

**Emotional wellbeing and access to culturally  
appropriate services:**

**A comparative study of Muslim men of refugee  
background from the Horn of Africa, living in the inner-  
northern suburbs of Melbourne**

**Victorian Transcultural Mental Health,  
St Vincent's Hospital, Melbourne**

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**ACRONYMS (CODING)**

- ES1 (Elder Somali man focus group participant1)
- EE1 (Elder Eritrean man focus group participant1)
- YS1 (Young Somali man focus group participant1)
- YE1 (Young Eritrean man focus group participant1)
- CR1 (Community reference focus group participant1)
- YOHAMM (Young and Older Horn of Africa Muslim Men)

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# **EXECUTIVE SUMMARY**

## **Introduction**

Historically, the Horn of Africa has endured decades of protracted civil wars and dictatorships. Men have been especially affected by these events because of their greater involvement in war and politics compared to women. Many are forced to flee to refugee camps in neighboring countries. Refugee experiences significantly predispose these men to emotional difficulties. After many years in refugee camps, some men resettle in the West, including Australia. However, resettlement brings additional stressors due to the cultural differences. These include language barriers, social exclusion, discrimination, unemployment, unrecognized qualifications, family conflicts, intergenerational conflicts and many other issues.

Traditionally, Horn of Africa people respond to emotional and social difficulties by seeking support from their immediate and extended families together with religious services. However, prolonged civil wars damage family structures by dispersing family members across different countries and continents. Therefore, family support has been significantly eroded.

While family support has been weakened, Horn of Africa Muslim men have also experienced difficulties accessing Australian mental health services. This is possibly due to not understanding the new system plus the scarcity of culturally responsive mental health practitioners.

Despite the extensive social, mental and emotional problems observed, there has been very little research exploring the mental health of Horn of Africa Muslim men, their access to mainstream services and their cultural and traditional practices in Australia. This qualitative study attempts to address this gap. It will investigate the experiences and perceptions of mental health by Horn of Africa Muslim men, the perceived

stressors and underlying causes of mental health problems and will explore possible solutions. The following is the summary of the research findings from this study.

## **Research findings**

### **Chapter 3: Horn of Africa Muslim men's understanding of mental illness**

Mental illness had various definitions:

- Mental illness was incurable, associated with craziness and danger;
- Mental illness featured disordered speech and bad experiences;
- Mental illness could be inherited or caused accidentally;
- Depression was a diplomatic term used for mental illness and madness;
- Sleeplessness and lack of remembrance or acknowledgement of Allah were signs of having mental illness;
- Mentally ill people were seen as unproductive and a burden on society;
- The Somali language lacked accurate vocabulary to describe disturbances of mental health;
- Buufis (blown out in mind and emotion) was a new phenomenon of mental illness that was specific for Somalis and had developed from experiences in refugee camps and civil wars.

### **Chapter 4: Causes for stress and emotional difficulties**

The main causes for stress and emotional difficulties identified were:

#### **Unemployment**

- Unemployment and racism in the labor market were the biggest stressors. Outlawing racism was seen as a formality, symbolic and just rhetoric;

- African Muslims felt they did not receive the same opportunities as the mainstream or non-Muslim Africans because of religious racism e.g. Islamic names and religious visibilities;
- African Muslim youth changed their names in order to get jobs. However, that negatively affected their psyches, identity and emotional wellbeing;
- Working in menial and degrading jobs by men with high qualifications lowered their self-esteem and caused them stress, emotional difficulties and lack of confidence;
- Elder men worried about their own unemployment as well as their children's unemployment;
- Lack of useful networking with the mainstream reduced employment opportunities and led to social isolation.

### **Language difficulties**

- Language difficulties limited the speed of social integration and employment opportunities for elders and newly-arrived young men from the Horn of Africa. This caused stress and depression;
- Language constraints made well-educated elder men feel that their knowledge was worthless and not useful. This lowered their self-esteem, confidence and hopes of success;
- Elder men had difficulties learning English and consequently, were more anxious when communicating with the mainstream.

## **Culture shock and identity crisis**

- Large cultural differences between Australia and the Horn of Africa resulted in enormous stress, ambivalence about identity and confusion particularly with young men;
- Identity crises brought emotional instability, confusion and frustration particularly with young men;
- The question of ‘where are you from’ contributed to feeling like an outsider and alienation.

## **Family and community problems**

- Loss of Al-Qawaamah (men’s domination over women) greatly worried elder men and newly arrived young men;
- Australian family law had become a source of fear for elder men. It was perceived to disempower them and marginalized their traditional role in the family. It was felt that existing laws were designed for Australian families and not for African Muslim families;
- Raising children in Australia was particularly distressing for older men;
- Lack of support from immediate and extended family members had created new challenges, stress and anxiety;
- Young men believed that disorganized community organizations and incompetent and ineffective community leaders contributed to worries, disappointment, and demoralization;
- Lack of positive and successful role models undermined the aspirations and ambitions of young men and led to them feeling alienated and victimized;



- Dysfunctional tribalism and devaluing each other upset participants from the community reference group and the young Somali group;
- Young men, particularly young Eritreans, were affected by a victim mentality, lacked motivation and were sensitive to negative judgments from the older generation;
- Living in high rise public housing apartments had perceived negative impacts on social wellbeing, self-esteem, and psyches of young African men.

### **Difficulties in practicing Islam**

- Practicing Islam in the workplace was described as very difficult and stressful;
- Not hearing muezzin and daily calls for prayer caused emotional distress for elder men;
- Buying houses and cars through the mortgage system was believed to be haram (illegal in the Islamic perspectives) in Islam. This was a source of stress and worry for some men;
- The scarcity of halal (legal in the Islamic perspectives) food in the mainstream restaurants was depressing and worrying.

### **Civil wars and pressure from back home**

- Prolonged civil wars caused significant ongoing trauma for African men;
- Families overseas pressured men to provide financial support. However, this was an additional pressure on the men who already had difficulties adjusting to the new environment and culture. This created significant stress and emotional instability.

## **Substance abuse**

- Drugs and gambling were felt to contribute to criminal involvement, subsequent imprisonment and mental problems;
- Smoking shisha and chewing khat led to unemployment, hopelessness and depression.

## **Chapter 5: Barriers for not seeking help**

The main identified barriers for not seeking help were:

- Lack of awareness and understanding of the institutionalized services;
- Mainstream mental health services not sufficiently responding to the cultural needs of African Muslim men;
- Negative rumors and speculation about the mainstream mental health services such as perceived injections for African patients if they utilized those services;
- Mainstream practitioners having perceived poor cultural responsiveness;
- Scarcity of well-trained community representatives in the mental health sector;
- Lack of recognition, denial of having mental illness and shame. There was a culture of silence amongst African men.

## **Chapter 6: Existing treatment strategies**

The main treatment strategies and recommendations identified were:

- Family members, relatives and friends representing the first source of help;
- Fathers being very important for newly arrived young men;

- Having faith and practicing it was felt to be very effective for recovery;
- Religious treatments such as inviting Sheikhs to read the Quran on the patients, and listening to the Quran were agreed to be very helpful healing strategies;
- Thikri (remembrance or contemplation of Allah), fasting the month of Ramadan, giving charity, performing prayers in the Mosque in a congregation, taking affected people to Hajj (pilgrimage) and Umrah (a lesser pilgrimage) were increasingly becoming popular because they were believed to be very effective treatment strategies for people with emotional difficulties;
- Journeys for emotional, psychological, religious and cultural rehabilitation in Africa or The Middle East were becoming increasingly popular and were believed to help recovery;
- Somalis could be effectively treated through their oral tradition (talk therapy.);
- Thinking positively, developing resilience, confidence in Allah, and imagining a better future were effective strategies during the process of recovery;
- Ridding oneself of unrealistic attitudes assisted in recovery;
- Smoking shisha, chewing khat, taking drugs, drinking alcohol or gambling were identified as maladaptive ways of dealing with stress and depression;
- Socializing and talking to each other at community restaurants for long hours were used by elder men as informal treatments;
- Silence and denial of mental health problems were common strategies among elder African men;

- Elder men tended to use traditional and cultural strategies while young men who grew up in Australia tended to blend both traditional and cultural and mainstream strategies. However, as the young men matured, they also tended to use more cultural strategies.

## **Chapter 7: Recommendations**

The main recommendations identified were:

- Accepting and admitting to having mental problems in order to identify appropriate solutions;
- Being educated and aware about mental problems as well as knowing about the available services;
- Motivating and empowering young people to develop self-esteem and self-confidence;
- Avoiding self-blame, victimization and marginalization;
- Having positive and successful role models within the Horn of Africa communities;
- Developing community-specific supports;
- Being accepted by the wider Australian society;
- Treatment through a deeper understanding of the wisdom of the Quran and the teaching of the prophet Mohamed;
- Taking mentally unwell people to relevant hospitals;
- Assisting African parents to develop a better understanding of how to raise their children in the Australian environment.

## **CHAPTER 1: LITERATURE REVIEW**

This chapter begins with an introduction; defines mental health and mental illness and explains the role of the Horn of Africa Family and religious practices in healing. Western and African views on mental illness and gender experiences are compared. At the end, there is a discussion of existing mental health studies of Horn of Africa communities in the West, particularly in Australia.

### **Introduction**

Horn of Africa countries have been in protracted wars, conflicts and have often been ruled by dictatorships. During the cold war, the Horn of Africa experienced militarization and proxy wars. These took different shapes including territorial disputes and cross-border conflicts (Sharamo and Mesfin, 2011; Tesfagiorgios-date unknown.) Post-cold war, the Horn of Africa is still affected by violence and civil wars which have resulted in much death and destruction. These conflicts have seriously undermined peace initiatives and many developing states' quests for nationhood (Sharamo and Mesfin, 2011.) As a result, many people from the Horn of Africa countries have been forced to flee their homes and seek asylum and refuge in other countries such as Australia. Horn of Africa men have particularly suffered because they are overrepresented in politics, violence, and wars compared to women (Sharamo and Mesfin, 2011.)

After their resettlement in Australia and the West, Horn of Africa refugees faced new acculturation challenges including culture shock, language difficulties, discrimination, stigma and exclusion. These resulted from their ethnicity and even religious visibilities, which potentially impacted on their social status and emotional and mental wellbeing (Omar, 2011; Omar, 2007.) Despite all these problems, there have been very limited studies investigating the emotional wellbeing and mental health of African Muslim men and their access to culturally appropriate mental health services.

## **Literature review**

The Horn of Africa consists of Somalia, Eritrea, Ethiopia and Djibouti (Ssali, 1998.) Countries from the Horn of Africa have historically experienced centuries of turmoil caused by European colonization, political turmoil, prolonged social crises, religious and ethnic conflicts, violence, and wars over decades (Williams and Logan, 2007; Ssali, 1998.) Men from the Horn of Africa are more likely to have witnessed and experienced violence compared to women. Protracted exposure to violence has been found to contribute to mental health disorders within the Horn of Africa populations (Ghebrat, 2008.) For instance, schizophrenia and personality disorders were identified as common diagnoses amongst Eritreans (Ghebrat, 2008, p. 17.)

Because of their political involvement, men are more often targeted and arrested by their governments compared to women. Often, they are forced to leave loved ones behind and flee to neighboring countries. Some of them resettle in the West. The flight, displacement, loss, grief and settling in refugee camps often results in disempowerment, emotional instability and mental health problems. These issues are compounded by severe shortages of mental health services in Sub-Saharan African countries (Ghebrat, 2008.) In spite of the resilience shown by African Muslim men from refugee backgrounds, research suggests that African men experience negative mental health effects related to both pre-migration trauma and post-migration stressors (Tempany, 2008.)

## **Definition of mental health and mental illness**

**Mental health** is defined by the World Health Organization as “a state of wellbeing in which the individual realizes his or her own abilities to cope with the normal stresses of life, to work productively and fruitfully, and to be able to make a contribution to his or her community.” (Ghebrat, 2008, p.15.)

**Mental illness** is defined by the Australian National Community Advisory Group on Mental Health as:

“Problems which if not addressed result in severe disadvantage, continued dependence on mental health treatment and crisis services and which severely curtail the ability of the individual to live independently in the community to their fullest potential.”

Problems associated with behavioral and/or personality disorders fall within this definition. In a clinical context, mental illness can be defined as a clinically recognizable set of symptoms relating to mood, thought, or cognition or behavior. This is associated with distress and interference with functions (that is, impairment leading to activity limitation or participation restriction.)” (Department of Health and Aging, accessed on Thursday 17<sup>th</sup> October 2013.)

### **The role of the Horn of Africa family in healing**

From a sociological point of view, the immediate and extended family is the most important social institution that provides support, identity and emotional security for the Horn of Africa people. In addition to that, clans and tribes constitute the Horn of Africa societies (Scuglik et al, 2007.) The clan, after the family, is the most important source of social support for its members. Therefore, the clan influence shapes members’ attitudes and their opinions (Williams and Logan, 2007, p. 581.) African adult men, particularly elders, are the decision makers of their families and clans. Therefore, they are respected and their authority is not challenged (Williams and Logan, 2007; Ahmed, 2004.) After resettling in Australia and in the West generally, Horn of Africa men have gradually lost their status, power and are less respected within their families. This has negatively affected their psychological, social and emotional wellbeing (Ahmed, 2004; Williams and Logan, 2007.)

As explained above, the Horn of Africa societies including Somali and Eritrean

cultures emphasize the function of family and community compared to western cultures (Araya, 2001; Williams and Logan, 2007.) If a family member such as an adult male develops mental illness, he tries to manage this problem himself using personal “coping strategies” due to the stigma associated with mental illness (Cinnirella and Loewenthal, 1999; Johnsdotter, 2011.) If he loses control over his life, then his immediate and then extended families provide support. It is uncommon for a family to seek help outside the family unless the affected person causes physical harm to others. Seeking outside support may be perceived as a sign of the family’s incapacity to solve its own problems (Araya, 2001; Williams and Logan, 2007; Johnsdotter, 2011.) Thus, families attempt to restrict information about the person with mental illness to family members. This is because mental illness is perceived as shameful and embarrassing to the family and this negatively affects its social status in the community (Araya, 2001; Williams and Logan, 2007.)

Finally, civil wars, refugee camp experiences and resettlement challenges in the West have severely damaged the structure of Horn of Africa families and communities. Family members have been scattered all over the world and the supports that families traditionally provided to their members have been greatly weakened and eroded (Williams and Logan, 2007.)

### **African versus Western perspectives of mental illness**

In western countries, mental illness primarily centers on the individual. However, in African countries like Somalia and Eritrea; mental illness is much more associated with social, spiritual and religious dimensions. This means that mental illness in African culture is not isolated to single individuals but involves one’s relationship with others, with God, and with other spirits such as jinn (Johnsdotter, et al 2011, p. 750.) This view was endorsed by a study on explanatory models of mental illness in sub-Saharan Africa that found a diverse range of beliefs relating to mental health.



Spiritual causes were frequent explanations for mental illness (Patel 1995.)

Since mental illness in the Horn of Africa has social and spiritual aspects, people with mental illness are traditionally treated, supported and healed through social networks, and through religious treatments. For example, family and community support for Somali men has been found to be useful for depression related to resettlement challenges (Silveira and Allebeck, 2001.) Similarly, Guerin (2003, p. 6) found that social activities for Somali women which created opportunities to discuss past and present troubles could promote emotional wellbeing. These social events were perceived as “early interventions” for social and mental well-being. This finding was endorsed by Halcon et al (2004) who reported that women were more likely to respond to stress, sadness, frustration and social problems by organizing group social events whereas men tended to respond to their stress by physical exercise. This was because women were more able to discuss stresses related to social problems compared to men who reported stresses related to physical issues.

In exploring western treatments for mental illness, some studies indicated that Eritreans and Somalis were familiar with traditional and physical medical treatments but were unfamiliar with modern, Western, mental health treatments (Araya, 2001; Cinnirella and Loewenthal, 1999.) Therefore, when they were referred by their GPs to mental health clinicians, they expected treatments to be similar to physical medical treatments. Patients expected to receive clear instructions similar to the instructions given by physical medicine doctors, traditional and religious healers. They were confused by the process of ‘talk therapy’ because they wanted to see mental health clinicians as authorities who would tell them what to do and not just talk. Therefore, if direct instructions did not occur, they would potentially not return to the mental health provider (Araya, 2001.) However, despite this issue, other studies in the UK concluded that ethnic communities preferred to consult with mental health professionals from the same cultural background. This was reflected in previous calls to establish “ethno-specific mental health provision” as a potential way to improve

help-seeking strategies for mental illness in ethnic communities (Cinnirella and Loewenthal, 1999, p. 521.)

## **Mental health and gender experience**

Understanding how refugee and migrant men and women access mental health in the context of their changing roles is very important (Andermann, 2010, p. 508.) It was found that Somali, refugee men who experienced socio-economic challenges; unemployment problems or did shameful menial work suffered more depression and stress. This was potentially because of the role of men as breadwinners in their country of origin. Therefore, poverty due to unemployment could lead to more psychological and mental problems in males compared to females (Andermann, 2010; Ahmed, 2004.) Another study on gender and mental health issues in Canada found that women coped with stress better than men. Men were more stressed because of the burden of having responsibility for the family (Andermann, 2010.) Additionally, studies conducted on Somali refugee adolescents in the USA identified that boys who participated in American culture and dressed in ways which reflected the wider community lifestyle were less depressed and had better mental health. In contrast, girls who actively participated in the Somali culture, community activities, used Islamic dress code - the hijab, and maintained a strong connection with the Somali community showed better mental health (Ellis, et al 2010.)

Traditionally, in Eritrea and Somalia, there are gender-related spirits and mental illnesses. For example, *zar*, (spiritual/mystical aspects of illness) predominantly affects women with grievances against their husbands. Therefore, the treatment of *zar* is dealt with by women (Williams and Logan, 2007; Bruzzi, 2012.) In the process of healing related to *zar*, women activate the spirit of the patient through ecstatic dances (Bruzzi, 2012, p. 8.) Apparently in Somalia, *zar* have subcategories including *mingis* and *borane* which involve singing, dancing, and trance (Johnsdotter, 2011.) However,

some religious groups (the vast majority of Islamic teachers, explainers and interpreters are men) argue that *zar* contradicts Islamic practices and therefore, the practice of *zar* is haram (illegal in Islam) (Johnsdotter, 2011.) Additionally, religious healing treatments are almost always conducted by religious men and not women (Ali, Milstein and Marzuk, 2005.)

