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# Do Cultural Misconceptions About Mental Illness Coupled With Other Social Barriers Prevent Somalis In Minnesota From Seeking Mental Health Treatment?

Ali Shireh  
*St. Catherine University*

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Do Cultural Misconceptions About Mental Illness Coupled With Other Social Barriers Prevent  
Somalis In Minnesota From Seeking Mental Health Treatment?

by

Ali Shireh

MSW Clinical Research Paper

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

Master of Social Work

Committee Members

Rosella Collins-Puoch, Ed. D., MSW, LICSW (Chair)

Kadar Hadis, MA, LGSW

Jason Griswold, MSW, LGSW

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.

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## **Abstract**

Minnesota has the largest Somali population in the United States that is estimated between 28,000 and 60,000 (Minnesota Historical Society, 2015). Somalis in the United States have a low rate of mental health utilization despite experiencing trauma in their homeland (Ellis et.al. 2010). There is a gap in the current literature on if cultural values coupled with social barriers prevent Somalis in Minnesota from seeking mental health services and how to address these barriers. This study examined data from eight qualitative interviews with mental health professionals with experience working with Somali consumers in the greater Minneapolis-Saint Paul area. These interviews explored the Somali community's views on mental health, barriers faced by the community, the role of traditional and spiritual treatments and how to overcome the barriers when providing mental health services to Somalis. The themes that emerged from the data suggest that it is important to understand how Somalis conceptualize mental health, and the need for community psycho-education and combining traditional Somali and Western treatment methods. In addition, the data identified current barriers such as concerns about confidentiality when working with interpreters, as well as how to address the barriers. The implication of this research is it may be used to inform the delivery of mental health services to the Somali community. This can also be used to inform in the development of policy to address the disparities of mental health services in Minnesota.

## INTRODUCTION

Mental illness is a serious condition, and one in four individuals in the United States will experience mental illness in a given year (National Alliance on Mental Illness, 2014). Many African immigrants, are less likely to access mental health services, are more likely to drop out of treatment, and are more likely to be dissatisfied with care than Caucasians (Whitley & Williams, 2010). For example, many members of the Somali community experienced trauma in war torn Somalia, and these individuals are extremely vulnerable to mental illness (Onyut, et. al., 2009). However, unfortunately, many Somalis are not participating in mental health treatment. One of the possible contributing factors may be that culturally appropriate mental health treatment may not be widely available to the Somali community in the United States. In addition, Somalis who suffer from mental illness face other barriers such as language, denial of mental illness, and a lack of family and community support, because there is no definitive context for treatable mental illness in the Somali community. This may or may not be due to the lack of political infrastructure and moral support from family members in Somalia.

To illustrate, Somalia is a country in the horn of Africa and it borders, Djibouti, Ethiopia, Kenya and the Indian Ocean. Just like the rest of Africa, the Somali peninsula was partitioned by European powers. As a result, Djibouti, Ethiopia and Kenya have large Somali populations. The Somali culture is a clan based social system and emphasis is placed on family and communal bonds even in the Diaspora communities (CIA Worldfactbook, 2014). As a result of the civil war, about 45% of the Somali population was displaced and million sought refuge in the United States and Western Europe (Condon, 2006). Due to a lack of central government since 1991, intra-clan fighting has forced over a million Somalis to seek refuge in the United States and other Western countries (Dejong et al., 2011). These refugees had to witness the destruction

of their lives and relocated to alien societies. In the new host communities, they had to struggle with learning a new language, culture, bring of what is left of their families together and live in communities that are almost hostile to their culture and religion. This makes mental health services secondary to surviving in these new communities.

In the Somali culture, the father is the head of household, and he is responsible for providing for the family. Women are responsible for the household and taking care of the children, but the extended family helps with raising the children. In the Somali culture, having large families is desirable. Almost all Somalis are Sunni-Muslims and Islam influences every aspect of a person's life (Kroll et al., 2009). Somali elders are held in high esteem and they are called upon to solve all issues that may come up in a family, including mental health challenges.

At any rate, Minnesota has the largest Somali population outside of East Africa. A large percentage of these Somali immigrants in Minnesota have experienced trauma in war torn Somalia. However, only a small percentage of Somalis in Minnesota appear to be utilizing the mental health services throughout the state (Jaeger, 2014). Consequently, it is important for mental health professionals to be aware of the views about mental illness among Somalis and how to help them access and participate in mental health treatment. Therefore, the purpose of this study is to examine how Somalis in Minnesota view mental illness, and what are the barriers they face in accessing mental health services. A number of studies have shown that refugees have higher rate of mental health symptoms, but underutilize the mental health services that are available in the host communities (Guerin, Guerin, Diiriye, & Yates, 2004). There is a gap between the need for mental health services and utilizing those services in the Somali community.



The Somali population in Minnesota experienced trauma in their homeland because of the war and famine, and as a result mental health professionals have a role to play in helping the community. By understanding how stigma, barriers and misconceptions of mental health prevents community members from seeking mental health services, social workers can close the gap between the need and use of mental health.

The purpose of this research is to find out if cultural misconceptions, coupled with social barriers prevent the Somali population in Minnesota from seeking mental health services.

## LITERATURE REVIEW

### **Mental Illness Among Somalis in the United States**

The review of the literature begins with explaining the literature of mental health barriers by the Somali population. The literature review will cover mental health views in the Somali community and barriers faced by Somalis that suffer from mental illness. The research will explore if mental health professionals think cultural misconceptions and social barriers affects the mental health behavior of Somalis in Minnesota.

Mental health research regarding Somali immigrants in the United States is limited. A study conducted in Minnesota by Kroll, Yusuf, and Fujiwara (2011); found that Somali women had higher rates of post-traumatic stress disorder (PTSD) and depression, compared to Somali men. In addition, this study found that the overwhelming majority of Somali men under 30 had “acute psychoses that have mixed paranoid and affective components (p. 481). The older men showed predominantly “depressive and post-traumatic stress disorder symptoms” (p. 481). Moreover, Kroll et al. found that the number of Somali males suffering from depression and PTSD could be significantly higher, because Somali men are reluctant to acknowledge their experience of trauma and its affects. Guerin, Guerin, Diiriye & Yates (2004) estimated that about half of refugees have mental health problems. This study also found 60% of Somalis with emotional problems did not seek mental health services. An estimated 92% of the refugees and immigrants that can utilize mental health services never receive them (Ellis et. al. 2011, p. 70). Post-traumatic stress disorder (PTSD) in refugees is estimated at 39-100% compared to 1% in the general population (Schuchman & McDonald, 2008). Refugees and immigrants such as the Somalis that need mental health services seek help at later stages.

