders of Somalia. At the time of independence, a civilian government was established in Somalia.

In 1969, General Mohammed Siad Barre led a coup and created a socialist military government with himself as its President. Initial popular support for his regime waned after increasing oppression and human rights violations. In the late 1970s and early 1980s, clan-based militias developed to oppose and overthrow Barre. Political instability increased in the early 1990s, resulting in a humanitarian crisis and a territorial civil war. The United States supplied military and economic

DOI: 10.4324/9781003051862-83
aid to Somalia but suspended their efforts in 1989 because of the Barre government’s human rights record. Civil war erupted from 1988 to 1991, culminating in Barre’s exile in January 1991.\textsuperscript{2–4} Since 1991, various clan militias have fought against each other for control of the country.\textsuperscript{2–4} Government in Somalia has been unstable since, contributing to cyclical violence and famine.\textsuperscript{1,5} The US Army estimated that by the fall of 1992, 40% of the population of Baidoa, a city in the southwestern Bay region of Somalia, and 20% of Somali children under age five had died due to famine. In late 1992, the US and UN forces intervened in Somalia to aid the humanitarian crisis and by March 1994 all foreign troops had withdrawn.

At the present time, inter-clan disputes continue within some regions of Somalia forcing many Somalis to relocate to other countries to escape famine and risk of death. Recent elections have been peaceful and demonstrated signs of progress toward sociopolitical stability, but Somalia remains divided by insurgent groups and rival militaries.

\textbf{People}

Ethnic Somalis are unified by culture, language, Islamic religion, and common ancestry. People of Somali origin account for approximately 85% of the population, with minority ethnic groups accounting for the remaining 15%.\textsuperscript{2–4} Ethnic groups in Somalia are further divided into clans.\textsuperscript{2–4} Clans hold social and political importance and membership is determined by paternal lineage. Those of Somali origin or “nobles” belong to one of four patrilineal clans: Darod, Hawiye, Dir, and Rahanweyn (which includes the Digil and Mirifle people). These clans dominate modern government and politics, in addition to economy and urban life. Somalia’s minority clans are very diverse and are not defined by ethnicity, religion, or linguistic variance but may also be identified by social and historical distinctions. Minority clans live in poverty and have been subject to discrimination and exclusion.

Clans are a very sensitive topic for many Somalis due to enduring tension and ongoing conflict. The US Centers for Disease Control and Prevention recommends that clinicians avoid discussing clans with Somali patients as many may find it disrespectful or offensive.\textsuperscript{6}

\textbf{Immigration and Relocation}

Somalis began emigrating in 1991 to escape widespread hunger, rape, and death after years of civil war, famine, unequal distribution of aid, and poor economic prospects. Over a million Somalis fled to neighboring countries such as Ethiopia, Kenya, Djibouti, Yemen, and Burundi. Many stayed in refugee camps established to house them and resettlement programs enabled families to migrate to Europe and the United States. Somalis in the United States have relocated primarily to Minnesota, New York, Southern California (e.g., Los Angeles and San Diego), Washington, DC, and Washington State (Seattle).

\textbf{Language}

Somali is the official language of Somalia and was primarily an unwritten language until a uniform script was adopted in the 1970s based on the Latin alphabet.\textsuperscript{1} The second official language is Arabic, mostly spoken in northern Somalia or in coastal towns. It is mainly used to read the Quran. Until the 1970s, education was conducted in the language of colonial rule; therefore, older Somalis from northern Somalia are conversational in English, while Somalis from southern Somalia are conversational in Italian. Somali is the language of instruction in schools, although Arabic, English, and Italian may also be used.
Somalia is a collectivistic society and communication depends on affinity and trust. For example, talking with a fellow Somali is significantly different from talking to a non-Somali. Communication with elders tends to be softer and indirect and often preceded by a term of respect such as adeer or abti (uncle) or eedo or habaryar (aunt). Additionally, gender boundaries are commonly known and accepted. Cultural norms are more emphasized in communication with the opposite gender, and physical touch (e.g., handshaking) is generally avoided.

Building rapport is essential with Somali clients. For example, it’s helpful to start the evaluation with a cultural greeting like salam, ask generally relevant rather than personal questions, and be clear about the purpose of the encounter. Additionally, it is important to ask about and consider gender-match if possible and avoid handshakes with the opposite gender if not offered. These considerations might help build trust and rapport, especially considering the power differential between Western providers and Somali clients.