## **Religious healing**

In any society, religious values have a significant impact on people's health and well-being (Rassool, 2000.) Religious healing is particularly important for Somali people (Johnsdotter et al, 2011.) Like followers of other main religions such as Christianity, Muslims are culturally heterogeneous and therefore they practice Islam in different ways when it comes to mental health issues and healing (Rassool, 2000.)

In Eritrea, and Somalia, there is an Islamic tradition of *Ziyara* that is associated with spiritual medicine and religious healing. In *Ziyara*, people visit their local shrine or a living *Wali* (a friend of God/Saint in western perspectives.) Some Eritrean Muslims and Somalis believe that *Ziyara* or *Wali* can heal people affected with *Jinn*, which are invisible spirits that have the power to penetrate the lives and bodies of human beings and cause mental and psychological problems (Bruzzi, 2012.) The existence of *Jinn* is explained in the Qur'an. For that reason, Muslims are obligated to believe the existence of *Jinn* as the majority of Muslim scholars confirm that *Jinn* can cause harm to human beings (Johnsdotter et al, 2011.) Therefore, from the Islamic perspective, religious therapists can heal people from *Jinn*, evil eye or *Sexir* (sorcery/black magic) in which someone intends to inflict harm to another by using magic (Johnsdotter et al, 2011, p. 744.) Tuncer (1995), explains that "Special words or prayers or surahs from the Quran may be used both preventatively and as therapy against mental illness. These prayers are also applied against *Jinns*."

In general, religious communities including Muslims tend to develop stereotypical beliefs about modern mental health professionals. Therefore, depression maybe believed to be impossible in truly religious individuals (Cinnirella and Loewenthal, 1999, p. 506.) As a result, religious communities in the UK prefer using religious healing services as first line treatments for emotional problems instead of seeing mental health clinicians (Cinnirella and Loewenthal, 1999; Ali, Milstein and Marzuk, 2005.)

Despite the importance of Islamic religious healing within Muslim communities, studies of imams (who by definition were males) in the USA found that imams have far less formal training in mental health compared to other religions (Ali, Milstein and Marzuk, 2005.) Somali Imams living in the West used healing strategies that were similar to the strategies used in their country of origin such as reading the Quran on the sick person, including those with mental health problems. Reading the Quran on patients was the most widespread healing method for Somalis. Interestingly, young Somalis who grew up in the West were still reluctant to use Western mental health services but were willing to use religious healing methods (Johnsdotter et al, 2011.) This was in agreement with Ellis' (2010) findings that showed that Somali refugee adolescents were found to have low rates of mental health service utilization but more frequent access to school and religious workers.

Other strategies for religious healing included community prayer. This created important social supports and networking which could contribute to the emotional well-being of the participant. For that reason, Johnsdotter et al (2011) underlined the importance of seeing religious healing services as complementary to the modern, western, mental health services, which necessitated cooperation between religious and mental health therapists.

## **Studies of mental health on migrants from Africa**

It is well-established that concepts of mental health and wellbeing differ cross-culturally (Tempany, 2008.) Studies on perception of life satisfaction, anxiety and depression in older Somali men in London found that Somali men may feel less assertive or inclined to seek support for their mental problems (Silveira and Allebeck, 2001.) Many African men may be unaware of sources of help (Silveira and Allebeck, 2001; Johnsdotter et al 2011.) If they are aware, they may fear that any contact with these services will lead to loss of status. Alternatively, they may feel that these services are not meeting their cultural requirements or they may have negative perceptions of mental health services and be unwilling to seek help (Keating, 2007.) In the Horn of Africa, talking about mental health problems or seeking help for mental problems is associated with weakness and inferiority – particularly for men (Williams and Logan, 2007.)

In the UK, Keating (2007) found that African and Caribbean men had negative perceptions of mental health services and therefore they delayed seeking help. A different study in the Netherlands (Gerritsen A, 2006) showed that Somali refugees utilized less medication and sought out medical treatment less frequently for mental health problems compared to Afghani and Iranian refugees. Somalis in the USA rarely acknowledged mental health problems, yet traditional treatments were ineffective in the West (Williams and Logan, 2007, p. 581.) A study conducted in the UK (Palmer D, 2006) found that Somali refugees made considerably less use of mental health services due to cultural factors. They were also more pre-occupied with post-migration stressors including immigration status, housing, social and socio-economic factors.

A study undertaken by Asgary (2011) examined African asylum seekers - particularly men and their access to health care. It found that barriers to accessing health care included mental illness, fatalism, mistrust, perceived discrimination, affordability,

limited services and inadequate interpretation. Further barriers included resettlement challenges such as shelter, food, employment, difficulty navigating the system and inadequate community support.

Additionally, studies on Somali refugees in the USA (Carroll, 2004) found that mental illness was conceptualized as a consequence of war experience and was attributed to trauma and spirit possession. Another study (Fenta H, 2006) found that somatization and under-utilization of mental health services was common in Ethiopian refugees and immigrants to Toronto.

## **Relevance to Australia**

The population of the Horn of Africa community has been steadily increasing in Australia, particularly in Victoria and often concentrating in disadvantaged locations. After resettlement in Australia, Horn of Africa men face many unfamiliar challenges in the new environment which affect them mentally, socially and functionally. As the Horn of Africa diaspora grows, policy-makers, service-providers and practitioners are increasingly faced with questions regarding how best to promote wellbeing and intervene in the mental health of Horn of Africa refugees. Resettlement experiences significantly impact on Horn of Africa men's mental health and wellbeing. Such experiences include:

- Culture shock and language difficulties, particularly for the older generation where children have become interpreters for their parents. This dramatically changes the normal parent-child relationship and places children in a position of power over their parents as they control information and communication. This changed relationship dynamic weakens the position of parents - particularly fathers and affects them mentally and emotionally (Williams and Logan, 2007; Alitolppa-Niitamo, 2004.)
- Exclusion and social isolation by the Australian mainstream (Silveira and

Allebeck, 2001.)

- Feeling unaccepted by the mainstream because of their physical features and colour visibility.
- Feeling discriminated against because of their religion including their Islamic names (Colic-Peisker and Tilbury, 2007; Omar, 2007.)
- Changing gender responsibilities, which have created ongoing husband-wife conflicts and diminished the role of men in the family making them feel worthless and unstable emotionally and socially (Warfa N, 2012; Williams and Logan, 2007; GLAPD, 2013.)
- Loneliness, physical unfitness due to lack of physical activities and lack of social networks and relationships where they can confide their grievances. This predisposes to depression and anxiety (Silveira and Allebeck, 2001.)
- Low levels of social integration that prevent utilization of available mental health services (Silveira and Allebeck, 2001.)
- Questioning of their leadership position in their families (Ahmed, 2004.)
- Not holding the power of sole decision-making in the family (Ahmed, 2004.)
- Loss of status and not receiving the same respect from family members and the community compared to when they were in Africa (Ahmed, 2004; Silveira and Allebeck, 2001.)
- Children not being obedient to their fathers' orders and instructions (Omar 2011; Ahmed, 2004.)
- Intergenerational and family conflicts (Alitolppa-Niitamo, 2004.)
- Youth criminal involvement and confrontation with police (Smith and Reside, 2009.)
- Youth identity crises and uncertainties about their future (Omar, 2011.)
- Socio-economic challenges, unemployment problems or undertaking menial jobs which they perceive to be shameful (GLAPD, 2013; Ahmed, 2004.)
- Qualifications and previous skills not being recognized (Correa-Velez and Onsando, 2009; Colic-Peisker and Tilbury, 2007; Omar, 2007.)

The above-mentioned factors impact negatively on Horn of Africa men's emotional stability, mental health and social wellbeing on different levels depending on their age differences and cultural gap. This suggests that Horn of Africa men will have differing experiences of integration into the new society because older men may find it harder to learn English or adapt to the Australian culture compared to younger men (Williams and Logan, 2007; Silveira and Allebeck, 2001.) Thus, social integration based on age differences will have different impacts on emotional stability, mental health and wellbeing. Although Horn of Africa men have been and are still experiencing traumas, emotional frustration and mental health problems, they (particularly older men) struggle to recognize that they have mental health problems (Keating, 2007.) This may be attributed to cultural influences and lack of awareness of the existence of mental health problems. Silveira and Allebeck (2001) found that young and elder African men may be less inclined to recognize symptoms of mental illness that may take different forms such as anger, anxiety, aggression and talkativeness.

In relation to age differences and mental health, young African men in Australia and in the West are influenced by media, Hollywood, the internet and the general lifestyle in the West. Some aspects are positive e.g. joining fitness clubs which are good for their health and wellbeing. However, some aspects may bring new stressors (Andermann, 2010.)

Although some research has been done about African men's experiences in western countries, little is known about how African men conceptualize their understanding of mental health problems and wellbeing in the Australian context (Tempany, 2008.) In our literature review, we identified few studies exploring concepts of mental health and wellbeing from the perspectives of African men who had migrated to Australia. Few studies have addressed African men's emotional wellbeing, mental health conditions and their access to Australian mental health services. One article (Kokanovic et al, 2008) found that African men experienced an illness such as



depression as a collectively-derived and experienced condition compared to the local Australian population who experienced the condition individually. A master's thesis (Ahmed, 2004) highlighted resettlement issues for African men including frustration and loss of status but did not examine mental health issues.

An Australian article (Bruce, 2003) highlighted the climate of violence and trauma that Sudanese people are exposed to but did not investigate links to mental health of that population here in Australia. An article published by Tempany (2009) in which she reviewed the literature of mental health and psychosocial wellbeing of Sudanese refugees found that although Sudanese refugees have symptoms of traumatic stress, their functioning was not necessarily reduced, and they themselves often reported more concern with current stressors such as family problems than with past trauma. It was also found that many Sudanese refugees used coping strategies such as silence, stoicism, and suppression. Few studies were available regarding appropriate interventions for Sudanese refugees and it remained unclear which aspects of standard treatments used by western-trained mental health practitioners were beneficial for members of this population.

A recent comprehensive Australian study (Colucci et al 2012), examined the access of young refugees to mental health care. It found that respect and understanding by clinicians as well as an awareness of the patient's pre and post-settlement experiences facilitated utilization of mental health services. However, concepts of mental health and illness in African refugees were notably different from western conceptions and many refugees continued to rely on traditional knowledge and healing. Creating safety, advocacy and user-led services for these refugees were recognized as facilitators to mental health access.

However, given the lack of research in Australia for African Muslim men of different ages, it is important to undertake research with this particular community employing a

constructionist bottom-up approach (Tempany, 2008) in order to improve understanding of their concepts of mental illness and wellbeing and how they access mental health services in Australia.

## **CHAPTER 2: RESEARCH METHODOLOGIES**

### **Introduction**

This chapter outlines the study rationale, research questions, aims and design. It also describes the nature of qualitative research, research interview sites, recruitment strategies, inclusion and exclusion criteria of participants, methods of data collection and data analysis. The chapter concludes with the profiles of the Somali and Eritrean Community in Australia and the demographics of the participants.

### **Rationale for this project**

There is insufficient data available on how Horn of Africa Muslim men conceptualize mental health problems and wellbeing. It is also largely unknown whether they end up accessing mainstream mental health services in Australia. Understanding a person's cultural perspective on mental health improves the relationship between patients with mental problems and the providers of mental health services (Groen, 2009.) This study will help practitioners and decision makers understand how Horn of Africa Muslim men see mental health issues and how and when they access mental health services.

### **Research questions**

Research questions include:

1. How do Horn of Africa Muslim men identify and describe mental health problems in Australia?
2. What are the most common help-seeking strategies that Horn of Africa Muslim men have for those identified problems in Australia?
3. How do Horn of Africa Muslim men make decisions about seeking help from mainstream mental health services in Australia?

## **Aims**

The aims of this study are to:

1. Explore and compare the experiences and views of young and older Horn of Africa Muslim men (YOHAMM) on emotional difficulties, causes of emotional difficulties and mental health illness in an Australian context.
2. Examine YOHAMM's access to culturally appropriate mental health services in the Australian context and the best strategies of seeking help.

## **Design**

This study involved five focus group interviews for a total of 36 participants. The participants were random representatives of young and older Horn of Africa Muslim Men and key community workers from Somali and Arabic speaking backgrounds from Somali and Eritrean communities in Victoria. The focus group interviews explored the experiences of this sample and their understanding and conceptualization of mental health issues, emotional difficulties, causes of these difficulties and what helped affected individuals and their families get access to mainstream mental health services. Focus group participants were assured that all information about these experiences would remain confidential. The focus group interviews were audio recorded, coded, translated into English and transcribed. The study continued for 11 months and employed qualitative research methods using thematic analysis. All narrative data was thematically analysed.

## **The significance of this study**

Although there are many international studies examining African migrant mental health and access to mental health services, few studies have examined YOHAMM mental health and their access to mental health services in Australia. This study

addresses that knowledge gap as it investigates YOHAMM's experiences and views on the causes of mental illness, their access to mainstream services as well as their perspectives on effective treatments - cultural or professional in the Australian context. It concludes with proposing possible solutions for barriers to accessing appropriate health care.

## **Qualitative research**

This study is a qualitative research project that investigates the Horn of Africa Muslim men's experiences and perceptions of emotional difficulties in the Australian context. Qualitative research is a naturalistic, holistic and inductive approach which "moves us increasingly toward a greater understanding of how the world works in natural ways" (Strauss and Corbin, 1996, p. 4.) The study was ethnographically informed. The ethnographic approach is the primary method of research in anthropology, psychology, psychiatry and sociology because it describes and analyses peoples' ways of life, thinking and their cultures, assuming that "any human group of people interacting together for a period of time will evolve a culture" (Patton, 2002, p. 81.) It can be applied to any research in the individual or group setting. It explores the experiences, cultural phenomena, social changes, transformations and movements of the study subjects (Strauss and Corbin, 1996.)

Qualitative ethnographic research usually does not impose preconceived assumptions or formulated theories but puts emphasis on the context of the research situation, assuming that the natural world is not fixed or static but it is constantly shifting and changing, presenting the researcher with diverse realities (Hines, 1993, p. 734.) Ethnographic research can uncover the ways of life of invisible groups enabling the researcher to "lift the veils that obscure what is going on." (Hines, 1993, p. 735.) This type of research is particularly well suited for studying "hard-to-access groups" such as refugees and immigrants, or groups resistant to survey methods (Hudelson, 1996.)

## **Sites, recruitment and interviews**

The study was conducted in five different settings in Inner-Northern Melbourne suburbs. The sites were: the Hub community centre in West Heidelberg of Banyule, Carlton Community Development Worker & Community Centre in Carlton, Yassco Training & Consultancy Centre in Flemington, VICSEG Centre in Coburg and a Youth Residential Apartment in Pascoe Vale. The primary researcher, Dr Yusuf Omar, is of Somali background and he studied in Sudan where he developed an understanding of Sudanese and Eritrean culture. He has significant networks with African community organisations and leaders and recruited all five focus groups through these networks. Focus group interviews continued over 1½ hours to 2 hours. During interviews, the participants were happy to discuss mental health issues openly with the primary researcher who shared their language and culture.

## **Participants**

The total number of participants was 36. There were 9 young Somali participants, 9 young Eritrean participants, 6 elder Somali participants, 6 elder Eritrean participants, and 6 community reference group participants. All of the community reference group were of Somali background.

The two elder men focus groups were aged between 40-60 years old while the two young men focus groups were aged between 18-29 years old. With one exception, the community reference group participants were aged between 30-40 years old. Only one man from the community reference group was aged between 50-60 years old. We believe that the arbitrary age groups of 18-29 and 40-60 form more homogenous groups and that these age ranges adequately reflect a younger and older Horn of Africa Muslim men population. The reason for including the community reference group was that they were knowledgeable about their community situation. They were often contacted and asked for information and support by their communities for

problems including health related problems. Therefore, they provided valuable information and lived experience gained through everyday interaction with their communities. These community reference group participants included a social worker, community development worker, photographer, and public speaker.

One older men focus group was from the Somali ethnic group from Somalia and Djibouti because these two communities speak the Somali language. The interview of elder and young Somali men focus group was conducted in Somali by Dr Yusuf Omar. The second elder men focus group was from the Eritrean Muslim community and Arabic language was their first language. The interview of this focus group was conducted in Arabic by Dr Yusuf Omar who is fluent in Somali, Arabic and English languages. The interviews of young Eritrean men and community reference groups were conducted in English by Dr Yusuf Omar. Other researchers from VTMH attended and observed some of these focus groups.

Non-English transcripts were translated by Dr Yusuf Omar into English. Another researcher assisted in transcribing English interviews. Each focus group took the form of a facilitated discussion using a semi-structured questionnaire (See Appendix A):

### **Inclusion / Exclusion Criteria**

In terms of inclusion criteria, participants were selected based on their connections with the Horn of Africa community by the bilingual researcher, Dr Yusuf Omar. Identification of membership of the Horn of Africa community in Melbourne was the key inclusion criteria. The participants in the two young men groups were aged between 18-29 years old while the participants in the two elder men groups were aged between 40-60 years old. Participants were included if they were fluent in Somali, Arabic or English as described earlier in the methodology.

## **Data collection**

Data was collected through audio recordings, field-work observations, and transcriptions of semi-structured focus groups. These data were subsequently stored at Victorian Transcultural Mental Health and were only accessed by researchers involved in the project. After 7 years, the data will be destroyed.

## **Data analysis**

The transcripts of the interviews from the focus groups were translated into English (for the Somali and Arabic interviews) by Dr Yusuf Omar. This narrative data were then analyzed by hand, coded and grouped into key themes. An “emic” perspective was adopted in order to ascertain the views of participants. Transcripts were analyzed with the objective of grouping and refining common as well as contrasting themes. The themes identified were reviewed by Dr Yusuf Omar, Dr Justin Kuay, Dr Can Tuncer and Miss Kimberley Wriedt.

