An exploration in understanding mental ill-health, available treatment and experience of help-seeking: Perspectives of Somali refugees living in the UK

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Preface

This portfolio covers three pieces of work that together encapsulate my journey in counselling psychology. It commences with a doctoral thesis research section which aimed to explore how mental ill-health and available treatment is understood by Somali refugees living in the UK, and how they experience help-seeking for mental ill-health in the UK. This is followed by a combined case study and process report of my work with a client, Lisa (a pseudonym has been used to protect the anonymity of the participant), where there were strong pulls into enactments between us that were challenging but provided us with a relational understanding of the origins of her problems. The portfolio ends with a publishable research paper which draws on the findings of the doctoral research.

These three pieces of work illustrate an overarching theme of the importance of the dynamic relationships between clinicians and clients that can influence the ability to access good mental health care and continue to receive mental health support. My experiences within these three pieces of work have re-emphasised the importance of reflecting on the micro-relationships of the client and the importance of respecting the client's and participants' history, identity and difficulties in a non-pathologising manner. Moreover, working together with the client in a collaborative manner allows there to be a sharing of power and trust which I have seen to be a real vehicle of change within my journey in professional practice and research. Furthermore, the three pieces of work in the portfolio have allowed me to reflect upon my learning at a macro level and to appreciate and understand the importance of the position in which clients and participants are placed in the social world. They illustrate that social adversity and systems of oppression cannot be ignored in counselling psychology, and that social advocacy should be embraced (Speight & Vera, 2004). I began to realise in my three years of training as a counselling psychologist that therapy alone will not be able to end

the oppression and social disadvantage clients or participants may face. I learnt that as counselling psychologists there is a need to constantly negotiate our relationships with clients depending on their individual and unique needs, whether that is working with community groups, third-party organisations or engaging with community-based research.

Furthermore, my identity as a Black Somali Muslim woman brought up in the UK has given me a desire to voice social inequalities that exist within Black, Asian and Minority Ethnic (BAME) communities in the provision of mental health care, as the doctoral thesis findings showed that the intersectionality of race, gender, social class and religion appears to influence the Somali community's ability to access good mental health care.

Section A: Doctoral Research

The doctoral thesis aimed to explore how mental ill-health and available treatment is understood by Somali refugees living in the UK, and how they experience help-seeking for mental ill-health in the UK. This study adopted a qualitative research design using purposive sampling. Ten participants (five females and five males) aged between 28 and 63 were recruited and interviewed. Furthermore, a snowball sampling recruitment technique was employed to attract more potential participants. Individual face-to-face semi-structured interviewing was used as a method of data collection. This research study followed Fereday and Muir-Cochrane's (2006) hybrid Thematic Analysis approach of inductive and deductive coding. Five overarching themes emerged from the data analysis. The findings showed that participants experienced mental health professionals to lack cultural competence in understanding the influence of Somali culture and Islamic beliefs in their understanding of mental ill-health. Participants highlighted that the intersectionality of race, gender, social class and religion appears to play on the

Somali community's ability to access good mental health care. The study highlighted the host of mental and social conditions experienced by Somali refugees, which are exacerbated by acculturative challenges such as stigma, cultural barriers and a dearth of culturally and linguistically appropriate approaches. The study highlighted potential suggestions to increase service delivery, utilisation and sensitivity. In addition, the study looked at how mental health services can tackle the fears, anxieties and suspicion of the Somali refugee community. One suggestion is to increase efforts to continue the work of demystifying the different prejudices that mental health professionals and institutions hold, but also to promote agency within Somali communities through the sharing of information about all available services and treatments so that this community can make a more informed choice about the support it requires.

Throughout the research process, I did reflect on my cultural background, values, and how these may interrelate to participants. I pondered how coming from a Somali background similar to that of the participants might have influenced the research process. I reflected on how this could be beneficial in relating to participants, but that it could also activate stigma within participants. I was aware from my own experiences within the culture that discussing the phenomenon of mental ill-health in the Somali community is taboo. I was mindful to embrace an insider/outsider position with participants in an attempt to counteract these issues that may prevent them feeling safe and comfortable in expressing themselves in this initially daunting research experience (Hammersley & Atkinson, 2019).

Section B: Combined Case Study and Process Report

In this section, I present my work with Lisa, who presented with borderline personality disorder (BPD), obsessive compulsive disorder (OCD), low mood and anxiety. I adopted a Cognitive Analytic Therapy (CAT) approach with Lisa as it

appeared there needed to be a relational understanding of the origins of her problems and symptoms. Lisa had done great work with previous therapies and services to stop self-harming, to remain abstinent from alcohol and to keep full care of her son. However, she seemed to struggle with relational issues, intense intrusive thoughts, intense anxiety, anger and loneliness. A CAT approach would hopefully be non-pathologising and be more personalised to her experiences, thus seeing her as a whole person. One of the key themes that will be highlighted in this case study is the therapeutic challenge, since in therapy there were strong pulls into enactments between myself and Lisa that were challenging. Nevertheless, reflecting, naming and transparently discussing the enactments and dynamics in the room between us allowed the therapeutic relationship to evolve and be a vehicle of change. Working together with Lisa in a collaborative manner allowed there to be a sharing of power and trust.

I was able to develop my skills in empathic challenging and manage my own part in the therapeutic relationship. I needed to be more active in the room, remain curious and to name the dynamics in the room with Lisa. This experience allowed me to grow in my professional practice by increasing my confidence.

Lisa was able to find new ways of relating to people as well as intrapersonally in terms of how she relates to her identity as a mother, which has always been challenging for her. We were able to explore the macro level systems in her life and to have flexibility to navigate relationships with these other systems. When thinking of this case and my learning at a macro level, I do feel it is important to understand the position in which the client is placed in the social world. Lisa has faced a life full of social adversity and abuse as a former care leaver and having children in care herself. Now as a single mother, working full-time and paying childcare fees, there are times when she struggles financially and emotionally. This position, and the impact of social adversity on Lisa's presentation, was often brought into the therapy. CAT, similarly to the doctoral

thesis position, assumes a social constructivist model (Dunn, 2002).

Section C: Publishable Paper

In the final section of the portfolio, I present a research paper which was drawn from the findings of the doctoral thesis. The journal *Health and Social Care in the Community* was selected as a relevant publication for this paper, as it has a multidisciplinary audience which includes counselling psychologists. This seems like an appropriate audience for the paper as the participants highlighted the relationship with mental health clinicians including general practitioners (GPs) as important in accessing good mental health care. The paper will highlight the difficulties in the relationship between clinicians and Somali refugees living in the UK from the perspectives of Somali refugees, and potential ways to improve this in order to increase trust and confidence towards clinicians as well as towards service delivery and utilisation. The hope in publishing this paper is to share with the multidisciplinary audience in health care the work of continuing to demystify the different prejudices that mental health professionals and institutions hold but also to promote agency within Somali communities through the sharing of information about all available services and treatments so that this community can make a more informed choice about the support it requires. The study shows that cultural competence from clinicians and mental health services, as well as cultural representation, is needed to provide better support for the Somali refugee community living in the UK.

