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**Addressing Mental Health with the Somali Population
in the Twin Cities Area**

by

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MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
In Partial fulfillment of the Requirements for the Degree of
Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

ABSTRACT

Minnesota is home to one of the highest populations of Somali heritage in North America. Mental illness is reported to be prevalent in this population and there is an underutilization of available mental health services. The purpose of this study was to see how health providers can better identify and discuss mental illness with the Somali community to improve utilization rates of mental health clinics in the Twin Cities area. To do this, six qualitative interviews were conducted with participants who at the time were currently working with Somalis, in a hospital, clinic, or health care agency setting. Content Analysis was used as a method of analysis to identify and interpret themes found from the recorded interviews. The main themes that emerged were: 1) prevalence and recognizing mental illness; 2) the stigma of mental illness; 3) impact of interpreters; and, 4) dialoging about mental health. Findings confirm previous research studies in that there is little uniformity between health professionals on what treatments to recommend to improve utilization. However, findings showed that being culturally aware, building rapport, and discussing mental illness in terms of physical symptoms, all improve utilization rates of Mental Health Services. Somali Americans access medical health through hospitals, clinics, and health care agencies. Because of this, it is important for health care professionals to be culturally aware of Somalis and how to mutually discuss mental illness due to their access to this population.

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In 1991 a civil war left an estimated 45% of the Somali population displaced (Condon, 2006). This resulted in Somali's seeking refuge in many different countries (Jaranson, Butcher, Halcon, Johnson, Robertson, Sivik, Spring, & Westermeyer, 2004). In the USA specifically, the largest population of Somali immigrants are found in Minnesota (Condon, 2006). Refugees and immigrants carry a large burden with relocating their entire lives (Loewenthal et al., 2012). Somali refugees have had to witness their old lives be torn apart, uprooted, and relocated to places all over the world. Upon arriving, immigrants and refugees have to often learn a new language, learn how to interact with new culture, find a job, keep their families together, and live with a culture that understands little about their religious and cultural backgrounds.

Due to the stressors of relocating as well as the war trauma experienced, there is a high prevalence of Post Traumatic Stress Disorder, Depression, and Generalized Anxiety Disorder in the Minnesota Somali population (Kroll, Yusuf, & Fujiwara, 2010). Studies have shown that refugee groups historically have a high rate of mental health symptoms, but an under utilization of the mental health services with Somali refugees being no different. (Guerin, Guerin, Diiriye, & Yates, 2004). This shows that there is currently a gap between the need for and the utilization of mental health services in the Minnesota Somali population.

Often members of the Somali community refuse to talk about mental health issues because they believe they will be stigmatized (Warfa, et al., 2006; Guerin, et al., 2004). Because of this stigma, reaching out to this population can be difficult. However, Somali refugees currently utilize clinics and hospitals to receive care for physical symptoms (Guerin, Guerin, Diiriye, & Yates, 2004). Bhui et al. (2003) reported that Somali's

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describe mental illness symptoms as physical complaints. Bhui et al. (2003) goes on to say that often times Somali's are given medications for physical ailments when the root cause was later found out to be mental illness.

Given this population's increased risk and prevalence of mental illness and utilization of hospitals and clinics for physical symptoms, health professionals have a role to play in helping Somalis. By learning how to distinguish mental illness from the physical complaints, and how to discuss mental health with this population, the gap for utilization of mental health services could be bridged.

The purpose of this research is to see how health providers can better identify and discuss mental illness with the Somali community to improve utilization rates of mental health clinics in the twin cities area.

Literature Review

The review of the literature begins with explaining the two primary stressors that lead to an increased risk of developing mental illness in the Somali population. The first cause is the actual experience of trauma related to the civil war in Somalia and the second is the resettlement experience of a Somali refugee or immigrant. Current supports and barriers the Somali community has in relation to mental illness will be identified. Finally, responses mental health professionals have had with different refugee populations to overcome barriers to access of mental health services will be explored.

The two most prevalent mental illnesses among the Somali refugees are Post Traumatic Stress Disorder and Depression (McCrone, et al., 2006). Post Traumatic Stress Disorder (PTSD) is a common experience of those affected by war. PTSD "is an anxiety disorder with exposure to actual or threatened death, serious injury or sexual violation...

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The exposure must result from one or more of the following, directly experience the traumatic event, witnesses the traumatic event in person, learns that the traumatic event occurred to a close family member or close friend, or experiences first hand repeated or extreme exposure to aversive details about the traumatic event” (American Psychiatric Association, 2013). The experience of PTSD in this population can include flashbacks and exaggerated startled responses to normal stimuli (Warfa et al., 2006). In addition to the stressor, a person must experience symptoms, including “intrusive symptoms such as recurrent, involuntary, intrusive memories, traumatic nightmares, dissociative reactions, intense or prolonged distressed after exposure to traumatic reminders, and marked physiologic reactivity after exposure to trauma-related stimuli” (American Psychiatric Association, 2013). Being displaced and moving from one’s home as well as the experience of war contributes to mental health problems in the Somali community (Warfa et al., 2006; McCrone, et al., 2006). In addition to a stressor and symptoms, a person must avoid trauma-related stimuli. They often have marked negative changes in mood after the event and have problems with concentration or have sleep disturbances. These symptoms have to have occurred for more than a month (American Psychiatric Association, 2013).

Depression is another prevalent mental illness in the Somali population. Depression is defined as having at least five of these nine symptoms: “irritable, decreased interest or pleasure, significant weight change, or change in appetite. Change in sleep, activity fatigue or loss of energy, guilt or worthlessness, lack of concentration, suicidality” (American Psychiatric Association, 2013).

The Experience of Trauma

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The Somali people have traditionally been nomads, traveling between the two main rivers Shabeele and Juba, as well as fishing around the coast (Warfa, et al., 2006). Since around the mid-1800s, the country of Somalia has been colonized and divided by several foreign entities (Bhui et al., 2003). This included France, Great Britain, Italy, and Ethiopia. For generations, the people of Somalia have witnessed firsthand violence and wars. It was not until the 1960's that Somalia became independent (Guerin, Guerin, Diiriye, & Yates 2004). The civilian government was overthrown after 9 years of being in power. General Barre became the new ruler of Somalia (Bhui et al., 2003). This lasted until 1991 when civil war broke out. This civil war led to an estimated 400,000 deaths, as well as 45% of the population being displaced from their homes (Condon, 2006). At the time of the study in 2003, there were several warlords fighting for control of the country (Bhui et al., 2003).

The trauma experienced throughout the civil war was not done over night. There were many different traumas that the Somali population witnessed and experienced over a long period of time. The experience of repeated trauma has a snowballing effect where one experience builds upon another each time (Brune et al., 2002). Brune et al. (2002) goes on to say that each new experience of trauma increases the mental health distress and likelihood of developing PTSD.