However, according to Kroll, Yusuf, and Fujiwara (2011), some Somali men believe the psychotic picture in young Somali males can be explained by a combination of war trauma experience in childhood, early malnutrition, the demands of the male role in Somali culture, heavy marijuana use, and the use of khat (khat is a mild stimulant that is used in East Africa and Yemen; the users get high from it). Nevertheless, Kroll, Yusuf & Fujiwara (2010) stated that “most khat chewers obtain a mild high from the plant without developing psychosis or long-lasting personality aberrations” (p. 488). Despite its purported minor psychological effects, the use of khat is illegal in the United States, which suggests that the extent of the psychological effect on users may be both harmful and clinically significant.

### **Stigma Associated With Mental Illness among Somalis**

Terms such as depression and anxiety were not prominent in Somali culture prior to the 1990 civil war and these mental illnesses may not be recognized as a problem until they are perceived as “impeding with one’s daily function” (Bentley et al., 2008). Furthermore, Somalis who suffer from mental illness may suffer cultural stigmas associated with mental illness. For example, Johnsdotter, Ingvarsdotter, Ostman & Carlbom (2011) found that Somalis keep mental illness as a secret within the family as long as the person is not harming himself, herself, or others, out of fear that they will suffer social stigma. Ndeti et.al. (2013) found the only mental health condition that is recognized in Kenyan culture which is similar to Somali culture is madness.

According to Gary (2005) stigma is “a collection of negative attitudes, beliefs, thoughts, and behavior that influence the individual, or the general public to fear, reject, avoid, be

prejudiced, and discriminate against people with mental disorders” (p. 980). For example, Somalis believe that people who are mentally ill are possessed by evil spirits, or Jinn (Bently & Owens, 2008). In addition, Somalis who suffer from mental illness are not accepted as a part of the community (McGraw-Schuchman & McDonald, 2008). Moreover, Somalis also believe that mental health disorders come from Allah (God), and that the person is suffering because he or she deviated from the righteous path of God; consequently, those who are suffering from mental illness are viewed as weak and helpless (Bently & Owens, 2008) . Therefore, because of the stigma associated with mental illness, Somalis are unlikely to seek mental health treatment. Guerin, Guerin, Diiriye and Yates (2004), found that “Somalis view mental illness only as encompassing the most severe and possibly untreatable cases” (p. 59).

### **Somali mental health terms**

To understand mental health from a Somali’s point of view, it is important to understand terms that are used to describe mental illness in the Somali culture. According to Bently and Owens (2008), waali, murug, jinni, mingis, sarr, and wadaado are some of the most common terms used to describe mental illness among Somalis. For example, waali describes a person who is either crazy, or mentally unfit. Waali is characterized by “disorganized appearance, aimless wandering, and potential random acts of violence” (p. 1). Carroll (2004) defined murug as “sadness and is spectrum ranging from everyday sadness, stress, or disappointed at one end to a more serious depression that could cause physical illness or craziness at the other extreme” (p. 123). A jinni is a form of psycho-social disorder that does not have natural causes, but is influenced by spirits (p. 1). Mingis is a spirit condition that Somalis believe is put upon a person, or an entire family, unwittingly, because someone “made the spirits mad” (p. 2). Saar is

characterized by dissociation episodes that include “shouting, laughing, hitting the head against a wall and weeping” (p. 2). Finally, wadaado is a condition characterized by symptoms of “body ache, severe headaches, lack of sleep, and inappropriate behavior” (p. 3).

## **Social Barriers to Utilizing Mental Health Care Services among Somalis**

### **Language Barriers**

A major barrier in accessing mental health services in the United States for refugees is that they have limited English proficiency skills. The language barrier makes it difficult to communicate with mental health care providers (Gong-Guy, Cravens, & Patterson, 1991). When individuals do not speak English, they may be afraid they will be given the wrong treatment potentially leading to the worsening of their condition (Silveira & Allebeck, 2001). In London, language was identified as the biggest barrier faced by those with limited English language proficiency, which affected the quality of service they received (Palmer & Ward, 2007). In Minnesota, language barriers could cause a significant challenge for Somalis who are suffering from mental illness, and for mental health care providers who attempt to treat their mental illness. For example, Somali clients may not want to discuss their mental health condition with an interpreter in the room out of fear of the community finding out about their condition, which could lead to stigma (Gary, 2005). The Somali language does not have as many words as the English language to describe the varying degrees of mental health issues (McGraw-Schuchman, & McDonald, 2008). Furthermore, Flores (2006) opined that patients who speak limited English were more likely to be diagnosed with severe psychopathology, as compared to the general population. However, without an interpreter, most mental health care providers in the United States cannot treat Somalis who are suffering from mental illness.

### **Access Barriers**

According to Palmer and Ward (2007), language, stigma, cultural beliefs, and a lack of knowledge about mental illness diagnoses are barriers that prevent refugees and immigrants from accessing mental health services. In addition, Elmi (1999) found that a “lack of communication and understanding of how the mental health system works creates for many people difficulty accessing the services they may or might need” (p. 14). Flores (2006) also found that individuals with limited English proficiency utilize mental health services at a lower rate than the general population. In addition, Guerin, Guerin, Diiriye, and Yates (2004) found that Somalis do not access mental health services because of barriers such as “language, inappropriate use or lack of interpreters, unfamiliarity with provisions of such service, bureaucratic barriers and transportation issues” (p. 59).

### **Cultural Barriers.**

Culture plays an important role in how people view mental health and this could have an effect on whether they seek services. The Somali cultural perspective regarding modern medicine differs from the Western cultural perspective, which creates treatment difficulties for Somalis who suffer from mental illness. The Somali population talks about headaches and other physical ailments, but avoid mental health discussions because of cultural views on mental illness. Johnsdotter, Ingvarsdotter, Osman and Carlbom (2011) found that, “Somali immigrants in Western societies doubt that there is much help to get from seeing a Western psychologist or psychiatrist” (p. 749).

To illustrate, according to Palmer (2006), “Depression and anxiety, post-traumatic stress disorder, and other Western diagnostic labels are not regularly recognized in Somali healthcare and can therefore impact individuals’ willingness to access health care and treatment” (p. 46). Palmer also argued that it is very important for providers to understand Somali cultural traditions to ensure that they are getting the help they need. Gong-Guy, Cravens, and Patterson (1991) found that drugs may not be effective in treating mental illness in the Somali community because of barriers such as language, and due to the cultural lack of acceptance for the use of drugs in treating mental illness. Research by (Bently & Owens, 2008; Johnsdotter, Ingvarsdotter, Ostmanand & Carlbom; 2011) revealed that psychological problems are not discussed because of fear of being labeled as crazy in the Somali culture. Therefore, Ellis et al. (2010) found that a Somali person will assume you are crazy if you are seeking the services of a therapist.