In summary, the overarching theme relates to the importance of the dynamic relationships between clinicians and clients that can influence the ability to access good mental health care and continue to receive mental health care support. As I have mentioned, the three pieces of work in the portfolio illustrate this overarching theme. It is significant to understand the role of identity and

power and how this can influence relationships with others, and this has been explored in the doctoral thesis, combined case study and process report and publishable paper. As a counselling psychology professional, I am afforded some powers that may have not been accessible to me as a Black Somali Muslim woman. Therefore, it is important for me to recognise this new privileged position to which I have some access.

Section A: Doctoral Research

An exploration in understanding mental ill-health, available treatment and experience of help-seeking: Perspectives of Somali refugees living in the UK

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Supervised by: Jessica Jones Nielsen

Abstract

There is a high prevalence of mental ill-health and barriers to accessing mental health support in the Somali community living in the UK. Forced migration brings a host of mental and social conditions experienced by Somali refugees, and these are exacerbated by acculturative challenges. McCrone et al. (2005) found that Somali refugees living in London had a range of needs relating to psychological distress, housing, food and language but found low levels of service use in the UK.

This research aimed to explore how mental ill-health and help-seeking is understood by Somali refugees living in the UK, and how they experience help-seeking. The study adopted a qualitative research design and ten participants (five female and five males) aged between 28 and 63 participated in semi-structured interviews. Papadopoulos et al.'s (1998) model to address culturally competent research was used in the study. The data was analysed using Fereday and Muir-Cochrane's (2006) hybrid TA approach of inductive and deductive coding.

Five overarching themes emerged: (1) 'understanding mental ill-health'; (2) 'Cultural and religious beliefs'; (3) 'Perceptions of available UK support and treatment'; (4) 'Experiences of help-seeking'; and (5) 'The relationship between Somali refugees and professionals'. The findings revealed that participants experienced mental health professionals to lack cultural competence in understanding the influence of the Somali culture and Islamic beliefs in their understanding of mental ill-health. Participants highlighted the role of acculturative challenges as a cause of mental ill-health and a barrier to accessing mental health care. The study concluded that the intersectionality of race, gender, social class and religion appears to play on the Somali community's ability to access good mental health care. Many implications for clinical practice are outlined in the study. It is hoped that the findings will lead to increased promotion of cultural competence, sensitivity and representation.

1. Chapter One: Introduction

1.1 Introduction

After the civil war in Somalia in 1991, many Somalis found themselves in neighbouring African countries and in Westernised countries. The rate of Somali-born people coming to live in Europe and the UK was the highest of any group (BBC, 2005; The UN Refugee Agency, 2020). Over 2.1 million Somali citizens have been displaced and over 870,000 registered as refugees (The UN Refugee Agency, 2018). Many of these refugees have faced challenging health and mental health issues due to hardships experienced through war, famine, and poor living conditions. Forced migration, in particular, brings a host of mental and social conditions experienced by Somali refugees, which are exacerbated by acculturative challenges such as stigma, cultural barriers and a dearth of culturally and linguistically appropriate approaches.

Refugees can experience many traumatic events such as loss of family members and land, violence, torture and famine (McGraw et al., 2004). Bhugra (2004) indicated that trauma and forced migration increase the risk of an individual developing a mental illness. McCrone et al. (2005) also found that Somali refugees living in London have a range of needs relating to psychological distress, housing, food and language but found low levels of service use in the UK. Bhui et al. (2006) stated that common mental health disorders such as depression and post-traumatic stress disorder (PTSD) are prevalent amongst this group.

The Somali population can be viewed as idiosyncratic, which is why it is important that further research highlights how cultural knowledge about this population translates into the mental health field. The intersectionality of Somalis has a unique feature due to the social and political history of the country. Somalia is one of the only African countries with an almost entirely homogenous population, with 98% describing themselves as Somali (Bhui et al., 2006). Somalia consists of a single homogenous ethnic group with a uniform religion, culture and language (Lewis, Hussein & Ahmed, 2005). The Islamic faith has a central role in

social customs, beliefs and attitudes within the Somali population. Nevertheless, there are enduring socioeconomic differences and tribal conflicts within the Somali population which contributed to the civil war in the 1990s (Kusow, 1994). Despite the Somali British and Italian colonial era ending in 1960, this still had a significant impact on the political unravelling of the 1990 civil war. The civil war escalated to clan-based violence and 'clan cleansing', therefore creating further tribal clan divisions (Kapteijns, 2004). It is notable that decades later a large Somali population sought refuge in the UK, a country that once colonised it (Day & White, 2002). These differences and conflicts continue to resonate, with the ongoing high level of displacement of Somali refugees. As mentioned earlier, the rate of Somali-born people coming to live in the UK was the highest of any group. Common mental health disorders and psychological distress are prevalent yet service use is low amongst this group (Bhui et al., 2006; McCrone et al., 2005). The idiosyncrasies highlighted earlier within the Somali population can further provide a rationale as to why the current research is needed to highlight Somali cultural knowledge and how this translates to mental health needs in the UK.

In light of the impact migration and acculturation have on Somali refugees' mental health, this chapter will aim to explore the literature around mental ill-health and treatment in the Somali community, especially those living in the UK. Throughout, relevant work around Somali refugees will be critically appraised and gaps in current literature exploring Somali refugees' experiences in the UK will be identified. The chapter will begin by exploring the definitions and concepts of mental health in the UK. This will be critically evaluated and described and the position of Western psychiatry and psychology in the UK will be scrutinised. Following this, the chapter will further explore the needs of refugees, which will include a close examination of their mental health needs. This will, in turn, be followed by an examination of mental health service experiences from ethnic minorities and refugees, especially in the UK. Previous literature on how the Somali community conceptualises mental ill-health and its experiences of help-seeking for mental ill-health will then be

summarised. The chapter will conclude with the rationale for this study and its relevance to counselling psychology.

A search of any literature published on the topic between 1990 and 2020 was conducted. Databases utilised were City Search, PsycArticles, PsycInfo and SCOPUS, with keywords such as ‘Somali refugees’, ‘BAME’, ‘help-seeking’, ‘mental health’, ‘Somali mental health treatment’, ‘ethnic minorities help-seeking for mental health’, ‘Refugees’, ‘Refugee needs’, ‘mental health services’ and ‘barriers to help-seeking’. The key terms were used in several combinations, starting with databases, as well as in browsing journals such as the *British Journal of Clinical Psychology, British Journal of Psychotherapy, Counselling and Psychotherapy, Counselling Psychology Quarterly, Current Opinion in Psychiatry, Journal of Mental Health UK* and *The British Journal of Psychiatry*. The rationale for the time period was to cover the period from when Somali refugees initially began relocating due to political unrest in Somalia.