## **Limitations of the study**

This study focused on young and older Horn of Africa Muslim men (YOHAMM) from Somalia and Eritrea and their experiences, understanding of emotional difficulties and awareness of problems facing YOHAMM in inner-northern Melbourne suburbs in Victoria. The study also explored the underlying causes of these emotional difficulties and problems as well as treatment and the best help-seeking strategies used by YOHAMM and the Horn of Africa community in general. Research findings cannot be generalised to all Horn of Africa Muslim men or women in Melbourne or Australia.



## **The Somali and Eritrean Communities in Australia**

### ***The Somali community***

The Somali community in Australia is relatively new and small in number. The data from the Australian Bureau of Statistics showed that six people of Somali origin arrived in Australia between 1961 and 1970 for unexplained reasons (Office of Multicultural Affairs and Citizenship, 2013, p.11.) Additionally, small numbers of Somali students arrived in Australia between 1971 and 1991; however, the majority of those born in Somalia arrived in Australia after 1992, mostly as refugees from the civil war in Somalia. More recently, they have been arriving as family migrants. The latest Census in 2011 recorded 5687 people born in Somalia residing in Australia. It seems that those with Somali ancestry were not included in this figure, and if the ancestries were included, the Somali population in Australia could be over 11, 000 people (Omar, 2012.) More than half of the Somali population in Australia lives in Victoria, mainly in the northern suburbs of Melbourne (Omar, 2012.) The Somali community in Australia is highly urbanized – 98.7 % live in capital cities. In Victoria, 99.1% of the Somali-born population lives in metropolitan Melbourne. The largest numbers of Somalis in Melbourne are concentrated in the Local Government Areas of Banyule, Moonee Valley, City of Melbourne, and Darebin (Office of Multicultural Affairs and Citizenship, 2013.)

The unemployment rate of the Somali community in Australia was 22.1% in the 2011 census. In contrast, the corresponding rate of unemployment for all Australians was 5.6%. In terms of faith, the major religious affiliation amongst Somali Australians was Islam (95.4%) in the 2011 Census (Australian Government, Department of Immigration and Citizenship.) This information can be accessed on:

Department of Immigration and Citizenship. Community Information Summary, Somali-Born

[http://www.dss.gov.au/sites/default/files/documents/02\\_2014/somalia.pdf](http://www.dss.gov.au/sites/default/files/documents/02_2014/somalia.pdf)

### ***The Eritrean community***

Similar to the Somali community, the Eritrean community in Australia is relatively new and small. Before 1983, only a few Eritreans arrived in Australia as refugees, students or stowaways. The data from The Australian Bureau of Statistics showed that four people born in Eritrea arrived in Australia between 1951 and 1960 (Office of Multicultural Affairs and Citizenship, 2013, p.11.) However, after 1983, Eritreans fleeing the unrest and war in Eritrea were resettled under an Australian Humanitarian Program. The 2011 Census recorded 2841 people born in Eritrea residing in Australia and mainly in Victoria followed by Western Australia, Queensland and then New South Wales (Office of Multicultural Affairs and Citizenship, 2013.) Apparently, the Eritrean ancestry group was not included in this figure, and if the ancestries were included, the Eritrean population in Australia could be much higher than the abovementioned figure. The unemployment rate of the Eritrean community in Australia was 15.3% in the 2011 census (Australian Government, Department of Immigration and Citizenship.) In terms of faith, the major religious affiliations amongst those born in Eritrea were Islam (53.5%), Eastern Orthodox (16.9%) and Catholic (9%) in the 2011 Census (Australian Government, Department of Immigration and Citizenship.) This information can be accessed on:

Department of Immigration and Citizenship. Community Information Summary, Eritrea-Born

[http://www.dss.gov.au/sites/default/files/documents/02\\_2014/eritrea.pdf](http://www.dss.gov.au/sites/default/files/documents/02_2014/eritrea.pdf)

## **Demographics**

As shown in Table 1, both elder Somali men and the community reference group were well-educated. Almost all community reference group members worked in professional jobs while elder Somali men with one exception, worked in menial jobs not relevant to their qualifications. The difference could be attributed to English language proficiency and being educated locally in the case of the community reference group compared to the elder men who possessed limited English and overseas qualifications. On the other hand, young Somali men were less educated and not working as professionals. This was likely because they were new to Australia and had limited English. Again, we believe that the arbitrary age groups of 18-29 and 40-60 adequately reflect a younger and older Horn of Africa Muslim men population.

As presented in Table 2, elder Eritrean men were well educated compared to the young Eritreans. Both elder and young Eritrean men had few professional jobs. The reason was that most elder Eritrean men had language difficulties and unrecognized overseas qualifications. In contrast, young Eritreans were proficient in English but they lacked high qualifications.

**Table 1: Somali men focus group participants**

<b>Variable</b>	<b>Young Somali (YS) Men Focus Group No: 9</b>	<b>Elder Somali (ES) Men Focus Group No: 6</b>	<b>Community Reference (CR) Focus Group No: 6</b>
<b>Country of birth</b>	Somalia: 8 Ethiopia: 1	Somalia: 3 Djibouti: 3	Somalia: 6
<b>Age range</b>	9 participants: 18-29	5 participants: 40-50 1 participant: 50:60	5 participants: 30-39 1 participant: 40-50
<b>Level of education</b>	Primary: 1 Intermediate: 1 Secondary: 6 Postgraduate: 1	Tertiary: 3 Postgraduate: 3	Tertiary: 3 Postgraduate: 3
<b>Marital status</b>	Single: 7 Married: 1 Unknown: 1	Married: 6	Married: 3 Single: 2 Separate: 1
<b>Professional occupation</b>	Student: 5 Meat company: 2 Cleaner: 1 Unknown: 1	Teaching: 3 Accounting: 1 Software designer: 1 Public relationship and advertising: 1	Community development: 3 Social worker: 1 Photographer: 1 Food technologist: 1
<b>Current job</b>	Studying: 1 Meat industry: 4 Employed but not stated what kind of job: 2 Unemployed: 2	Self-employment: 2 Accountant: 1 Taxi driver: 1 Cleaner: 1 Studying: 1	Social worker: 1 Public speaker: 1 Public servant: 1 Photographer: 1 Managing director: 1 Community development: 1
<b>Religion</b>	All Muslims	All Muslims	All Muslims
<b>Languages</b>	Somali: 5 Somali & some English: 3 Somali & Kiswahili: 1	Somali & Arabic: 2 Somali, Arabic & English: 2 Somali & English: 1 Somali, Arabic, English & Italian: 1	Somali & English: 6
<b>Length of residence in Australia</b>	3 participants: 4 years 1 participant: 3 years 2 participants: 1.5 years 1 participant: 2 years 1 participant: 1 year 1 participant: 7 months	1 participant: 24 years 1 participant: 15 years 2 participants: 3 years 1 participant: 4 years 1 participant: 2 years	1 participant: 22 years 1 participant: 20 years 1 participant: 18 years 1 participant: 16 years 1 participant: 12 years 1 participant: 2 years

**Table 2: Eritrean men focus group participants**

<b>Variable</b>	<b>Young Eritrean (YE) Men Focus Group No: 9</b>	<b>Elder Eritrean (EE) Men Focus Group No:6</b>
<b>Country of birth</b>	Saudi Arabia: 5 Eritrea: 2 Sudan: 2	Eritrea: 4 Ethiopia: 1 Unknown: 1
<b>Age range</b>	9 participants: 18-29 years old	3 participants: 40-50 3 participants: 50-60
<b>Level of education</b>	Secondary: 7 Tertiary: 2	Primary: 1 Secondary: 2 Postgraduate: 3
<b>Marital status</b>	Single: 9	Married: 5 Separate: 1
<b>Professional occupation</b>	Client service: 1 Business: 1 Carpenter: 1 Security: 1 Student: 4 Unknown: 1	Accounting: 1 Electrical engineering: 1 Teaching: 1 Community development: 1 Unknown: 2
<b>Current job</b>	Security: 2 Community liaison: 1 Apprentice carpenter: 1 Youth work: 1 Self-employed: 1 Unemployed: 3	Driving instructor: 1 Mail officer: 1 System admin: 1 Housing officer: 1 Unemployed: 2
<b>Religion</b>	All Muslims	All Muslims
<b>Languages</b>	Arabic & English: 8 Arabic, English & Tigre: 1	Arabic, English, Tigrinya: 2 Arabic, Tigrinya: 2 Arabic, English, Amharic, Tigrinya: 1 Arabic: 1
<b>Length of residence in Australia</b>	1 participant: 25 years 2 participants: 23 years 3 participants: 20 year 2 participants: 17 years 1 participant: 16	1 participant: 25 years 1 participant: 20 years 1 participant: 17 years 1 participant: 14 years 1 participant: 3 years 1 participant: unknown

## **RESEARCH FINDINGS**

The following three chapters present research findings.

### **CHAPTER 3: HORN OF AFRICA MUSLIM MEN'S UNDERSTANDING OF MENTAL ILLNESS**

#### **Introduction**

This chapter explores the definition of mental illness according to Horn of Africa Muslim men. Other issues discussed include 'sane and insane circumstances,' speaking negatively and difficulties expressing mental health problems in the Somali language. The chapter also explains the phenomenon of "Buufis," which is a new mental illness affecting Somalis who aspire to migrate to the West. It concludes with a discussion of "survival mode," which potentially masks mental illness.

#### **Definition of mental illness**

Mental illness had differing definitions across the focus groups and varied in severity and presentation. However, a participant from the community reference group argued that Africans learnt these different concepts of mental illness after their resettlement in Australia:

"When we came here we learnt a lot about types of mental illness and many things...one of the staff told "do you think we are sane" I said what do you mean? No one [is sane] because if you go back to types of mental illness no one is immune to be mentally sane, you will be one of the types." (CR5)

One Somali elder commented that Somalis were not even aware that they could be mentally unwell:

“It appears to me that people are not aware that they are sick. Even though they are sick, depressed with problems and sleeplessness they don’t know they are sick, because, this is something new to the Somali man. He leaves a normal life and his brain works extensively and if he is told “you are sick” he says “I am not sick.” This is because mental problem is not a sickness that you fall down with; you can do your task, but you feel slight changes such [as] change in your sleeping system.” (ES1)

### **Sane or insane**

A dominant view described across all focus groups was that a mentally unwell person was mad, crazy, dangerous to society, isolated, and running naked in the streets:

“[In] the Somali context, [it] is someone who has totally lost it, violent, naked [and] should be on chains and all the rest.” (CR1)

“[it] is madness in which the person jumps around and shouts without reason. He sometimes throws his clothes and walks naked.” (ES4)

Thus, Somalis’ struggled with seeing mental illness as a continuum - either you were mad or normal:

“We just use between two extremes: you [are] sane or insane – very simple. If you [are] insane it’s easy to tell, you are going nuts, and you should be in a straight jacket or somewhere. If you are sane you understand, if I ask you “what’s your name” and you can reply back that means your sane, you’re normal, but obviously there is a grey area in between.” (CR)

Interestingly, an elder Eritrean focus participant believed that the Western concept of ‘depression’ meant ‘madness.’ However, depression was a diplomatic term used to avoid labeling that depressed person as mad:

“There is a modern sickness that they call ‘depression’ or stress. In fact that is *junuun*’ (madness) but they don’t say madness. It has all characteristics for madness. Using these words can be part of the solution and it is good not to be called *junuun*...” (EE2)

### **Speaking negatively**

Mentally ill people were also described by a few Somali elders as people who talked to themselves or to others in a disorderly way. They would speak about their hardships and bad experiences; but socialize normally and undertake religious duties:

“[it] is a situation in which the person talks disorderly. He sometimes talks to you and then you will observe some disorders in his talk but he normally socializes with people; he doesn’t harm them; and even he performs well his worships like prayers as others.” (ES4)

“He speaks disorderly with himself. It is a situation in which person talks only about bad experience he has undergone. He talks only about his predicaments.” (ES2)

Two participants from the young Somali and the community reference focus groups differentiated between stress and mental problems arguing that what people were complaining of was life stress and not a mental problem:

“When you are in mood of stress, you will be on the road but you think a lot, you know? So, I think, what we are complaining is stress not a mental problem.” (YS9)



## **Mental problems and the Somali language**

A few participants from the Somali community acknowledged the existence of language difficulties when it came to explaining and describing mental health problems. They argued that the Somali language was not complex enough to describe different types and severities of mental problems:

“There is a language problem. You can get three words in English but in Somali you can get [only] one word. So, the meaning of *Waaali* in English, it can be three or four [words], crazy, mad, mental illness, it can be, but in Somali...so, it is almost the *Waaali* (madness) [that is] mental problems.” (YS9)

“We don’t have the right terminology to define the mental health; we just come up with all this [these] terminology [terminologies] to describe someone who is not quiet there. So, I think the problems is not how do we deal with it [but] about how we define mental health, it how do we define classification, is the biggest problem.” (CR6)

Participants from the Eritrean community who were Arabic speakers did not mention any language difficulties when explaining and describing mental health problems. One possible explanation was that the Arabic language is richer, older and more academically-oriented compared to the Somali language which was written only in 1972.

## **Buufis as a new phenomenon of mental illness**

A participant from the community reference group described the phenomenon, ‘*buufis*’ as a new mental illness affecting Somalis trying to migrate to the West to find better life opportunities. At the beginning, it was believed that Somali refugees in Kenya and Ethiopia developed buufis after the civil war in 1991. However buufis had

become similar to depression for many Somalis living in Africa, Asia, South East Asia, and the Middle East who were trying to reach the West but unable to get there:

“The word buufis actually came from people attempting to go overseas...they have this mentality of being in paradise if you go to any western country so this person would attempt to go to Europe or Australia or America again and again and again to a point they develop a mental problem and that’s called buufis...” (CR4)

During the course of this research project, the primary author noted an example of buufis when traveling in Istanbul. At the Blue Mosque in Istanbul, the primary author met two young Somali women accompanied by a young Somali man. The primary author asked them, “Are you students?” “No, but where are you from?” they answered. The primary author said “from Australia.” They looked at him in an admiring way and one young woman said, “we are affected with buufis to get there.” The other young lady repeated the same words.

Finally, a young participant from the Eritrean youth focus group argued that mental illness was increasing among the Horn of Africa community and without addressing and treating it, the situation would worsen:

“it [mental problem] actually increases...the symptoms of mental health will actually increase without addressing it; without helping yourself, without getting treatment...it increases overtime you know, particularly and it becomes more seriously, you know.” (YE7)

Intergenerational differences toward mental illness were identified by an elder who argued that young people perceived mental illness like any other sickness and therefore it could be cured. In contrast, the older generation perceived mental illness

as incurable. They also saw a person with mental illness as unproductive and a burden to society:

“In our old generation, we believe that the mental sickness...is an unacceptable illness... If a person has mental illness, he is believed to be unproductive and burden to society and no one can be close to him or care for him and so on. In contrast, the new generation has different understanding to mental illness. They perceive that it is similar to any other illness like cancer and so on, and it can be cured and people with mental illness can recover.” (EE5)

### **Survival mode masking mental illness**

A community representative shared how mental illness sometimes only presented after immediate threats in the home country were resolved:

“I think a lot of issues people when we come to Australia initially or when we in refugee camps prior to arrival we dealing with the emergency issues, real life issues, how do I feed my kids, safety issues - all of suddenly there’s no immediate risk to your wellbeing and then the mental health issues come because now you have time to think about your wellbeing. We were in survival mode.” (CR1)

## **Conclusion**

This chapter has explored understandings of mental illness by the various groups. Some participants believed that mental illness was similar to madness. It was incurable and associated with danger and craziness. Insomnia, lack of remembrance or acknowledgement of Allah, speaking disorderly and talking about ones' bad experience were said to be the main signs and features of mental illness. Mentally ill people were described as unproductive and mental illness could sometimes present in a new country after immediate safety threats were addressed.

## **CHAPTER 4: CAUSES OF STRESS AND EMOTIONAL DIFFICULTIES**

### **Introduction**

This chapter discusses causes of stress and emotional difficulties in the new environment including unemployment, racism, housing challenges, lack of networking with the mainstream, language barriers, culture shock and youth identity crises. Similarly, the chapter elaborates on other stressors facing the Horn of Africa Muslim men including family and community problems, loss of ‘Al-Qawaama’ (patriarchal role), Australian family law, issues concerning sponsoring family members such as wives, different child-rearing practices, lack of support from family members, and lack of community support. Additionally, the chapter comments on perceptions of poor leadership in African communities, lack of successful role models, tribalism, difficulties in practicing Islam in Australia e.g. missing the rhythm of muezzin, the issues of haram (illegal in Islamic perspectives), halal (legal in Islamic perspectives) and mortgages as sources of stress. It concludes with discussing the impacts of civil war, pressures from the country of origin and substance abuse as sources of stress and depression.