Education and Literacy

The civil war in Somalia decimated the educational system. Many schools were destroyed, and teaching materials became unavailable. Prior to the war, the government endorsed literacy campaigns in the 1970s–80s and all levels of education including higher education or college were free until 1991. Private schools were only available for those who could afford them. The Civil War rendered both public and private schools inaccessible. Somalia has one of the world’s lowest school enrollment rates with only 25% of children enrolled in primary schools and 6% enrolled in secondary schools. School enrollment is substantially higher for boys than girls. Literacy among Somalis is very low. Among those 15 years of age or older, male literacy is approximately 49.7% while literacy among women is at 25.8%.

Socio-Economic Status

Social and economic infrastructures in Somalia collapsed after the Civil War. Ongoing conflict and economic shock from increased global food and fuel prices led to the collapse of the Somali currency and unprecedented levels of poverty. An estimated 43% of the population lives in extreme poverty. Somalia’s economy is mainly based on agriculture, livestock, and fishery.

Values and Customs

Family structure is organized within a patriarchal framework. The father is the head of the Somali household and is responsible for providing for the family. Most household responsibilities and childcare are maintained by women. Extended family and close family friends additionally help with childcare.

Gender and Sexuality

Gender roles in the Somali culture stem from cultural values. Men are expected to provide for the family and ensure its safety, while women take care of children and elders and the household chores. Such roles, however, have been impacted by different societal, political, and economic changes over the last two decades, and many families are cared for by single mothers or have women who are the main breadwinners.
Sexuality is a sensitive topic for Somalis, especially regarding established norms and accepted behaviors of each gender. For example, female behavior is viewed as more reflective of her family's honor and that of her clan at large, so she might be punished or shamed if she behaves in a way that violates established norms. Diverse forms of sexuality such as same-sex attraction are highly stigmatized and individuals who identify as sexual minority may face discrimination and punishment.

Considering such cultural nuances is important for providers. For example, clients may not be comfortable disclosing sexual matters outside the boundaries of accepted norms or may avoid talking about sexual dysfunction. Thus, providers must attend to subtleties in expressions that might warrant a culturally sensitive examination of clients' sexuality and how it associates with their symptoms.

**Spirituality and Religion**

Majority of Somalis are Sunni Muslims. For those that practice Islam, religion entails a predominant role in life compared to what is typical in the Americas or Europe. Islam is considered a belief system, culture, government structure, and a way of life. The provisional federal constitution of Somalia recognizes Islam as the state religion and requires all laws to comply with the general principles of *sharia*. Attitudes, social customs, and gender roles in Somalia are primarily rooted in Islamic tradition.

**Acculturation and Systemic Barriers**

After resettlement in a host country, Somalis face various barriers to utilizing mental health services. Common cultural barriers include stigma, concerns about privacy, and the struggle to recognize the need for professional care (e.g., seeking services for physical illness only). Additional systemic barriers include lack of information about services available, scarcity of interpreters, and economic and financial challenges. Such barriers breed misinformation and mistrust in the system and overarching goals of available services. For example, some might fear disclosing information about interpersonal or familial discord lest agencies like Child Protective Services get involved. These factors may impact the types of services sought in all aspects of the clinical or neuropsychological evaluation, from the initial introduction to feedback and follow-up.

Somalis’ level of acculturation to a host country and its system may impose yet another challenge for mental health utilization. Acculturation has been found to influence mental health symptoms across different cultures. Research shows that Muslims resettled in the United States who maintained their culture of origin and identified more with their culture endorsed more severe depressive symptoms. Moreover, for Somali adolescents, acculturative stress is associated with post-traumatic stress disorder (PTSD) and depressive symptoms. Acculturative stressors are often rooted in practical considerations that influence functioning and wellbeing in ways that may be invisible to Western providers. For example, like other Muslim communities, Somalis may encounter stressors related to purchasing housing and/or transportation with financial assistance because of the Islamic concept of *riba* that prohibits use of economic interest.

**Health Status**

Research on health conditions experienced by internationally displaced Somalis is limited. Available data suggests similarities with other communities of refugees and asylum seekers. For example, data collected by the Somali Health Board of Seattle in November 2014 identified most prominent health concerns in a sample of 141 Somalis (age range 18–78, with 94% of the respondents born in Somalia). A subsequent survey about common conditions treated within the community...
was collected from 21 Seattle-based health providers in March 2015. High blood pressure, diabetes, high cholesterol, heartburn, and arthritis were the top diagnoses, in order of highest to lowest frequency, reported by respondents from the Somali community. Healthcare providers identified diabetes, depression, PTSD, h. pylori and obesity as the top five diagnoses treated.