1.2 Definitions and Concepts of Mental Health in the UK

Western psychiatry and psychology have dominated the theory and practice of mental health in the UK (Gopalkrishnan, 2018). Researchers argue that mental health is a concept that can have many different perspectives intertwined with cultural and social values that are inevitably diverse (Fulford, 2001). One leading approach that psychiatrists have adopted is the biomedical/psychiatric approach which pathologises mental health (Pilgrim & Rogers, 2005). The systems used to define and categorise mental health in the UK describe mental health as an absence of a mental disorder or symptoms of psychopathology (Pilgrim et al., 2011). One of the systems most notably used by mental health practitioners in the UK is the ‘International Statistical Classification of Diseases and Related Health Problems’ (ICD-10). This is an international diagnostic manual tool which is created and managed by the World Health Organisation (WHO) and which classifies mental and behavioural disorders (WHO, 1993). Another system is the ‘Diagnostic and Statistical Manual of Mental Disorders’

(DSM-5), which is widely used in the United States (American Psychiatric Association, 2013).

These systems are viewed as global classification systems, yet their many critics see the use of a dichotomous classification system for mental health as pathologising. Of further concern in this regard is the focus on whether an individual meets the criteria for a specific disorder rather than the psychological distress the individual may be experiencing (Pilgrim & Rogers, 2005). By following a biomedical/psychiatric approach, culture, vulnerability, psychosocial stressors, conceptualisation of illness and how different cultures may relate or interact with mental health practitioners can often be overlooked (Gopalkrishnan, 2018). In using a biomedical model to explain mental health, there is an assumption that there is a single root cause of a disease/disorder, and that there are certain thresholds and cut-off points for one to be deemed to have a psychiatric diagnosis. Many argue that these global classification systems avoid suggesting the cause of the disorder, and solely base diagnosis on observable behavioural symptoms. This can be problematic as we live in a diverse and culturally rich society where there are cultural differences with regard to expressing distress and help-seeking behaviours for alleviating distress. Applying a Western concept of distress/mental illness/disorder on individuals from different communities and ethnicities runs the risk of misdiagnosis, over-diagnosis and misunderstanding that could hinder an individual from receiving care for their distress.

Many psychologists globally and in the UK in particular advocate for a dimensional approach to mental health in their practice, given that mental health and mental ill-health lie on a continuum (Krueger & Piasecki, 2002). WHO (2013) described mental health as a state of wellbeing in which an individual realises their own abilities, can work productivity, copes with the normal stresses of life and has the ability to contribute to their community (WHO, 2013). Mental ill-health is an umbrella term that covers mental illness and mental health problems (Fox et al., 2000) which account for an interference in an individual's emotional, social and cognitive abilities (WHO, 2013). Mental illness is described as mental and

behavioural disorders that are diagnosed by mental health practitioners using the global classification systems described earlier and which vary in severity (WHO, 2013). For example, mood disorders such as bipolar disorder and depression are considered mental illnesses. Mental health problems tend to have a shorter duration and less severity than mental illnesses, and often occur because to current life stressors (WHO, 2013). Nevertheless, when mental health problems are left unresolved or increase in severity they can develop into a mental illness (Keyes, 2005). The difference between mental ill-health and mental illness is that mental ill-health covers a wide scale of distress from the worries and grief that all human beings face in everyday life to more debilitating distress that makes it difficult to carry on with everyday life (Horwitz, 2020). Mental ill-health can often be used to describe mental health problems/poor mental health that are not diagnosable mental illnesses/disorders but are more to do with situational factors that are affecting the wellbeing of a person (Gamm, Stone & Pittman, 2010). In addition, mental ill-health also covers mental illnesses that are often described as a mental/psychiatric disorder that is diagnosed using the global classification systems such as the DSM-5 and ICD-10 (Horwitz, 2020). The main differences between mental health problems and mental illnesses are in terms of the severity of how they are affecting the wellbeing and functioning of the individual (Gamm et al, 2010). Mental health problems are often time limited or situation specific whereas mental illnesses have a more significant effect on the individual's life (Gamm et al, 2010). Consequently, mental ill-health also includes mental health problems and bouts of poor mental health. Therefore, when the umbrella term mental ill-health is used in the study it will cover both mental health problems and mental illnesses. The dimensional approach to mental health adopted by many psychologists argues that everyone is susceptible to experiencing distress in their lives, and individuals can display many characteristics or traits. This is in contrast to the dichotomous classification system that requires the presence or absence of a mental illness/disorder (Krueger & Piasecki, 2002). Over the years there have been many explanatory models developed based on mainstream Western ideology and which attempt to conceptualise mental health, mental ill-health, and distress (Cromby et al., 2013).

It could be argued that the current thinking in the UK among mental health professionals leads to the biopsychosocial model of mental health. One of the global classification systems – the DSM-5 – received much criticism after its release, most strikingly from the British Psychological Society (BPS) (BPS, 2011). One of the criticisms was that the DSM-5 does not allow exploration of the cause of the mental illness/disorder such as the psychosocial (sociocultural) factors and/or normalising the possibility that the client may just be responding in the most natural way to their distress and experiences (BPS, 2011). Therefore, many argue that a biopsychosocial approach allows medical, biological, developmental, social, psychological and organic factors in order to understand the client's experiences, which can allow for an exploration of the most helpful interventions and treatments (BPS, 2011).

Others argue that combining psychological formulation and the DSM-5 classification can allow for increased understanding of the client's situation and of how there may have been many factors that have led to the distress (Craddock & Mynors-Wallis, 2014). Some researchers also suggest that psychological formulation can be viewed as a complementary tool that can aid diagnosis (Johnstone & Dallos, 2006). Nevertheless, many of those who continue to advocate for a biopsychosocial model do not explain the links between the different elements of the model and why the biological element appears to take precedence (Cromby et al., 2013). It could be argued that even in textbooks and taught programmes centred around mental health, which promote a biopsychosocial model, psychiatric diagnoses are primarily used to shape our understanding by normalising the use of labels and explanations of diagnoses to present learning (Cromby et al., 2013). It can be argued that there is a geopolitical element in the focus of a biological approach to explaining distress as this may relieve responsibility from politicians and governmental agencies in their contributions to people's distress (Cromby et al., 2013). For example, the conditions associated with social inequalities, such as poor housing and poverty, are often blamed on individual pathology when a biological approach is promoted (Gopalkrishnan, 2018). Despite

the push for a biopsychosocial approach one researcher found that the unrealistic time restraints and pressures on psychiatrists in the UK make it difficult to develop and maintain formulations that are holistic (Hughes, 2016).

That is a brief exploration of some of the concepts of mental health in the UK. Due to the overwhelming amount of literature surrounding this subject and the limits of this thesis, it has not been possible to discuss all the concepts in depth. However, another area that is important to mention, and which steers away from the psychiatric diagnosis approach, is the positive psychology view of mental health that focuses more on how humans maintain wellbeing and life satisfaction (Pilgrim et al., 2011). This would align with the humanistic (existential) explanatory model whereby mental health is not viewed as the absence of an illness or disorder, but rather as a fulfilling, purposeful and enjoyable state (Min et al., 2013). Mental health according to this framework is about aiming to maintain and achieve positive wellbeing and being equipped to cope with adversity (Kalra et al., 2012). This approach has been met with some praise for suggesting that emotional wellbeing is crucial in defining mental health (Power, 2010). Nevertheless, others argue that the construct of 'wellbeing' that is being followed is that of a Western individualistic culture that may not translate to cultures that are collective (Pilgrim et al., 2011).

