Recognized Symptoms in the Somali Community

- Hallucinations
- Impulsivity or failure to plan
- Change in appetite causing weight loss or gain
- Suicidal thoughts and feelings
- Increased need for sleep
- Reckless disregard for safety of self or others.

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 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 somatization disorder. However, in Somali households these behaviors are accepted as part of life and is not worthy of seeking treatment (Guerrin, Guerrin, Diarie & Yates, 2004). Somali immigrants and refugees are more likely to talk about their behavior as being sad or sleepy, headaches, lack of appetite, and tiredness but they do not see it as related to a larger mental health diagnosis (Scaglhi 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 illness is often 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 providing mental health services to Somali individuals and families. IRB approval was granted by Minnesota State University, Mankato. Key informants were identified as practitioners who 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 three years. Consent to participate was obtained by the practitioner. These respondents consisted of three practitioners that have participated in this project and met with an open-ended group interview. In addition, after completion of the interview the audiotaped data was transcribed and responses to questions were analyzed by identifying common themes or patterns in the responses.

The stigma associated with mental health (A. Abdulla, personal communication, May 21, 2011) and families are solution oriented. For that reason Somalis are not open to their mental illness and wait until they are hospitalized for hurting themselves or others. The stigma associated with 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.”

The western view of mental health services to the Somali population seems foreign and doesn’t mesh 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

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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 foreign and doesn’t mesh 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.

Contacting a professional mental health provider is an approach that is not used to the DSM diagnosis or mental illness label because Somalis 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”).

The American Psychiatric Association would consider them to be one 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. Another method that has demonstrated to work with the Somali population is going over the symptoms of the diagnoses. Somalis 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 PTSD. Parent and Child Relationships 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 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 early at all stages of their mental illness and wait until they are hospitalized for hurting themselves or others. The sequence of events most clients seek 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 they refer that individual. Also, they are referred by their family doctor or county worker (A. Abdulla, 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 mental health providers are perceived by the immigrant community once they are diagnosed because no one will take them seriously or treat them normally. To normalize the mental health diagnosis will seek traditional treatment by religious healers or spirituality services (D. Schuchman, personal communication, May 21, 2011).

Practices

There are very limited evidence based treatments that have been conducted in the Somali community. A majority of Somali-based practitioners use a practice that is based on the Somali culture, language barriers, and understanding of what mental health needs is. 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 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.

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. Education is needed within the Somali families in terms of building support for the individual that is diagnosed. In addition, Somali individuals 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.