### **Fear and Mistrust for Mental Health Care Providers**

Unfortunately, Copeland (2006) argued that clinicians “lack of awareness of cultural bias and clients’ fear and mistrust of treatment services” prevents African Americans from seeking mental health services” (p. 411). Somalis hold similar views regarding mental health treatment held by African Americans. For example, Elmi (1999) found that Somalis suffering from mental illness in Toronto were misdiagnosed because of language and cultural differences. Consequently, both groups (Somalis and African Americans) tend to seek treatment at lower rates than Whites (Buser, 2009).

### **Lack of Family and Community Support Systems**

According to Silveira and Allebeck (2001), Somalis who are suffering from mental health issues lack family and community support. In the Somali culture, family and the clan play an

important role in people's lives, and as opined by Silveira and Allebeck, those who do not have family and clan support system suffer from severe symptoms of anxiety and depression. Palmer (2006) found that some Somalis suffering from mental health issues believe other Somalis in the community have their own problems, so they are not able to help them. Scutlik, Alarcon, Lapeyre III, Williams, and Logan (2007) found that "deterioration of the supportive family system has resulted in a concentration of stressors, focused on the individual" (p. 592). Furthermore, McGraw-Schuchman and McDonald (2008) found that individuals that suffer from mental illness in the Somali community will need family support and community advocates to reduce the stigma associated with mental illness, so that they can get the help they need. On the other hand, Somalis who have the support system seek mental health treatment from family because mental illness is viewed as a family issue that should be dealt with by the family.

### **Denial of the Existence of Mental Illness**

Somalis tend to deny that either they or a family member is suffering from mental illness. As a result, Carroll (2004) found that "nearly all participants felt that mental illness was a new problem for their community that did not exist to the same extent in prewar Somalia" (p. 119). According to Scuglick et al. (2007), mental illness is not discussed in the Somali community, so this may prevent them from seeking help. However, Somalis in America may seek help when a family member's condition is severe enough to interfere with his or her daily living (Scuglick et al., 2007). However, if a Somali individual does seek help, and is diagnosed with mental illness, they may be ostracized by the community.

For example, London and Palmer (2006) found that Somalis reported mental health caused stigmatization in the community, and that individuals were excluded from their families and the community. According to Scuglick et al. (2007), a mental illness diagnosis caused stigma



for the entire family, and it affected every aspect a family's functioning. For this reason, Elmi, (1999) argued that mental health is addressed within the family, and sometimes even medical professionals are not informed. In discussing mental illness in the Muslim community, Ciftci, Jones, and Corrigan (2013) found that Muslims will not seek mental health services to avoid being labelled as mentally ill. Furthermore, Guerin, Guerin, Diiriye and Yates (2004) found Somalis do not see the value of talking to a therapist as a part of the mental health treatment process. In the final analysis, in the Somali culture, mental health treatment is the last option the family will pursue, and they will seek treatment only after they have exhausted the traditional ways of healing.

The Somali belief system about mental illness and the treatments are vastly different than the Western mental health views and treatments. By understanding the struggles the community has faced, mental health views and concerns, conceptualization of mental illness and traditional and spiritual treatments, social workers will be able to view the Somali mental health problems through an informed lens.

### **Traditional Healing Practices to Address Mental Illness**

Traditional and spiritual healing is very important in the Somali community, and these are the main methods of treatment currently used for those who are suffering from mental health issues in the United States and Somalia. Traditional healing is defined as "the practice of using local herbs for the treatment of disease" (Ae-Ngibise et al., 2010, p. 559). Today, traditional healers still play an important role in providing mental health services in Africa, even with the increased presence of Western medicine (Ae-Ngibise et. al., 2010). Ndeti and associates (2013) found that almost 15% of people in Nairobi sought traditional treatment for mental health because they were referred by family and friends while almost 30% visited traditional healers

because they did not get well after visiting Western treatment providers. They also found that people seek traditional healers because they are accessible. A study conducted by Scuglik, Alarcon, Lapeyre III, Williams, and Logan (2007) found that Somali families usually seek traditional medicine when a family member needs medical treatment, either mental or physical. Research that was conducted in Somalia by (Ahmed, 1988) found that most Somalis live in rural areas and seek services for medical and psychological problems from traditional healers.

### **Religious or Spiritual Healing**

Most Somalis in their native Horn of Africa live in rural areas and traditional or spiritual healers' provide mental health services and Western treatment methods are not available (Elmi, 1999; Ngoma, Prince, & Mann, 2003) areas. Western methods such as counseling are viewed as alien, even when it is available in Somali language (Palmer, 2006). Ellis et al. (2010) found that "problems understood to be of a religious nature would logically lead to a path engaging religious leaders and ultimately religious solutions" (p. 792). However, according to Ciftci, Jones and Corrigan (2013), the Muslim community believes that "illness is one method of connection with God and should not be considered as alien but rather an event, a mechanism of the body that is serving to cleanse, purify and balance us physically, emotionally and spiritually" (p. 23). In Somalia, religious and spiritual leaders use the Quran to treat all psychiatric disorders (Ellis et al., 2010). The Somali community believes that mental illness comes from God, and they are evil spirits (McGraw-Schuchman & McDonald, 2008). Consequently, Ciftci, Jones & Corrigan (2013) found that only a small number of Muslims would seek help from mental health providers, as compared to religious or spiritual leaders. Simich, Maiter, Moorlag & Ochocka (2009) found that "mental well-being for the Somali participants overwhelmingly revolved around religion and the connection of mental and spiritual strength" (p. 211). Matthews et al

(2006) found that Somali religious and spiritual leaders argue taking medication is tantamount to losing faith in God. They believe that suffering in this world will lead to the person's sins being forgiven in the afterlife (Elmi, 1999).

Alternatively, some researchers (Ae-Ngibise et al., 2010) have raised concerns about traditional, religious and spiritual healers for treating mental health. At issue, according to Ae-Ngibise et al. (2010) is the safety of the methods used. Moreover, Ae-Ngibise et al. suggested that traditional, religious and spiritual healers may be taking advantage of vulnerable people in the Somali community because they do not understand what mental illness is or how it is treated.

### **Summary**

Data regarding mental health and mental treatment for Somalis in Western society is scant. Somalis that are diagnosed with mental illness suffer cultural stigmas associated with mental illness. Somalis believe that people who suffer from mental illness are possessed by evil spirits. They also believe when people have deviated from the righteous path of God, they become mentally ill. The research also shows that there are a number of social barriers that prevent Somalis from accessing and utilizing mental health care in Minnesota. Finally, religious and spiritual healers play an important role in the treatment of mental illness in the Somali community, which traditionally has been the preferred method of treatment among Somalis.