### Mental Health Views

Generally, Somalis think of mental health in two broad categories: sane or insane, with some research suggesting that the concept of mental health and treatment is fairly new among many Somalis. Many psychological difficulties are recognized as part of the individual’s personality or as a result of daily stressors. Such view is intertwined with the stigma surrounding mental health terminology, diagnoses, and treatment. In understanding mental health symptoms, many Somalis rely on religious and cultural concepts pertaining to the cause and appropriate healing of symptoms. Common explanations for mental ailment are predetermined fate, punishment from Allah for lack of faith or poor life decisions, and interference of supernatural forces such as evil spirits and witchcraft. With that said, more Western contributors to mental illness are known in the Somali culture such as life stress, aversive events, and excessive negative emotions.

Not all Somalis who seek neuropsychological services refuse conventional ways of treatment or adhere to traditional views. However, the consideration of these cultural views and practices is important for rapport, evaluation approach, case conceptualization, and treatment.

### Approaches to Neuropsychological or Psychological Evaluations

Like clinical psychology more broadly, clinical neuropsychology does not exist in Somalia. Moreover, there are currently no neuropsychological instruments normed for use with Somali clients. Considering cultural differences and nuances is important for successful clinical and neuropsychological evaluations. Not many Somalis self-refer due to various cultural differences and barriers mentioned above. Additionally, Somalis may present their difficulties differently or may emphasize somatic symptoms rather than emotional or otherwise psychological concerns.

If interpretation services are utilized, providers are encouraged to ensure the quality of such services. When working with interpreters in small communities, it is important to ensure an agreement and understanding of confidentiality. For example, an evaluator who serves the Somali community might want to ask the client whether they know the interpreter and assess their level of comfort disclosing information in the interpreter’s presence.

Traditional approaches to psychological and neuropsychological formulation may need to be adjusted in a way that captures the multi-systemic and inter-related mechanisms behind symptom presentations by Somalis, particularly those who migrated to the United States as refugees or asylum seekers. While the biopsychosocial model presents a more comprehensive framework compared to the biomedical model, it does not capture the cultural factors or multi-systemic barriers that influence the refugee experience. Thus, utilizing a conceptual model that highlights different systemic levels that interact with the individual’s subjective experiences may provide a more accurate understanding of their symptoms and help in offering a more acceptable and effective treatment. The case study we present next illustrates the potential utility of an integrated social-ecological framework for evaluating psychosocial and environmental challenges encountered by refugees.

### Section II: Case Study — “All Pains Are Connected”

Note: The following composite case represents life experiences and themes that have emerged in Somali refugee cases encountered by the authors in clinical and community contexts. Potentially
identifying information and personal history have been altered and combined across people to protect patient identity and privacy.

Mr. Yousuf Adam is a 40-year-old Somali man referred by his primary care physician in a local International Medicine Clinic to evaluate symptoms of “confusion” and generalized cognitive difficulties. The referral noted diffuse somatic symptoms for which there was no medical explanation after a thorough medical examination and neuroimaging work-up.

**Behavioral Observations**

Mr. Adam arrived for his appointment with his wife. He was alert, fully oriented, and cooperative but somewhat guarded. He was conversational in English and requested that the evaluation be conducted in either Somali or Arabic. The clinical interview and testing were conducted by an English-speaking psychologist assisted by a Somali-speaking certified medical interpreter. When conversing through the interpreter, Mr. Adam never bypassed the interpreter, either by responding before what the psychologist had said was interpreted, or by responding in English. This suggests that he was much more comfortable in Somali than in English. The rest of his informed consent process and mental status exam was unremarkable. No difficulties were noted in vision, hearing, movements, speech, language, social or sensory-motor functions. Mr. Adam displayed a mildly restricted range of affect and tended to be subdued. His facial expressions were generally blunted when discussing his history. He appeared anxious at the outset and initially expressed uncertainty about what to expect from the evaluation. He visibly relaxed as the interview progressed and after the assessment procedure was clarified. I (JB) prefaced my questioning by describing my previous professional experience with the Somali community and communicating that my goal was simply to try to understand his experience as best as possible to hopefully be of assistance. Rapport was gradually developed and well-maintained throughout the evaluation. Mr. Adam appeared aware of the quality of his test performance, gave good effort on the tests, tolerated frustration well, but occasionally benefited from encouragement on particularly challenging tasks. The evaluation appeared to provide a generally accurate reflection of factors influencing his functioning; however, test interpretation required significant caution due to the absence of directly applicable norms or validation studies of neuropsychological instruments in Somali (see the Test and Norm Selection section for details).

