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Best Practice in Working with the Somali Population

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Recognized Symptoms in the Somali Community

- Insomnia
- Suicidal thoughts and feelings
- Impulsivity or failure to plan a head
- Uncontrollable crying
- Failure to conform to social norms with respect to lawful behavior as
- Inflated self
- Lack of interest or pleasure in usual activities
- Change in appetite causing weight loss or gain
- Slow speech, fatigue, and poor coordination
- Depressed mood and low self
- Feelings of guilt, hopelessness, or worthlessness
- Fantasy of ideas or subjective experience that thoughts are racing
-堰
- Fight of ideas or subjective experience that thoughts are racing

Dawakhaad
Dhimir
Ku
Khafiif
Educate Somali individuals and families about

Their illness. In addition, individuals with mental illness may be ostracized from their community and may be refused treatment (Guerin, Guerin, Diiriye & Yates, 2004). Somali immigrants and refugees are often not aware of the mental health system and feel that they are not able to seek services for their mental health needs. For example, in the Western culture if an individual is experiencing frequent crying, insomnia, and chronic headaches this would be related to depression or somatization disorder. However, in Somali households these behaviors are accepted as part of life and is not worthy of seeking treatment (Guerin, Guerin, Diiriye & Yates, 2004). Somali immigrants and refugees are more likely to talk about things such as sadness, headaches, lack of appetite, and tiredness but they do not see it as related to a larger mental health diagnosis (Scuglik et al., 2007).

The majority of Somalis with mental illnesses are socially isolated because of their illness. In addition, individuals with mental illness may be ostracized from their community. However, the Somali community is very powerful and unwilling to seek services. This causes a significant impact in the process of healing and impedes their progress in completing their treatments successfully (Schuchman & McDonald, 2010).

Methodology

This research project employed a quantitative design consisting of key informant interviews with professionals in the Minneapolis metropolitan area who are experienced in providing mental health services to Somali individuals and families. IRB approval was granted by Minnesota State University, Mankato. Key informants were identified as practitioners that are licensed in Social Work, Counseling, Marriage and Family Therapy, or Psychology as mental health providers. These practitioners have been providing mental health services to Somali individuals and their families for over three years. Consent from the practitioner was obtained. The respondents consisted of three practitioners that had participated in a focus group open-ended questioner. In addition, after completion of the interviews the audiotaped data was transcribed and responses to questions were analyzed by identifying common themes or patterns in the responses.

The stigma name associated with mental health- (A. Abdulahi, personal communication, May 21, 2011).

Barriers

- Somali individuals and families hardly seek mental health services because of the stigma associated with mental health issues. However, a majority of Somali individuals and their families that are currently seeking mental health services are because they have been referred by school systems, court ordered, or hospitalized for civil commitment. The Somali individuals do not seek treatment at early stage of their mental illness and wait until they are hospitalized for helping themselves or others. The sequence of events by which the Somali clients seeks mental health services are usually by a word mouth referral because another Somali individual that has been experiencing similar symptoms was seen by that professional and refer that individual. Also, they are referred by their family doctor or county worker (A. Abdulahi, personal communication, May 21, 2011).

Best Practice in Working with the Somali Population

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Diagnosis and the recognized symptoms in the Somali Language (D. Schuchman, personal communication, May 21, 2011)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Recognized Symptoms in the Somali Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar</td>
<td>Regular moods</td>
</tr>
<tr>
<td>Depression</td>
<td>Low energy levels and apathy</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>Low self-esteem</td>
</tr>
</tbody>
</table>

Educate Somali individuals and families about disorders

Normalize the diagnosis and instill hope
Focus on the individual’s emotions and feelings
Assess the probability of the individual completing homework assignment
Assess likelihood of the individual ability to track symptom patterns and what triggers the symptoms
Note: For Somali individuals, homework assignments will be challenging for them to complete due to their English language proficiency (D. Schuchman, personal communication, May 21, 2011)

Education-based Interventions

Practice case breathing
Mindful eating
Walking meditation

Note: Somali individuals and families tend to be more focused to the relaxation methods. It is not realistic for the individual not to focus on the problem. Also, relaxation techniques help the Somali individual to decrease their symptoms related to mental health issues (K. Lyke, personal communication, May 21, 2011).

Somali Words that Translate to English Mental Illness

- Bipolar -抑郁
- Depression -(steps 
- Schizophrenia -schizophrenia

Summary

Defining mental health service to Somali clients

Mental health services are very limited to Somali immigrants and refugees because the limited professionals who speak the Somali language and their level of cultural competency. Using interpreters also limits the ability to build a trusting relationship between the clinician and client. Explaining what mental health is to Somali immigrants and refugees is challenging to mental health practitioners. In the Somali culture there is no translation of mental health diagnoses. Also, the western view of mental health is a new and foreign concept to the Somali population. It’s important for the practitioners not to say “mental health” because in the Somali community mental health means crazy. Explaining the western view of mental health services to the Somali population seems more challenging to Somali clients when providing services. Psychotherapy is not a way of working with the Somali population especially the older generation. The older Somali population does not seek therapy in order to talk about their issues. They usually tend to seek religious individuals such as Imam or family members when they are facing issues.

Best Practice in Working with the Somali Population

Barriers

- Somali individuals and families are interested in identifying best practices in working with Somali individuals and families requiring mental health interventions and services. Best Practices in working with the Somali Population?

- Somali individuals and families believe there is not a mental health problem until it begins to “interfere” with everyday life. While practitioners would agree that a majority of clients do not seek services until the problem is interfering with their daily functions, the Somali concept of “interference” might be very different than what the practitioners considers mental health needs. For example, in the Western culture if an individual is experiencing frequent crying, insomnia, and chronic headaches this would be related to depression or somatization disorder. However, in Somali households these behaviors are accepted as part of life and is not worthy of seeking treatment (Guerin, Guerin, Diiriye & Yates, 2004). Somali immigrants and refugees are more likely to talk about things such as sadness, headaches, lack of appetite, and tiredness but they do not see it as related to a larger mental health diagnosis (Scuglik et al., 2007).


Based Interventions

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