## CONCEPTUAL FRAMEWORK

The ecological theory looks at the relationship between the individual and the environment, utilizing the person-in-environment perspective. The ecological theory is similar to systems theory, in that it takes into consideration a person's involvement in systems outside of the individual's own system. It also builds on the systems theory by discussing interactions between the individual and their wider systems. The ecological systems theory appears to be the most appropriate framework to inform a research study to better understand what is preventing the Somali community from seeking mental health treatment in Minnesota.

The ecological theory helps to understand the micro, mezzo, macro, levels of engagement, and how they each influence people and their behavior. For example, Forte (2007) stated that "human behavior evolves as a function in the interplay between the person and the environment" (p. 135). Forte went on to explain that (1) the micro-system is the immediate setting of the individual, and mental illness can impact an individual; (2) the mezzo-systems deal with groups such as community and cultural change, such as the extended family and the clan system that is widely used by Somalis (Zastrow & Krist-Ashman, 2006); and, (3) the macro-system is a system that refers to the broad social context including the culture, values, and customs of society, which in the context of this study, include the Somali community and the mental health care system.

This theory provides an understanding of human behavior by examining the person, his or her environment, and how it affects the person. Ungar (2002) stated that "as a person enters each new situation, he or she usually adapts to its demands, and by his or her presence, changes the situation at least structurally" (p. 481). Therefore, through the ecosystems lens, this research will examine whether or not cultural misconceptions, coupled with other social barriers prevent Somalis in Minnesota from utilizing mental health services.

## METHODOLOGY

The focus of this research is on the question of whether or not cultural misconceptions about mental illness, coupled with other social barriers, are preventing Somalis in Minnesota from accessing mental health treatment. The study utilized the qualitative research method, to identify and understand feelings, values, and perceptions that underlie and influence behavior of Somalis regarding mental health treatment. This researcher conducted a semi-structured, 45-60 minutes interview with mental health professionals, to learn about the participants' perspectives regarding the cultural and other social barriers they believe their Somali clients face in accessing and utilization of mental health services.

### **Sample**

This researcher used purposive sampling to select eight mental health professionals to participate in the study. Each of the eight participants selected were licensed, clinical social worker (LCSW), a licensed marriage and family therapist (LMFT), or a psychotherapist, who have provided mental health care for Somali clients in the 7 county metropolitan areas in Minnesota, for at least 5 years. This researcher contacted potential participants, via telephone, from the African Mental Health Care Provider directory produced by David McGraw-Schuchman. A total of ten mental health professionals were recruited to participate in the study, but only eight were interviewed. The two extra participants were informed that they will not be interviewed unless others drop-out of the study. The two extra participants recruited were not interviewed because non-of the selected participants dropped-out of the interview process.

## **Data Collection**

Data for this research was collected using a semi-structured interview format, because it allowed the researcher some flexibility in asking clarifying questions. An interview schedule related to the research question was utilized to collect the data (see Appendix A). The interviews were conducted in the mental health professionals' office to protect the confidentiality of the information that was being shared. The study participants were interviewed for 45 to 60 minutes, and the interviews were tape recorded. The recordings are being stored in a locked cabinet and the tapes will be destroyed according to the policy of the University of St. Thomas/St Catherine University School of social work.

## **Data Analysis**

The data obtained from the interviews was analyzed using the grounded theory method. For example, according to Monette, Sullivan, and Dejong (2011), grounded theory methodology is utilized when theory is developed as it emerges from the data, through the continual process of data collection, analysis, and theory development. According to Chamazi, (2008) grounded theory "starts with a systematic inductive approach to collecting and analyzing data to develop theoretical analysis" (p. 155). This researcher used this technique to initially code the data from the transcribed data using the technique of open coding. According to Berg (2008), open coding is combing through the data, line by line by line, and the researcher will produce concepts and ideas that are similar from the data. Initially the data was coded for similarities and differences, and the researcher reviewed the data a second time for patterns or similarities. When patterns emerged, they were merged into larger themes for the analysis.

## **Protection of Human Subjects**

Prior to conducting the study, permission was granted by the Institutional Review Board (IRB) at the University of St Thomas. A sample Informed Consent Form (ICF) (see Appendix B) was approved by the IRB. The ICF was explained and signed by the researcher to the participants. A copy of the ICF was provided to the participants for their records.

**Researcher Bias.** This researcher had biases that could have affected this study. First the researcher did not expect some of the non-Somali mental health professionals not be familiar with Somali mental health terms. Secondly, the researcher may have subconsciously given subtle clues with body language that may have subtly influenced the respondents into giving answers skewed towards the researcher's own opinions. Finally, the researcher is Somali and is preparing for a career as a mental health professional and that could have affected the questions asked and the impression of the emerging themes. The chair and the committee members reviewed the questions to avoid any that could be leading the respondents.

## **Findings**

### **Sample**

This portion of the research is intended to give context to the data obtained from the study. This was a qualitative research project, which included eight semi-structured interviews with mental health professionals who provide services to members of the Somali community in the Twin Cities. Participants were recruited from an African mental health provider list that is distributed through e-mail. The researcher distributed information sheets to those who indicated interest in participating in the study. The interviews lasted between 45-60 minutes and were

recorded with the interviewees' permission. Interviews were transcribed and coded using open and axial coding in order to develop themes in the data.

The demographic information is important in order to understand the participants' experience in working with Somali people and their perspective on Somali cultural views on mental health. The study sample included eight social workers who work in the field of mental health care with Somali consumers in the Twin Cities. Twelve people were invited to participate and eight participants agreed to participate in this study. Eight participants were interviewed for this research project. One of the participants was a Somali female; three were Somali males that have worked in the field of mental health for an average of seven years. The remaining four participants were non-Somali speaking males that have worked with Somali speaking mental health care consumers for an average of ten years.

This research project explored whether or not cultural misconceptions, coupled with other social barriers prevents Somalis in Minnesota from seeking mental health treatment. Individual qualitative interviews were conducted with social workers experienced in working with the Somali community in the greater Minneapolis-Saint Paul area. The interview questions (see appendix A) were intended to gather information about the interviewees' experience with and knowledge about the Somali community and specifically views on mental health and the barriers faced by the community. The interviewees discussed how the barriers faced by the community can be overcome. The purpose of the interviews was to gain an understanding of how to serve the mental health needs of the Somali community in Minnesota more effectively. The questions were designed to elicit themes related to these questions and addressed the individual, family and



the wider community's views on the subject. Ideas that were shared by at least five participants were considered themes and included in the analysis.