Relocation

There are several main stressors this population is going through with the process of relocation. Their homes have been taken away, their country divided, conquered, and they have witnessed several regime changes (Warfa et al., 2006; Bhui et al., 2003).

Throughout this the residents have been working hard to hold onto their heritage and

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family ties (Warfa et al., 2006). Families that chose to flee for safer places to live found asylum in several parts of the world, including the United States (Warfa et al., 2006; Jaranson et al., 2004). Research has found that the longer Somali refugees resided in the U.S., the more psychological symptoms they had. This shows that while the experience of trauma is a contributing factor to increased mental illness, the experience of relocating exacerbates the effects (Jaranson et al., 2004). There are several major stressors that come with becoming a refugee that add to the overall mental health distress of this population.

Acculturation

While it is important for the Somali population to hold onto their cultures and customs, moving to a new country requires a certain level of acculturation (Brune et al., 2002). As stated earlier, there are laws and customs that are different here than in Somalia just the same as there are different laws from state to state in the USA. Adjusting to what is and is not allowed takes time and learning. In addition to laws, the cultural norms can differ as well. Because of the stressors related to acculturation, stress-related mental health disorders can occur (Jaranson et al., 2004).

Family Structure

Somalis use a family or clan system to keep their identity (Warfa et al., 2006). For Somalis, families are the largest source of identity as well as security (Warfa et al., 2006). Within these families, the elders are held in high regard and are the decision makers as well as the culture keepers (Bhui et al., 2003). The role of elders changes as they move into a new culture. The elders do not have their families relying on them the same way they were in Somalia. A change of roles within a family is another part of transitioning when moving. Younger children often learn the language faster and the elders rely on

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their children for communication. This is important because of the added stress it puts on the elders. With the younger generations adapting quicker, the elders are experiencing stress because their identity as the main decision maker is changing (Ali, 2008; Bhui et al., 2003).

Parenting has also had to change a lot upon moving to Minnesota (Bhui et al., 2003). In Somalia, the parenting style is considered to be that all adults of the community help raise the children, while in the immediate family, the father has last say (Guerin et al., 2004). In Minnesota, the main parenting style is that the immediate family will raise the children. With the Somali parenting style, children are allowed to run freely since any adult of the community is a part of raising the child (Guerin et al., 2004). If an adult outside of the immediate family finds a child behaving poorly, it is not uncommon for that adult to discipline the child (Guerin et al., 2004). In the United States of America, it would usually be considered taboo for anyone other than the immediate family to provide discipline (Warfa et al., 2006). This has eventually translated to a strained family system in the Somali community where the adults outside of the immediate family over-discipline, or end up letting the children roam free as they did in Somalia (Ali, 2008).

Somali children frequently learn the English language at a faster rate than their parents do because they are going to English speaking schools. Because of this, parents and elders rely on their children to communicate with non-Somali speakers (Ellis et al., 2008). In Somalia, the parents did not need to rely on their children to communicate to get resources such as where to get groceries, where to get the car fixed, etc. Because

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parents cannot get access to many resources due to the language barrier, they rely on their children to communicate. This is known as role reversal: “a situation in which someone adopts a role the reverse of that which they normally assume in relation to someone else, who typically assumes their role in exchange” (Oxford University Press, 2014). With the role reversal, and this new way of parenting, there has been a high amount of stress and responsibility put on the population’s youth (Warfa et al., 2006). The increased stress of the role reversal, in addition to the stressors of relocation, puts the elders and youth of this population at risk of developing mental health disorders (Bentley, 2011). This experience is unique for the Somali culture, as Somali families have never dealt with the role reversal before, especially not in such a small time frame.

Parent-Child Communication

Upon coming to Minnesota, the elders have been taken out of their role due to not being able to adapt to the new way of life (Jaranson, et al., 2004). Because of this, there has been a role reversal where the children are now the experts (Jaranson, et al., 2004). Children with this expert status have used this to their advantage. Often, due to the language barrier between the adults and schools, the children will act as interpreters and withhold information, thereby leaving the parents uninformed (Ali, 2008; Jaranson, et al., 2004). With the lack of accountability and supervision, the past few years have seen a trend of high crime rates in the Somali youth population (Ellis, et al., 2010). Ellis et al, (2010) states that this has caused further distress in the parents as well as the children, increasing the likelihood of developing mental illness.

Current Supports

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There are three main supports for the Somali population (Ellis, et al., 2010). These are religion, family, and community-based supports. Ellis et al., (2010) report that the Somali population will first look to religion for mental health support. Virtually all of the Somali population is Muslim (Warfa, 2006). This shows that mosques and other places of worship are major supports for the Somali population. While in the study by Ellis et al., they stated that families and family-based supports are considered supports, they reported that because of the stigma around mental illness, families have been shown to shun mentally ill members of the family (Ellis, et al., 2010). The third support is community based support. Somalis are unlikely to seek help from mental health clinics (Bentley, 2011). Medical clinics are utilized because in the Somali culture it is not taboo to seek help for a physical symptom (Ellis, et al., 2010). While there are not many, there are several mental health clinics that specialize in work with the Somali population, such as the ‘Somali and East African Behavioral Health Services Program’ and ‘Somali Family and Youth Services Sabathani Center’, both located in Minneapolis, Minnesota (Volunteers of America Minnesota, 2014; Healing Resources for Refugees, 2014). The problem is these programs are being underutilized due to several barriers such as stigma and language.

Barriers to Mental Health Treatment

Stigma

In the Somali culture, there is no grey area for mental illness; either you are sane, or insane (Nwaneri et al., 1999). Traditionally, people suffering from a mental illness go to their elders or religious leaders to be cured or cleansed (Bentley, 2011). In Minnesota, there is an active Somali-based religious community. With this support present, the high

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prevalence of mental health disorders in this population shows that the cultural norm of using religious leaders to cure is not effective in treating this population (Wilder Research, 2010).

While there is a need, there is still the issue of the stigma of mental illness in the culture. The cause of mental illness for Somalis is often believed to be because of an evil spirit (Warfa, et al., 2006; Guerin, 2004). The spirit has come to punish the individual for any immoral acts they have done (Warfa, et al., 2006; Guerin, 2004). Somalis, being a very close community, do not want anyone seeing them associated with mental illness, fearing that they will be stigmatized (Warfa, et al., 2006; Guerin, 2004). Because of this strong stigma, it is very hard to reach out to this culture (Warfa, et al., 2006; Guerin, 2004).