It could be argued that there is a breadth of literature on the refugee experience that emphasises growth through and after adversity. Joseph and Linley (2006) highlight that there is personal gain to be found in human adversity. Although not a novel concept in existential and psychological literature, this has now gained more ground in empirical research on growth through and after adversity. Linley and Joseph (2004) further argue that only focusing on negative appraisals of trauma and adversity may create a biased view in understanding post-traumatic reactions. They also suggested that significant changes can be observed where the individual can gain a higher level of functioning prior to the event. Linley and Joseph (2004) expressed that the variables associated with growth after trauma and adversity are higher cognitive functioning, optimism, faith and acceptance. Similarly,

Papadopoulus (2007) suggested that through the process of adversity and struggle the individual can find development due to their resilience and resourcefulness. There is an emphasis on refugees' reactions to adversity not being limited to being traumatised but also including Adversity-Activated Development (AAD) and resilience (Papdopoulus, 2007). AAD focuses on understanding the refugee experience through a non-medical lens, by emphasising that an individual does not have to be traumatised after experiencing adversity. For example, the premise of post-traumatic growth (PTG) is that a refugee has experienced trauma and has found growth post-trauma, whilst in AAD there is an emphasis on adversity rather than trauma, and the fact that this may be ongoing as refugees may continue to experience adverse conditions after displacement. The individual can find development at any point on this continuum, as development can occur during the initial adverse event (e.g. civil war, natural disasters), during, and/or after the displacement (Papdopoulus, 2007). Overall, AAD highlights that new characteristics and developments can occur that did not exist prior to adversity, but that this may not always be known by the individual themselves.

Furthermore, the Power Threat Meaning Framework (PTMF) gives an alternative non-diagnostic conceptual system to psychiatric diagnosis (Johnstone & Boyle, 2018). PTMF looks at developing a framework that incorporates social, psychological and biological factors as an alternative to a dichotomous classification system that relies on a psychiatric approach. PTMF shifts from 'what is wrong with you?' to 'what has happened to you?' (Johnstone & Boyle, 2018). It is a framework that advocates a non-pathologising approach and locates distress within the wider social context. Johnstone and Boyle (2018) further highlight that PTMF also aims to put back all the many power influences in our lives that are excluded from diagnostic and psychological understanding. This encompasses all types of power i.e. social power, political power, personal power, abuse, poverty, structural violence but also ideological power (social norms, media). PTMF also focuses on the effect of this and how power creates threats in various aspects of our lives (Johnstone, 2020). Johnstone and Boyle (2018) argue that PTMF focuses on creating a narrative and making meaning in

order to conceptualise these experiences/situations. PTMF highlights that meaning comes from wider social understandings and is very often ideologically driven. In psychiatry this is known as symptoms but in PTMF it is covered by threat responses. PTMF explores how when you look at someone's strengths, this gives you the material to put these together as a narrative that can operate at a personal, family and community level (Johnstone, 2020). This framework can challenge a way of thinking, as well as language and assumptions. Similarly, this current research may highlight refugee experiences through the lens of systemic and structural issues.

Overall, there have been many attempts throughout history to conceptualise human distress, mental health, mental ill-health, etc. These descriptions have changed according to the social and cultural norms of society. An example of this is homosexuality, which was deemed to be a mental disorder under the DSM until 1973 (Carr & Spandler, 2019). This example highlights the influence of social and cultural values on how we understand, classify, help-seek, and treat mental health. Furthermore, conceptualisations of mental ill-health can be more difficult when one may not hold the dominating cultural values of the society one lives in, as is true of marginalised groups in the UK.

1.3 The Needs of Refugees

Millions of people have been displaced in response to natural disasters, wars, human rights violations, torture and violence (Tribe, 2005). As such, the term refugee is defined as someone who:

> *'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is*

unable or, owing to such fear, is unwilling to return to it' (The UN Refugee Agency, 2019).

The UK is of one of the countries that hosts refugees and attempts to cater to their different needs (Tribe, 2005). This segment gives context to the variety of needs of refugees, which relates to the research topic. Discussing the general needs of refugees will highlight the impact of displacement and how it relates to Somali refugees in particular. Research has shown that acknowledging the unique needs of refugees when they move to their host country can provide reciprocal benefits to both the host country and the refugee. For example, refugees can provide a significant workforce, increase economic wellbeing and culturally enrich the host country when provided with the resources. Tribe (2005) highlighted that investing in skilled refugees can contribute positively to the UK, as the data emphasised that reintegrating doctors with a refugee status in the health sector costs significantly less then training a doctor from scratch. It can be implied that this would ease some economic burden for the UK.

Nevertheless, despite these reciprocal benefits, Kindler et al.'s (2015) review described the plethora of literature highlighting the unmet needs of refugees in Europe. The authors also underscore how social deprivation is perpetuated by poverty, poor social housing and racism, which all were shown to contribute to poor mental health. They also traced the origin of these issues to the macrosystems whereby public policies and practices as well as cultural and societal structures influenced the wellbeing of refugees in their study. This is further supported by Newman and Newman (2020) who suggest that these macrosystems frame education, health care, finance, media, laws and how they are implemented in the society (Newman & Newman, 2020). Kindler et al. (2015) further locate the issues within the local and national policies that are found lacking in enabling growth and integration of refugees within the host country, as the inter-ethnic, multifaceted relationships are not catered for appropriately. For example, research has emphasised that the British government needs to put in place better policies and practices to reduce this socio-economic

disparity as a way to promote social cohesion and mental health (Gopalkrishnan, 2018; Letki, 2008).

There are not many existing studies about the needs of Somali refugees in the UK in the academic literature; however, it is valuable to use the literature available about Somali refugees in other Western countries that may resemble the UK culture. One study looked at Somali women and Oromo refugees living in Minnesota, USA and investigated the characteristics of this group and their trauma and torture experiences. Robertson et al. (2006) carried out a quantitative study recruiting a sample size of 458 refugees with over half being mothers. The findings suggested that women with larger families reported higher levels of trauma and torture and tended to be older, with poor formal education, and less likely to be fluent in English. Furthermore, Robertson et al. (2006) suggested that women with larger families were less likely to access English classes, employment programs and social networks, making this group more isolated and vulnerable. They also found that the older participants were more likely to have seen their general practitioner in the last 1.3 months and had been prescribed medication for stress. One limitation of the study was that the data was self-reported and so may have been skewed. However, the implications from this study highlight the need for health care providers to develop a more comprehensive understanding of the range of refugee women's experiences and the spectrum of needs post-settlement. Robertson et al. (2006) further suggest the need to move away from a biomedical model to holistic and collaborative frameworks that can better support refugee groups. Nevertheless, this study only investigated Somali refugee women's experiences in Minnesota, which makes it difficult to generalise to the UK population of Somali men and women refugees.

