Best Practice in Working with the Somali Population

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Since the early 1990s, the state of Minnesota has had an unprecedented increase in refugees from Somalia. These individuals have emigrated from a war-zone country and arrived in the United States with a range of trauma-related injuries and mental health issues. As a result, Somali individuals and families who have migrated to the United States will require physical and mental health support. There is, however, a lack of research on effective interventions with Somali individuals and families. With the stigma that surrounds mental health and negative cultural views of mental health in the Somali community, practitioners at Comsmates Latinaa and Urban Health Center (C-UHC) are interested in identifying best practices in working with the Somali population. The main purpose of this project is to gain knowledge about best practices in working with Somali individuals and families and to address their mental health needs. The result will help fill the gap in the literature on how to overcome the cultural barriers and serve the mental health needs of Somali individuals and their families.

**Research Question**

The purpose of this project is to identify evidence-based practices in working with Somali individuals and families and to provide evidence-informed mental health interventions and services. Best Practices in working with the Somali Population?

**Literature Review**

Mental health cannot be defined in the Somali language. There are no Somali translations for the common diagnoses found on the DSM such as Depression, Anxiety, Social Isolation, and PTSD. In the Somali community mental health is perceived as state of sanity or insanity. Somali immigrants and refugees may talk about topics related to mental illness. This perspective prevents many individuals, especially men, from seeking services for their mental health needs (Scagghi et al., 2007).

Somali individuals and families believe there is not a mental health problem until it becomes “interfering” 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 consider 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 somatic disorder. However, in Somali households these behaviors are accepted as part of life and is not worthy of seeking treatment (Guerin, Guerin, Diiaye & Yates, 2004). Somali immigrants and refugees are more likely to talk about subjects such as family, sadness, headaches, lack of appetite, and tiredness but they do not see it as related to a larger mental health diagnosis (Scagghi 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, their family and community are powerful tools than willingness to seeking 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 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 families for over ten years. Consensus by the practitioner was obtained. These respondents consisted of three practitioners that have participated in an open-ended questionnaire. 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 names associated with mental health (A. Abdilah, personal communication, May 21, 2011).

**Names of Western Disorders**

- Schizophrenia
- Bipolar
- Depression
- Anxiety
- PTSD
- Major Depressive Disorder
- Personality Disorders
- Schizoaffective Disorder
- Somatoform Disorders
- Dissociative Disorders
- Eating Disorders
- Attention-Deficit/Hyperactivity Disorder
- Trauma-Related Disorders
- Substance Use Disorders

**Somali Words that Translate to Western Mental Illness**

- Dhig: Schizophrenia
- Wal: Bipolar
- Eegoo: Depression
- Haal: Anxiety
- Isku: PTSD
- Dhik: Major Depressive Disorder
- Dhuk: Personality Disorders
- Kaabi: Schizoaffective Disorder
- Haddii: Somatoform Disorders
- Shool: Dissociative Disorders
- Qaarka: Eating Disorders
- Barro: Attention-Deficit/Hyperactivity Disorder
- Ciyaaraha: Trauma-Related Disorders
- Xaalad: Substance Use Disorders

Mental health cannot be defined in the Somali language. There are no Somali words or phrases that translate to the common diagnoses found on the DSM such as Schizophrenia, depression, and bipolar. Names of Western disorders are translated into Somali language there is no translation for the majority of common mental disorders found in the DSM such as Schizophrenia, depression, Anxiety, and Post-traumatic stress disorder (PTSD). In the Somali language there are no words that have demonstrated to work with the Somali population over the years. The common symptoms Somali immigrants and refugees experience are related to PTSD, Depression, Anxiety, Bipolar, or Schizophrenia and Social Isolation.

Older adults experience co-occurring disorders such as depression and PTSD. Parent and Child Relations problems is a common issue in the Somali immigrants and refugees due to the parent’s lack of ability to speak the English language and parents using their children as interpreters or translators (D. Schuchman, personal communication, May 21, 2011).

**Evidence-Based Interventions**

- Educate Somali individuals and families about disorders
- Normalize the diagnosis and instill hope
- Focus on the individual’s emotions and feelings
- Assess the severity 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 would be challenging for them to complete due to their English language proficiency (D. Schuchman, personal communication, May 21, 2011).

- Solution focused and not problem focused
- Emphasis on the present and the future
- Emphasis on what is imaginable and changeable for the client
- Emphasis on the client’s strength
- Preference on short-term treatments

Note: Somali individuals and families are solution focused. They like to focus on the solution and not the problem. Also, in the Somali community it is against the family tradition to talk about family issues to an outsider, for that reason Somali clients are not open to talking about the past. (A. Abdilah, personal communication, May 21, 2011).

**PtG: Practice of the Group**

- Mindful eating
- Walking meditation

Note: Somali individuals and families tend to be more accurate to the relaxation methods because it allows the individual not to focus on the problem. Also, relaxation techniques help the Somali individuals to decrease their symptoms related to their mental illness (K. Lytle, personal communication, May 21, 2011).

**Background**

Studies of mental health services are usually by a word of mouth referral process because another Somali individual that has been experiencing similar symptoms was seen by that professional and they refer that individual. Also, they are referred by their family doctor or county worker (A. Abdilah, personal communication, May 21, 2011).

- The barriers associated for not accessing services are the stigma from their community, language barriers, and understanding of what mental health needs is. Another barrier is how a Somali client is diagnosed because no one will take them seriously or treat them normally. To normalize the mental health illness, the individual will seek traditional treatments by religious healers or spirituality services (D. Schuchman, personal communication, May 21, 2011).

**Experience with Mental Health Professionals**

- Somali individuals and families hardly seek mental health services because of the stigma associated with mental health. 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 an early stage of their mental illness and wait until they are hospitalized for hurting themselves or others. The sequence of events in Somali culture allows the mental illness services are usually by a word of mouth referral process because another Somali individual that has been experiencing similar symptoms was seen by that professional and they refer that individual. Also, they are referred by their family doctor or county worker (A. Abdilah, personal communication, May 21, 2011).

**Interventions**

There are very limited evidence based treatments that have been conducted in the Somali community. A majority of the practitioners are not taught using evidence-based approaches when providing services to Somali individuals and families. The idea of a therapist as a professional and not a friend is alien to the Somali population. Somali individuals and families are solution focused oriented. They seek a short-term treatment that is focused on the current problem with no emphasis on their past. They want to solve their issues in order to move forward.

**Limitations**

Limitations to this study included the “limited evidence-based practice” that is available in the research. Also, the key informant interviews were conducted in a metropolitan area and not in rural areas. However, practitioners in rural setting could use this study because the individuals they serve face the same barriers and challenges of seeking services in the mental health.

**Conclusion**

This study brought to light the many barriers that hinder the ability of Somali immigrants and refugees to access mental health services. Also, providing educational training to the Somali community is highly needed in order to change their perspective of mental health services. Education is needed within the Somali families in terms of building support for the individual that is diagnosed. In addition, Somali individuals need to also develop a clear understanding of what mental health is in the Somali and Western communities. This project’s results will be shared with the mental health staff at Comsmates Latinas Unda En Servicio (CLUES) to increase their understanding of how Somali individuals and their families perceive mental health services.