**Presenting Concerns**

Mr. Adam reported concerns about “not feeling like [him]self” due to experiences of “confusion,” episodes of “thinking too much,” headaches, and diffuse body aches. He described forgetfulness in daily activities and somewhat frequent instances of misplacing his personal items (e.g., wallet, car keys). These symptoms had reportedly been present for several years but worsened over the last several months. Consistent with his medical records, he denied any acute medical events or chronic health conditions that could potentially explain these cognitive difficulties. His wife had expressed concern to him about times where he seemed “blank” and interpersonally distant.

**Daily Functioning**

Mr. Adam was employed as a data entry technician for a longitudinal research project at a local academic institution until grant funding ended approximately six months ago. He had a driver's
license and worked as a delivery and rideshare driver since the data entry job ended. He was able to cook some foods, although his wife did most of the cooking in the household. He managed all financial bills in the family. He reported no problems with managing finances and had a bank account and a credit card. He scheduled and managed his own medical appointments through use of a calendar. Mr. Adam was proficient at computer searches, social media, and GPS navigation. He reported recent marital difficulties but mentioned no concerns about sexual function, although this represented a culturally sensitive topic that was not thoroughly assessed. He indicated his family had many family friends from the mosque where they worshiped, but over the past year or so he did not feel connected to them and avoided most social activities.

**Health History**

Mr. Adam was not aware of any problems with his birth or with his mother’s pregnancy. He denied knowledge of any childhood health problems but noted historical, intermittent food insecurity within his family of origin. He denied having any premorbid history of medical or psychiatric conditions. He had no prior history of surgery or hospitalization. There were no known toxic exposures. As an adult, he had experienced occasional headaches treated with over-the-counter medications. His most recent bloodwork was unremarkable, with normal thyroid function and nutrient levels. Recent brain scans were also unremarkable. He had no history of substance use. His family medical history was largely unknown but appeared notable for hyperlipidemia, hypertension, and type II diabetes. His father had a history of stroke with residual lower limb paralysis and expressive language impairment. There was no known family history of dementia or other neurologic conditions.

**Educational History**

In Somalia, Mr. Adam received approximately 12 years of formal education. He described his educational experience as intermittent and often interrupted due to family responsibilities and occasional concerns for safety resulting from nearby violence in Mogadishu. He denied being held back in classes or any history of academic difficulty in any subject. He reported occasional difficulty with focusing during school due to distractions associated with local violence and, as he got older, the need to help support his family through paid work. He put forth effort in school and thought that he could have performed at a higher academic level if not for worry about safety and economic stability in his family. He later received further education on Islam through a madrassa (religious school) in Kenya, but instruction was curtailed by resource limitations and inconsistent access to teachers. He could read the Quran in Arabic and had participated in occasional classes at the local mosque since his arrival in the United States nine years ago.

**Language Proficiency**

Mr. Adam spoke Somali and learned to speak Arabic from an early age. At the refugee camp in Kenya, he received some instruction in English. Though he had not otherwise completed any formal English as Second Language classes, Mr. Adam’s English language skills were conversational for common interactions in daily life. His degree of English language proficiency meant that age-based norms of available English-based neuropsychological test measures would likely be limited in their applicability. He expressed a preference for testing in either Somali or Arabic, the languages he felt most confident in reading and speaking. An evaluation in his native language was the most accurate way to ensure that the testing approximated his current cognitive status rather than simply obtaining a proxy for his English language proficiency.
Cultural History

Mr. Adam was born in Mogadishu, the capital of Somalia. He attended primary and high school in his hometown. He was the oldest of nine children, with four sisters and four brothers. His extended family lived nearby and often shared housing. His father worked as a cross-country truck driver; his mother worked as a homemaker. Mr. Adam described his family of origin as “loving” and mentioned that his father worked hard to save money for their extended family. As a result of his father’s frequent work travel and in response to expectations as the oldest son in a traditionally patriarchal culture, Mr. Adam was often responsible for maintaining household responsibilities. This meant taking time away from school to help with providing food and taking care of the family’s home and property. He characterized his childhood as “good” overall, without any early childhood traumatic exposure or abuse, though local famine contributed to periodic food insecurity within his family of origin.