Another study, conducted by Makwarimba et al. (2013), aimed to identify the needs of Somali and Sudanese refugees living in Canada. Makwarimba et al. (2013) conducted in-depth interviews with 68 participants. Refugees reported many needs such as for services and support for finances, housing, employment and language. They also reported many

barriers to accessing services to support them with such needs and that these services were limited by discrimination and language barriers. In addition, participants reported feelings of loneliness after separation from family. In both Somali and Sudanese culture, family is the main source of support. Makwarimba et al. (2013) found that participants suggested that they would value group-level support supplemented by individual support aimed at sharing resources and information to alleviate loneliness and promote social integration. The implications from the study suggest that it is important for further research to continue to assess support needs, barriers to accessing support and preferences of diverse refugee groups, as these can inform the design and enhance the relevance of support services to be more culturally and linguistically appropriate (Makwarimba et al., 2013). This study identified such needs in Somali and Sudanese refugees living in Canada, and it could be argued that this should be explored further for Somali refugees living in the UK.

A further study, conducted by Stewart et al. (2008), looked at Chinese and Somali immigrants and refugees, service providers and policy makers in Canada. The authors examined the support that was taken up, as well as other support that was available. They found through individual interviews that the main difficulties that arise for these groups revolved around language, poor health, racism, unemployment, seclusion, reduced family networks and the rejection of existing qualifications from the native country. Like Makwarimba et al.'s (2013) study, participants felt their needs were not being sufficiently met. However, it could be argued that there are many cultural differences between Chinese and Somali traditions. For example, Stewart et al. (2008) found that Chinese participants looked to the government and institutions for support, whereas Somalis looked to their family members.

In summary, the implications from the three studies encourage mental health and social care support services to better support diverse refugee groups and make services more culturally and linguistically appropriate to their needs (Makwarimba et al., 2013; Robertson et al., 2006; Stewart et al., 2008). As described earlier, refugees can contribute

positively towards the host country; however, literature highlights the socio-economic disparity that hinders their ability to thrive.

As we have seen, refugees also experience pre-migration trauma, and post-settlement difficulties and adversities. This segment explores how the factors mentioned previously influence the wellbeing and mental health of refugees. Some studies have highlighted how the general refugee population requires different mental health support depending on the pre-migratory trauma that they have experienced (Rousseau, 2018; Silove et al., 2017; Tribe, 2005). It is important to distinguish the experiences of different refugee populations as the experiences that led to the displacements are unique. By understanding the uniqueness of the different populations, the hosting countries can provide better tailored support in the field of mental health and beyond. It also important to note, as O'Donohue and Elliot (1992) attempted to understand, whether the psychological distress experienced by refugees represents normal human reactions rather than mental health concerns that warrant labelling. As such it is important to acknowledge the distress that pre-migratory trauma has caused but refrain from labelling before understanding the context and culture of the individual. In the case of this research study the information gathered can inform psychologists, policy makers and other systems on how to better support Somali refugees more sensitively and effectively.

Some studies have shown a link between pre-migration, trauma and the need for mental health support. One such study found that there was a 30% prevalence of PTSD and major depression from a systematic review of over 80,000 refugees and that this was often linked to trauma and torture experiences from the conflict in the home country (Steel et al., 2009). Furthermore, Bogic et al. (2015) carried out a systematic review which found that refugees from war-torn countries still experience significant psychological distress five years after settling in the host country. A close look at these systematic reviews highlights that a large number of refugees suffer from a range of psychological distress associated with pre-migration trauma such as depression, anxiety disorder and PTSD. Nevertheless, the

systematic reviews also underline that pre-migration trauma alone does not account for the mental health needs of refugees, but rather it is the combination of post-settlement difficulties and pre-migration trauma that best predict this phenomenon.

Steel et al. (2009) suggested that mental health issues are often intensified by post-settlement difficulties. Many researchers argue that treating refugees based only on their pre-migration trauma ignores the current post-settlement difficulties that they endure (Li et al., 2016; Miller & Rasmussen, 2017; Porter & Haslam, 2005). Li et al. (2016) also reported that socio-economic and political factors in addition to interpersonal factors exacerbate pre-migratory acquired psychological distress. Their study further emphasises the need to review policies that affect the wellbeing of refugees in a more comprehensive manner. For example, Silove et al. (1998) found that the immigration interview process that refugees and asylum seekers face is often extremely distressing as they must detail their pre-migration trauma in a non-therapeutic manner and setting.

A systematic review found that although there is sufficient research to show that pre-migration trauma combined with post-settlement difficulties contribute to refugees' psychological distress, there is limited research showing the effectiveness of multimodal interventions on post-settlement difficulties and pre-migration trauma combined (Hynie, 2018). It could be argued that the existing interventions do not cater sensitively for the different refugee populations. Perhaps the limited effectiveness mentioned by Hynie (2018) is due to an approach that is still too generalised and looks at the refugee population as a homogenous group. Part of the aim of the current research is to move away from viewing refugees as a homogenous group and instead recognise that there are many subgroups of refugees that hold different cultural values and as such may respond differently to the mental health interventions offered in the host country (Newbigging & McKeown, 2007). Therefore, by focusing on the Somali refugee population it is hoped to gain an insight into their cultural values and how these inform their responsiveness to the available services and treatment in the UK.

The available grey literature on Somali refugees captures some of the experiences that they encounter in host countries. It is necessary that information being published by non-academic sources be included in academic research as it gives an understanding of the wider literature. This allows a richer understanding of certain nuances that could have been missed within academic literature. The Race Equality Foundation published a report on how the political climate can influence how refugees integrate in neighbourhoods in the UK (Jones & Mullins, 2009). The article suggested that refugees are often placed in the poorest areas (Jones & Mullins, 2009). In addition, the Open Society Foundations specifically focused on 'Somalis in London' as part of a seven-city series titled 'Somalis in European cities' (Open Society Foundations, 2014). They highlighted how Somali refugees view, experience and interact with different aspects of society (i.e. housing, education, identity, employment, and health and social protection). Although the report did highlight some positive aspects of the Somali refugees' integration, it also spoke of various barriers that research should focus on. For example, the report suggested that there are still significant barriers regarding the interaction of Somali identities within the health system, suggesting an ongoing lack of cultural sensitivity to needs of the refugees (Open Society Foundations, 2014). As such, it is important to have current appraisals of such concerns, alongside further research. One of the aims of the current study is to explore the experiences of help-seeking within the Somali refugee community in the UK.

Narrowing down academic studies exploring the mental health needs of Somali refugees reveals limited papers that explore the needs of Somali refugees specifically living in the UK. One such study, that of McCrone et al. (2005), aimed to assess the mental health needs and service use of Somali refugees living in the UK. Two measures were disseminated; the 'Camberwell assessment of need' and 'the client service receipt inventory' to 143 study participants. The authors found that many of the participants had common mental health disorders such as depression, and only a small proportion had serious mental health conditions. McCrone et al. (2005) concluded that Somali refugees residing in London

for a period of five years had high levels of need but low levels of service use. This study was the first of its kind to systematically assess the needs of this target population residing in London.