## **Qualitative Data**

The remainder of this findings section will explore the content obtained from the qualitative data that was gathered through one-on-one interviews. The data collected from the eight qualitative interviews were transcribed and a content analysis was done to extract themes. The five main themes include community mental health education, barriers faced by the community in Minnesota, gender differences, stigma associated with mental illness and lack of culturally competent providers. These five main themes and sub-themes will be explored in the following sections.

## **Findings/Themes**

### **Community Education on mental health is needed.**

The Somali community's views on mental health were assessed by asking for the social workers' understanding of the Somali community's views on mental health. All eight participants stated that there is a stigma associated with mental illness in the Somali community. All eight participants spoke about the importance of religious leaders in educating the community about the importance of mental health services and ailments. The eight respondents talked about the significance of involving elders in any community education program because elders have a lot of influence in the community. All eight participants said that community education is needed to address the stigma and to help people that are suffering from mental illness. Five participants said that the view on mental health depends on the person's age.

Individuals that grew up in Minnesota are open to Western views and believe that mental illness is biological. The older people and recent arrivals believe in traditional ways of viewing of mental health and that it is caused by evil spirits. Finally, all eight participants stated the important to involve religious leaders in any community education program. In discussing the barriers faced by consumers and the significance of community education, respondent two stated.

*The Somali people believe that mental health problems are caused by Allah and only Allah can make someone feel better. The younger generation is accepting of different world views of mental health while the older generation holds to traditional Somali views of mental health. There is a great need for community education program that involves Somali mental health professionals, community and religious leaders. There are stigmas and misunderstandings of mental health in the community and education on the causes and the services that are available will help improve the situation.*

## **Barriers**

All participants discussed the barriers faced by the Somali community. One of the barriers discussed by all eight participants was working with interpreters. One of the barriers of working with an interpreter is the amount of time it takes to explain things. The non-Somali social workers feared the interpreter will add his/her own opinions or have a side conversation with the client. They were also concerned about the interpreter breaking confidentiality and sharing information about clients with members of the Somali community. Respondent four stated:

*There a lot of barriers Somalis with mental health problems face in their own community. Language is the biggest barrier. Some people think their English is good and*

*refuse to have an interpreter but they don't understand mental health terms and diagnosis. Others fear people will find out about their condition so they refuse to have an interpreter because they don't want to be ostracized in their own community. Another barrier is not being able to explain Somali terms such as Jinn, wadaado and buufis to an American mental health provider.*

A sub-theme that was seen as a barrier that came up a number of times is not being able to explain Somali mental health terms to non-Somali speaking mental health professionals. All of the social workers said that Somalis view mental health as spiritual struggles and Americans view it as biological, and this causes the clinician and the consumer to not be on the same page. In discussing this barrier, respondent one said, "If someone thinks they have Jinn, they will not seek treatment from an American therapist because they don't understand the concept of Jinn."

Another sub-theme that was discussed as a barrier is that there is a shortage of Somali speaking mental health professionals in the Twin Cities. There are few Somali speaking Licensed Clinical Social Workers that serve a population estimated high as 100,000. When talking about this issue, respondent six stated, "The barriers include stigma, language, and lack of Somali mental health professionals."

Another sub theme that was mentioned by six of the respondents is that Somalis view mental health as a family matter and keep it as a secret. Because there is stigma associated with mental illness in the community and people with mental illness face discrimination mental health status is not shared with anyone. Individuals with mental illness are socially isolated from community activities and families don't want that for their children, siblings, and relatives. In discussing this issue, respondent three stated:

*In Somalia, people with mental illness were mistreated and as a result people keep mental health issues as a family secret. This is done to protect the suffering person because he/she will not be able to actively participate in the community if it is known he/she has mental health diagnosis.*

## **Gender Differences**

An important theme that was found in this research is gender differences in seeking mental health services. Five respondents talked about the difference between Somali men and women when it comes to seeking mental health treatment in the community. The remaining three respondents felt that both Somali men and women were reluctant to seek mental health treatment because of stigma. Respondent one stated

*In Somali culture men are not supposed to admit needing help because that is viewed as a weakness. Because of that cultural belief, Somali men normally do not seek help until they are in crisis. Women on the other hand are viewed as weak and needing help. It is culturally acceptable for women to seek help and as a result large numbers of Somali women seek mental health services compared to men. Most of the Somali clients I work with are women and young children that they bring for treatment.*

Respondents two and five did not see any differences between men and women when it comes to treatment seeking behavior of Somali patients. Respondent two said.

*I don't really think there is a difference between Somali men and women when it comes to seeking mental health treatment. Both groups are reluctant to seek treatment because there is*

*stigma associated with mental health and they don't want to admit because it will be seen as a spiritual weakness.*

The final sub theme that was discussed by all respondents is building trust. The participants stated that it takes a long time to build trust with Somali consumers of mental health services and this prevents patients from continuing with treatment if they do not trust their providers. The respondents stated that Somalis mistrust the mental health system and providers do not take the time to educate their patients. Fear of the government finding out about someone's mental health status and not being able to find jobs and housing was a main concern. One of the respondents said that Somalis are afraid they will not be able to find housing, jobs, or participate in society if it is known they have been diagnosed with mental illness. In discussing the issue of trust with Somali clients respondent two stated.

*You know Somali people have hard time trusting outsiders especially people that have experienced the civil war. People want to protect themselves and do not trust people including providers. Because they do not trust providers, they do not believe the treatment will be effective and many do not come back after the first couple of appointments.*

### **Culturally Competent Practice**

Most participants talked about the importance of culturally competent mental health services. When a person does not seek treatment because of the cultural value of toughing it out or letting time heal the problem, it is really important to have providers that understand the culture to be able to help the patient. Respondent one stated

*Culturally competent mental health care is needed by the Somali community. Consumers don't feel comfortable explaining Somali mental health terms to providers that don't understand it. Somali consumers also don't understand western views on mental health and the provider does not take the time to explain the different worldviews and they just clash.*

One participant thought cultural competency was not really important because an individual cannot be competent in a culture unless he or she lives in that culture. He stated that

*I don't think you can be competent in a culture unless you live in that community and participate in community activities. I think it is just important to meet the client where he/she is at and treat them like you would want to be treated. I know couple of Americans that learned to speak Somali and their spouses are Somalis. Even after learning the language and culture, they still do not understand the cultural nuances and I would argue that they are not competent in our culture.*

### **Traditional/Spiritual healers**

A theme that was discussed by all of the respondents is the important role traditional and spiritual healers play in treating mental illness in the Somali community. The respondents said traditional healing is a method most Somalis are familiar and comfortable with when faced with the challenges of mental illness. They are able to provide services that are not provided by mental health professionals trained in Western biomedical method. The traditional healers are able to communicate with the spirits and request the spirits to leave the patient. The patient provides gifts and sacrifices an animal to please the spirits into leaving without causing him/her harm. When discussing this issue, respondent three stated

*A large number of people I work have used traditional healers. Clients say the healers speak with the Jinn and spirits and convince them not to harm and leave the client alone. The spirits promise to leave the patient for a period of time in exchange for a sacrifice that costs a lot of money.*

All of the participants said spiritual healers are the first method of treatment families seek when they suspect mental illness. The participants also said Somalis believe mental illness has spiritual causes and as Muslims believe the Koran is cure for all ailments including mental health issues. Respondent four said “Sheikhs recite the Koran on the patient and this is viewed as the best available treatment method.”