### **Jinn, Evil Eyes, and Sleeplessness**

Some elder Eritrean men attributed mental problems to evil eyes. Additionally, one participant believed that it was an accidental sickness or inherited:

“mental problems could be attributed to Jinn and evil eyes and something like that.” (EE3)

“mental health is an accidental sickness... Everyone can accidentally become sick mentally...people can get affected by mental sickness, or inherit or can get it accidentally.” (EE1)

Additionally, sleeplessness and lack of memory were mentioned as signs of having mental problems:

“I think they [people with mental problem] don’t have a good sleep... you don’t you remember [anything].” (YS9)

## **Unemployment, housing and racism**

### ***Unemployment***

Unemployment was the main stressor identified across all focus groups except the young focus group from the Somali community. Unemployment was described as a significant issue both by older and younger men who grew up in Australia, acquired English as a first language and had an Australian accent compared to the first generation from the Horn of Africa. An unemployed person was thought to become more isolated, insecure and suspicious of others:

“...frustration and hopelessness causes stress, because if they can't find jobs and stuff like that they get frustrated...” (YE2)

“Unemployed person seems isolated from society...he develops sense of suspicion and mistrust...unlike later arrivals in Australia, it was very hard for the earlier arrivals to find someone who can assist them find housing, or take them to the centrelink and it is possible when these problems are accumulated, man can get depressed...” (ES2)

“I did work and done a lot of umm focus groups with men for... my previous work with Muslim men and most of the issues that comes up was unemployment and mental health issues...” (CR5)

### ***Racism and employment***

Racism was identified by many participants as the biggest hurdle to obtaining a job. The community reference focus group and the young Eritreans were very vocal on this subject in contrast to other focus groups. This was possibly because of their

difficulties finding jobs despite their fluent English, knowledge of and participation in Australian culture. They believed that unemployment was a problem existing in Australia even before their arrival and unrelated to acculturating to Australian society. Some participants believed that the Australian government's policies of cultural diversity, outlawing racism and discrimination were just symbolic and ineffective. They reported discrimination against their skin colour and religion as ongoing realities that impacted on their wellbeing and mental health:

“Racism, so, ultimately it [Australia] is a racist country. So, the same opportunities are not given to the people of Horn of Africa Muslim men as they will be given to...Caucasian, white men.” (YE3)

...someone may be qualified or overqualified ... but they may not get [job] because the[y have] been discriminated against, so the problems are not something we came with here or we created, some of the problems the[y have] already been here before us...So racism is one of them being discriminated especially in the workforce....” (CR4)

“So in one hand mainstream Australia says you have to fully integrate into mainstream society but that demines [diminishes] your cultural beliefs, your religious values, your cultural identity, Even though there is a formal government policy of multiculturalism, for the Somali its mainly symbolic it's just rhetoric...Racism also prevents you from on gaining meaningful employment. Racism also impacts on having a fair go in anything.” (CR1)

A few participants felt that Horn of Africa Muslim men and Muslims in general were not given the same employment opportunities as non-Muslims. This made them feel that they were treated unfairly:

“...there is a general perception that non-Muslims have more opportunities. This is because this country [Australia] is believed to be a non-Muslim country. As a result, educational opportunities, employment opportunities

and so on are more available for them [non-Muslims]...An African Muslim person believes ‘that non-Muslim Africans have more opportunities than me...’ (EE5)

Racism and discrimination against their skin colour and their Islamic names frustrated the young African men. Some considered changing their real names in order to obtain an interview. However, at the interview, they could still miss out on the job because of their appearance:

“So there was a discussion the other day where young people were saying ‘Should we change our name in order to get a job?’ And someone else said ‘well what are you going to do when you step through the door and everyone sees how you look like and who you are?’ so these problems with the glass ceiling do exist.” (CR4)

Men from the Horn of Africa also had difficulties finding jobs due to not understanding the job-finding strategies in Australia:

“The ways of finding jobs here is not similar to the ways jobs used to find in Africa. We know the system in Africa. In Africa, graduating groups used to be advised to go to the employment ministry. That is not working here.” (ES1)

A participant from the community reference group also identified that Horn of Africa Muslim men were not only unemployed but underemployed. This contributed to a sense of worthlessness, stress and then mental problems:

“...[the problem] it is not purely being unemployed, we’re also talking about underemployment... so a lot of men...are doing jobs that they’re overqualified for...and that leads to mental health issues...There are a lot of



people who are employed but they're under employed..... [it is] degrading... and their brains not accepting that.” (CR1)

Sometimes, overseas qualifications were not recognized and employment agencies pushed educated men to take menial and degrading jobs rather than helping them find jobs they were qualified for. This was another risk factor identified for developing mental illness:

“So, overseas they [Eritrean] were very qualified you know...when they came here, they had to start from scratch and their qualifications are not recognized and that causes frustrations in the community...so many issues.” (YE1)

“For example, when I came here I explained that I brought my expertise and educational background and I requested to be assisted in order to get job in my area of specialization. However, I was rejected. I was told that if I receive social security [benefit] I should work as a public toilet cleaner in Richmond if I am transferred to do so...Therefore, the system in this country is not designed to train the person according to his qualifications and experience to be employed in his qualifications.” (ES1)

### ***Elder men's worries for their children's unemployment***

Besides worrying about finding employment for themselves, elder Eritrean men were also conscious of their children's struggle to obtain employment. Elder men from the Somali community did not mention this issue:

“Lack of employment is the main problem facing Africans and there are many young men receiving from centrelink [because of unemployment] and then they will be lost to the street. There are also very diligent and qualified people who do not find job... When our son graduates or our daughter graduates, they can't find jobs quickly. This is one of the stresses and problems.” (EE1)

“There are a lot of gaps in finding jobs. For example, there are graduates from different programs who may find job after three, or five years from their graduation; it is a big number...” (EE1)

### ***Dependence on welfare***

A culture of dependence on welfare and government assistance was an additional barrier to finding employment because of the disempowerment that being on welfare resulted in:

“but our governments there we have learnt to depend on others, you know, just waiting for aids. The general culture was that and we came here [with that culture].” (YE2)

“our culture of dependency. It is something new...I think Eritrean community, it is bit, it is little more self-sufficient...number one [of problem] is foundation of our culture...” (YE5)

### ***Housing***

A community reference participant argued that Africans had no access to private rental because of racism:

“but when it comes to reality, a lot of the problems underlying issues and racism impacts on housing, you can’t access private rental.” (CR1)

### ***Resumes and preparation for interviews***

Preparation for interviews, writing resumes and attending job training were sources of stress for elder Somali men:

“You are required to prepare your CV; join twelve specialist organizations who have their own projects in order to make money.” (ES1)

In addition, a few elders from both Somali communities suggested that the Australian government should direct all new arrivals to jobs and provide them with clear instructions and guidelines on how to do those jobs. This perspective was common in Somali, Eritrea and generally in Africa where the system was very directive in finding employment for its countrymen:

“The existing system here is not supportive. It is not imposing employers to employ... the system followed in this country does not support.” (ES1)

### ***Lack of networking***

Lack of useful networking with the mainstream was a source of frustration for Eritrean youth. Eritrean youth believed that they lacked skills for networking with the wider community. This impacted negatively on their employment situations. Unlike non-Africans in the wider community, African youth felt that they did not have successful relatives and community members in the labour market and public service. After graduation, their counterparts were assisted to find jobs by relatives, family members and friends who had existing influential positions in companies. However, African youth felt that they could not access these networks. Therefore, after prolonged unemployment, they could become involved in drugs and gambling and ultimately end up with mental problems:

“Most jobs here is done internally...so, if you know people just put little effort to try to network and, it can come back [to you] slowly... There is lack of training of how to network.” (YE9)

“there is definitely lack of networking, because we don’t have; we are new migrants to this country, we don’t have uncles, nieces and cousins in these fields [the labour market] ... It is all about networking and who you know not what you know. Because some of us do have degrees and things like that but we are still unemployed...when I hang up my white friends, many of them, you know, got graduate positions and some of them even may not have

qualifications but some getting before us...that obviously affects self-esteem which affects your income, which affects your employment, which affects where you live in, which affects why you do drugs, why you sell drugs, why you gamble, why you do that, and why you're in trouble with law, and it is just roll and effect." (YE8)

## **Language barrier, culture shock and identity crises as sources of emotional difficulties**

### ***Limited language***

Two elder focus groups and the newly arrived young Somali focus group pointed out how poor English fluency caused enormous problems, disappointments and stress. Generally, inadequate English impacted on all new migrants regardless of their backgrounds. Insufficient English impaired communication with the mainstream and affected access to employment and educational opportunities. English was described as the main key to integrating into wider Australian society. Difficulties in learning English were particularly prominent in older age groups. Younger men tended to learn English more easily, avoiding the stresses and emotional difficulties caused by this for the older people:

"The old people, they can't learn but the young people, they can learn, if they get a chance they can learn. Most of them [youth], they learn and they communicate the people. The old people, they can't get a chance because, they believe they can't learn." (YS8)

"they [Australian government] are interested in anyone aged 9 years and younger, because he learns language quick like drinking water and he easily adopts their culture and lifestyle." (EE1)

"For them [African refugee men] learning language is difficult. Also, benefiting from other opportunities is limited... some people [African men] came here elderly and therefore, learning and working was very hard for them." (EE3)

Lack of adequate English made elders feel that their past knowledge learnt in other languages was worthless and therefore, was not useful in Australia:

“Lack of language means erasing the whole your knowledge, information and everything you have learnt in the past. For example, I graduated from accounting; I came here [Australia] and I was an accounting graduate; I swear by Allah even I can’t work in a tea café. I am irrelevant to work in a coffee shop [because of lack of language] forget to work in an accounting job. This means all knowledge and information my mother and father taught me over 16 years has become like sugar put in water [means it melts/disperses]. From there, I am going to start from alphabet, A, B, C, from zero. This is the biggest emotional and real problem. It is very big problem.” (EE2)

“Everything was erased. I started a new page in my life...this means your life in the past has ended... We are elders and therefore I suffered a lot in learning language.” (EE6)

Moreover, elder participants felt that they were disadvantaged in English compared to their counterparts from India or from other English-speaking African countries like Kenya:

“They have recently brought Indians who all have skills and good understanding of everything. Indians are well educated. You bring them and then they become productive for the nation but when we came here we didn’t product anything. We have already spent our time and then we came here...Nothing can enter into our head.” (EE1)

“The first problem facing them is language. Because they are from the Horn of Africa, and the common spoken language here in Australia, is not the language they speak perfectly.” (ES5)

The community reference group and young Eritreans were fluent in English but acknowledged that limited English could cause communication difficulties. In contrast, a young Somali man argued that his insufficient English made him feel alone and isolated. This was because he couldn't communicate effectively with other young Somali men who lived in Australia most of their lives and spoke English as their first language:

“The first problem was English. I don't understand English even young Somali people like my age. They speak in English and I don't know what they are saying. So, I feel like I am alone and I have got no one.” (YS4)

### ***Culture shock***

Participants across focus groups identified how large cultural differences between Horn of Africa societies and Australia caused enormous stress and confusion. Cultural differences were assumed to be detrimental to social integration. Some participants noted the use of different strategies by people during their social integration process. Some people lived double lives:

“Some people will live in double lives: some times with the original culture and tradition and sometimes with the new culture and new lifestyles. And some of us will mix these cultures.” (EE5)

“Culture shock -plus keeping your culture, keeping your family happy also staying with your community and also trying like to integrate [into the new society] and you're always jumping up and down, you just get confused sometimes.” (YE9)

“Very quick and rapidly changing we find very difficult. I would say we as Somali Muslim men it's difficult for us to because the way you brought up very difficult. Older you get, it gets worse because you go back to your ways...” (CR2)

“we came to a diverse culture that is completely different to ours. All these problems make people not to cope with these challenges. People were not ready. Language is a problem; culture is a problem; religion is a problem.” (ES3)

To illustrate Horn of Africa men’s frustration caused by huge cultural differences between the Horn of Africa societies and Australia, an elder Eritrean man compared the differences with other Horn of Africa countries like Somalia and Sudan:

“For example, as an Eritrean if I go to Sudan, my culture is quite similar to Sudanese culture. Even if I go to Somalia the two cultures are close with each other...But you travel all the way to Australia, and you find that these cultures [Eritrean and Australian cultures] are very different...When an African migrant comes here, these two cultures which are at the two opposite ends of the spectrum will definitely affect his mindset, thinking, his relationships, his children, and even his personal development.” (EE2)

On the other hand, a young Eritrean man argued that Horn of Africa families were not equipped to cope with emotional difficulties posed by culture shock.

Interestingly, some focus group participants from the Somali community argued that Somalis were an exclusive society and had difficulties engaging with the wider Australian community. Instead of integrating with other cultures, Somalis kept to themselves to avoid problems:

“...I don’t think we integrate well with the wide, the community. I think we do a fantastic job in terms of integrating amongst our own Somali groups.” (CR2)

“We are actually Muslim men. [back home], all the people they were practicing same culture, same religion, especially [in] Somalia. But here, you

[can] see two people in front of you; they are [from] two different cultures. Each of them has his own culture and own religion. So, you need to share your culture and your religion to these people and that will cause problems.” (YS9)

### ***Youth and identity crises***

Identity crises and not knowing who you were could lead to confusion, ambivalence and frustration. Identity crises were identified more commonly by young Eritreans compared to young Somalis. These differences were ascribed to the fact that Eritrean youth had lived in Australia for longer compared to Somali youth who were new arrivals. Participants from the community reference group also emphasized the relationship between identity crises and emotional difficulties:

“We are in between of identity [loss], we don’t know if we are Australians or different.” (YE1)

“I think the young generation, the young boys... the pressure is on them as wasn’t on us ... The way they dress, the way they look ... I think the more concern is the way they dress, the way they look, the music and fashion.” (YE5)

“The main problem that [young] Australian male Muslims carry out, is their identity! Am, they don’t know who they are, and that is very much to be a problem.” (YE1)

“There is the whole notion of um identity you know, where there is loss of identify or whether there is a confusion ah whether one wants to be identified as an Australian or whether they want to be identified as Somali...” (CR2)

“[for] the young people, the culture is big problem... where are you from? [Australians ask] “Somalia” they [youth] say. And their [Australian] culture is very different...that they [Somali youth] get confused.” (YS8)



### ***Where are you from?***

Many participants from the different focus groups reported how certain questions from non-Africans could alienate Africans. These included:

“where you are from? How long have you been in Australia? Do you like it here?” (CR1)

The question ‘where are you from?’ was frequently expressed by different participants. This question made Africans feel foreign to Australia. It made them feel like outsiders:

“You may work for a company and all your colleagues could be white people and all of them may ask you ‘where are you from’ and they may ask you about your colour.” (YS3)

“Do they [Australians] regard you as Australian? Impossible, they will never regard you as an Australian...They ask “what is your country?” I respond “my country is Eritrea”. That means I haven’t become an Australian...Australians themselves don’t make you feel you are an Australian... It is impossible to become an Australian.” (EE6)

“...here people ask you where are you from and that automatically communications with you that you are not from here, so that you don’t belong here whereas in Somalia, nobody asks you where are you from, maybe they ask you which tribe you are, but they don’t ask you where are you from because...you belong there, that’s home.” (CR1)

Some participants acknowledged that mainstream Australians expected migrants to adopt and assimilate into Australian lifestyle at the expense of their culture of origin. However, it was argued that would never happen as long as they had black skin colour and were Muslim. This indicated that some African Muslims did not believe that they

could genuinely become Australians because of their skin colour and faith. This made them feel like outsiders, could contribute to stress and perhaps lead to mental problems:

“I think that’s what lacking when dealing with a lot of mental health issues. You don’t belong here. ... Mainstream Australia says you oh have to be like us but we can’t be like everybody else because we are black and we are also Muslim and we are also ethnic, so a demand to assimilate.” (CR1)

## **Family and community problems**

### ***Loss of patriarchal role (Al-Qawaama)***

Family problems created by the new environment were perceived by older Somali and Eritrean men participants as very challenging. Family problems were seen as more severe than unemployment and language constraints. Loss of “Al-Qawaamah” (men’s domination over their wives) was mentioned as the biggest challenge facing Horn of Africa Muslim men. Al-Qawaamah is mentioned in the Quran and was explained by some participants to be an authority derived from men’s natural roles and responsibilities for their families. These roles included breadwinning and protecting their families, which allowed men to have decision-making power and authority and lead their families. However, many aspects of these roles changed after resettlement in Australia. Wives and children began to earn some of their own income and challenged the man’s decision making and family leadership role. This led to many disputes within African families and worry, frustration and depression for Horn of Africa Muslim men:

“the meaning [of Al-Qawaamah] is that upper hand is better than the lower hand (means a giving hand is better a receiving hand.) In the past, man was the breadwinner and the supervisor of his family. He was the one who could

give or reject. Now, woman [in Australia] is a self-reliant...Women are like men [breadwinners]...Surprisingly, she [woman] lives the way she likes...may Allah make easier our life.” (EE1)

“the biggest problem encountering men from the East Africa is loss of leadership role in the West that they had in their countries of origin. ‘Al-Qawaamah’ (Dominance), leadership and authorities which men had over their families back home have been lost. His power [an African man] is challenged by his wife and children and he is not allowed to decide solely. If he tries to talk to his children, they will challenge and argue. He is powerless...He comes out of his house and you can see on his face huge frustration caused by bickering and yelling happening at home...The dominance that the Somali man was known to have, and his role as breadwinner do not exist anymore.” (ES3)

“When I entered the house my wife sat beneath my heels and I used to feel stability, strength and pride... When I came to this country, the first thing I observe is that my daughter disobeys and my son starts to disobey me... He [his son] goes out like someone whose father is not present and he comes at any time he wants; We do not know if he is studying well or not and we cannot monitor him. If we contact to school, they say “Oh, he is 18 years old” shut up...everything is finished. I regret the day in which my father and mother married me to [my wife]; I hate the day we had this son...I hate the current situation...my wife is not anymore enjoying my orders.” (EE2)

### ***Australian family law***

Two elder focus group participants described Australian family law as a source of fear and anxiety. Older men believed that Australian family law contributed to family conflicts by encouraging women to challenge men over their rights. Elder men felt that the law disempowered and marginalized men and gave women the power to expel their husbands at any time. Some elders commented how Australian law felt irrelevant for African Muslim families:

“In Australian law, if a husband disputes with his wife, the husband is removed [by government] and thrown down into the street. As migrant Muslims, this is not part of our culture, tradition and religion; he [man] is not expelled from his house unless he harms her physically; and in our country if he harms her [his wife] physically, they take him away from his house and he will sleep with his neighbors and friends until his problem is considered and investigated. (EE1)

“if he is expelled from home by his wife, he may get angry and beat her and then police will come and he is banned to enter and live in his house while there are 8 children of whom only his wife can’t handle... In Africa, if he beats her, elder men come and convince his wife to forgive her husband by blessing her or preaching through Quranic chapters. (ES1)

African men felt disempowered because they also did not understand Australian law in the workplace. They did not know their rights, nor how to deal with perceived prejudices and unjust decisions:

“Things that tend to happen is not knowing the law, not knowing your right. Therefore, not fighting back and not actually demanding your rights... you just turn the other cheek rather than do something about it - write a letter to your MP representative or, call to your city council, call the police. It adds up to all these frustration...” (CR4)

“The main source of African men problems are associated to with the lack of understanding of the rules and laws of this country [Australia]....understanding of the employment opportunities available e.g. your rights in the workplace.” (EE5)

### ***Sponsoring wives to Australia***

Elder Eritrean men commented how the process of sponsoring wives to Australia created stress, frustration and possible depression. It could take years to bring a wife

over and after coming to Australia, these wives were not eligible for any government assistance for years. Additionally, these wives were not legally allowed to work and could not afford fees to study. These challenges were seen as contributing to family breakdowns: separation and then divorce:

“my son who is 30 years old, may bring his wife from Africa, from Eritrea, from Somali, from everywhere, and she remains without income in two years and the government will not assist; aha, it is a difficult situation; she can’t study because study requires fees; she can’t work because she does not have permanent visa and she does not know language and she can’t do anything.. he will be depressed and he can’t express his feelings. (EE2)

“When men get married from overseas and brings his wife, she stays two years or three years before she earns citizenship. He [husband] is the only person who gets an income... he [husband] is unable to bring his wife three or four years...and he suffers a lot and then divorce will take place...” (EE1)

### ***Different methods of childrearing***

Many participants from the elder and community reference groups emphasized how raising children in Australia was stressful and difficult. There were differences to the Islamic way of raising children such as forcing them to pray or even beating them if they did not comply with their parents’ instructions. In Africa, members of the extended family, neighbors and others were involved in raising children, but this was not the case in a more individualistic society like Australia:

“When I came to this country, the first thing I observe is that my daughter disobeys and my son starts to disobey me... He [his son] goes out like someone whose father is not present and he comes anytime he wants...If we contact to school, they say “Oh, he is 18 years old” shut up...everything is finished. I regret the day in which my father and mother married me to [my wife]; I hate the day we had this son although having son was very much

appreciated in my culture...” (EE2)

“I just wanna say is the problem we facing fundamentally is raising our children and educating our family... my understanding is, I was very young when I left, your aunties your uncles tell you how to behave.” (CR3)

“His power [an African man] is challenged by his wife and children and he is not allowed to decide solely. If he tries to talk to his children, they will challenge and argue. He is powerless.” (ES3)

“The problem of upbringing children with us in Australia is, for example in the case of prayer, there is an Islamic tradition saying “instruct children to perform prayer at age of 7, and if they don’t perform the prayer until the age of 10, beat them”...that helps control, discipline and direct and monitor their children’s attitudes. Here in Australia, we can’t do all these things with our children.” (EE6)

Few elders argued for African parents to adjust to a more mainstream parenting style to improve relationships with their children. This view indicated that many African parents, particularly older generations, were not trying to learn new parenting skills relevant to the Australian context. Instead, they were still practicing their old parenting style.

### ***Lack of support from family members***

A young Somali participant observed that lack of support from immediate and extended family members contributed to stress. This view was endorsed by a Somali mother who was treated for depression. She explained that having many children without sufficient family support made her and other Somali women she knew depressed:

“...back home people used to help of each other but in this country no one can help the mother and the family. There are a lot of problems happening in the family.” (YS6)

### ***Lack of community support***

Community organizations were described by a young Somali and young Eritrean participant as a bridge to Australian society. However, the African community was seen as competitive, unhelpful and disorganized compared to other ethnic communities:

“there are too many Muslim communities like Arabian, African, Asian, but when you see Arabian they are united; when you see Asian Muslims they are united but when you see the African communities they are not united.” (YS9)

“In general, our community, our people are very competitive with each other. So, positivity and support system amongst even small groups and large groups is not very common. Therefore, that may result with lack of self-belief, with lack of motivation and competitiveness with, where we are trying to compete with each other rather than with the wider society.” (YE7)

“back home people used to help of each other but in this country no one can help the mother and the family.” (YS6)

“there are too many organizations [in] my community, but they can’t help anyone. They can just get money from the government and use it but they do not help the people.” (YS8)

### ***Poor leadership as a source of stress and worries***

Poor leadership was identified as a source of stress and frustration by the community reference group and the two young men focus group participants. The community reference group identified that established African professionals were not reinvesting their knowledge and skills into their community but instead only focused on themselves:

“We don’t have the capacity or people who are employed in government agencies such as the Victoria police, who can actually advocate for us... Somalia or Horn of Africa Muslim men who are supposed to be the leaders

because they are well established, are not actually coming back and investing what they have learnt and the know how into the community so the community can find themselves in a better long terms sustainable situation.” (CR2)

“With our community whoever does well, stays on their own and never goes back to the community to the young people especially try to mentor them and explain how things are.” (CR6)

Selfish leadership frustrated and worried young Eritreans compared to the other focus groups. The Eritrean youth argued that selfish leadership in the community was the biggest problem. These types of leaders were unhelpful and did not respect different views, or criticisms:

“Lack of leadership, this is number one. Very bad, not very bad [only] but very selfish... the lack of people caring or giving... none actually cares people...everyone has to have an opinion. So, whether the leader is doing right job or not, no one has right even saying about [them]...and that is the bottom line... (YE5)

“Leadership-a lot of selfish [leaders] and not to care anyone but about them, their interests...they don’t care what community actually needs...for example if you don’t have a good leader how you gonna get community to develop?” (YE1)

### ***Lack of successful role models***

In addition to selfish leadership, young Eritreans were also worried about the lack of successful role models. They felt that current leaders were unhelpful and unable to understand young adult issues. Additionally, Eritrean youth did not believe that new capable leaders were emerging or stepping up:



“because we were new to integrating into this society...most of our leaders don’t understand the society and the upbringing we’ve had. So, they don’t understand the problems and the issues that young people actually face. So, therefore, their leadership rather than going and doing research to find out what is actually going on and happening with young people they would rather think they have all answers...at the same time, yes, new leaders also have not stepped in with the reality of, what I mean to live... as Australians, a multicultural Australian.” (YE7)

“Role models, mentors-we’re here a new community to Australia. So, therefore, we haven’t got elders or positive role models or leaders in our community who are able to assist us with the resources, with the direction, with the guidance, with the education to understand the problems we are facing and how to find solutions for them...” (YE7)

“your aunties your uncles tell you how to behave and then you get married one day and then you tell your children that’s simple it goes, but we don’t have it here” (CR3)

### ***Tribalism in the community***

Participants from the community reference group described problems created by tribalism in the Australian context. They observed that other migrant and refugee communities lived together harmoniously but tribalism created mistrust, conflict, divisions and dysfunction among the different tribes of the Somali community in Australia. Consequently, Somalis devalued each other based on their clans and this led to stress, and mental health problems. In fact, the community reference group commented how Somalis fled their country to come to Australia because of tribally-based civil war in Somalia. Because of tribal divisions, different Somali tribes concentrated in different suburbs in Melbourne:

“...if you just see where they [Somalis] live, they live in different places due to their tribal affiliations...we all Somalis we are here because of the action

and problem of other tribes who are trying to intimidate other tribes...Tribal conflict...there are still some element out there...mainly umm for the adults...not the young ones. The young ones are more integrating but the adults are still half tribal.” (CR5)

“...if I am, let’s say...open community support office, then the people that will would come to me and seek my help would categorize me and evaluate me based on who I am and which part of Somalia I come.” (CR4)

“the problem...is the way we came here as at tribal and war, and what happened after that is we lost to trust each other, and hard to value ourselves, because when you don’t value yourself, you often end up having a mental health because valuing yourself is how good you are, so then you wouldn’t have a problem with being black and being Muslim.” (CR3)

### ***Lack of confidence and judgmental attitudes***

Eritrean youth lacked self-esteem and confidence to manage their own affairs. A victim mentality, lack of motivation, and lack of positive attitudes were identified by Eritrean youth as a problem in their communities. Other issues that worried Eritrean youth included a fear of negative judgments towards them. They also described envy and unhealthy competition within the Horn of Africa communities. These issues were believed to diminish beliefs in self-efficacy, competency in the workplace or at school and lead to stress and depression:

“[Lack of positive approach] may result with lack of self-belief, with lack of motivation and competitiveness...we are trying to compete with each other rather than with the wider society and also [lack of] believing that we actually have those same opportunities if we just step outside [of the internal community competition]...” (YE4)

“to give up quick rather than try again and try again. So, we got that victim mentality that is the self-destructive.” (YE2)

“If you want help me don’t judge me, just help me, simple... the problem

with our community is there is just too much opinion; too much judgment and you can see it on their actions..." (YE1)

## **Difficulties in Practising Islam in Australian Society**

### ***Young men's perceived role for girls***

Practising Islam in a primarily non-Islamic society was felt to be very difficult and frustrating. Newly-arrived young Somali men were particularly disappointed to see Muslim girls dress inappropriately, wear no Hijab and go out without paternal permission. These young men stated that it was difficult observing their sisters disobeying their father and brothers. Instead, girls did what they wanted and expressed their points of view. These young men feared similar future difficulties if they became fathers in a society where their daughters would not obey their orders:

"When we were in Somalia the father was a king, the president of house, the leader, and everybody listens to him, but here he can't do anything, he can't. He feels bad thing...He feels always unhappy. If he sees his daughter she is wearing jeans, and she didn't [doesn't] use scarf, he will be disappointed...when I was in Somalia, if I see my sister doing something bad, straight away I give her instruction and say "don't do this one" but here if you say "don't do this one" she laughs and she says who are you?...Here is freedom, democracy, do whatever you like...you go with your heart...That worries Muslim men...Automatically what I am expecting is something like that, you know when I [will] become a father and [that will happen to me]." (YS8)

"Your daughter may reject wearing hijab. She may go and walk the whole day through city without her head covered and you can't tell her to cover her head and not to go to the city... so, you feel hurt...She may also smoke or drink. So, your heart feels something and therefore, you will be

overwhelmed with a lot of stresses and disappointment and you ask yourself ‘do I take them back to my country?’ because you can’t beat or punish them.” (YS3)

“They [also] face family problems, because I have seen many African Muslim men who are complaining [from] their families. They say “my wife or my children are not following my religion or they are not properly practising the religion. So, after that, he [an African Muslim man] will become disappointed, you know, and he will not continue his normal life.” (YS9)

### ***Practising Islam in the workplace***

Many participants – particularly elders and newly arrived young Somalis, identified stress over practising one’s religion in the Australian workplace. An elder man commented that there was a conflict between obligations to perform prayer and work regulations in Australia. When explaining this issue, in Somalia or Eritrea they spoke of how it was easy to practice their religion because of the availability of mosques or prayer locations in or around the workplace. Additionally, it was mentioned that some managers at workplaces in Australia were hostile to practising Muslims and would not allow them to go for prayer. Friday prayer that required attendance in congregations was mentioned to be particularly difficult:

“You are a Muslim and you can’t pray because you have to do your job. So, you feel a lot of stress concerning your religion...when African Muslim men in Africa, you know when he [man] went to the job, a workplace, [when] the time you pray is close, you automatically [stop your job], you know. When it is Friday, there is no work. But in here [Australia] [it] is different...you can’t go the Mosque. So, what I can say [is] what is going on in this environment is different to back home.” (YS9)

“...if the prayer time, Muslim man wants to perform prayer during work. Therefore, it will be very difficult for him to perform the prayer. So, he must

ask permission. It will be very hard.” (EE4)

“Finding job is not an easy too, because of the clash of job regulations and Allah’s obligations such as to perform your prayers in congregations like Friday prayer put a lot of pressure on you and at the same time you are expected to work full time” (ES1)

### ***Missing the rhythm of muezzin***

A few participants from the elder Eritrean and newly-arrived young Somali groups raised the issue of emotional difficulties posed by not listening to muezzin and call for prayers, missing hearing azans (holy calls) five times a day. They mentioned that listening to calls for prayer was common in the Horn of Africa, good for their emotional wellbeing and was a reminder to pray and remember Allah:

“in Somalia if you go to the Mosque you will see that Muezzin calls for prayer, and people will gather in the congregation and socialize but here you can’t hear Muezzin calling for prayer even if that is close to you and you can’t see people coming together. This makes you feel that Muslims are not free to practice everywhere.” (YS3)

“Problems we see include that a new arrival Muslim had habit to pray five times per day and he used to listen to a calling for prayer everywhere and every corner. You come here [Australia] and even you don’t know when the afternoon prayer is. It is very difficult. There, in our country, you can do ablution everywhere without any problems and when you come here [Australia] you are encountered at the beginning by these problems [lack of place for ablution].” (EE2)

During the course of the writing of this research, the primary researcher had an encounter with a young Australian Somali woman, who grew up in Australia and recently visited the United Arab Emirates (UAE). Similar to this view, she expressed and shared her positive emotional feelings in regard to hearing Muezzin early in dawn

in UAE compared to Australia where she could rarely hear Muezzin. She wrote on her Facebook:

“There's nothing more soothing than to hear the adaan [Azzan] (call to prayer) early in the morning when it's dead silent everywhere. Reminding you despite the distractions and the chaotic lives we lead there's a higher purpose and an opportunity to reconnect with the Most High. Juma'a Mubarak.”

### ***Haram and mortgage issues***

The issue of haram created stress for the Horn of Africa Muslim men. For example, buying a house using a loan was said to be haram (illegal or prohibited in Islam.) This caused stress particularly for young men who aspired to have their own houses:

“Our stresses are very different. Our parents had to eat every day and make sure that their herds were okay, you know, like a much more different distress. Our distresses [are] “am I gonna have mortgage, that is haram. How am I gonna buy house and then keep my job?” (YE9)

“Somalis have a lot of children and they live in two or three rooms and they couldn't bear to live in that situation. And then the family [husband and wife] clash and disagree what to do: if they could buy house with usury or not.” (ES3)

To overcome the issue of mortgage, Some Muslim communities in Australia such as the Somali community developed an ‘Ayuuto’ system. An Ayuuto system is a saving scheme in which members of a group contribute money and then each uses the fund in turn:

“Alhamdullillaah (thanks for God), Ayuuto is now in place. Ayuuto solved a lot of problems which banks were in the past asked to help. Car mortgage problems were solved. House problems will be solved slowly, slowly if Allah wishes.” (ES3)

### ***Halal food and drink***

Other issues related to haram, which caused problems for Muslims, included finding halal food and avoiding alcohol and pork. This limited participation in community events and led to isolation from the wider community. This had possible adverse psychological and social effects:

“I lived in this country for a long time. In my experience, one of the biggest our problems was finding halal things e.g. halal meat...The issue of halal made us stressed and confused. It was very difficult to be convinced what was halal...it was very difficult to eat when there were neighborhood events or meetings with police because there were no halal meat.” (EE2)

“you can’t integrate into your workplace, because you can’t behave at events organized in your workplace as others do; you can’t drink alcohol with them; you can’t go to disco and behave like them because it is an open society.” (ES1)

In fact some participants believed that avoiding alcohol, pork and so on hindered Muslims from accessing employment opportunities available for non-Muslim Africans:

“In the workplace, a Muslim [person] cannot work at alcohol businesses, however, a Christian [person] doesn’t care and he can work at and sell alcohol, so, you use this as an example for other activities...In that perspective, non-Muslim African man has better... and even better employment promotion opportunities compared to an African Muslim man.” (EE5)

## **Civil Wars and Pressures from Back Home**

### ***Past war traumas causing mental illness***

Some participants across different focus groups recognized that civil war in the Horn of Africa contributed to mental problems such as post-traumatic disorder. As an elder Eritrean man put it:

“we are unfortunate to come from burning places. There is fight in the evening and there is fight in 6am... There are social strife and disputes. We came from burning places.” (EE6)

Some young Eritreans described inability to contact family members arrested by military regimes over decades. This caused significant worry. Furthermore, Somali elders shared how their family members were scattered around the world, which made them feel distressed and disconnected from their families:

“in terms of mental problems umm I think we do have certain mental issues for example the certain post traumatic sort of disorders due to the war we went through...” (CR4)

“So, our depression comes from not knowing where our family members back home are or things like that. You know we have uncles locked up [in prisons by] government and we can’t contact them [for] decades...” (YE8)

“Unexpected predicament happened to Somalis at one time. People were scattered. People who fled to Australia or America were not prepared for the migration to Australia or America.” (ES3)

### ***Providing for family overseas***

Pressures from family members and relatives back in the country of origin were identified as sources of stress by elder and young Somali men. This was because those



in Somalia believed that their relatives in Australia were wealthy but not helping them as expected. Conversely, those in Australia complained that they could not fulfill their basic needs in Australia due to limited income. The pressure to provide for families overseas was an additional stress and distraction from adjusting to life in Australia:

“African people [back home] believe when you go there, you get everything, and they call you and they say “please send money.” If you say “I don’t have any money” they say “oh! You [have] changed your mind! Are you taking another culture and you forget for us. You didn’t [don’t] care us...what happened to you? If you say “I don’t have anything; I get centrelink and centrelink is not enough to me” they say “no, no, no. you have money...That creates stress and problem.” (YS8)

“I was under pressure because four families from my extended family who were living in Nairobi were dependent on me...I was a taxi driver for five days a week and working at factory for five night shifts. At the same time, I was studying in two nights per week...I decided to drop my study and started to work other two nights of driving taxi in order to cover the pressure from my families, because no one else was supporting them rather than me...Because of that huge pressure, you will finally reach to a level you can’t sleep during night. You will be affected with a lot of stresses, frustration and depression that will indirectly destroy your health.” (ES3)

Young people also experienced pressure coming from their families in Australia. This was because their families expected them to succeed in life in the new country:

“Young people are pressured from their families, and elders. They feel [youth] they need to succeed... Their family came out [here] to grab this opportunity, and so, the young person feels pressure for not maybe achieving success for their parents.” (YE7)

## **Substance abuse**

### ***Drug use and gambling***

A community group participant argued that drug abuse led to mental problems and to antisocial behavior, criminal involvement and then to prison. Drug addiction among African youth was also mentioned by the Eritrean young men group. Possibly, many young Eritreans who grew up in Australia had the same exposure to drugs as the mainstream youth. Somali youth did not discuss this drug issue, potentially due to not growing up in the mainstream culture. Drug abuse was not identified as a problem by the community group – perhaps due to their older ages. Eritrean youth stated that drug users were silent about their problem and this affected their health and social status:

“When you have addiction and you keep silent... it causes health issues too. So, you have social problem and after that you gonna have health issues because you are not doing anything about..” (YE1)

“Specifically crystal meth killing us...[some participants giggled], it is causing a lot of issues, you know with a lot young people...” (YE2)

“you look for newest paths, full stop. Everything, whatever it is. It could be anything. Could be marijuana; could be weed, speed, and opiates; it could be ecstasy, immediately, immediately, immediately.” (YE5)

Eritrean youth argued that African communities did not recognize the existence of drug use by young people and therefore, had no strategies to assist those affected. Alternatively, drug dealers had a good understanding of how to lure vulnerable youth to get them involved in the drug industry:

“these (drug) problems are not recognized in our community and are not admitted for, and therefore, there is no for strategies to try to help individuals suffering from [addiction] to recover.” (YE7)

“when we have problems as African community, generally as African

Muslim community, these [drug dealers] are our psychologists, the drugs, and speed. They [youth] don't know other support in other ways to get support..." (YE1)

In addition to drug use, Eritrean youth talked about problem gambling in African youth. They argued that gambling was similar to drug addiction. Gambling was described by these youth as a very taboo and shameful topic to talk about. However, it was widespread among young African men and negatively affected their lives. Despite all these problems, young Africans did not admit to gambling problems because of the stigma associated with it. Lack of employment was described as a factor pushing young men to gamble:

"gambling, very big issue, very, very big issue...the most hidden issue... people [are] gambling in groups... it is not a discussed issue... our people gambling in groups. It is a social, it is like drugs or smoking Marijuana or so..." (YE5)

"and it is obviously *haram* (impermissible in Islam) and...a lot of shame in it and a lot of taboo in it. So, we don't like to admit it. So, we obviously feel embarrassed...so, it is obviously epidemic...and it is gonna affect them [youth] in the long term." (YE8)

"You apply, you apply, you apply and you get nothing back...and you just give up aiming for you to think you are [not] capable off and you lower your standards and yeah, you just do that or again you turn to whatever like gambling or drug and like that." (YE8)

### *Shisha<sup>6</sup> and khat use*

While problems caused by drug use and gambling were mentioned by young Eritrean men, the community reference focus group highlighted problems created by smoking Shisha. The reference group explained that Shisha was used for fun and for socializing—similar to mainstream Australian youth going to pubs or discos. It was also believed that Shisha users spent many hours smoking it, resulting in inability to work during the day or find a job. Therefore, smoking Shisha contributed to social problems and affected wellbeing:

“The shisha it’s like a kind of it started with the socialize have fun like go into the pub and have a cup of beer...Particularly young men and females between 15 -20 -25 see like they hanging around the shisha place spending a lot of time during the night and sleeping all day so rather than going seeking jobs when all the jobs are available...” (CR5)

“That [is] why a lot of people use shisha and khat to kill time.” (CR6)

“If your classmate smokes, you smoke with him. If he takes Shisha<sup>7</sup> you try to be like him. And then when they put their feet into their Shisha [when they start using Shisha] they get addicted with it...That is the problem facing youth.” (YS4)

A participant from the community reference group identified khat as a problem affecting young Somalis. Interestingly in a qualitative research project on khat in 2012 among the Somali Australia community, khat use was mainly associated with elder Somali men rather than young men (Omar, et al 2012):

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<sup>6</sup>Shisha is an oriental tobacco pipe with a long flexible tube connected to a container where the smoke is cooled by passing through water. Available online: <http://www.thefreedictionary.com/shisha>

“And the other thing is the addiction I think one of the biggest thing people forget about is khat, we have that issues because I work with a sports club and umm we are kind of having that issues as well with some of the young guys staying up at night and just chewing and not doing anything for themselves.” (CR6)

Khat was banned in Britain on 24 June 2014. Khat was thought to be widely used by the males. The women who supported the ban complained that their husbands would chew the leaf incessantly. Khat was said to be causing marital problems, high absentee rates at work and financial problems (The Economist, 2014).

## **Conclusion**

This chapter has explored causes of stress and emotional difficulties expressed by the group members. Unemployment, racism in the labor market and workplace, lack of equal opportunities and working in menial and degrading jobs while having high qualifications were identified as the biggest stressors in Australia. Young men even considered changing their names and concealing their religious visibility to obtain a job, be called for an interview, or be accepted by the mainstream. However, these changes negatively impacted on their identities, psyches and emotional wellbeing. Lack of useful networking with the mainstream, poor community leadership, poor community support, tribalism, lack of positive role models, Australian family law, language difficulties, culture shock, identity crises, victim mentality, lack of motivation plus judgmental attitudes from the older generation were experienced as negatively impacting on the emotional and social wellbeing of African Muslim men - particularly youth. Other causes of stress included difficulties practicing Islam in Australia such as not hearing muezzin, the scarcity of halal food, haram issues, trauma caused by civil wars and substance abuse.

## **CHAPTER 5: BARRIERS FOR NOT SEEKING HELP**

### **Introduction**

This chapter examines the main barriers for not seeking help from mainstream mental health services. These barriers include the lack of mental health literacy, African men's perceptions of the unhelpfulness of the mainstream mental health services, lack of information about available mental health services, culturally un-informed practitioners, fear of injections, masculinity, stigma, and the culture of silence.

### **Lack of mental health literacy**

A few Somali elder men explained how Somali men were unaware of or denied being mentally unwell. Eritrean men did not mention this matter:

“it appears to me that people are not aware that they are sick. Even though they are sick, depressed with problems and sleeplessness they don't know they are sick, because, this is something new to the Somali man. He lives a normal life and his brain works extensively and if he is told “you are sick” he says “I am not sick.” (ES1)

Several participants from the community reference group and one participant from the elder Somali men group believed that Somalis did not benefit from mainstream health services. It was possible that they were not aware of these services in Australia. Instead of using these services, Somalis turned to familiar treatments through religion, family and support from relatives. On the other hand, Somalis no longer practised strategies such as chaining up mentally unwell people. They recognized that this was against Australian law:

“the institutional support mechanism is new to the Somalis. So usually,

traditionally you have a yak with their cousin, friends, family member but here help is a profession[al], it's industry, if you have a problem there's psychologist or social worker or other people you would deal with so it's not been accessed because it's new..." (CR1)

"Here, they don't take to hospitals because of the way we grew up and the way we were raised... Our minds are still locked with the two cultural practices we knew like chaining or reading Quran on the patient. Here, they [Somalis] can't chain because the law will catch them and punish them. Additionally, you can't keep [sick person] at home. So, the second option of reading Quran on him is the only option we have." (ES3)

"...they don't know how they get access to the mainstream services." (YS2)

"back home we used to have our relative and some sort of community support as a tribe or whatever it is but what replace here are services there are services that replace what we had before, most of these services are for free." (CR5)

### **"Putting your feet in gloves designed for hands": Perceptions that mainstream mental health services are unhelpful**

A small number of participants from the Somali community argued that Somalis did not use the mainstream institutions because they did not see any evidence showing that affected people were healed through mainstream institution treatments. Additionally, talk therapy was not perceived by one Somali young man as a means of useful treatment. Instead, they (Somalis) expected some practical intervention. Others felt that the mainstream institutions were designed for Australians who were culturally and religiously different to Somalis.

"so with the mental problem...usually we deal with in the community based religious way of dealing with it rather than institution because we...don't believe in, we don't think it's the best way to go forward we haven't seen any

proof in it to show us it has worked therefore we don't use it...it's like two things that don't fit each other. It's like putting your feet in a glove that was designed for a hand.” (CR4)

“I think as a Somali, I don't like to go to someone who is just talking. I would like to go to someone who can make action, not just talk. If I need money, someone who can lend me money. I like that, not just talk, talk, talk.” (YS4)

### **Lack of helpful information about available services**

Several participants claimed that lack of reliable and authentic information about mental health services was a barrier to seeking help from relevant mainstream services. Information about mental health issues circulated in the Horn of Africa communities was instead based on negative rumors and speculation, which created fear. In addition to the fear created by these rumors, mental illness was taboo in the community. Therefore, any information related to mental problems was not properly circulated through the community leading to non-utilization of mainstream health services:

“you can't find information from its real resources. So, there is no reliable information. It is quite hectic...there are deficiencies in the information provided and services delivered at early stages.” (EE5)

“Not taking information from its original resources creates a lot of complications. When such rumors [e.g. injection] spread, everyone will be scared. You know, here [in Australia] there is a system. They can't take everyone and give him an injection. However, such rumors and information are speculated within people and therefore, there is fear...” (EE5)

“They may not know where to go. Can I go to emergency? Can I go to police? Can I go to hospital? What kind of hospital I can go?” (ES2)

“I think mental issues is seen as a taboo in our community...nobody wants to



listen to any information they just walk past any information that that talks about mental health or anything like that...so in terms of seeking help you can't seek help if you don't know where to get that help so I think that's a major issue." (CR6)

### **Practitioners' limited understanding of providing culturally responsive care**

Some participants from two elder focus groups and newly arrived young Somalis believed that mainstream practitioners did not did not respect African explanatory models of illness and treatments. There was a sense that mainstream health providers were confused about how Africans would sacrifice themselves for their family rather than look after themselves e.g. financially. Consequently, some Africans would not seek help from mental health practitioners whom they felt would not understand or respect their beliefs. Furthermore, a newly arrived young Somali man described how it would be unusual for a person to seek help from outside his family and relatives. The community reference group and young Eritreans did not mention the issue of cultural barriers in practitioners. This could be because they had integrated well into the mainstream society. Therefore, they did not notice these cultural and language barriers:

"If you go to mainstream counselors, you can't clearly explain your problems. This is because the way they behave and the way you behave are of great differences. Even they don't understand if you tell them...we believe that you [should] support and send money to your immediate family, extended family and even your distant relatives. They will get confused of your situation if you tell them "I send money for four families every month, they can't believe you" they will say "you are crazy. Think about yourself"... (ES3)

“The person [mental health practitioner], who is treating us, does not know how he may treat us and the nature of our problems. If I tell him [mental health practitioner] “I have this problem and that problem” he can’t understand. Allah knows but he can’t understand comprehensively to what I am saying. There are some things I don’t like to say and he can’t understand...I swear by Allah, the doctor is not qualified to treat with Africans who are suffering with mental.” (EE6)

“If you go [to] someone strange that is not your family, how he can help you? So, he is strange, he is not your family, is not your friend. So, how he can help you? ... I remember my friend, who said “if you don’t know the way, your family helps you solve your problem...” (YS8.)

The issue of the non-culturally-responsive practitioners was compounded by a lack of well-trained community representatives who understood mainstream mental health services. This view was expressed by participants from the elder Somali men group who believed that if such representatives from the community were recruited, a lot of people with mental problems would contact them and seek their help:

“If mental problems are happened in the community there are no representatives from hospitals whom community members can trust and accept and at the same time can understand and work with doctors... If there are some people from the community who can understand doctors and the community, I believe that many people with these mental problems would have trusted and come to them.” (ES5)

“There is no one who can take him or refer him to where he can get healing and at the same time promise that they will keep his confidentiality and what he is confiding in them. If that bridging person is found, I am sure that a lot of people will come to and tell their problems and then their problems will be solved.” (ES6)

## **Fear of injections**

Fear of deliberate sedative injection was one of the main barriers to seeking help from the mainstream services. This view was particularly held by elder Eritrean and Somali men. Elder men had the belief that white doctors saw mentally unwell African men as violent and would give them injections in order to calm them down. Some men believed that these injections would increase the level of madness instead of help. Therefore, elder men argued that hospitals and mainstream services were the last place to go because there was fear within the Horn of Africa communities that they would be injected if they went there:

“white man thinks that if a black man is agitated and becomes irritated he can possibly become violent and can destroy everything. Therefore, the injection is to make him calm...they directly give you an injection and there is no person or community to defend you...that is all, so you can die... A man with depression who I met him told me that government gives injection straight away soon they identify that you have mental problems. [Everyone laughs as a sign of approval of his views...]” (EE6)

“When people are first identified with these issues [mental illness] they are injected or given tablets. As East African communities, my community that I am from, we believe that if a person is injected, he’s gone; forget that person; he’s finished. He will be dependent on an injection whole his life. He can’t work; he can’t do anything...therefore, our community says “do not take him to the hospital because the doctor will make him crazier through injection.” (ES2)

## **Masculinity, stigma – Suffering in silence**

A culture of silence and secrecy “until the last breath” (EE2) was identified as a primary factor that hindered African men from seeking help and support. African men did not like to talk about their problems. Instead, they “concealed their problems

[even] from their wives let alone from others.” (ES5) African men did not recognize, accept or admit their mental problems until they could no longer hide them. African men were too proud to speak of their mental problems as they feared accusations of being weak and therefore did not seek help:

“African men, they generally, you know, they are too proud some times to admit that they have health problem, you know! ... Of course when you don’t admit the problem you can’t then, you can’t really solve it [or seek help]...” (YE2)

“I think Somali men suffer in silence ... I have three very active cases of mental health now that I’m dealing um and all three have got one thing in common they’re are all well established, high profile community members who would be regarding as successful but they all have mental health issues and they do suffer in silence ... and I think that leads to the masculine issues. Men expected to be strong and as such deal with any challenges.” (CR1)

“the hardest thing, however, is that he can’t accept that he is unwell. A person can seek medicine or advice when he accepts and realizes he is sick. However, the person can’t accept at the beginning that he is unwell and for that reason the problem gets worse and worse to the point the problem gets out of his hands and becomes clear to everyone.” (ES2)

Young Eritreans associated silence and secrecy with the older generation rather than the younger generation. This difference was attributed to the youth growing up in Australia and developing a culture in which people talked about their problems while the older generation grew up in Africa where a culture of secrecy was prevalent:

“the old generation... they’re more secretive and they have more pride...the younger they are generally the more...they are grown up in this society. They don’t really have....that pride. They talk their problem, the young people in generally... (YE2)

“...the young ones accept their problems [unlike] the old ones. The old ones, they may accept the result but they don’t think it affects others around them. (YE1)

However, a young Eritrean man believed that the youth had developed a culture of silence and secrecy from their parents and old generation:

“... for me personally, it is our parents, they have tradition of secrecy and shame with this big thing. So, we have same tradition but in our own way of secrecy and we are ashamed now. Therefore, we don’t like issues to be discussed...somehow, someway, we took their methods...” (YE9)

Some respondents, particularly elder Somali men, felt that shame or shyness was an obstacle to mentally unwell people seeking help. In addition to this, close friends and acquaintances distanced themselves from affected people with mental illness if they talked about their problems. This meant that people with mental illness were culturally forced to be silent:

“...a lot of people who do have issues, the shame makes them not to seek help...” (YE9)

“it is difficult for person from East Africa to seek help when symptoms of sickness are observed. That is not only because of their arrogance but they shy very much. They shy to say “I am diagnosed with depression; I went there for help.” (ES2)

“culturally it is not common to reveal when he gets ill mentally because that was shame back home...many of his own people become his enemy should his mental problems becomes visible...he is forced to keep his problems into himself because if the community knows that his information will reach everyone.” (ES6)

Respondents from the elder Somali men group described how pride prevented African men from talking about their mental problems and seeking help. The sense of arrogance was compared with being proud like a lion:

“men are so proud with themselves. He [an African man] still feels here that he is a lion and powerful as he was in Africa.” (ES3)

“I believe that a Somali man or men from East Africa hide their problems. Some of them feel too proud to talk about their problems; some are uncomfortable to be described “this man is an unemployed. He is stressed...” men from Africa feel self-importance. They are arrogant; they don’t like that their weaknesses to be informed for others...” (ES5)

Interestingly an elder Eritrean man who heavily interacted with Somalis identified that the Somali society was open, expressive and talkative. Therefore, the Somali problem could be understood and solved. In contrast, he believed that the Eritrean community was secretive and therefore, its problems could not be easily understood nor solved:

“in my experience as a community volunteer, the Somali society is expressive; it is talkative. They talk about their problems with their friends, families, acquaintances, and everyone. Therefore, their problems can be solved. [In contrast], Eritrean society does not talk at all. Now, we do a lot of work for the Eritrean community and when there is a problem, they will not come to us seeking solutions, and if they come to us, they swear us seven times to keep the issue secret and not to mention their names at all. They don’t like that their news to be spread into the cousins and the community.” (EE2)

## **Women more likely to seek help than men**

Several respondents from the elder and community reference focus groups agreed that African women were more likely to seek help than men. In their views, the difference was that women were culturally expected to express their feelings and obtain support from others while men were not expected to do so. In Africa, women would go to their families and relatives to get support. In Australia, women also went to social workers who did not exist in Africa. Other venues where women would seek help included Mosques and religious services, even for emotional difficulties. For men, it was a sign of weakness to discuss their problems and seek help. However, when men's problems became obvious, members from their families and relatives would intervene and provide private counseling:

“wife resort to social workers. The social worker solves all her problems. But African Muslim man feels embarrassed if he seeks support from a social worker...He is burning...he can't go to the social worker. If he thinks to go, he will hide himself from people because they think he is a weak...” (EE2)

“people who are accessing spiritual healing to deal with the mental health issues through the presentation of the Koran and seeing a sheikh 99 per cent are females ...that leads me personally to conclude that those men who have mental health issues don't seek support because of the expectations of being a man and those masculinity issues...I think culturally women are expected to express their feelings...men are expected to just basically, using an Australian slang ‘suck it up you know and just deal with it.’” (CR1)

“It is not our culture that man to go to official counsellors and confide his difficulties in order to get help and solution...When problems become bigger and bigger, his cousins or his relatives will come and help him and try to find whatever solution they can offer in private and secret ways: both for men and women, however, men particularly hide their problems but women can reveal...” (ES3)

## **Conclusion**

This chapter has explored some of the barriers to accessing help shared by the group members. Main barriers for not seeking help from mainstream mental health services included a lack of information and awareness of mental health problems or denial of those problems and a lack of understanding of services. There was also felt to be a lack of responsiveness to the cultural needs of African Muslim men – that mainstream practitioners were not culturally informed and that there was a scarcity of well-trained community representatives in the mental health sector. Additionally, there was a fear of being treated with an injection for mental health problems. Other barriers included a culture of silence about problems, stigma and feelings of inferiority if one sought help outside one's family.