One other study explored the associations between khat use, traumatic experiences and psychotic symptoms amongst Somali refugees living in Kenya (Widmann et al., 2014). Khat is a traditional East African plant associated with socialising among males. When chewed, khat has a stimulating effect that increases energy, social skills and a feeling of increased general wellbeing. Participants in the study associated excessive khat use with forgetting about traumatic experiences (Widmann et al., 2014). The findings of this study also showed that khat users mostly had khat-associated psychotic symptoms and post-traumatic stress disorder, and that unemployment in urban Kenya could have been a factor. Moreover, they found that khat was consumed more once participants had fled Somalia to help cope with the traumatic experiences and strengthen their cultural identity in the host country (Widmann et al., 2014). This study further suggests that there is a need for the development of culturally appropriate and community based mental health support that can address the needs of Somali refugees. Nevertheless, the sampling method of the study may not be representative as it could be argued that the study recruited an extreme khat user group and therefore findings may not be generalisable to the rest of the Somali male refugee population.

Other studies have used a qualitative approach to explore mental wellbeing in Somali refugees living in the USA, Australia and UK. Whittaker et al. (2005) conducted semi-structured interviews with young Somali refugees on their subjective understanding of mental health. Themes of resilience, identity and beliefs came up in addition to themes of keeping secrets through fear of being stigmatised with being ‘crazy’, and just getting on with life. Religion is viewed as one way of promoting mental wellbeing but it is often absent in Western psychology. In addition, concepts such as spirit possession and preferred methods of religious healing were explored (Whittaker et al., 2005). Freeman et al.’s (2013) findings

complement those of Whittaker et al. as religion is highlighted as important in making health decisions, and recitation of the Quran out aloud is a preferred method of treatment for mental health concerns. Participants have a belief that everything is 'God's will', which helps them to cope better with mental ill-health. Other studies have found that Somali refugees think of depression as more of a collective and systemic issue rather than an individualistic issue and that support is provided within the community from others (Kokanovic et al., 2008; Rae, 2016).The implications from the studies mentioned advocate the need for mental health practitioners to have knowledge and awareness of cultural practices and religious beliefs when addressing health needs of Somali refugees (Freeman et al., 2013; Kokanovic et al., 2008; Rae, 2016; Whittaker et al., 2005). Based on the appraisal of the relevant literature, refugees are more likely to be vulnerable when entering the host country, and vulnerability and not having access to needed resources can affect mental wellbeing. As mentioned previously, there is limited research on the needs of the Somali refugee population, especially in the UK, therefore it is of interest to understand the experiences of other ethnic minorities in accessing mental health services in the UK. This will be explored in the next segment.

1.4 Black, Asian and Minority Ethnic (BAME) Barriers to Accessing Mental Health Services

This segment explores how the BAME community, as a whole, experiences barriers to accessing mental health services and its experiences of help-seeking. Following the earlier segment which explored the needs of refugees and concluded that mental health needs are prevalent within this population, it is now important to direct our attention to the cultural aspects related to the barriers surrounding accessing mental health services for BAME groups. As refugee populations make up a large proportion of service users amongst BAME communities, it is important to highlight this in the existing literature (Loewenthal et al., 2012).

In recent years there has been heavy criticism of the term ‘Black and Asian Minority Ethnic (BAME)’. It has been argued that the term ‘BAME’ does not highlight the unique experiences of people of colour (DaCosta, Dixon-Smith & Singh, 2021). Many argue that this term categorises and labels groups that do not have universal experiences. Gabriel (2021) highlights that this categorisation and homogenising of minoritised groups can have three detrimental effects: concealing inequalities faced by different minoritised populations; strengthening the privilege of the white identity; and repeating unequal power relations. The current research took into account these criticisms and took steps to ensure that the experience of Somali refugees was not lost within the term ‘BAME’. It included studies using the term ‘BAME’ in the literature review, since there was limited literature on the Somali refugee community alone, but the criticisms of the term ‘BAME’ were held in mind during the literature review and the research study itself, as the literature on ‘BAME’ refugee communities in the UK is insufficient to understand the uniqueness of the Somali refugee community. Further research is needed to focus specifically on different communities in the UK in regard to the barriers surrounding accessing mental health services. Nevertheless, the studies in this segment will sensitively explore the literature on ‘BAME’ communities.

Some of the barriers to accessing mental health services were raised in Rabiee and Smith’s (2013) study with African Caribbean and Black African participants, which included Somali participants. This study showed that African Caribbean and Black African participants held different cultural beliefs regarding mental health and help-seeking (Rabiee & Smith, 2013). This study also highlighted the need for clinicians and health providers to expand their understanding of and sensitivity towards diverse cultures as a way to increase service utilisation among African Caribbean and Black African communities (Rabiee & Smith, 2013). Furthermore, Rabiee and Smith (2013) emphasised that African Caribbean and Black African participants believed that there were social inequalities in the provision of mental health care which perpetuated their mistrust and fear of mental health services in the UK. However, a limitation of the study was that they found it difficult to recruit Black African

participants and due to time restraints decided to focus on participants from Congo and Somalia. Therefore, it could be argued that this was not representative of other Black African counterparts living in the UK (Rabiee & Smith, 2013).

Bhui et al.'s (2015) systematic review found that experience of care, stigma, issues around relationship with the clinician and insight are just a few of the prominent barriers faced by Black African, Black Caribbean and Asian communities in accessing psychological therapies. However, the review suggested that culturally sensitive approaches improve the effectiveness of the interventions provided by services. This assertion suggests the need for future studies to expand and evaluate the cultural adaption of psychological therapies (Bhui et al., 2015). From this systematic review only four studies were from the UK and the remaining seventeen were from the USA (Bhui et al., 2015). It could be argued that more research is needed from the UK and other European countries in evaluating mental health support services and interventions designed to improve therapeutic communications between BAME communities and clinicians.

Dockery et al. (2015) also emphasise the role of stigma as a significant barrier for service users from BAME communities in accessing mental health care services. The study aimed to examine the role of stigma in delayed treatment-seeking and recruited 202 service users and 89 caregivers. The authors found that service users were more likely to report stigma-related barriers when accessing mental health services compared to caregivers that sought treatment on the service users' behalf (Dockery et al., 2015). However, the study reported that caregivers from a Black background were more likely to report stigma-related barriers compared to caregivers from White backgrounds. Dockery et al. (2015) reported that multifaceted approaches are needed to reduce stigma-related barriers when accessing services and treatment. Nevertheless, it could be argued that the findings of the study may not apply to those not engaged with mental health services as the participants recruited were already engaged with services and assessed by clinicians to be well enough to participate in the study.

When looking closely into a specific mental health condition like psychosis, Islam et al. (2015) reported significant barriers in accessing early intervention services for BAME service users. The study evidenced, firstly, that there are multiple concepts of illness from BAME service users' perspectives which conflict and oppose Western perspectives. Secondly, the authors suggest that clinicians have a limited understanding of the role of faith and spirituality which informs the model of healing and illness for BAME service users, and this is further supported by Kalra and Bhugra's (2011) findings. Thirdly, they expressed the need to improve the collaboration between mental health services and community organisations to involve cultural, spiritual and personal needs. Lastly, they suggested that better education can improve the effectiveness of accessing mental health services. It might have been helpful for the study to have distinguished between culture and ethnicity as beliefs such as *'jinns'* are religious and cultural beliefs rather than a phenomenon of ethnicity.