Cultural views of mental health and other social barriers contribute to the treatment-seeking behavior of Somalis in Minnesota. The participants mentioned several ways to reduce the barriers and improve the delivery of service of Somali consumers of mental health services. One of the methods of addressing these multiple barriers is psycho-education for the Somali community so people understand the treatments that are available. The participants also mentioned the importance of having culturally competent practitioners and the need to increase Somali mental health professionals. Culturally competent practice can be achieved by increasing the number of Somali mental health professionals in Minnesota.

## Discussion

### **Community Education.**

The literature and findings were congruent in that there is a need for community education programs in the Minneapolis-Saint Paul area. In discussing how to improve mental health access of Somali Canadians, Elmi (1999), suggested a community education program that focuses on helping people accessing the mental health services. He also recommended using videos and radio programs since that is how most Somalis receive information. In discussing overcoming barriers faced by Somali mental health consumers in New Zealand, Guerin, Guerin, Diiriye & Yates (2004), found that it is important to use community brokers to help people learn about the mental health system in the host communities. Carroll and associates (2007) found that Somalis preferred to learn from other knowledgeable Somalis.

When working with Somali clients, it is important for the mental health professionals to understand Somali cultural views on mental health. It is also important for the clinician to educate his/her patient on how mental health is diagnosed in the west. Finally, Somali people are mistrustful of medications and the mental health professional should provide educational materials to the patient. The social work emphasis on interaction between person, group and environment fits the person-in-environment area of social work practice. In addition, social workers focus on relationship between clients and their natural support systems. This relationship-centered approach makes it easier for social workers to educate the community about mental health. Fairview hospital in Minneapolis has a training program that enlists Somali imams in the Twin Cities as allies in addressing the mental health stigma in the community and increase the number of individuals that are utilizing mental health services when it is needed. Making this training available to a larger number of Somali leaders in the Twin Cities can go a long way in addressing mental health stigma in the community.



## **Barriers.**

Another common theme in the findings was the barriers faced by Somalis seeking mental health services in the Twin Cities such as using an interpreter. In discussing barriers by ethnic minorities in the United Kingdom, Leowenthal, Mohamed, Mukhopadhyay, Ganesh & Thomas (2012) found that Somalis mistrust interpreters because of concerns about confidentiality. In discussing the barriers faced by Somalis, Elmi (1999) found that the lack of people that understand their language and culture forces Somalis not to seek mental health treatment. The findings from the literature confirmed that Somalis have concerns about interpreters breaking confidentiality.

The barriers by the community are many and social workers can empower consumers to overcome the challenges. One of the strategies that social workers can use is client education. They would educate clients about the illness he/she is diagnosed with. This also involves teaching the client communication and problem solving skills so consumers are able to take part in meaningful discussion. In addition, social workers can empower clients by conveying understanding, respect and making sure the information provided to the client is clear. Finally, social workers can empower their Somali clients by accepting consumers' choices even when it goes against the social worker's recommendation. In working with Somali consumers of mental health services, it is important for mental health professionals to be aware of concerns about confidentiality. It is important for professionals to develop a close working relationship with few interpreters and to explain the importance of confidentiality to the field. The professional should also explain what confidentiality is to the patient and the consequences of breaking confidentiality.

Another barrier that came up was the difference in how Somalis and Americans view mental health. In discussing barriers to mental health services for Somalis, Loewenthal and associates (2012) found that Somalis did not understand western conceptualization of mental health services that were available. Palmer and Ward (2007) found that Somalis have a different way of understanding mental health and western terms such as stress and depression did not exist in their country.

Based on the findings and the literature, it is important for mental health professionals to explain western conceptions of mental health and inquire how the patient understands mental health. It is also important for the mental health professional to be non-judgmental when patients are explaining unfamiliar concepts.

A theme that was in the findings is gender differences in accepting mental health services. This theme was not present in the literature. It could be true that Somali women are more accepting of mental health services because Somali women have taken on the role of prime income earners in the west. This could also be true because the women want to get better and be there for their children. The women may be accepting of mental health services because it may be a requirement to continue receiving public assistance. Loewenthal and associates (2012) found Somali women in the United Kingdom were more knowledgeable about mental health issues compared to the men.

In working with Somali consumers, it is important for mental health professionals to keep in mind the gender roles of the Somali community. In addition, the gender of the client should be taken into consideration when assigning new clients to mental health professionals. In the Somali culture, it is not acceptable for a Somali man to ask for help and the professional should explain

the benefits of the services and how that may help the patient rather than asking what the patients wants. It is also important to remember that the women may be more willing to accept mental health services because they are motivated by a desire to get well and be there for their children.

The literature stated that Somalis treat mental health as a family secret and only immediate family members are made aware of the situation. When discussing how Somalis view mental health, Loewenthal and associates (2012) found that Somalis wanted to escape from the community and that people move from the area if they are diagnosed with mental illness. Scuglick and associates (2007) also found that Somali families rarely acknowledge psychiatric problems and this makes seeking treatment more difficult. Finally, Palmer (2007) found that Somalis are isolated from community activities if they are diagnosed with mental health problems.

The literature shows that Somalis associate mental health with shame and keep it as a family secret. It is important for mental health professionals to be aware and explain confidentiality to their clients. It may be easier for the patient if an interpreter over the phone is used because then the client is not worried about knowing the interpreter. In a small close-knit community like the Somalis, it may be difficult to find an interpreter that the client will not interact with in the community so an interpreter over the phone may be the only way to overcome this barrier.