There are several reasons which make it hard for providers to reach out. The first reason is the Somali's view on mental illness being a challenge that god gave them, and therefore being their burden to carry and pray about (Ellis et al., 2010). Asking for help can be felt as being shameful because of it being their burden to work through (Ellis et al., 2010). Another reason that makes it hard to reach out is due to the stigma and potential for being viewed by the community as insane (Guerin et al., 2004). This is a challenge because those in the Somali community tend to deny that they have an illness and will instead say they have aches and pains (The Minneapolis Foundation, Wilder Research, 2010). There is also a mistrust of mental health providers. Somali's are wary of the integrity of their personal information staying private, as well as wary of the providers' ability to help (Loewenthal et al., 2012). Because of the strong religious

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presence, Somalis generally trust prayer over therapists when it comes to mental illness (Nwaneri et al., 1999).

Language

Another large barrier to service is language (Loewenthal et al., 2012). In the Twin Cities there are very few practicing mental health professionals that speak their native language (Ali, 2008). With that said, there are Somalis that immigrate and speak English, but the majority of these refugees and immigrants arrive without knowing the language (Loewenthal et al., 2012). There are also times when words or phrases do not directly translate with the same meaning from English to Somali, or Somali to English. This can lead to a gap in communication.

Interpreter

While it is best to practice therapy without the use of an interpreter, due to a lack of available Somali mental health professions, this can't always be achieved (Ali, 2008; Bolton, 2002). Ali (2008), reports that therapists find it difficult to pick up on nonverbal queues when using an interpreter.

Ali (2009), also reports that in the case of Somali interpreters, due to the close knit community, members might feel uncomfortable sharing potential stigmatizing information. With the Somali culture, it is a custom to pray for each other to get better. Because of this and the tight knit community, Somalis are worried that the interpreters will go to the community with this stigmatizing information because it is the cultural norm to ask other community members to join in praying for the person (Guerin, 2004). This has led to mistrust in interpreters.

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Despite the mistrust, and barriers to working with interpreters, there are several benefits to working with an interpreter. Bolton (2002), explains that interpreters can be used to gain cultural awareness for providers.

Education

Related to the language barrier is the educational barrier. Children entering school speaking little to no English are hindered in their growth in school (Ellis et al., 2010). Youth will get behind in school work and often not have support at home to catch up due to the language barrier, and differences in education systems between Somalia and Minnesota (Ellis et al., 2010) Falling behind in school, can in turn cause more issues like depression when compared to other classmates. It also can keep them from making friends and can set them back even more socially which can contribute to more mental health stressors (Ellis et al., 2008) Throughout its history, the Somali education system has been sporadic. The biggest harm to the education system came in 1991 when the state collapsed into civil war. While there were still a few private schools operating, the public school system became nonexistent (Loewenthal et al., 2012). As of 2005, about 20% of the school-aged children were actually going to school (Ellis et al., 2010). Because of the unfamiliarity of formal education, the Somali youth are at a disadvantage compared to their non refugee classmates (Loewenthal et al., 2012). For the youth, this has brought on a lot of stress (Loewenthal et al., 2012). This also occurred with the parents who struggled to adapt to such a structured society (Ali, 2008).

Concept of Time

Perception of time is a large barrier that can create a gap in providing mental health services to this population. The Somali community views time differently than the

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Western way of thinking. Oftentimes practitioners are finding that Somali clients will arrive a day late, a day early, or even several hours before or after the arranged meeting time (Loewenthal et al., 2012). Because of this, it is hard to schedule set times to meet (Ali, 2008). This has made it hard for practitioners who are paid by the unit rate and can't be reimbursed for missed meetings (Loewenthal et al., 2012). This flexibility can be tough to manage when carrying a full caseload (Bentley, 2011).

Suggestions to Overcome Barriers to Treatment

Due to the strong stigma the Somali population associates with mental health, health professionals should adapt their approach of addressing these issues to Somali clients. Addressing symptoms rather than giving a label or diagnosing a mental health issue can be more appropriate for this community. By emphasizing the physical symptoms of psychological distress, like having low energy or not sleeping enough, instead of emotional symptoms, practitioners can bypass this stigma (Bentley, 2011). Through bringing up the symptoms and framing them in a culturally-sensitive way to avoid this stigma, this population can be reached (Bentley, 2011). Openly discussing symptoms will in turn allow the health providers to better assess for and identify underlying mental health concerns.

General Education

Ellis et al., (2010) stated that to help overcome the stigma of mental illness, general education with health providers needs to be completed about the Somali's view of mental illness. By having health providers understand the Somali view of mental illness, they can better discuss mental health in a culturally appropriate way (Bentley, 2010). By doing this and explaining mental health in terms of physical presentation, the

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utilization of mental health services in the Somali community could be increased (Bently, 2010). Social workers, doctors, nurses, and interpreters could all have a role here given their profession and access to the community. To achieve this, regular trainings, and culturally specific questionnaires could be developed that clinics and hospitals could use to discuss mental health.

Several possible areas and community resources for workers could use to connect with the Somali population are religious mosques and hospitals. With the Somali population being so medically based, oftentimes Somali patients will describe the physical symptoms of depression to their doctor. By improving the communication between health professionals and the Somali population, and promoting positive dialogue, the mental health needs can be better addressed.

Conclusion

In this review several barriers to treatment were discussed. Without addressing these barriers, the general Somali population will continue to have untreated mental illness. These barriers are important to think about when addressing this population. Without being culturally competent, the practitioner could do more harm than good in trying to reach out to Somalis. After reviewing the literature, two things are evident. There is a gap between the need for mental health treatment and the utilization of the services available. Currently the Somali population is utilizing hospitals and clinics to receive help for physical symptoms. Nurses and doctors are not always specifically trained to work with the Somali population in a culturally specific way (Nwaneri et al., 1999). This causes difficulty for these clinics to correctly identify, diagnose, and treat

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mental illness. This is an important issue for mental health providers due to the high prevalence of mental illness in the Somali community.

Based on the literature, and the current utilization of hospitals and clinics for mental illness, the research question was to see what strategies medical personnel are using to identify and discuss mental illness with the Somali community.

Conceptual Framework

I view this research from the lens of the ecological perspective. The ecological framework views the person's environment as an important factor in their welfare (Bronfenbrenner, 1979). Rogers (2006) states that the way an individual perceives and understands their environment has a significant effect on the individual's wellbeing. A person's development is affected by family, friend group, local neighborhood, and community (Bronfenbrenner, 1979).

With the ecological theory, there are four different levels that make up a person's environment. The first level, or "microsystem", focuses on the person's home, workplace, and neighborhood. The second level, "mesosystem", focuses on the interactions that the microsystems have with each other. The third level, "exo-system", consists of external environmental systems such as social settings where one might interact. The fourth level, "macrosystem", consists of laws, beliefs, and cultural values (Bronfenbrenner, 1979).