Williams et al. (2006) underlined that part of the barriers in accessing mental health services were related to an over-reliance on Eurocentric approaches that lack cultural representation from other worldviews. These Eurocentric approaches have assumptions and practices that discourage BAME communities to access services and eventually perpetuate misunderstandings that negate BAME experiences of psychological distress (Williams et al., 2006). Furthermore, these misunderstandings extend to unequal retrieval of information that can be relevant to accessing primary care services for common mental health problems (Kovandžić et al., 2011). A striking finding from a systematic review suggested that individuals from BAME communities may conceptualise their issues as social problems rather than mental health problems, which often creates a dissonance with the Eurocentric mental health models that clinicians and mental health services utilise (Lamb et al., 2012).

Shefer et al. (2013) point out that there are significant barriers regarding accessing services due to stigma attached to seeking psychological help and how the stigma can impact the relationships with family and help-seeking behaviours. Specifically, some BAME

cultural beliefs do not align with the Eurocentric framework of treating mental ill-health and therefore can affect the relationships within a family, as family members may have opposing views which could affect help-seeking for mental health issues. These studies highlight the difficulty of integrating the dominant Eurocentric framework with other worldviews that are marginalised in the UK, and as such can lead to stigma within a community and perpetuate a sense of isolation if an individual veers towards cultural values that are different from those of their families (Kovandžić et al., 2011; Shefer et al., 2013; Williams et al., 2006). This is seen and evidenced in a study that highlighted how Somali, Urdu, Tamil and Bengali communities in the UK would access mental health services as a last resort, when their distress is severe, compared to non-BAME populations (Loewenthal et al., 2012). Mclean et al. (2003) emphasised that active participation from the BAME community in mental health services could aid accessibility and effectiveness of services. They felt that it was important to allow the community to have agency in voicing their preferences about the care they would like to receive (Mclean et al., 2003).

Bhattacharyya and Benbow's (2013) systematic review reported that elders from BAME communities were at risk of being socially excluded and found it difficult to access mental health services in the UK. The systematic review found that there was a gap in appropriately sensitive services in supporting BAME elders with mental health problems (Bhattacharyya & Benbow, 2013). Among the prominent barriers mentioned were the language barriers experienced by this group. Moreover, a similar study looking into BAME elders suggested similar barriers and added the concept of depression is understood differently due to their cultural beliefs, meaning that they may not access psychiatric services as they believe these should only be used by those who are violent, out of control and a danger to society due to their illness (Marwaha & Livingston, 2002). Therefore, further research is recommended to understand why current services are under-utilised in the UK by elderly BAME communities (Bhattacharyya & Benbow, 2013). It was also recommended that future learning from research should be retained and disseminated so that it can be

applied in practice for all communities in the UK (Bhattacharyya & Benbow, 2013). Additionally, the available research identified that in order to reduce the barriers and enhance care pathways there is a need to promote cultural representation in the mental health services as a means of bridging the gaps in the understanding of the role of culture and race within mental health (Sass et al., 2009).

The studies mentioned in this segment have highlighted multiple barriers BAME communities face in accessing mental health care services. Highlighting such barriers could aid understanding of the difficulties Somali refugees may face as they are part of the BAME community and identify as Black Africans. However, this current study will spotlight the experiences of the Somali refugee community in the UK, thus allowing the uniqueness of their experiences to be highlighted and not lost in research that generalises cultures within the 'BAME' label.

1.5 Somali Concept of Mental Health and Barriers to Help-Seeking

The previous segments broadly covered the needs of Somali refugees and how related BAME communities experience accessing mental health services. This segment will explore the available literature on how the Somali community in particular conceptualises mental health. This will highlight gaps in the literature and provide further rationale for the importance of the present research. Markova and Sandal (2016) carried out a study in Norway which explored how Somali communities viewed the concept of depression and their preferred coping strategies. The results showed that Somali participants conceptualised depression as either possession of spirits, social isolation, and/or previous trauma. As a result, Somali participants expressed that they would prefer to seek support from family, elders and religious leaders for help with depression (Markova & Sandal, 2016). It could be inferred that perhaps the concept of mental health for the Somali community is significantly informed by family, elders and religious leaders. This study highlights a striking difference between the Eurocentric and Somali explanatory frameworks of depression. Markova and

Sandal (2016) also highlighted the need for community members such as religious leaders and elders to be involved in the mental health care systems of the host countries to enable better access to services. Nevertheless, the study was conducted in Norway and their policies and cultural norms differ from those of the UK. In addition, the study explored a specific psychiatric diagnosis and it may be more helpful to initially understand the general concept of mental health and issues with accessing services as the psychiatric terminologies such as depression can be unfamiliar (Markova and Sandal, 2016).

A study carried out by Pratt et al. (2015) in Minnesota, USA explored the perceptions of mental illness in the Somali community. The focus groups used by Pratt et al. (2015) highlighted similar results to Markova and Sandal (2016). Pratt and colleagues described that Somali participants' views of mental illness are informed by the impact of trauma, religious beliefs and historical experiences. They also added that stigma plays an important role in the decision to seek treatment. Pratt et al. (2015) evidenced the need to involve religious leaders as they believed that these leaders inform the views of the Somali community significantly. This is important research as it offers significant findings on which to build further. For example, the use of focus groups might offer insight into the sort of ideas and beliefs that the Somali community might be willing to share. However, one of the points highlighted in the study was the significant role that stigma plays and as such it is possible that there are views about mental health that people did not share out of worry. For example, Pavlish et al. (2010) described how Somali women in the USA would not share their views on mental health to health care providers as some worried that their beliefs would be looked down upon. The study by Pavlish et al. (2010) showed that Somali women believe that mental illness can be associated with being cursed. This belief can carry a high level of stigma but also influence how they would seek help. A further limitation highlighted by Pratt et al. (2015) within their study was that the sample size did not represent the whole Somali community. They expressed how the opportunistic sampling might have excluded a part of the Somali population that was less forthcoming in discussing mental illness.

There has been other similar research carried out across Western countries such as Finland, USA, New Zealand and Australia (Guerin, 2004; Kokanovic et al., 2008; Mölsä et al., 2010). These studies reported common findings regarding the importance of the Islamic faith which influence views about mental health. For example, their reference to spirit possession, being cursed and the role of religious leaders are significant religious and cultural beliefs and practices among the Somali community (Kokanovic et al., 2008; Mölsä et al., 2010). In addition, these studies found that the Somali community views mental health issues as social problems and that depression is seen as more of a collective experience (Kokanovic et al., 2008). Other studies emphasised that Somali participants expressed that they viewed mental illness as confined to severe and untreatable cases (Guerin, 2004). Nevertheless, these studies highlight the importance for research of bridging the gap in understanding how to meet the perceptions and needs of the Somali community (Guerin, 2004; Kokanovic et al., 2008; Mölsä et al., 2010).