Another sub-theme is building trust between the patient and the mental health provider to overcome barriers. This mistrust can stem from not understanding the mental health system because they do not understand the language that is used. This mistrust can be a barrier that can make treatment ineffective because of lack of culturally competent mental health services. Ellis

& Lincoln (2010) found that Somali consumers would prefer if Somali and western mental health treatments to be integrated. This study as is the case in the literature found that culturally competent care by providers is needed so consumers can feel valued and then they may buy into the treatment process.

### **Cultural Competency**

A theme that was brought up by the respondents is the importance of cultural competency in providing mental health services. This is important because the American and Somali cultures are different and the conceptualization of mental health is significantly different. Carroll, et. al. (2007) found that patient centered communication is the backbone of addressing culturally mediated issues. On the other hand, Leowenthal and associates found that improving mental health services to ethnic minorities should include addressing cultural and language barriers.

There were two social workers that did not think culturally competent care was important. The literature did not contain any information about culturally competent care not being important. This disparity could exist because the social workers may be think that Somalis live in Minnesota and should have an understanding of American culture and its worldview on mental health. It could also be that they truly believe one cannot be culturally competent because it is assuming the role of the expert rather than treating the client as the expert on his/her life and culture. All of the literature that was reviewed discussed the importance of culture when working with people from diverse cultural and racial backgrounds.

The field of social work values self-determination of clients and individual dignity and cultural competency compliments these values. There are a number of strategies social workers can employ to provide culturally competent practice. A strategy that can be used is adhering to

professional values, ethics, while understanding how these values conflict and accommodate working with diverse populations. Being aware of personal values, beliefs and biases and how this influence the therapeutic relationship is another strategy that can be used. In addition, social workers can learn about the traditions, family systems, and communication styles of diverse groups that make up most of the clients of their agency. Using strategies such as these can make the therapeutic relationship beneficial to diverse consumers of mental health. Social workers should incorporate culturally sensitive assessment and collect information on acculturation, language, religious practice, and cultural values. The Somali culture has gender roles that are more rigid compared to western gender roles and including the male head of the household in the process may contribute to building trust in the therapeutic relationship. It is also be helpful to collaborate with families and the community with the client's permission. Taking only European views of mental illness into consideration in diagnosing and treating mental health issues may lead to over diagnosis and a failure to include strength perspective into consideration.

### **Traditional and Spiritual healing**

An important theme that was in the findings was the importance of traditional and religious healing to the Somali community. In discussing the role of Muslim leaders in treating mental health, Ciftci, Jones & Corrigan (2013) found religious leaders are good resources for Muslims that are experiencing mental health issues. In studying the role of religious and traditional healers in Ghana, Ae-Ngibise and associates (2010) found that cultural values and economic conditions play a significant role in a large number of people seeking spiritual and traditional healers for mental health issues. Traditional healers are trusted in African societies and Ndetei et.al. (2013) found 95.8% of people that use traditional healers were satisfied with the

services they received. One of the benefits of working with traditional healers in Africa is they use concepts people understand. For example, Ndetei and associates (2013) stated “depression was not to traditional healers but thinking too much” is a diagnosis they are familiar with. Affluent members as well as the poor seek treatment from traditional healers for mental illness (Ndetei et.al, 2013).

The literature included the importance of traditional and spiritual treatments in the Somali community. Social workers should be aware of this and ask if the consumers sought spiritual and traditional healing. In addition, the mental health professional should not tell the patient not to include traditional and spiritual treatments because this may destroy the therapeutic relationship. It is also important for social workers that work predominantly with Somali consumers to develop a working relationship with spiritual and traditional healers so they understand what is involved in that process. Traditional and spiritual healers play an important role in treating mental health in the Somali community and mental health professionals should not ignore them. Social workers and other mental health professionals should collaborate with traditional and spiritual healers to protect clients from harmful practices.

### **Researcher Reaction**

This researcher observed that most of the mental health professionals were familiar with the culture and values of the people they work with. This researcher expected the non-Somali professionals to have limited knowledge of the barriers faced by the community in the Twin

Cities. This researcher did not expect the professionals to be aware for the culture and able to explain Somali terms such as waali and jinn. Finally, this researcher did not expect these professionals to provide ideas on how to help individuals such as combining Somali and western treatment methods.

### **Strengths**

There are several strengths of this study. One of the strengths of this research is contributing mental health professional perspectives' to the current research on whether cultural misconceptions coupled with other social barriers prevents Somalis in Minnesota from seeking mental health services. Most of the current literature is focused on symptoms and is quantitative and qualitative literature is limited on the subject. This study adds the voice of mental health professionals that work with Somali consumers to the literature. One of the main strengths of the study is that the participants' expertise and it included the voice of several Somali mental health professionals. Most of the participants have provided mental health services to the Somali community for many years. The expertise of those mental health professionals informed this study. This research encourages mental health professionals to consider how treatment is provided to Somali speaking consumers in Minnesota. The study encourages professionals to consider how to better serve the mental health needs of the Somali community in Minnesota. Finally, and perhaps more important, the research contributes to the current body of knowledge and empowers mental health professionals to develop culturally competent mental health services for the Somali community.

### **Limitations**

The limitations of this study include the second hand nature of the information that was gathered from mental health professionals. Another limitation is that the study did not gather information from Somali consumers' perspective on the barriers in seeking mental health treatment may be viewed as more credible than the professionals' perspective. In addition, the sample size is a limitation because the study was limited to eight participants and the Twin Cities area and it would be meaningful to gather the perspectives of larger mental health professional group. Finally, the data cannot be generalized because the size of the study was small.

### **Implications for practice**

This study has several implications for mental health professionals and other social workers. It allows mental health professionals to gain a broader understanding of the Somali community. It also fosters a deeper understanding of the Somali community and their mental health needs. Implications for practice can be drawn from understanding Somali mental health conceptualization and overcoming barriers. The gap between the need for and utilization of mental health services by Somalis is apparent in the current literature. Because of the large number of Somalis in the Twin Cities, mental health professionals have a great opportunity to help this population access proper mental health services. The final implication is the need to combine traditional Somali mental health treatments and western practices.

Mental health professionals can provide an effective mental health services based on the above recommendations. Mental health professionals can also provide effective mental health services by educating Somali consumers on how to understand and navigate western mental health services. The recommendations that are suggested in this study are an integral part of



understanding how to engage people from diverse cultural and ethnic backgrounds in mental health services.

The study also showed for community mental health education to educate people about mental health services that are available in the Twin Cities. This community education needs to involve community and religious leaders because they are trusted sources of information.

The study also showed that spiritual and traditional healers are important to the community and usually are the first sources of treatments. It is important that mental health professionals to be aware of this and incorporate traditional and spiritual healing in the mental health treatment process.