Because the ecological theory views the environment as an important factor in an individual's wellbeing, the conceptualization of the need for mental health treatment in the Somali population fits perfectly into the ecological perspective. Somali refugees, when arriving in Minnesota, have many strained microsystems. For example, when coming to Minnesota, a Somali who was a doctor in Somalia, might not be able to

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transfer their doctor license to Minnesota and there for be unable to practice in Minnesota. Another example of a strained microsystem is the neighborhood. With many new families moving into an area, this can strain existing relationships. With the many challenges and changes that a Somali refugee experiences to their microsystems, the increased stress and risk for mental illness can be explained. Once one microsystem is not functioning smoothly, the other environments will be effected as well, ultimately affecting the individual's welfare (Rogers, 2006).

The ecological perspective also focuses on a person, or system's strengths (Bronfenbrenner, 1979). When looking at the strengths of the Somali population, they are very good at ensuring that their physical health is taken care of. In addition, when suffering from a mental illness, they present their symptoms as being physical such as pain in arms, or tiredness. Currently the stigma is one of the biggest barriers to Somalis accessing mental health services in the Twin Cities. According to the ecological perspective, the ethnic traditions are important in that they help the individual create a sense of self and congruence between microsystems (Rogers, 2006). By looking at the historical background of stigma in this population, social workers can use the physical symptom presentation of mental illness as a strength. Social workers can use the ecological perspective by working to improve the interactions people have with their different systems, thus improving the person's overall wellbeing (Bronfenbrenner, 1979). In this specific case the literature shows that Somalis are going to hospitals or clinics with physical symptoms when the underlying cause is mental illness. By being aware of this and reframing what mental illness is, the two systems can better work together, thus improving the person's wellbeing.

Methods

Research Design

This researcher explored how medical personnel can better assess and connect Somalis with mental health resources. In order to investigate the experiences medical professionals have had when working with this population, a qualitative approach was used. According to Monette, Sullivan, and Dejong (2008), qualitative research gives the researcher a chance to gain a deeper understanding of the topic matter. Qualitative interviews give the participant a chance to expand upon and explain a response that they normally wouldn't be to explain on a quantitative survey (Monette et al., 2008). The interviews consisted of nine open-ended questions (see Appendix B) regarding each participant's professional experience with Somalis who come in reporting physical symptoms when the underlying cause is mental illness.

Sample

Medical personnel who had experience working with Somali's in a health care setting such as doctors, nurses, social workers, or interpreters, were recruited to participate in the study through purposive snowball sampling. For the purpose of this study, Medical personnel were defined as professionals who have worked in hospitals, clinics, and health care agencies who have worked with Somali patients. This was chosen because any professional in this setting has worked with Somali patients and therefore could impact service delivery. Snowball sampling referred to the process of using referral sources to identify other referrals who worked in the same subgroup (Monette et al., 2008). The participants were selected purposively in that they were currently working as a social worker, nurse, doctor, or interpreter, in a hospital, clinic, or health care agency.

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Purposive snowball sampling was used to recruit participants because it would allow for the researcher to find participants who worked as medical personnel with limited current contacts that work with the Somali population. This writer used existing contacts to obtain referrals. These participants were asked to pass on the research study information and consent form (Appendix A), to others that worked in the same setting. This allowed for potential participants to contact the researcher, to set up a time to interview.

Participants were not notified who referred them to the researcher for the study to ensure confidentiality. Phone or email was used as a means of communication to set up the interviews. Initial contact form (Appendix C) was used for initial communication to set up the interviews. Interviews were done in person.

Protection of Human Subjects

The participants in this research study were protected by confidentiality. The consent form (Appendix A) was used to describe the safeguards of confidentiality and understanding of the purpose of the research. The consent form consisted of information on the voluntary nature of the interview, potential risks and benefits, confidentiality, and the participant's ability to withdraw at any time during the interview. This researcher went over the consent form with each participant prior to the interview and used professional judgment that the participant understood each aspect of the form. The consent form was reviewed by this study's research chair, committee, and was submitted and approved of by the St. Catherine University's Institutional Review Board (IRB).

In handling the confidential information, the researcher ensured that the participants were aware that a transcriber had access to the data for transcribing only. Upon transcribing, all identifying information was removed and destroyed.

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Data Collection and Data Analysis

The data collection tool that was used in this research study was a set of 10 research questions (appendix B). Each interview was between 45 and 60 minutes. Interviews were audio recorded on an iPhone and then transcribed. All transcribed information was kept on a USB device. Identifying information was removed or altered to ensure confidentiality. All information was kept in a password protected USB and kept locked in a room.

The data was analyzed by using content analysis. Berg (2008), states that content analysis is a way to evaluate raw data to look for repeated themes. Each individual interview was analyzed and themes that emerged were compared with the other interviews.

Findings

The sample consisted of 6 participants. Four of the participants were nurses, one worked in a hospital, two worked as Personal Care Assistant supervisors, and one worked as a Nurse Case Manager for a health care agency. One respondent was a doctor who was doing their residency, and one was a Somali interpreter. All participants interviewed were female and were all working in their field for less than 10 years, with the medium time worked being 3 years.

The following section details the participants' responses to the semi structured interviews. Each participant's responses were analyzed, then coded. The purpose of the interview questions was to obtain information about the participants' experiences discussing mental health with the Somali community.

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A total of 6 participants were interviewed and all have had experience working with the Somali population in a health setting such as a hospital clinic or health care agency. The interview questions were designed to encourage a free flow of ideas. After analyzing and coding the interviews, four main themes emerged. They are (a) diagnosing with two subsets of prevalence and recognizing mental illness, (b) the stigma of mental illness, (c) impact of interpreters, and (d) dialoging about mental health with three subsets including rapport, approach, and suggesting treatments.

Diagnosing

In this section, there were sub-themes that came up when talking about diagnosing patients. They were prevalence and recognizing mental illness.

Prevalence

All of the participants identified depression as a prevalent diagnosis in the Somali clientele that they work with. Also all of the participants identified PTSD or anxiety as another prevalent mental illness. In addition, all six participants referenced the underutilization of formal mental health services in this population. When describing why there is so much underutilization, undiagnosed mental illness was a common theme, The Nurse Case Manager stated:

There seems to be a lot of undiagnosed mental illnesses in the Somali population. I'll notice after a few sessions that they sometimes bring forward symptoms that could easily be linked to depression or PTSD, but when looking in the chart, there really is not much on it.