He was 25 years old when he was forced to leave Somalia. A few years prior to leaving Somalia, he had begun working as a field interviewer for a research firm that did work for non-governmental organizations on regulations related to food supply and irrigation. During this time, his work became increasingly dangerous because the projects he was working on angered local political groups who did not want to see the results published. Mr. Adam reported that some local government officials also opposed the work as they wanted to avoid potential financial losses and the appearance of corruption if the data were made public. According to Mr. Adam, he and his colleagues were a visible part of this work as they interviewed local communities and thus were at high risk. Ultimately, they were targeted for their work thus forcing Mr. Adam to flee to neighboring Kenya for safety (see Emotional Functioning section below for more information about secondary impacts of his displacement and migration process). After residing in a Kenyan refugee camp for six years, he was able to seek refugee status in the United States with the assistance of an international non-governmental organization.

Since arriving in the United States, Mr. Adam had been able to connect with local East African and Muslim communities. His parents still lived in Mogadishu, but several of his siblings resided in areas of Canada and Europe. He married a Somali-American woman seven years ago and had three children, ages two to six. At times, he and his wife had difficulty relating to each other. His wife did not see him as reliable at the time of evaluation, stating that he seemed distracted and not present at times. He felt a strong sense of responsibility to support and provide for his family. In addition to efforts to provide financial security for his wife and children, he also regularly sent money to his parents and extended family in Somalia. Financial pressures had been a consistent recent source of stress. Mr. Adam had also experienced racist and Islamophobic encounters that impacted his social integration. For example, he had been called a “terrorist” when overheard speaking in his native language in the community and questioned about whether he knew any “pirates” when disclosing his Somali heritage to members of the majority culture. In response, he tried to ignore these encounters and seek solace through Islam and the local East African community. The mosque he attended had been vandalized multiple times, with broken windows and threatening xenophobic graffiti.

Emotional Functioning

Mr. Adam’s emotional status appeared associated with traumatic experiences related to displacement from Somalia as well as stressors encountered since relocating to the United States (e.g., financial instability; Islamophobia; racism).

Regarding pre-migration traumatic exposure, one event clearly troubled Mr. Adam more than others. Several years into his work as a field researcher, Mr. Adam began receiving threatening
text messages from private numbers such as, “stop what you are doing” and “if you don’t, we’re going to come after you.” He believed these texts were related to the anti-corruption project he was completing at the time. He indicated that the language of the text messages made it clear that the persons knew where he was and suggested that they were following him. For example, he relocated to remain safe from these threats but then received texts indicating that these people knew where he had moved. He forwarded these texts to his employer, at which point he received a response stating that this was just part of the work and that he needed to persist. Shortly thereafter, Mr. Adam and colleagues were traveling by car down a remote road from a village outside of Mogadishu when a group of men in another vehicle forced them to pull over. He and his colleagues were then forced out of their car. After a brief exchange, the other group of men pulled out firearms and shot at Mr. Adam and his co-workers. A bullet grazed Mr. Adam’s head and he reported that he remembered feeling it pass through his hair. He was the first to fall to the ground, quickly followed by his colleagues. Their bodies covered him. He remained still, not fully understanding what had just happened, until the other group of men returned to their vehicle and sped away. He recalled being covered in blood; as he struggled to stand, he began to realize that he was the only survivor and that the blood he felt was not his own. Following this event, he became certain that these individuals would eventually kill him if he did not flee from Somalia.

In the clinical interview, Mr. Adam described often feeling “confused,” reported extended periods where he kept to himself and mentioned sometimes “just thinking too much” during those times of isolation. He referred to feeling preoccupied by thoughts of guilt related to surviving the roadside attack while his colleagues perished. He had decreased interest in previously enjoyed activities and relationships, difficulty sleeping, felt fatigued during the day, and described frequent headaches and diffuse body pains. As mentioned above, he was also distressed by noticing situations in which he would walk into a room and realize that he had forgotten why he entered it to begin with and other instances in which he would misplace objects such as his car keys. He denied any active suicidal ideation, citing his faith and familial commitments as protective factors.