## CHAPTER 6: IDENTIFIED EXISTING TREATMENT STRATEGIES

### Introduction

This chapter investigates existing treatment strategies used by the Horn of Africa Muslim men living in Australia. The main strategies include but are not limited to: talking to family and friends. Religious treatments include use of the Quran and taking people with mental health problems to Mosques or going on Hajj, Umrah or travelling to Muslim countries. Positive thinking and repatriation for cultural rehabilitation are also possible treatments. Substance abuse and silence are used as maladaptive strategies to escape from stress and emotional difficulties. The chapter also looks at intergenerational differences in traditional practices.

Information gleaned from our focus group participants showed the diversity of treatment strategies when dealing with diverse problems:

“there will be diverse solutions for diverse problems. Every man has his own ways to deal with. If he faces family problems, employment or psychological problems he goes to specialist people.” (EE4)

One of the main treatment strategies for mental illness was to seek help from the family. All focus groups acknowledged the importance of the family's role in solving individual problems such as mental illness. However, young Somali men were more expressive of this issue compared to other groups. Somali youth emphasized the roles of their father and elders to solve their problems. Somali youth explained that their fathers and elders had many years of experience in solving problems. Fathers and elders inherited problem-solving skills from their fathers and grandfathers and each generation passed their skills and experience to the following generation. Seeking help from one's own community was also mentioned as a resource:

“For me, if I see something new, for me, I feel a lot of stress. If I see a small problem, it is big for me to solve but it is easy for my father because he has got a lot of experience.” (YS8)

“Family is usually [where we go], when it comes to this kind of issue... I think when it comes to seeking help we are still stuck with the traditional method of dealing with problems and that is through family that’s my experience.” (YE1)

“we actually turn around to our families to apply either tradition or religious healing or way of resolving our issues.” (CR2)

A young Somali participant identified consulting family and relatives as a method of treatment and problem solving that worked in Africa. However, this was not the case here in Australia. This was because the family, relative and clan systems which worked in Africa were not as relevant to the Australian environment. Additionally, friends and peer groups were described by several participants mainly from the young Somali focus group as useful supports for dealing with stress, depression and general problems. Peer groups exchanged information, consulted with each other and compared their experiences to deal with emotional difficulties:

“If I want solution, I may ask my friends and they may ask me too if they want solution and I can tell them. I told them [my friends] about my brother [who had some problems] and they may give different ideas and I took the best...When African men want solution, the first place they go is their friends and families.” (YS4)

“Family, friends and the community - He [an African man] can seek help from his friends or acquaintances or family and relatives who have some experience in that field.” (EE4)

## **Oral tradition**

A young Somali man suggested that Somalis could effectively be treated through their oral tradition (talk therapy) because this kind of treatment suited their oratory culture:

“...we are oral people, we have no any writing, we have oral traditional [culture],so when you go to your family they help you [through oral advice]...” (YS8)

## **Quran, Mosques and treatment by Sheikhs**

Reading and listening to the Quran, going to the mosque and inviting Sheikhs to read the Quran on the patient were believed by many participants across focus groups to be the best treatments for stress, depression and emotional difficulties. Participants emphasized the importance of going back to traditional religious healing. Preston Mosque was specifically mentioned as a centre for spiritual and religious healing. Having faith and practising religion was particularly important for young Somalis. From the perspectives of the Horn of Africa Muslim men, performing prayers in congregations in the mosques and interaction with worshipers and religious groups were seen as the best ways to recover from mental illness:

“I think sometimes you get diagnosed by the family members and the first thing you get, is, you need to see a sheik and you to get someone to read Koran to bless you sort of and I think Christianity too is quite like exorcism<sup>8</sup> or something like that to take all these demons’ from you.” (CR6)

“...a lot of people who go to the mosque they tend to do better and recover better than those who try other services...it empowers each individual and give them confidence to take control of their lives basically... I think the best place of support if anyone wants anything is the Mosque. You know, Islam is

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<sup>8</sup> Exorcism is the ceremony that seeks to expel an evil spirit from a person or place

the only thing we have at the moment.” (YE2)

“...If you are sick, you go to the mosque and inform Sheikhs that you are sick and you want to have them into your house and family in order to read Quran in the house. And then they will read Quran on you and as Allah told us Quran is *shifaa*<sup>9</sup> (healing), so you will get healed if Allah wishes...If you know the Quran you can also read it into yourself to get healed.” (YS2)

“There is a big number of mentally sick people that resorts to Islam as healing such as Ruqqiyah (blessing and reading Quran on the person) etc. some parts from Muslim societies believe that these strategies are part of the healing and solutions. If you go to the Preston Mosque, you can see that these methods of using Quran as healing are practiced regularly...faith helps and some people practice that.” (EE5)

“There was a young man who was in hospital for a while... we took him away from hospital we brought him home and we were tying him, and pushing him to the ground because he was fighting us. I was one of these people who read Quran on him for seven days. After seven days, he got healed...I visited him after nine days and he led us in the prayer...He was our Imam.” (ES3)

In fact, a young Somali man argued that understanding the Quran could solve all the problems around the world. Another explained that different chapters and verses from the Quran could cure different mental illnesses. Specialist Sheikhs could diagnose the problem, prescribe and explain to the patient how to use different chapters and verses for different illnesses. In that line, an elder Eritrean man argued that Sheikhs themselves could be seen as doctors because they dealt with the same issues managed by mental health doctors:

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<sup>9</sup>Alluding to “We send down of the Qur’an that which is healing and mercy for the believers” *Suurat* (chapter) 17, *Aayah* (verse) 82.

“take him to the Sheikh to help him [with]some Quran, yeah. Because there are some *suuraat* (chapters from the Quran) which is good you know for healing from the Satan. So, you need to take him to the doctor and to take him to the Sheikh when he has that kind of problem [mental problem...some of the *suuraats* (chapters from the Quran) are good for the eyes of the people, and some, they are good for the stress, and some they are good for [healing in] different ways.” (YS9)

An elder Eritrean man described *thikri* (contemplation and remembrance) of Allah as a useful strategy to develop peacefulness, tranquility and aid recovery. Performing a special prayer during midnight when others were asleep, fasting during Ramadan, giving charity, and controlling sexual desire could bring some relief from stress and anxiety:

“some people can find healing through *thikri* (remembering of Allah.) As Muslims, Allah endowed us *thikr* as a tool for calmness, so, he [African Muslim man] can remember Allah...Performing *qiyaamu-layl* (mid night prayer) and lowering down your eyes when you come across women, solves all our problems...two days ago, I read a book saying that prayer, and charity and fasting during month of Ramadan can solve family and neighbourhood problems...” (EE4)

### **Taking affected people to Hajj and Umrah, Muslim countries and using Habat Assowdaa**

According to some interviewees, taking mentally affected people to Hajj (pilgrimage to Mecca) or Umrah<sup>10</sup> as a treatment was becoming increasingly popular in Australian

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<sup>10</sup>Umrah is a worship performed by Muslims. It is a lesser-pilgrimage through which Muslims do visit the Ground Mosque in Makkah during the year outside of Hajj

Muslim communities including Somalis and Eritreans. This kind of treatment was also used by the Lebanese community and other Australian Muslim communities before it was used by the Horn of Africa Muslim communities. Young men with mental illness symptoms and those involved in drug and criminal activities were particularly felt to benefit from Umrah and Hajj:

“These [Hajj and Umrah have] also [been] a fashionable thing that has been common among other Muslim communities, but it is becoming new special this year with Somalis and that is religious healing, so people going to Umrah, young men their family will pay for it [as] religion healing, there is religion’s health, go to the holy sites; is actually starting in April this year, this was practice among other Muslims, especially the Lebanese community but it’s a trend that now a lot of people are going to capitalise on and that’s organizing religious tours if you like returning those [with mental health] back.” (CR1)

In addition to Hajj and Umrah, some people with mental illness were also taken to Muslim countries like Sudan, United Arab Emirates and other countries where specialist Sheikhs treated them through religious practices. However, Sheikhs’ treatments were becoming more expensive and unaffordable. Some respected Sheikhs even required payment in advance. Some Horn of Africa Muslims took their sick relative or friend to other Muslim communities (Arab and Turkish) within Melbourne to access their religious and cultural treatments:

“...tickets are organized for some sick people who are sent to Dubai and Sudan. There are Sheikhs who can treat them through Quran. The mind of Somalis is locked with that belief. They are locked with the idea that there is man in Dubai who can heal from all of these problems: the depression, the

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designated dates performing the same pilgrimage rites.

craziness and talking disorderly. They don't trust the GP; they don't trust the mental illness doctor..." (ES3)

"...our brothers from Turkey and Arab communities who live here do receive people with mental problems and treat them sometimes through showering, and sometimes they beat them little bit, so these traditional methods are still working here." (EE2)

"...as Somalis: men and women, we do not see that a doctor can resolve and heal people affected with depression. The one who can't get access to Sheikhs is the one who can go to hospitals. The truth is that Sheikhs charge with money. \$300 are put into envelope and given to each Sheikh. 300 dollars are given to every Sheikh in cash." (ES3)

*Habat Assowdaa* (black seeds) are commonly used in Muslim countries for physical illness. However, an elder respondent from the Eritrean community indicated that they were also used for physical, mental and emotional problems within Muslim communities in Australia:

"in Saudi Arabia, there was a phenomenon of healing people through '*Habat Assowdaa*' (black seeds)... people here can be influenced by what is going there...Now, I can see these practices in all [Muslim] communities including the Somali community." (EE2)

## **Positive thinking**

A few participants from elder Somali men stated that some people with mental problems espoused self-healing strategies by thinking positively, developing resilience, and having confidence in Allah to recover well. Faith-based hope and optimism were also proposed by elder Somalis to be effective treatment for Muslims. One of the best healing strategies Sheikhs used was to preach and convince mentally

unwell people to change their behaviour and ways of thinking from negative to positive and at the same time, trust in Allah to help solve their problems and recover quickly:

“Some men remain resilient and keep confidence in Allah because we are Muslim communities, and they have some hope for their future.” (ES2)

“...the family takes the issue to religious men and religious men will, from their side, try to heal mentally sick people through reading Quranic verses and teaching of the prophet and he [the affected man] will be encouraged to entrust and be confident in Allah by transferring his situation to Allah to solve it.” (ES3)

A small number of participants from elder and young Somali men argued that one of the best treatments for mental illness was to be realistic in goal-setting. These participants explained that Islam taught Muslims not to worry about things that they couldn't achieve. Worrying was seen as a sign of weak faith in Allah. Therefore, in their views, good Muslims were immune from mental illness:

“some of the Muslim men are safe from mental problems because of religion, because of the *eamaan* (faith).” (YS9)

“a Muslim person should not be stressed or worried basically, because if he is afflicted with problems he should be resilient and patient and then he will be blessed by Allah and if he is in a good condition he will be grateful to Allah as his messenger [Mohamed] said. Those people who get sick because of life stresses, their faith is weak.” (ES1)

“His religion teaches him that he shouldn't worry repeatedly; or shouldn't repeat into his mind unachievable things which could lead him to think stressfully and create him problems.” (ES6)



Young Eritrean men were less aware of the existence of cultural treatments through religion or other traditional treatments. As a young Eritrean participant put it:

“Traditional healing doesn’t exist- no, that doesn’t exist and I have not heard what so ever.” (YE1)

This could be attributed to their experience of growing up in Australia and being ignorant of the cultural treatments, as well as disconnection from the older generation. In contrast, newly arrived young Somali men were aware of the existence of cultural treatment strategies. This was because they retained their cultural knowledge from Somalia.

### **Dhaqancelin (cultural rehabilitation)**

Many participants from the Somali focus groups reported the existence of therapeutic journeys to Africa. These were seen to benefit both the young and elder Somalis. This view was not common among the Eritreans. Somali tendencies to use travelling as treatment could be attributed to the Somali history of nomadic and pastoral lifestyles.

These treatment trips to Africa were conducted in different ways. The younger generation were often repatriated by their parents and family members (known among Somalis as *Dhaqancelis* (cultural rehabilitation).) During this process, young men underwent different types of cultural and social treatments through marriage, introduction to their relatives and clans, learning the Somali language and reading the Quran. In fact, some of these young men would memorize the whole Quran while they were in Africa. Many of the young men taken to Africa (Somalia, Kenya or Ethiopia or Middle East) were often involved in drugs, alcohol, gangs, other criminal activities, or had dropped out from school. In most cases, these young men experienced individual transformation and positive change. One possibility was their increased

social standing in Africa due to being from Australia. The financial support from their families in Australia, plus their Australian citizenship granted them middle or upper class status in Somalia. These positive social changes boosted their self-esteem, confidence, and future aspirations:

“Especially amongst young men who have drug abuse or mental health issues exacerbated by their drug abuse so there’s a growing trend that families send their young one back home for cultural rehabilitation...By and large the experience of the young men who are sent back home is actually good. They will live a better standard they will be...regarded as high class when they go back, because their families send money from here, they will lead a good life, they will have maids and servants...I think that helps them with their self-esteem...” (CR1)

“And there’s also the younger generation where they have been sent to experience the culture and also to take them away from umm from their destructive lives, such as like the night clubs and drinking and drugs and stuff like...” (CR4)

As mentioned above, young men were repatriated to Africa for cultural, social and mental rehabilitation. In contrast, older men went to Africa to obtain relief from stress, depression, and anxiety. They believed that the familiar African environment e.g. weather, social life, or having another wife would counter the family, social and cultural stressors they experienced in Australia. Similar to the younger generation, older men received much respect from the local Somalis when they went to Somalia. Even if they were a lower socioeconomic class in Australia, they appeared successful in Somalia due to coming from a western country. Consequently, many families in Somalia offered these men their daughters for marriage. These families perceived marriage as a way for their daughters to escape the harsh African life and poverty:

“Some of them [men] they do go to holiday when they get problems to feel you know free...They say, “I am get tired, I have too much stress, I have too much problems... After four months, five months you goanna see him, [and you ask] “oh! You came back” [and he will say] “yes I came back” [and you will ask] “how you feel?” [And he will say] “I am happy, because I have been on holiday.” (YS9)

“...anecdotal evidence show that when people return back home umm normally into neighbouring countries you know Kenya, Ethiopia, Uganda their general health improves lot... a lot of people who are on high blood pressure medications or some anti-depressant tablets tend to stop using and I was talking to one elderly guy and said everything is different here you know it smells familiar, the sun is familiar everything is familiar there’s not the urgency of here and now...And some of them marry multiple wives as well to do the dishes...I was in Kenya recently and every day I was offered girls...Because they see a man from a western country as a way out of poverty, as a way, as a ticket, way out of that. It doesn’t matter what your background is or whether you’ve been successful in Melbourne or not, it doesn’t matter. So long as you’re from there the offers will come.” (CR1)

Travelling to Africa, however, was not without problems. Somali men living in Australia had different cultural experiences and expectations to those who had remained in Somalia. Thus they had difficulties fitting into Somali culture:

“...one of the things that happens (when they are taken to Africa) is the younger they are, they would actually experience more problems when they get there because ...they grow up here o[r] they live the system they know is based on here, they don’t know that much about Somalia, even the older generation, they been here for 20 year and Somali has changed, it is not the way they remember. So when they get there they experience their own problem of fitting in.” (CR4)

## Using shisha and khat and fadhikudirir

A number of participants across focus groups confirmed that chewing khat and smoking Shisha were used to alleviate stress, depression and worries and use up free time. Shisha smokers and khat users believed that socializing with others by chewing khat or smoking shisha in groups over several hours would improve their emotional difficulties and stresses. However, some men tended to chew khat individually and could end up isolated. Those participants later agreed that after finishing chewing khat or smoking shisha, stress and worries increased and new mental, social and health problems emerged:

“They try to go to shisha place to deal with the issues to just forget, and kill the time. Also those who can afford chew khat.” (CR5)

“He resorts to chewing khat and he stays away from home and he doesn’t like to talk which is quite different to how it [khat] was back home such as talking a lot, and sleepless...to feel sense of solution, he [African man] chews khat in order to forget these problems and he thinks that is a solution and this kind of attitude will bring him more problems.” (EE2)

“And some try to rid of their depression through social life. They sit around restaurants and chew khat in order to solve their problems. When they are chewing khat in an isolated and locked rooms, they are trying to solve some problems inside them...however, chewing increases their problem.” (ES5)

In addition to smoking shisha and chewing khat, another strategy to deal with stress and depression was to go to community restaurants, argue and talk about politics in Somalia. This was called ‘*fadhikudirir*’ (literally an armchair fighter) which meant meaningless quarrelling mostly happening at Somali restaurants and community centers. Fadhikudirir may continue over many hours:

“...you can see a lot of people [men] sitting in restaurants, and talking about

political [issues] all the day. They already gave up, [because] they know that they don't get job..." (YS4)

## **Drugs, alcohol and gambling**

A few young participants from both Eritrean and Somali communities commented that when young African men encountered frustrations posed by unemployment, they tried to ease their problems by taking drugs, gambling or drinking alcohol:

"they feel a lot of pressure to become stressed [and] stress become[s] mental [problem] and when they have the problem they drink too much [that] they never did before and they take drugs and they become [affected with] a mental problem." (YS8)

"You apply, you apply, you apply and you get nothing back... and you just give up aiming for you to think you are [not] capable of and you lower your standards and yeah, you just do that or again your turn to whatever like gambling or drug and like that." (YE8)

## **Silence and denial as a solution**

Several participants mostly from elder Eritrean men believed that silence or denial of the existence of mental illness were common strategies used by African Muslims. This was because those keeping their mental problem secret felt that as time passed, they would recover. In addition, some men denied the existence of mental illness:

"The most strategies I see are, that people try to deny they have mental problems...Some people conceal their problems. They don't share their problems with others. This is a common phenomenon...People are silent when it comes to mental problems like it doesn't exist. Some people believe

that the silence is a solution...they haven't seen any other solution...and therefore, he [man] believes that denying is the best strategies to cope with mental problems.” (EE5)

## **Chaining when in Africa**

Somali elder men remembered the way mentally sick people were treated in Somalia such as shackling and locking them up. This harsh strategy was a result of limited treatment options. Additionally, people felt that mental illness was incurable and it was shameful and stigmatizing to be associated with patients and their families. Some patients would sleep amongst rubbish wearing dusty, dirty and torn clothes. In some cases, children used to follow mentally sick people, tease and shout at them and perhaps harm them by stoning:

“As far as I know, people with mental problems were and are still chained in Somalia. They are psychologically destroyed and there is no medication for them...Somalis believe that if a person is crazy, he's gone. He can't re-engage with people properly; he has finished; he is mad; he is to be labeled. They [Somalis] don't believe that it is a curable sickness. That is why they believe that if he is injected at once, he is gone...” (ES3)

“Persons with mental problem were treated negatively and were stigmatized and they were not given any medicine. The common treatment was to chain the affected person with mental problems...he is stigmatized by instigating children to harm him and stone him...After that, the sick person will sleep at rubbish wearing dirty and torn garments. He is denied to have the basic human rights: no respect and nothing...Back home, a few were treated by their families and relatives by locking them somewhere without providing any care, support and medication.” (ES5)

## **Intergenerational differences and traditional practices**

Our participants provided two different views of using traditional healing strategies. Some participants, mostly from elder Somali men and young Eritreans believed that youth and older men were different in their approaches to dealing with mental problems and emotional difficulties. Older men were said to use traditional practices such as religious treatments (either inside or outside Australia) whereas younger men preferred to use the mainstream services. A possible reason was the lack of awareness in older men of available services or belief in them. In contrast, young men who grew up in Australia, studied locally, grasped the local culture and Australian way of life had an understanding of mental health issues. They knew where to go if they were mentally unwell and how to use mainstream services but did not seem as aware of traditional healing. However, in some cases, young men were forced by their parents to use traditional practices even though they (youth) did not believe in their effectiveness. Elder Somalis believed that young men were more realistic, less arrogant, and did not feel ashamed talking about their mental illness or seeking help for it. Furthermore, professional young men could possess private health insurance enabling access to mainstream services:

“our traditional ways of healing mentally sick people do not exist here, and therefore the only option you have here is to go to mental problem doctors...for elders with mental problem, they prefer to go to homeland and get healed by Sheikhs but the new generation is not welcoming these traditional methods.” (EE3)

“For our old generation, if someone is sick we quickly invite Sheikh to read Quran on him and I don’t think that young people use Quran as a healing...some do not know how to read Quran and some even do not believe that it could heal...For them, they believe the hospital, and the [Australian] system that they grew up and adopted... Youth I know them who are university graduates and have jobs are in private health insurance...I have

never seen young person who grew up here and seeking healing through reading Quran on him. Some are forced to accept reading Quran on them as healing and as far as I know, some, their parents beg them to accept reading Quran on them as healing...but, realistic speaking he doesn't believe..." (ES3)

"I have children and when we discuss and debate, they say to us "you guys Somalis, you guys Somalis". So, when they say to you "you guys Somalis" that means that they exclude themselves as being Somalis. That means we are not Somalis but you are Somalis. So, that means "you are old generation, if you have some mental problem it is up to you if you read Quran on you, or use spiritual healing but we are not part of that process...so they are mentally, educationally and culturally different from us." (ES2)

Some participants from elder Somali men offered a different explanation to the abovementioned view. These participants argued that young men were multicultural and therefore they used both services: community services and mainstream services. In their opinion, young men integrated both Australian culture and Somali culture and would use treatments from both cultures. Marriage would also influence younger Somalis to practice the traditions of their fathers:

"I believe that young generations are not much different from their parents who came from Somalia. They have both cultures. They believe reading Quran and healing through *foox* (frankincense - which is traditional spiritual treatment) and I see them doing that. The educational system through which they studied and the local culture also teach them to go to hospitals if they get sick. So, they use both cultures." (ES1)

"...by the time he is ready to get married or when he gets married he must comply to the Somali system and culture... And then his new house must be an Islamic family through blessing by reading Quran in his new house as his



father was; and he should inherit his father's legacy and culture. In his turn, when he becomes a father, he will start to believe that Quran will salvage his family as he was taught by his father. He will teach Quran to his children like his father and in that sense he will eventually comply with the Somali system....otherwise his community will interpret that he is an outsider of his community..." (ES6)

## Conclusion

This chapter has examined existing treatment strategies employed by community members when faced with diverse problems. The main treatment strategy used by Horn of Africa Muslim men with mental problems or emotional difficulties is to consult family members or friends. Fathers were particularly important for young men facing difficulties. Effective religious treatments included being blessed by Sheikhs who read the Quran on the patient, listening to the Quran, and having faith and practicing it. Furthermore, *thikri*, (remembrance/contemplation of Allah) fasting during Ramadan, giving charity, thinking positively and realistically, performing prayers particularly with congregations in the Mosque, confidence in Allah, socializing and talking to each other, taking patients to the Hajj (pilgrimage) and Umra (a lesser pilgrimage), and making purposeful journeys to Africa and Middle East were becoming popular healing strategies. On the other hand, silence, and denial of having mental problems were strategies used mainly by elder men. Finally, most elder men tended to use traditional healing strategies while most young men mixed traditional strategies with the modern Western treatments.

## CHAPTER 7: RECOMMENDATIONS

### Introduction

This chapter highlights recommendations provided by the participants. These include acceptance of having mental health problems, mental health education and awareness, empowering young people through positive role models, developing specific community supports and being integrated into the wider Australian community. The chapter also looks at treatment strategies through a deeper understanding of the Quran and Ahaadiith, taking mentally unwell people to relevant hospitals and helping African parents learn parenting skills relevant to Australia.

Participants across the focus groups provided valuable suggestions to support people affected with mental illness. These recommendations included acceptance and admission of having mental problems so treatment could be received. Raising awareness of available services would also enable people to identify mental illness, understand its root causes, and inform them of which services to seek support from:

“The first solution is to admit that you have a problem and then investigate solutions. When you identify the problem, go to find solutions, e.g. you can take panadol.” (EE5)

“Hey Bashiir you need to go to the centrelink, hi Mohamed come and take this thing; hi Ahmed come and undertake this; hi take your right, hi, hi, hi...” that will solve the problem. In that sense I know where I can go and where I came from and what I can do, and then they can talk about the education and what you need to study like this and that. That will solve the problem. From that perspective we can solve the problem.” (EE2)

## **Empower young people and create positive role models**

Several young Eritrean participants and one young Somali man articulated the need to motivate and empower young people to fulfill their potentials and avoid drugs, gambling and criminal involvement. These young participants underlined the importance of instilling self-esteem, self-belief, confidence and motivation into the psyches of young African Muslim men through positive storytelling, counseling and empowerment. They also warned about focusing on victimization, blame and worthlessness which could lead to isolation, marginalization and then mental problems:

“with big hope and expectations [you get healed]...if you have no goal you shrink.” (YE6)

“I think the most important thing we need now is empowerment, you know! We need to believe we can do things rather than just, you know, blaming. We need to be empowered; we need to lift our self-esteem somehow. That is the first step... if you feel you are worthless, you are not gonna move... but if you get hope, you know what I mean! If you can dream, that will motivate you to move...” (YE2)

“the best way to support him [man with mental illness] is to calm him down, talk to him and tell him some stories in order to bring back his confidence or to walk with him around. That is how we can help.” (YS6)

Young Eritrean men also suggested that having positive role models for young people would provide visible, inspirational examples:

“...Role model [is important], someone that we can see as a leader, someone we can see as honest and as credible... (YE2)

“Exactly, we need someone to make it. We need to be motivated. For example, like in sports, if one, if one athlete from our community makes it, it

will completely change generation, if just one makes, if just one of the boxing star TV. Now they know they [could]. Seeing is believing.” (YE5)

I am just gonna say how everyone is saying role models, one person does make sport...one person becomes an accountant, and then just different roles.” (YE8)

## **Develop community support**

It was observed that developing better community supports would help address some of the problems:

“You know we living in a society where your sort of have to save yourself no one will come and hold your hand and say this is how you do it’s a know how you so I think we have to use community knowledge and community wisdom where we can to get to the best.” (CR1)

“...The common strategies, are establishing ethnic community organizations. Ethnic communities have their own organizations that can find solutions for community problems. For instance, there is a community organization for Eritreans. This community organization knows how we came here, tries to find solutions for our problems...” (EE2)

## **Being accepted by and integrated into the wider community**

An elder Eritrean man commented that being positively regarded and integrated into the wider Australian society was important for social and emotional wellbeing. In this view, better integration and positive interaction with the wider Australian community would assist migrants in obtaining jobs. This view was also supported by an elder Somali man who emphasized the importance of finding a job to integrate into the mainstream:

“One of the solutions for emotional difficulties is that when someone comes

to this country, he should...believe that he is an Australian; integrate into Australian society; and forget the view that he is not in his country. He [man] should integrate and say “this is my country”; seek his rights and adjust to the lifestyle of this country and try to get job seriously.” (EE3)

“If I talk about unemployment, it leads to socio-economic problems. If anyone wants to join the upper class, he has to work hard for a long time and then he can be equal to Australia mainstream people.” (ES5)

### **Treatment through a deeper understanding of Quran and Ahaadiith<sup>11</sup> wisdom**

Quran and *Ahaadiith* (teaching of the prophet Mohamed) were recommended by some participants as effective healing strategies if they were performed properly. However, a community reference participant claimed that there were misunderstandings around healing because of poor understanding of the Quran and the teachings of the Prophet Mohamed:

“...although the Koran is a cure and almost profoundly so, the problems becomes [are] that some of us lack the understanding of the [Quran]...we don’t have good understanding of the religion, we’re actually stumbling in the dark.” (CR2)

A young Eritrean man was of the view that if the Quran and the teaching of the Prophet Mohamed were applied correctly, they would make a huge difference in the lives of mentally unwell people. In his opinion, Islam was a major source of wisdom and healing for Muslims. By applying the Quran to life, Muslims would experience

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<sup>11</sup> Are collections of traditions containing sayings of the prophet Muhammad which, with accounts of his daily practice known ‘*the Sunnah*’ constitute the major source of guidance for Muslims apart from the Quran.

security and comfort. This participant argued that those Muslims who went to the Mosque and practised Islam felt empowered, confident, disciplined and could recover quicker and more completely than other Muslims who did not practice Islam:

“I think the best place of support if anyone wants anything is the Mosque. You know, Islam is the only thing we have at the moment...we find comfort in the Islam, I mean with the Quran and Hadith (teaching of prophet Mohamed.) There are a lot of wisdom, you know, can actually get better...So, a lot of people who go to the mosque they tend to do better and recover better than those who try other services...it empowers each individual and give them confidence to take control of their lives basically.”  
(YE2)

In another account related to treatment through Islam, a young Somali participant offered the view that mature people who had stress and emotional problems should be provided with religious advice. In contrast, immature adolescents with mental problems should be managed and handled by their guardians when providing them with religious treatments.

### **Taking mentally sick people to relevant hospitals**

There were a few participants who suggested taking mentally unwell people to the relevant hospitals. As an example, an elder Eritrean man argued that every disease could be cured through a specialist doctor. Therefore, Africans should understand and follow the Australian health system and take their people with mental problems to appropriate hospitals:

“look, every disease has a doctor. And doctor is someone who has learnt what he is doing. This is a modern and developed country and therefore, youngsters and elders must follow the system.” (EE1)

## **Relevant parenting skills**

According to an elder Eritrean's point of view, training African parents how to raise their children in the Australia environment would solve a lot of family problems. This would reduce parent-children misunderstanding, which if not addressed could lead to family disconnections, unhealthy relationships, mistrust and ultimately to stress and mental illness. Also, an elder Somali man identified a strategy of men becoming more involved in child-rearing:

“East Africans have a lot of children: seven, eight, or nine children. Only mother can't handle the problem of 7 or 8 or 9 children, you see. Three children may need to be taken to school; two are sick; and two are sleeping at home. Therefore, he (the husband) should drive night shift and stay with children at home during day when she is at work or taking some children to school. That is a solution called shift changing. He stays at home during day and she stays at home during night.” (ES3)

## **Conclusion**

This chapter has outlined some recommendations provided by group members to address emotional health problems. Recommended strategies included admission and acceptance of having mental problems which assisted in identifying suitable solutions. Education, awareness, knowing about the available services, providing positive role models for youth, motivating, empowering, and helping them develop self-esteem while minimizing self-blame and victimization were also suggested. Developing community-specific supports, better integration into the wider Australian community, deeper understanding of the wisdom of the Quran and the teaching of the prophet Mohamed were also emphasized as important healing strategies. Assisting African parents to develop relevant parenting skills, understanding how to raise children in Australian society and also taking mentally unwell patients to appropriate hospitals were recommended.

## **GENERAL CONCLUSION FOR THE RESEARCH FINDINGS**

Participants of this study provided diverse views about the definition of mental illness. However, the dominant view was that mental illness was similar to madness and this was incurable and associated with danger. Mentally ill people were said to be unproductive and a burden on society. Poor sleeping, lack of remembrance or acknowledgement of Allah, speaking in a disorderly fashion and talking about one's bad experiences were described as the main features of mental illness. Participants also believed that mental illness could be inherited or accidental.

The major causes of stress and depression among African Muslim men in Australia were unemployment, racism in the labor market and workplace, and lack of equal opportunities compared to the mainstream. Another stressor was working in an unskilled job despite having high qualifications. Young African Muslim men even changed their names and concealed their religious visibilities in order to progress in job applications, or be accepted by the mainstream. However, changing their names or concealing their religion and values negatively affected their identities, psyches and emotional wellbeing.

Lack of social connections and networking with the mainstream, poor community leadership and lack of positive role models, perceived incompetent community organizations and dysfunctional tribalism contributed to social isolation for African Muslim men. Australian family law and language difficulties made it difficult for them to navigate the system and services available. Identity crises, culture shock, a victim mentality, lack of motivation and judgmental attitudes from the older generation toward young people further negatively impacted on the emotional and social wellbeing of African Muslim men, particularly among youth. Other stressors which led to depression and mental problems included difficulties in practicing Islam in Australia such as not hearing calls for prayers (muezzin), the scarcity of halal food (food Islamically allowed to be eaten), haram issues (issues Islamically prohibited to



use), trauma caused by civil wars and substance abuse.

On the other hand, barriers for not seeking help for mental health problems included a lack of information, lack of awareness, and lack of understanding of the mental health services in Australia. Furthermore, mainstream practitioners with perceived poor cultural responsiveness and the scarcity of well-trained community representatives in the mental health sector were additional barriers to accessing help. Other obstacles for not seeking help by our participants included negative speculations about the mainstream mental health services such as perceived injections for African patients. The participants also described a tendency to deny or not recognize mental illness. This coupled with a culture of silence, perceived stigma, weakness and inferiority made men unlikely to seek help or admit to having mental illness.

Existing treatment strategies for mental illness identified by the study participants included seeking help from family members and friends, religious treatments from Sheikhs and the use of the Quran and practicing authentic faith. Within families, counsel from fathers regarding serious issues was particularly important for young men. Furthermore, *thikri* (remembrance/contemplation of Allah), fasting during Ramadan, giving charity, thinking positively, having realistic expectations, and performing prayers with congregations in the Mosque were identified as effective healing strategies. Having confidence in Allah, socializing and talking to each other at community gatherings, going on the Hajj (pilgrimage) and Umra (a lesser pilgrimage), and journeying to Africa and the Middle East have also become popular healing strategies. On a less positive note, silence and denial of mental problems were communal adaptive strategies used mainly by elder men to deal with depression and social problems. Finally, some respondents acknowledged that elder African Muslim men tended to use traditional healing strategies while youth tended to use mainstream Australian services or mix traditional strategies with the modern Western treatments.

Participants provided several recommendations for treatment of people with emotional difficulties. Some respondents commented that admitting to having mental problems was the first step required, which would then lead to suitable treatment options. Improving mental health literacy through education about mental problems and available services was one suggestion. Providing positive role models for youth, motivating, empowering and helping them develop self-esteem while minimizing self-blame and victimization were also suggested as effective healing strategies. Developing community-based support, promoting integration within the wider Australian community, developing deeper understanding of the wisdom of the Quran and the teaching of the prophet Mohamed were also emphasized as important strategies for treatment. Assisting African parents with understanding how to raise their children in a culturally and linguistically diverse society was also believed to minimize youth-parent misunderstandings, reduce conflict and improve wellbeing of parents and their children.

# APPENDICES

## Appendix 1: Demographics

### Emotional wellbeing and access to culturally appropriate services: A comparative study of ‘young and older Horn of Africa Muslim Men’ (YOHAMM) of refugee background living in inner-northern Melbourne suburbs

#### Participants’ Survey

**Your number** .....

Please circle the relevant response to the following questions. All responses are confidential and you will not be identified in this research report.

1. Gender: Male ☐ Female ☐
2. What is your age group?
  - 18-29
  - 30-39
  - 40-50
  - 50-60
3. What is your country or Birth?.....
4. What is your highest level of education?
  - Primary school
  - Intermediate
  - Secondary school
  - Tertiary degree
  - Postgraduate degree
5. What is your marital status?  
  
Married ☐      Single ☐      Divorced ☐      Separated ☐
6. What is your professional occupation?.....
7. What is your current job?.....
8. What is your religion?.....
9. What languages do you speak?.....
10. How long have you been in Australia?.....

## **Appendix 2: Semi-structured Interview Questions**

1. What problems do Horn African Muslim men have in Australia and how would you describe these problems?
2. What are the causes of these problems?
3. What would Horn of African Muslim men do when dealing with these problems?
4. What are the most common help-seeking strategies for YOHAMM who are experiencing the abovementioned problems in Australia?
5. How do you describe mental health problems?

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