A common diagnosis reported by all 6 participants was depression. The Clinic Nurse stated, "Older Somali women who came in talking about classic signs of

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depression, you know low energy, always tired, headaches, she even talked about missing her country.”

When discussing Somali clients who have depression, anxiety, or PTSD, the Nurse Care Coordinator explained why there is a difference between diagnosing and getting clients the correct services. She stated:

You see many Somalis coming in complaining of physical complaints that can be easily seen to us as a mental illness, however, you see very few actually following through and seeing a therapist for it. They will usually accept symptom specific medications, like for example, sleeping pills, but they won't go see a therapist. So, basically, their symptoms are being taken care of, but the mental illness is not being treated.

The above diagnoses are the most common mental health diagnoses in the Somali population according to the participants

Recognizing Mental Illness

A sub theme of diagnosis is recognizing mental illness. An important part in diagnosing mental illness is the ability to recognize it. All six participants stated that somatic or physical complaints are present in the Somali patients who come in with an underlying issue of mental illness. The mental illness in each case was determined later in the participants work with the Somali patients. To explain the physical presentation, the Somali Interpreter talked about an experience she had working with Somali clients, she stated:

They have a lot of pains and aches that they complain about in their body, and if you look at all the symptoms, it really is all of the symptoms of

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depression or mental health. It shows that but it just manifests its self in a different way.

An important part of working in this setting is that Somalis are currently going to hospitals and clinics to receive help. They view the nurse or doctor as someone who can fix their physical ailment. When talking the process of Somalis receiving help the Nurse Care Coordinator stated:

But with the clients where I see the more undiagnosed mental illnesses, they seem to say things like ‘I can’t sleep’, or, ‘I day dream a lot about back home’. I think since they see me as a nurse, they kind of see the link between, I have this physical symptom, and I know this person can help me fix it.

In addition to physical complaints, a common theme brought by five participants was Somalis saying the word “worry” to describe depression.

The Nurse PCA Supervisor, while explaining the commonalties she has seen with the Somali population stated, “they will say stuff like ‘I worry a lot’ or ‘I hurt a lot’ so they don’t really use the words we would use.”

Based on the responses from the participants, Somalis generally do not define their symptoms in terms of Western Medicine. The participants all reported that it’s important that health professionals are aware of the way somatic or physical symptoms are used to describe mental illness to have a more accurate understanding of the patients underlying concerns.

Stigma

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One theme that was prominent after interviewing the participants was the stigma of mental illness in the Somali community. All of the participants reported that the view of mental illness was stigmatized to the point where it created large barriers when discussing mental health. Four of the participants reported that Somali patients were worried about being labeled as “crazy” or “insane” by their community. In addition to this, four of the participants explained that status in ones culture was very important and it could be devastating to be associated with having a mental illness. The word insane came up several times. One of the questions asked in the interviews was how do you know a strategy didn’t seem to work. All six participants reported various reactions from their Somali clients, however they all reported that by not being culturally aware and stigmatizing their clients is what caused their strategy to not work.

The Nurse Care Coordinator stated, “It seems like being labeled as depressed in their culture is the same as being labeled mentally insane to us.”

The interpreter confirmed what the nurse said by stating how having a mental or physical difference can quickly turn into being a label that stays with the person. She explained:

Let’s say, today you are a nice young handsome man. You lose your arm, starting today, everyone’s going to say you are damaged or call you missing arm man. It’s a typical thing. So a lot of people in the same way don’t want to be labeled that they are paranoid.

The Clinic Nurse reported, “It almost seemed archaic how they viewed mental illness. Like instead of viewing it as a illness that can be cured in the brain, they view it as a punishment”

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To help explain stigma in terms of her own culture, and normalize the experience past just being an issue Somalis struggle with, The Nurse Care Coordinator explained:

I think a lot of times it is embarrassing to talk about mental illness. Even in our culture, people don't really treat you the same if they know you have a certain diagnosis... I think we as humans, kind of don't want to be labeled a negative thing and don't want to be treated differently because of it. I think the Somali culture is no different.

Another barrier of stigma that came up is the influence of religion. Three of the participants reported the view that any mental or physical sickness received was placed on them by god, and it's their burden to carry. All six of the participants reported that religion is a barrier. When discussing religion, The Somali Interpreter reported:

Yeah you are not supposed to complain what comes upon you, that's the cultural religion that you are put on this earth by god, therefore you have to obey him and do as he says, so if you challenge it or say why do I get sick, it's a sin.

Another view brought up was the idea that Somalis can view mental illness as a consequence of a past sin. The Nurse PCA Supervisor explained:

So yeah, I knew to like stay away from using a formal diagnosis, I knew about, like the stigma, the population has with mental illness, and how like, how you can be labeled as, instead of being labeled as you have depression, it's like worse than that with them, it's almost like it outs them from their community, their family, and how they will talk about this

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persons depressed because umm, they did something to deserve it so god is punishing them with that, so I thought that was pretty interesting.

As described by the participants, stigma was the biggest barrier for Somali's receiving services. The strong stigma comes from the view that mental illness is given to someone as a punishment, as well as the view that a person is either crazy or sane. Because of this, being viewed as mentally ill can change the way the labeled Somali is viewed upon their peers. By approaching the Somali member in a way that limits risk of being labeled and stigmatized, health professionals can more effectively discuss mental illness.

Interpreters

One theme that emerged from all six of the interviewed participants was the barriers and benefits of using an interpreter.

Barriers

Barriers in working with interpreters were reported by all six participants. Five participants reported that the interpreters cause a separation with the client. Three participants reported that a barrier was the increased time it took to explain things. Another common barrier reported by 5 of the participants was interpreters doing more than their required job of interpreting by adding their own opinion or conversing with the clients. Two participants reported that a large concern is that the interpreter is going to break confidentiality, and share the patients concerns to the Somali community. The Doctor stated, "It was really challenging because you had to slow down train of thought and make sure you were getting across what you needed."

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When discussing barriers the Nurse PCA supervisor brought up boundaries between her being a female, and working with a male interpreter. She reported:

There are more boundaries between me and a male interpreter. I was using a male interpreter with this other client, I'll just give you an example, and umm, it was (pause) it just created some boundaries in the room where I felt he wasn't being as sympathetic to the client as I was when asking these questions. I feel a tasteful interpreter can show their sympathy with their translation as well.

When talking with the Clinic Nurse, she reported getting frustrated by having to use interpreters regardless of gender. The Clinic Nurse stated, "It causes another degree of separation".

Another common barrier of using interpreters was the possibility that the client knew the interpreter, causing mistrust in the privacy of information shared. When talking about this, the Nurse Care Coordinator reported:

I can totally see why if my clients know the interpreter, it can make it awkward and hard to answer some questions, so I try to make sure the interpreters know they can't share anything they see or hear and I do the same with the client so they know we can't just share things with people.