**Preliminary Formulation**

At the end of the interview, it was clear to the psychologist that Mr. Adam was experiencing symptoms of post-traumatic stress and depression but did not recognize it. In addition to pre-migration trauma, post-migration and acculturative stressors were clearly influencing his clinical presentation. Mr. Adam had experienced multiple layers of personal loss related to his safety, security, and professional standing as well as communal losses experienced through separation from family and ongoing sociopolitical strife in Somalia. Additional barriers included poverty, racist and Islamophobic experiences, and an overarching sense of disconnection from dominant culture in the United States.

**Test and Norm Selection**

Considering the referral question and presenting problems, I selected a test battery that enabled a Process Approach to test the limits of performance across a variety of domains. This Process Approach seemed beneficial considering lack of relevant norms, influences of language and use of an interpreter in test administration, cultural impacts on timed tests, and potential lack of familiarity with healthcare evaluations based on paper and pencil tests. Given the lack of documented history of neurologic involvement and clinical hypothesis related to potential PTSD and mood disturbance, the battery was intended to provide impressions about attention, memory, executive, and intellectual functioning through both verbal and visual modalities. I administered the
following tests, generally recommended for people with potential trauma-related psychological conditions and potential comorbidities:

- Test of Memory Malingering
- Grooved Pegboard Test
- Montreal Cognitive Assessment (MoCA, Arabic version)
- The following subtests of the Wechsler Adult Intelligence Scale-Fourth Edition (WAIS-IV):
  - Block Design
  - Matrix Reasoning
  - Visual Puzzles
  - Digit Span
  - Symbol Search
  - Coding
- Hopkins Verbal Learning Test-Revised
- Brief Visuospatial Memory Test-Revised

For emotional functioning, in addition to the clinical interview, I administered brief questionnaires assessing symptoms of PTSD, depression, anxiety, and somatization in Somali with the help of a certified medical interpreter. These questionnaires included the Posttraumatic Stress Disorder Checklist (PCL-5), Patient Health Questionnaire (PHQ-9), Generalized Anxiety Disorder Scale (GAD-7), and the Somatic Symptoms Scale-8 (SSS-8).

**Test Results and Impressions**

According to age- and education-adjusted norms, Mr. Adam’s performance fell in the borderline to low average range across all cognitive domains assessed. Considering the number of cultural-linguistic factors present in the case, these findings likely represented somewhat of an underestimate of his cognitive abilities. For example, time-based visuospatial processing subtests (e.g., Symbol Search; Coding) tended to cluster in the borderline range (2nd percentile) based on norms. When allocating additional time and prompts to the context of the task, his performance appeared more consistent with low average performance (16th percentile). On learning and memory subtests, Mr. Adam demonstrated initial difficulties with encoding information during early trial. Through repetition, he showed a steady learning arc and retention of the acquired information over time. The encoding difficulties seemed consistent with his borderline performance on working memory tasks. Otherwise, language and executive functions provided no notable findings. Overall, his neurocognitive functioning appeared intact but was most likely influenced by emotional and psychosocial factors.

Emotionally, he reported significant symptoms of post-traumatic stress related to the Criterion A traumatic event detailed earlier in the chapter. His symptoms spanned DSM-5 clusters, with prominent loadings on re-experiencing and avoidance domains. Mr. Adam also reported severe symptoms of depression and moderate anxiety. Elevated symptoms of anxiety (GAD-7 score of 10) and depression (PHQ-9 score of 18) included anhedonia and hopelessness, but also appeared partially driven by somatic indicators. This was also reflected in an elevated score on a somatic symptom measure (SSS-8 score of 12). He reported being “bothered a lot” by somatic symptoms of headaches, trouble sleeping, dizziness, and diffuse body aches (e.g., back pain; pain in arms, legs, or joints).

Mr. Adam met full criteria for PTSD with comorbid major depressive disorder, moderate severity. I also acknowledged problems related to his employment status (Z56.7), migration and acculturation difficulties (Z60.3), discrimination (Z60.5), marital distress (Z63.0), and social exclusion and isolation (Z60.4) experienced within the context of previous exposure to war and conflict (Z65.5).
Feedback Session and Follow-Up

For his feedback session, both Mr. Adam and his wife returned to discuss next steps. The same certified medical interpreter participated in the feedback session. Mr. Adam's initial questions related to his somatic symptoms and possible etiologies. I began by briefly summarizing the medical documentation provided by the International Medicine Clinic, which provided no immediate explanation for his concerns. In summarizing the testing results, I shared a conceptualization that “all pains are connected” in an attempt to affirm his experiences while also shifting to a conversation about the range of psychosocial challenges and traumatic stressors described in our initial meeting. This provided a pathway to discuss the interacting and compounding effects of exposure to violence in Somalia, stressors incurred through forced displacement and migration, and ongoing challenges encountered following resettlement in the United States (e.g., poverty; discrimination; under-employment). Through this conversation, we were able to collaborate on a plan to remain engaged with his medical care to further rule out potential physical health explanations and establishing additional supports for addressing other psychosocial contributing factors.

