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Best Practice in Working with the Somali Population

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Abstract

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 population, practitioners at Comunidades Latinas Unidas En Servicio (CLUES) 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 to address their mental health issues. 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 requiring 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 never speak about topics related to mental illness. This perspective prevents many individuals, especially men, from seeking services for their mental health needs (Scuglik et al., 2007).

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 somatic symptoms such as feeling sad, headaches, lack of appetite, and tiredness but they do not see it as related to a larger mental health diagnoses (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, their fear of stigma might be more powerful 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 practitioners 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 their families for over three years. Consent by the practitioner was obtained. These respondents consisted of three practitioners that have participated in a 45 minute open-ended questions and an audiotaped interview. 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.

Figure 1

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

Names of Western Disorders	Somali Words that Translate to Mental Illness	Somali Words Translated in English
Bipolar	<ul style="list-style-type: none"> • Buufis • Dawakhaad • Dhimir • Isku-yaac • Isku-buuq 	<p>Crazy</p> <p>↓</p> <p>↓</p> <p>↓</p> <p>↓</p>
Borderline Personality	<ul style="list-style-type: none"> • Isla-hadal • Khal-khal • Khafiif • Ka-dhig • Ku-dhufasho 	<p>Insane</p> <p>↓</p> <p>↓</p> <p>↓</p> <p>↓</p>
Major Depressive Disorder	<ul style="list-style-type: none"> • Laba-miirree • Maraan • Qac • Waalli • Wareer • Wal-wal (wel-Wel) 	<p>Not stable</p> <p>↓</p> <p>↓</p> <p>↓</p> <p>↓</p>
Schizophrenia	<ul style="list-style-type: none"> • Walbahaar • Walaac 	<p>↓</p> <p>↓</p>



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Result

Figure 2

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

Diagnosis	Recognized Symptoms in the Somali Community
Bipolar	<p>Bipolar mania</p> <ul style="list-style-type: none"> • Inflated self-esteem or grandiosity • Decrease need for sleep • More talkative than usual or pleasure to keep talking • Fight of ideas or subjective experience that thoughts are racing <p>Bipolar depression/major depression</p> <ul style="list-style-type: none"> • Depressed mood and low self-esteem • Low energy levels and apathy • Sadness, loneliness, helplessness, guilt • Slow speech, fatigue, and poor coordination • Suicidal thoughts and feelings • Poor concentration • Lack of interest or pleasure in usual activities (American Psychiatric Association. (2000). <i>Diagnostic and statistical manual of mental disorders</i> (4th ed.). Washington, DC)
Borderline Personality	<ul style="list-style-type: none"> • Failure to conform to social norms with respect to lawful behavior s as indicated by repeatedly performing acts that grounds for arrest. • Deceitfulness, as indicated by repeated lying • Impulsivity or failure to plan a head • Reckless disregard for safety of self or others. • Lack of remorse (American Psychiatric Association. (2000). <i>Diagnostic and statistical manual of mental disorders</i> (4th ed.). Washington, DC)
Major Depressive Disorder	<ul style="list-style-type: none"> • Sadness, anxiety, irritability • Loss of energy • Feelings of guilt, hopelessness, or worthlessness • Loss of interest or enjoyment from things that were once pleasurable • Difficulty concentrating • Uncontrollable crying • Difficulty making decisions • Increased need for sleep • Insomnia • Change in appetite causing weight loss or gain • Thoughts of death or suicide • Attempting suicide (American Psychiatric Association. (2000). <i>Diagnostic and statistical manual of mental disorders</i> (4th ed.). Washington, DC)
Schizophrenia	<ul style="list-style-type: none"> • Delusions • Hallucinations • Disorganized Speech (e.g. frequent derailment or incoherence) • Grossly disorganized or catatonic behavior • Negative systems i.e., affective flattening, alogia, or avolition (American Psychiatric Association. (2000). <i>Diagnostic and statistical manual of mental disorders</i> (4th ed.). Washington, DC)

Figure 3

Evidence-Based Interventions

Evidence-Based Interventions	
CBT	<ul style="list-style-type: none"> • 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 <p>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)</p>
Solution-Brief Focused	<ul style="list-style-type: none"> • Solution focused and not problem focused • Emphasis on the present and the future • Emphasis on what is imaginable and changeable for the clients • Emphasis on the client’s strengths • Preference on short-term treatments <p>Note: Somali individuals and families are solution oriented. 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. Abdulahi, personal communication, May 21, 2011)</p>
Relaxation Techniques	<ul style="list-style-type: none"> • Practicing deep breathing • Mindful eating • Walking meditation <p>Note: Somali individuals and families tend to be more accepting to the relaxation methods because it allows the individual not to focus on the problem. Also, relaxation techniques help the Somali individual to decrease their symptoms related to their mental illness. (K. Lytle, personal communication, May 21, 2011)</p>

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 would create barriers to accessing the 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.

Common/ Presenting Mental Illnesses

An effective approach is not to use the DSM diagnosis or mental illness label because Somali individuals would not understand the difference or the meaning of their illness. Labeling diagnosis such as bipolar or depression would not make sense because in the Somali culture there is only one mental health illness (“crazy”). Classifying the disorders would not make sense to a Somali individual. In the 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). Another method that has demonstrated to work with the Somali population is going over the symptoms of the diagnoses. Somali individuals understand the symptoms and they can easily express their symptoms to practitioners. 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 PTDS. 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) .

Previous 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 the 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 the early stages of their mental illness and wait until they are hospitalized for hurting themselves or others. The sequence of events by which the Somali clients seeks 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. Abdulahi, personal communication, May 21, 2011) .

Barriers

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 the Somali community perceives the individuals once they are diagnosed because no one will take them seriously or treat them normally. To normalize the mental health issue the individual will seek traditional treatment by religious healers or spirituality services. (D. Schuchman, personal communication, May 21, 2011) .

Treatment

There are very limited evidence based treatments that have been conducted in the Somali community. A majority of the practitioners use a practice-based approach 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 issue in order to move forward.

Limitation

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. Educational training is needed within the Somali families in terms of building support for the individual that is diagnosed. In addition, Somali individuals and their families need to 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 Comunidades Latinas Unidas En Servicio (CLUES) to increase their understanding of how Somali individuals and their families perceive mental health services.

References

Please see additional Reference List.