The participants all agreed that working through the barriers, and limiting the negative effects interpreters can have on the communication between patient and provider is crucial to working with the Somali population. Three of the participants placed a big

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emphasis on how building trust by ensuring confidentiality is also an important piece to working with interpreters.

Benefits

With the barriers, there were also a lot of benefits reported by the participants. All six participants reported enjoying working with interpreters as long as there was a current working relationship with the interpreter. The participants reported the following were benefits to working with interpreters: culturally competent resource, added help in ensuring the patient understands what the provider is explaining and vice versa. The Doctor stated:

I have seen interpreters that really are culturally competent which is really helpful because, haha I'm nervous when working with an interpreter. So it's nice to have someone directly involved in the culture who can kind of provide those cultural (pause) like a bridge to the cultural gaps or something to help the patient understand what the doctor is saying or what the patient is trying to express.

The Nurse PCA Supervisor stated, "But also with, interpreters, I like it because they can sometimes guide me through visit (pause) interpreters will know the small things like do you take your shoes off." In order for the working relationship to be effective, and to gain the benefits of having a culturally aware interpreter, the Nurse Care Coordinator reported:

I always try to meet a little prior to or have specific interpreters I have worked with in the past and ensure that they are on the same page as me

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with things, and also like I said, use interpreters to be a resource before and after a meeting.

Based on the participant's responses, by having a working relationship with the interpreter, the cultural awareness and understanding of one another can have a beneficial influence on the relationship between health professionals and the Somali community.

Having the Conversation

When preparing to have the conversation about mental illness, six of the participants reported that while previous trainings and education helped, direct experiences with the Somali community carried more influence in feeling ready. There was a wide disparity of culturally based trainings given by participant's hospitals, clinics, and health care agencies ranging from a few per year to never. To prepare for the conversation, the Nurse PCA Supervisor explained:

The only real way to experience a culture is to dive into the experience, so that's why it's fun to go into clients houses and seeing, how they really live, the food that they eat, the tea they drink hahah.

When talking with the doctor, she was asked, what prepared her most for working with Somalis. The Doctor responded, "Not in my education. I feel like I have gotten most of my understandings from extracurricular activities."

Rapport

All six participants cited rapport as being crucial to having a successful dialogue. When explaining rapport, all six participants reported that, due to the nature of their jobs, the short time frame that they are working with the patients creates a barrier to having strong rapport.

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The Clinic Nurse reported, “Well unfortunately due to the short time frame I am with them it is hard to build a good relationship. I think jumping in too personally with the person’s past can make the conversation stop.’

To help build rapport, the Nurse Care Coordinator stated that by having the same doctor or nurses see the clients over time, they can overcome the short time frame of the visits. The Nurse Care Coordinator explained:

I have a few Somali clients that have been working with doctors for a while now. They receive medication and kind of understand why they are sad or at least understand what they need the medications for. These clients tend to be more open about what they are going through. I’m sure it wasn’t always that way with them but now that they have had many conversations about it, they seem to be more open with it with me.

The Somali Interpreter when talking about how long it can take to build trust and rapport brought up her own experience with a family doctor, she reported:

My grandma for 9 years had the same doctor asking the same questions for her to finally trust him enough to say yes, I’m going through this, I’m having nightmares, I worry enough, I can’t turn my worry of then she got treated and she was so much better and so much more pleasant to be around too.

While it’s important for the providers to build rapport over time, The nurse Care Coordinator stated that during the short visits:

There are several things that I do to create a safe space, I first and foremost make sure that I have a good working relationship with the

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client, haha I'm not going to just go and say hey! You seem depressed let's go talk about it, I make sure to let them know I really care about them and their wellbeing. I talk to them about their day to day life, I ask them what they want help with, I talk to them about their family, about what they do for fun, what they did when they lived in their home country. I think its important to have a certain level of trust before people will share any personal things with you.

The importance of using the time available with the Somali patient, to build rapport was stated over and over with all six participants. The participants all stressed the importance of really connecting and showing the client they genuinely care about successfully building rapport. Having an ongoing relationship and building on past interactions helps build trust that improves the chances of discussing mental illness.

Approach

A sub theme of having the conversation is the approach, when to start the dialogue, and how to do it. All six participants confirmed that using physical symptoms, to describe mental illness and avoiding labeling is crucial to the approach. All six participants also assigned importance to approaching the conversation by being open and non judgmental when discussing the subject. Three participants cited using the word "worry" instead of "depression" as being culturally appropriate. When discussing how to approach mental health with a Somali patient, the Nurse PCA Supervisor reported:

You always need to approach the situation, tactfully, whenever you are talking about this with anyone regardless of their culture, tips would include reflecting, back their posture, actually having a conversation, you

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just need to be open and sympathetic, and approach it in a non judgmental way, like this is okay to talk about.

A common theme that was brought up by all participants was not using formal diagnoses. When discussing this, the Doctor stated:

At that point when I decide it's time to talk about the mental illness, I try to for the most part stay away from formal diagnosis, I have noticed and been told by interpreters that instead of saying depression, use the word worry.

According to the participants, using physical symptoms when discussing mental illness was found to be more effective than using a diagnosis.

Treatments

Specific treatment suggestions were another theme that emerged. All six participants reported treatments that they or the doctor they worked for suggested. Five of the six participants reported successfully helping a Somali patient see a therapist for mental illness. All six participants cited non therapist based treatments, specifically treatments that can be done at home as being followed more than seeing a mental health therapist. Four participants reported finding difficulty in knowing if their Somali patient followed through with recommendations due to lack of follow up visits. There was a general inconsistency of what specifically to suggest for formal treatments. The Clinic Nurse stated:

Unless the patients come back for a follow up visit we really don't have much of a way right now to see how well the patients are following

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recommendations. I just know that they take the medication prescription and seem to be interested in the at home suggestions.

A theme discussed by three of the participants was the use of current supports to augment medications and therapy. PCA supervisor Nurse Stated:

I did work with her social worker a little bit and was able to get her to go to an adult day care, this specific place had other elders of her community that would get together that would talk during the day. I know it's not formal therapy or a medication, but she seemed to respond well to it, so with the sleep medication and her being able to be around others, she just seemed happier.

The biggest difficulty that was reported was, getting Somalis to be open to the idea of seeing a therapist. When discussing strategies used, The Nurse Care Coordinator stated:

I also do try to touch a little bit on how they can see specialized people who can help them through their thoughts, I try to stay away from words like counselors or mental health therapists, just say what those people can do for them, also since I do see them every few months I can follow up with them better than a doctor that seems them every six months.