In navigating the conversation, I took care to frame the discussion around efforts to seek healing as opposed to nesting it within a Western biomedical terminology (e.g., psychotherapy) related to mental health and assumptions related to mind-body dualism. Instead, we focused on existing resources within his local community that could be drawn upon. Specifically, with their approval and input, this meant connecting Mr. Adam and his wife to a Somali community-based organization focused on providing family education and resources. The connection was intended to provide a family systems intervention, such that Mr. Adam and/or his wife could gain culturally consistent and community-driven support for psychosocial challenges common within the East African community.

Recognizing that there is no word for “psychological trauma” within the Somali language, I began talking with Mr. Adam about how exposure to war and violence can influence wellbeing in ways that cannot always be seen. I used an analogy to describe how a physical wound can become infected and cause complications throughout the body if left untreated. Similarly, people can experience changes in their thoughts, feelings, and behavior after being exposed to war, violence, and threat to personal safety. If left unattended, over time, these changes can influence additional areas of life just as an infection in one area of the body can affect other seemingly disparate systems. The analogy resonated, and we began talking about compounding effects of losses and stressors they had experienced in their life. Intersections of his faith and a sense of seeking community and reconciliation emerged through the conversation, even if his ability to fully engage had been clouded by the range of challenges he encountered. I tried to validate his experience and normalize the presence of post-traumatic difficulties, while also working to establish a plan to reduce his distress going forward.

To manage his trauma-related symptoms, we talked through a variety of options. With his approval and written permission, I reached out to the International Medicine Clinic to collaborate with the clinic's consulting psychiatrist. Shortly after, Mr. Adam began taking a selective serotonin reuptake inhibitor (SSRI) to assist with his mood symptoms. He also began taking prazosin, an anti-hypertensive medication shown to aid in the management of nightmares experienced by trauma-exposed individuals, including refugees and asylum seekers. In addition, I provided Mr. Adam with information about a faith-based trauma intervention group co-developed by and piloted within the local Somali community. The program, Islamic Trauma Healing, integrates evidenced-based trauma treatment principles (e.g., cognitive-restructuring; imaginal exposure) with faith practices (e.g., Quranic readings; prophet stories; prayer). The program is led by trained leaders in the Somali community and groups run through local mosques. Mr. Adam expressed openness to learning more about the program and later attended an informational session.
Composite Somali Refugee Case

Section III: Lessons Learned

• Somali culture represents a rich tapestry of clan-based heritage, oral tradition, and communal practices deeply influenced by Islam.
• Mental illness has historically been stigmatized in Somali culture due to a “sane/insane” cultural dichotomy and reinforced through a history in Somalia of chaining people that have been institutionalized for mental illness.36,37
• Symptoms of conditions such as depression, anxiety, and post-traumatic stress may present somatically. Somatic symptoms and expressions of “confusion” or “thinking too much” may represent idioms of emotional distress.38,39 A thorough medical evaluation is critical for ruling out physical health conditions before assuming a psychosomatic presentation given vulnerabilities for refugees to go under-diagnosed due to fragile health systems in their country of origin, healthcare gaps encountered through migration, and barriers to post-resettlement healthcare access.
• Somalis may respond favorably when discussing health within the context of the Islamic worldview. Providing Somalis with the opportunity to share religious and spiritual beliefs can help to reduce stigma, develop an understanding within the practitioner about perceptions of wellness, and increase follow through with recommendations and referrals.
• Refugees experience stressors, challenges, and barriers that extend across multiple systemic levels. Conceptual frameworks grounded in ecological systems theory can provide practitioners with mechanisms for thinking through systemic factors. According to Bronfenbrenner’s theory,40 people are influenced by the various environmental systems with which they interact. Environmental factors are stratified across several nested systems and the interconnections among them. Systems include the (a) microsystem (e.g., an individual and their immediate environments), (b) mesosystem (e.g., interaction between microsystems such as the linkages between the person’s family and the health system), (c) exosystem (e.g., systems with which the person is only indirectly associated such as a caregiver’s workplace), (d) macrosystem (e.g., sociocultural and political ideologies, practices, values, customs, and laws), and (e) chronosystem (e.g., transitions across the lifespan).
• The Adaptation and Development after Persecution and Trauma model (ADAPT16) incorporates features salient to the refugee experience. The ADAPT model provides a broad framework that helps organize a wide range of recursive challenges encountered by refugees at individual, family, and community levels.17 Table 41.1 summarizes the five core pillars of the model. Several themes from the ADAPT model were apparent in the case of Mr. Adam, including the following: threats to his sense of Safety and Security stemming from his history of trauma and early exposure to sociopolitical conflict, fragmentation in his social Bonds and Networks through forced displacement, and significant shifts in his Roles and Identities.