### **Implications for Policy**

There are several implications for policy found in this study. Organizations that work with Somali mental health consumers can incorporate the findings from this research so that the needs of the Somali community are addressed. The agencies can also hire and train Somali mental health professionals to provide culturally specific treatments. The participants in this study reported that more Somali mental health professionals would increase the effectiveness mental health services to the Somali community.

### **Implications for research**

Further research is needed in this area to explore topics discussed in this research. It is important to continue doing research on Somali mental health in Minnesota because the literature

is limited to a few studies. Doing research is also important in engaging and educating the community about available mental health services. It is also important that future researchers study if there are differences in the treatment seeking behavior between Somali men and women. Qualitative research conducted with Somali consumers' mental health needs would be helpful in better understanding of how to best meet the needs of this growing population.

## **Conclusion**

This study explored whether or not cultural misconceptions, coupled with other social barriers prevent Somalis in Minnesota from seeking mental health treatment. The data in this study was gathered through eight qualitative interviews with mental health providers that work with predominantly Somali population. The researcher found that understanding traditional Somali views on mental health and treatment methods, as well as the mental health needs of the community are critical to understanding how to serve this unique population. If the views and needs of the community are identified and understood then strategies for overcoming the barriers can be identified.

This study identified several barriers that prevent Somalis in Minnesota from seeking mental health services. These barriers include, language, concerns about confidentiality, mistrust, stigma, and lack of qualified Somali mental health professionals. To address the barriers identified in this study, the data offered a number of approaches and solutions. These solutions included community education on mental health, incorporating Somali and western treatment methods, and increasing the number of Somali mental health professionals in Minnesota. An important solution is the need for collaboration between spiritual and traditional healers and mental health professionals in the Twin Cities. Social work researchers should continue to study

mental health in immigrants and refugees and how to provide services to this segment of the population. The implications in this research are substantial and really important to those in the Twin Cities' Somali community.

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## **APPENDIX A**

### **INTERVIEW SCHEDULE**

1. What is your understanding of the Somali community's views of mental health?
2. What do you believe are barriers that keep Somalis out of the mental health service systems?
3. What role do you believe culture plays in treatment seeking behaviors among Somalis in Minnesota?
4. How do you believe interpreters impact treatment seeking behaviors among Somalis?
5. What role do you believe spirituality and traditional healers play in mental illness treatment in the Somali community?
6. What do you believe are misconceptions among Somalis have about mental health?
7. What role do you believe Islam play in treating mental illness in the Somali community?
8. What do you believe is the preferred method of mental health treatment among Somalis in Minnesota?

## **APPENDIX B**

### **CONSENT FORM**

I am conducting a study to explore whether or not Somali cultural misconceptions and other social barriers prevent Somalis in Minnesota from seeking mental health services. I invite you to participate in this research. You were selected as a possible participant because you are a mental health professional, who has provided mental health care service for Somalis in the 7 county metropolitan areas for at least 5 years. Please read this form and ask any questions you may have before agreeing to participate in this study.

This study is being conducted by Ali Shireh. The Chair of my Research Committee is, Dr. Rosella Collins-Puoch, a professor in the Graduate School of Social Work at the University of St. Thomas.

#### **Background Information:**

The purpose of this study is to learn if Somali cultural misconceptions and other social barriers prevent Somalis from seeking mental health treatment in Minnesota. The research question is Do cultural misconceptions about mental illness and other social barriers prevent Somalis in Minnesota from seeking mental health treatment? The benefit of completing this study is that the findings will add to the body of literature regarding the mental health care seeking behaviors in the Somali community in Minnesota.

#### **Procedures:**

If you agree to be in this study, I will ask you to do the following things: I will interview you for about 45 to 60 minutes. During the interview, I will ask you to answer 8 questions about your perspectives about the mental health seeking behaviors of Somali clients, who you have provided mental health treatment within the past 5 years.

#### **Risks and Benefits of Being in the Study:**

The study does not involve any risk or benefits to the participants. The benefits to the mental health community are that it will add to the available literature on Somali mental health and contribute to developing culturally competent mental health services for the community.

#### **Compensation:**

There will be no compensation for your participation in this study,

**Confidentiality:**

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way. The types of records I will create include a recording of the interview, and a transcript of the interview that will not be in the published paper. Only the researcher and my Research Committee will have access to the interview recording transcript. The recorded interview and the interview transcript will be destroyed on May 30, 2015.

**Voluntary Nature of the Study:**

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of St. Thomas. If you decide to participate, you are free to withdraw at any time. Should you decide to withdraw from the study, data collected about you and I will be destroyed. You are also free to skip any questions I may ask by letting me know you want to skip that question.

**Contacts and Questions**

My name is Ali Shireh; you may ask any questions you have now. If you have questions later, you may contact me at 952-649-0229. My research Chair is Dr. Rosella Collins-Puoch, who can be reached at 612-669-9202. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

You will be given a copy of this form to keep for your records.

**Statement of Consent:**

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age.

\_\_\_\_\_  
**Signature of Study Participant**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name of Study Participant**

\_\_\_\_\_  
**Signature of Researcher**

\_\_\_\_\_  
**Date**

## APPENDIX C

### INFORMATION SHEET FOR THE STUDY

My name is Ali Shireh and I am a Master's of Social Work student at St. Catherine University/University of St Thomas and Dr. Rosella Collins-Puoch is my advisor. I am conducting a research to explore if cultural misconceptions coupled with other social barriers prevent Somalis in Minnesota from seeking mental health services. I am interested in learning how social workers and other mental health professionals view the barriers faced by Somalis in Minnesota. I hope that what I learn from this study will contribute to the current literature and approaches of providing mental health services to the community.

I am inviting you to participate in this study because you have experience working with Somalis who are suffering from mental health issues. The interview will last approximately one hour. I will conduct the interview at a location and a time that is convenient for you. If you agree to participate, I will go over the consent form, audiotape the conversation and if you have any questions. Participation in this study is voluntary and you may choose to stop participating at any time before May 1<sup>st</sup>, 2015.

There is no direct benefit to participating in this study. The indirect benefits of this study include, helping other professionals understand the mental health needs of the Somali community and the barriers they face. The information from this study will be available online through St Catherine University/University of St Thomas online. Confidentiality will be maintained and your name will not be used and the interviews will be recorded anonymously.

The interviews will be audio recorded with your permission. You will have the right to ask for the recording to be stopped at any time. The audio tapes will be kept locked in a cabinet in my home office and will be destroyed on May 30, 2015. All notes will be shredded at the same time.

If you have any questions about your rights as participant in this research, or feel you have been placed at risk, feel free to contact Dr. David Steele at the University of St Thomas Institutional Review Board at 651-962-60389.