Discussion

The themes that emerged from the findings of the participant's interviews were congruent with the current literature relating to prevalence of mental illness, stigma of mental illness, and the physical symptom presentation of mental illness in the Somali population. The findings were also congruent with the current literature in that mental

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health clinics are being under utilized in this population. In this section, the researcher will discuss how the findings of the study provide significant insight to the health professional's that work with Somalis. The themes that emerged from the findings section will be discussed and compared with the current literature. The major themes included, diagnosing, stigma, interpreters, and dialoguing about mental health.

It is important for the health providers working with the Somali population to understand the main mental illnesses, and how to identify and talk about these with the Somali population.

Diagnosing

Prevalence

The literature and findings were congruent in that there is a high prevalence of depression, PTSD, and general anxiety with this population. When referencing the most prevalent mental illnesses in the Somali population, Kroll et al. (2010) reported that due to the stressors of relocating as well as the war trauma experienced, there is a high prevalence of Post Traumatic Stress Disorder, Depression, and Generalized Anxiety Disorder in the Minnesota Somali population.

When working with the Somali population, it's important to know the most common diagnoses so the health providers can ensure that they look for these.

Recognizing Mental Illness

Another common theme in the findings was when identifying mental illness in this population, mental illnesses was presented as physical complaints. This was also congruent with the literature. Bhui et al. (2003) reported that Somali's describe mental illness symptoms as physical complaints.

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When working with the Somali population, health professionals, should focus on the physical symptoms brought up to effectively identify mental illness. It will be important to rule out physical causes to separate physical causes from mental illness. The literature and findings showed that it is common for Somalis to not openly discuss mental illness. This makes it important to check further into physical complaints to see if the root cause of the physical ailments is due to mental illness or a symptom of an underlying mental illness.

Stigma

Stigma was a common theme brought up that caused the biggest barrier to Somali's accessing mental health services. The current literature and findings agreed that often members of the Somali community will refuse to talk about mental health issues because they believe they will be stigmatized (Warfa, et al., 2006; Guerin, et al., 2004). In the Somali culture, there is no grey area for mental illness; either you are sane, or insane (Nwaneri et al., 1999). To explain further, the cause of mental illness for Somalis is often believed to be because of an evil spirit (Warfa, et al., 2006; Guerin, 2004). The spirit has come to punish the individual for any immoral acts they have done (Warfa, et al., 2006; Guerin, 2004).

By being aware of the stigma, providers can learn to navigate around it. This can be done by ensuring the information disclosed between patient and health professional is confidential, and using non stigmatizing language like avoiding labels and explaining mental illness in terms of physical or somatic complaints.

Impact of Interpreters

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Interpreters were a large concern and resource throughout the findings and literature review. The findings and literature agreed that Somali's have a concern about sharing personal information with an interpreter present due to the close knit nature of the Somali community. Where the literature and findings differed was the rationale behind it. The findings suggested that the mistrust comes from the Somali cultural norm of praying for one another. This causes the stigmatizing information to be shared with other members of the population so the individual who has mental illness can be prayed for. Because of this, Somali interpreters in the past have gone on to share confidential information with others in the community, with a mind set of doing what was culturally right. This has been a cause of some of the mistrust in the interpreters.

Interpreters can also be great resource for culturally aware service delivery. Bolton (2002), explains that interpreters, as well as being a bridge for the language gap, can be used to gain cultural awareness for providers if the interpreter is from patients same cultural background. The findings and literature agree that interpreters can assist the health professionals and Somalis in mutually understanding each other.

Based on the findings and the literature, it is important for health providers and interpreters to develop a close working relationship. This is to ensure the importance of gaining trust with the clientele, ensure that confidentiality is kept, and to ensure that the interpreter understands the provider's definition of mental illness, so when discussing mental illness with the Somali population, the correct meaning is being interpreted.

Dialoging About Mental Health

Rapport

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The literature focused more on being culturally aware rather than the findings focus of developing a relationship while being culturally aware. Due to the strong stigma the Somali population associates with mental health, health professionals should adapt their approach of addressing these issues to Somali clients. Addressing symptoms rather than giving a label or diagnosing a mental health issue can be more appropriate for this community. By emphasizing the physical symptoms of psychological distress, like having low energy or not sleeping enough, instead of emotional symptoms, practitioners can bypass this stigma (Bentley, 2011).

The findings focused heavily on the importance of building rapport with the Somali population. By having a healthy working relationship with Somalis, trust can be built and could build to having a level of comfort strong enough to be willing to trust the health professionals with personal information.

Approach

The literature stated that by explaining mental health in terms of physical presentation, the utilization of mental health services in the Somali community could be increased (Bentley, 2010). The findings and literature agreed that when discussing mental illness, using physical symptoms to describe mental illness is vital. By having health providers understand the Somali view of mental illness, they can better discuss mental health in a culturally appropriate way (Bentley, 2010). The findings and literature showed the best way to approach mental illness with the Somali population is to be aware of the stigma, check in with the patient often, and to explain clearly the physical symptoms that are presented and using empathy for how tough the physical symptoms are.

Suggesting treatments

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A big gap in the literature was how to actually go about suggesting treatments and what treatments to suggest. As previous sections stated, there is a lot of literature on the stigma, importance of using culturally aware approaches to discussing mental illness, but little on actually suggesting treatments, and even less on what treatments to suggest.

Based on the findings of this study, dialoguing about mental illness can be improved by building rapport, using somatic terminology to describe, and most importantly staying away from stigmatizing labels. For providers it's not lying, or hiding the truth, it's finding common ground and common language.

There was little agreement between participants on what treatments to suggest. The findings suggest that there is currently no common treatment that is being offered to Somali patients. This is important because this confirms what is already known in the current literature that the main hurdle to getting Somalis the help recommended is the discussion of mental illness.

Implications

There are several implications for health professionals as a result of the findings of this study. The gap between need for and utilization of mental health services was apparent in the current literature. Due to the high population of Somali- Americans in the Twin Cities area, and the current use of hospitals and clinics for receiving treatment for physical ailments, health professionals have an opportunity to help this population access appropriate treatment.

This study showed the importance that providers use physical symptoms to explain mental illness and identify mental illness in this population. It's important that

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providers be culturally aware of the weight stigma carries in this population when preparing to discuss mental illness with this population.

This study also showed the importance of building rapport with this population. The findings showed that a developed relationship over several visits, and follow up with this population helped build rapport and the ability of this population to trust providers with stigmatizing information.