Table 41.1  Five pillars of the ADAPT model16

<table>
<thead>
<tr>
<th>Pillar</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety and security</td>
<td>Sense of safety in the environment is important to recovery</td>
</tr>
<tr>
<td>Bonds and networks</td>
<td>Ability to form new bonds or grieve the lost bond due to separation from home country</td>
</tr>
<tr>
<td>Justice</td>
<td>Clinical experience has shown that ongoing preoccupation with injustice of the past may hinder psychological recovery</td>
</tr>
<tr>
<td>Roles and identities</td>
<td>Refugees must overcome possible unemployment and marginalization to find their role in the new country</td>
</tr>
<tr>
<td>Existential meaning</td>
<td>Understanding and finding meaning in the experiences refugees have encountered in the past is important to their health</td>
</tr>
</tbody>
</table>
through changes in his employment status that also interact with prescribed gender roles within traditional Somali culture.

- By integrating Bronfenbrenner’s bio-ecological theory⁴⁰ and Silove’s ADAPT model,¹⁷ Wong and Schweitzer¹⁸ proposed a bio-ecological adaptive model (BEAM) that provides a holistic framework to conceptualize the impact of individual, pre-migration, and post-settlement factors. The BEAM framework considers unique characteristics of the refugee experience and accounts for the reciprocal interactions that exist between the individual and various socio-ecological systems. Figure 41.1 provides a graphical depiction of the BEAM model with examples of relevant factors nested within each Bronfenbrenner systemic level.

![Figure 41.1](bk-tandf-irani_9780367509293-211307-chp41.indd)

*Figure 41.1* The bio-ecological adaptive model (BEAM¹⁷) applied to multi-systemic psychosocial considerations when assessing refugees
• Qualitative research focused on the service needs and gaps experienced by refugees has identified cross-cultural disconnect with healthcare providers as a primary concern in addition to various barriers to accessing social service and healthcare systems. Table 41.2 provides a list of healthcare utilization challenges commonly experienced by refugees.

Table 41.2 Barriers to healthcare utilization and service provision for refugees

- Separation from family and practical factors (e.g., employment; housing; education) may supersede medical care as immediate priorities
- Exposure to trauma and risk for psychological sequelae (often unrecognized)
- Anti-immigrant and anti-refugee sentiments in the United States
- Public health screening results are often not communicated to chronic care providers
- Refugees with complex medical conditions are often unable to establish care quickly
- Competing demands for services may overwhelm finite resources (e.g., time; finances)
- Unfamiliarity with the biomedical concepts and healthcare bureaucracy
- Mental illness stigma in the culture of origin and host community
- Health system limitations in origin country leading to undiagnosed or poorly controlled chronic health conditions
- Language differences

Note: Summarized and adapted from Jackson et al.

• Mr. Adam’s case underscored the importance of conceptualizing multiple influences on the clinical presentation of refugee clients by considering pre-migration exposures, migration-related risk factors, and post-migration psychosocial stressors distributed across time and systemic levels. This case also demonstrates the utility of local community partnerships that can inform biopsychosocial-spiritual formulations relevant to the neuropsychological/psychological assessment process.

Glossary

Sharia. An Arabic word that means the “pathway to be followed.” It consists of a set of principles that are mainly based on Quranic verses and Hadith (Prophet Mohammed’s sayings and way of conduct) and are interpreted by scholars to guide Muslims’ social, political, and legal matters. For a more detailed discussion.

Riba. The word Riba in contemporary Islamic banking refers to the monetary interest or increase above the amount owed. Riba is prohibited in Islamic or Sharia law and is sometimes translated to mean usury or unjust practice. Muslim scholars define more than one form of Riba and discuss different interpretations and practices.

References