Social Workers specifically have an important role to play in helping the Somali Population. Because of the nature of their jobs, Social Workers are set up to work with multiple resources in the patient's lives, and can use this to build rapport and an ongoing relationship. With interdisciplinary communication, Social Workers can bring the knowledge of the ongoing relationship to be a partner and a link to both the Somali patients, and the medical team.

Future research on the impact of staff trainings on cultural awareness, impact of gender, age, culture, and the use of culture specific mental health talking points to improve diagnosing of and utilization of mental health services would benefit this population. Findings from future research could eventually lead to changes in policy on educational requirements for cultural awareness.

Strengths and Limitations

The main strength of this study was that it gained specific knowledge that medical professionals could use when working with and connecting the Somali population in the Twin Cities to mental health services. The findings were specific to health professionals working with the Somali community in the Twin Cities area. The qualitative nature of the study allowed for an in-depth understanding of the subject matter.

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Participant bias is strength and a limitation. Participants selected, came forward to participate due to their own interest in Somali Mental Health. This means that the sample used in this study was familiar with the Somali population and brought with them knowledge of the Somali Culture. Because of their experience with this population, their responses are valuable, but it should be taken into consideration, their personal bias of the subject matter.

There were several limitations of this project. The first was the small sample size. This study was dependent on the availability and willingness of individuals to participate. The researcher's goal was to interview a minimum of ten participants, but due to time and scheduling constraints, obtained only six perspectives. A total of eight participants were selected to be interviewed for this study, however, two of the participants did not fit the criteria of working with this population so their interviews were not utilized for the findings. Due to the small sample size, and gender of the participants, it difficult to generalize the findings of this subject matter. There was an effort made to interview more Somali practitioners, however, due to the limited availability of many contacted, only one was interviewed. The results could be biased toward specific professions such as nurses, as they were the majority interviewed. The results are also gender specific due to there being no males interviewed.

Another limitation was researcher bias. Because of the qualitative nature of this study, the findings were generated by finding common themes. To prevent bias from having an effect on the responses of the participants, the interviewer followed a semi structured set up interview questions. The researcher also focused on minimizing

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responses to statements said by participants to limit bias influencing the conversation. To analyze the transcribed interviews, the same coding scheme was used to limit biases.

Conclusion

This research project explored how health professionals should be culturally aware when working with the Somali population to increase the utilization of mental illness treatments. This study interviewed six participants who work with the Somali population in a hospital or clinic setting. There were several themes identified and discussed in this study. The main themes that emerged were being culturally sensitive and aware when diagnosing, understanding stigma, and dialoguing about mental health. The results of this study imply that health professionals, who work with Somalis, have a culturally aware understanding of prevalence, physical presentation, and stigma of mental illness with this population. Another aspect of this study discussed is how to dialogue about mental illness with the Somali population. There is no current culturally specific standardized way to discuss mental illness with this population that has proven success rates. The findings suggest that rapport, trust, and follow up in addition to culturally sensitive approach to mental illness, all help improve likelihood of accessing mental health treatment

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Appendix A

Discussing Mental Health with the Somali Community in a Medical Setting
(Title of research)
INFORMATION AND CONSENT FORM

Introduction:

You are invited to participate in a research study investigating Somalian Mental health. This study is being conducted by Kristopher Jaeger, LSW, a graduate student at St. Catherine University under the supervision of Dr. Lisa Kiesel, PH.D., LICSW, a faculty member in the Department of Social Work. You were selected as a possible participant in this research because of your career in a hospital or clinic setting. Please read this form and ask questions before you agree to be in the study.

Background Information:

The purpose of this study is to see how might medical personnel better access and connect the Somali Population with mental health resources. Approximately 10 people are expected to participate in this research.

Procedures:

If you decide to participate, you will be asked to participate in a person to person interview. This study will take approximately 45-60 minutes. Interviews will take place in private settings in public places such as coffee shops, or libraries.

Risks and Benefits of being in the study:

The study has minimal risks. The participant might feel discomfort in answering the questions.

There are no direct benefits to you for participating in this research

Confidentiality:

Any information obtained in connection with this research study that can be identified with you will be disclosed only with your permission; your results will be kept confidential. In any written reports or publications, no one will be identified or identifiable. I will keep the research results in a locked file cabinet in my office and only I and my advisor will have access to the records while I work on this project. I will finish analyzing the data by May 15th 2014. I will then destroy all original reports and identifying information that can be linked back to you.

Voluntary nature of the study:

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with St. Catherine University in any way. If you decide to participate, you are free to stop at any time without affecting this relationship.

Contacts and questions:

If you have any questions, please feel free to contact me, Kristopher Jaeger, LSW, at 612-807-7500. You may ask questions now, or if you have any additional questions later, the faculty advisor, Lisa Kiesel, PH.D., LICSW, will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739.

You may keep a copy of this form for your records.

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Statement of Consent:

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time.

I consent to participate in the study, and I agree to be audiotaped.

Signature of Participant

Date

Signature of Researcher

Date

Appendix BDiscussing Mental Health with the Somali Community in a Medical Setting
Interview Questions

- What is your profession, how long have you been working in this field, and what are some examples of questions or concerns people come to you for?
- How prevalent is mental illness in the Somali Community that you work with?
- How does mental illness in the Somali community you see present its self compared to other populations you work with?
- When discussing mental illness with the Somali Community, what strategies do you use that work?
 - How do you know they work?
- When discussing mental illness with the Somali community, what strategies have you used that didn't seem to work?
 - How did you know they didn't work?
- What kind of trainings have you done or has your work given you to prepare you to work with the Somali Community?
- What are treatment options you or your agency have offered Somali's who you suspect have mental illness?
- Can you give an example of a time you suggested a treatment option?
- How often do the recommendations that you make regarding mental health services get followed? (i.e., what is the compliance rate with your recommendations?)

APPENDIX C**Initial Call or Email**

Hello,

My name is Kristopher Jaeger and you have been referred to me due to your experience in working with the Somali Community. I am the one that will be conducting the interview for my research. First I would like to provide you with some information about why I am conducting this research. Minnesota is home to one of the largest Somali populations in the US. This community, due to the stressors of relocating, and the high amounts of trauma due to the civil war, have a high rate of mental illness. The main source of solace and treatment for this population is through their religion. If this doesn't bring relief, instead of seeking mental health treatment, they currently go to their doctors or clinic's to receive help. This research study will be looking at how Medical personnel discuss mental illness with the Somali community to bridge the gap between the need for and utilization of mental health services. Because of your experience with this community, your input is valuable to this research. Do you have any questions for me about the research or interview? If you would like to participate, when would be a good time and place for us to meet for the interview? You do not need to bring anything to the interview and it will last between 45 minutes to an hour. I look forward to meeting you.

-Kristopher Jaeger, LSW