Bringing our attention back to research in the UK on how the Somali community conceptualises mental health, we see limited research on this topic within the country. Nevertheless, Palmer (2006) carried out a mixed method study which aimed to find out how the Somali refugee community in Camden (a London borough) perceived mental illness and barriers in accessing and utilising services. The study found that the significant barriers in accessing and utilising services were the practices of dominant Eurocentric models, language barriers, difficulties in trusting professionals, Somali cultural traditions, perceptions of mental illness and pre-occupation with post-settlement difficulties (Palmer, 2006). This qualitative aspect of the study recruited seven participants who were service users from a refugee centre, three of whom had mental health diagnoses. It could be argued that more research is needed to follow up on this study as it has been 15 years since it was published.

Hynie (2018) recently argued that existing interventions still do not cater sensitively to the different refugee populations, as these populations may still be generalised into one demographic. As previously described, BAME communities in the UK continue to experience

barriers in accessing mental health services and it could be argued that one of the reasons for this is a lack of cultural competence when working with different communities (Rabiee & Smith, 2013). Therefore, further research is needed in the UK to understand how Somali refugees presently think about mental health, to give a more up-to-date picture than Palmer's (2006) study, with refugees who have been settled in the UK for longer. Since the release of Palmer's study the views of Somali refugees may have changed, and current research would give insight into how Somali refugees are integrating their understanding and values with the host country. Similarly, Rae (2016) explored how Somali males in the UK understand depression, coping, and views towards mental health professionals. The study found that participants linked depression to post-settlement difficulties and that there was a collective view of depression that linked to an individual's self-worth (Rae, 2016). This resembles the findings from Markova and Sandal (2016), the Norwegian study mentioned earlier. Rae (2016) emphasises the need to understand the social and contextual factors of a community and how this can have implications for Eurocentric psychological therapies. This study focused on Somali men, though Rae (2016) expressed that for future research it would be helpful to include Somali women as this might provide further insights. These studies highlight the need for further research on the Somali refugee community in the UK in order to improve understanding of cultural conceptualisations of mental health, help-seeking and access to mental health services.

1.6 Conclusions and Research Questions

Research has found that Somali refugees presented with higher levels of need for psychological care, language and housing support, but were not accessing the relevant services (McCrone et al., 2005). Bhui et al. (2006) found that mental illness was more prevalent in Somali refugees than any other refugee group. The findings from a US study Freeman et al. (2013) revealed that Somali refugees did not 'risk' accessing mental health services due to beliefs around mental health and cultural stigma.

Furthermore, the studies conducted in the UK which were described in Section 1.5 summarise how far research has come and highlight the need to further the understanding in the area of cultural conceptualisations of mental health, help-seeking and access to mental health services in the Somali refugee community in the UK (Palmer, 2006; Rae, 2016). The findings evidenced that there are limitations that can be explored further. The concept of mental health in the UK has continued to evolve and whilst this has been solidified in Western cultures, it has put a strain on marginalised groups in the UK (Cromby et al., 2013). Moreover, this has raised questions about how models and treatments need to adapt for these marginalised groups. The present study intends to shed more light onto understanding how to improve access to mental health services by looking into one of these marginalised populations.

Therefore, the marginalised group being researched will be that of Somali refugees. It is evident that refugees have a number of different needs, however, the focus here will be on mental health as it addresses one of the most salient concerns given refugees' significant mental health needs due to pre-migratory trauma and post-settlement difficulties. Secondly, the Somali concept of mental health has been shown to conflict with Eurocentric concepts of mental health (Palmer, 2006). These two reasons create a rationale to further understand the Somali refugee community and thereby improve clinicians' understanding of their cultural concepts as well as help bridge the differences between the two concepts of mental health and allow them to co-exist. The study also attempts to tackle the issues surrounding barriers to help-seeking in the Somali community that was described in previous literature (Markova & Sandal, 2016; Pratt et al., 2015;).

Three questions were developed as the research questions. The first two will be analysed through an inductive, empathic, manifest approach, as they are concerned with allowing the data to emerge straight from the participants. This will allow an opportunity for the voices in this marginalised group to be heard. The third research question will be analysed through a deductive, latent and suspicious approach, as it will include previous

findings from the literature mentioned in this chapter. The reason for this is to allow important research with BAME and refugee populations to be used further and potentially contribute to greater understanding leading to change. As such the research questions are presented below:

1) How do Somali refugees in the UK understand mental ill-health?
2) What do Somali refugees understand to be the available support and treatment for mental ill-health in the UK?
3) How do Somali refugees experience help-seeking for mental ill-health in the UK?

1.7 Relevance to Counselling Psychology

Counselling psychology is based on a humanistic philosophy which puts high value on relationships and health rather than pathologies (Woolfe, 2016). Furthermore, Woolfe (2016) emphasises how cultures are in constant evolution and as counselling psychologists we need to move towards a more reflective stance. This study intends to give a voice to a marginalised group as a means to improve access to their world, which in return will improve psychology practices and policies. The under-utilisation of mental health services in the UK includes psychological therapies and therefore improving utilisation and access will support the counselling psychology field. Moreover, Kagan (2007) emphasises the importance for us as psychologists to understand the macrosystems that influence social, historical and political structures within society and how this can affect different communities such as the one being studied.

In addition, in the 'social justice agenda' Speight and Vera (2004) embrace that counselling psychologists have unique opportunities to investigate the processes involved in maintaining systems of oppression and provide strategies of combating injustices that may have arisen from marginalisation and cultural imperialism. As such, Kelly's (1970) ideas to

produce transformational change in the world carry significant weight within the field of psychology. What's more, it is hoped that the findings from the study are not only relevant to counselling psychology but can also impact public policy as this remains one of the macrosocial goals of counselling psychology (Nicholas, 2019).

There is a limited understanding of Somali refugees' specific mental health and service needs in the UK, which has prevented them from accessing mental health services. This study's findings could provide a better understanding of how Somali refugees cope with their mental health, and the dissemination of the study's findings could enhance service delivery and aid mental health practitioners to design more effective and culturally sensitive mental health treatments for this group. Mental ill-health can be understood to have several manifestations, understandings and experiences. This study will aim to study the different realities and experiences of mental ill-health. Therefore, it will adopt both a relativist ontology and, in order to understand or get access to the different realities, a social constructivist epistemology. This will help respond to the limitations raised earlier in regard to contextualising social, political and historical positions (Rae, 2016). Goodman and Kirkwood (2004) embrace six guiding principles for counselling psychology which carry a social justice agenda. The most relevant to the present study are those to do with sharing power and giving voice.

The current study intends to gain a deeper understanding of how Somali refugees in the UK understand mental ill-health and help-seeking as well as their own experiences. It is hoped that this research will add another perspective to how the Somali refugee community in the UK conceptualises mental ill-health. As the daughter of a Somali refugee, I have witnessed first-hand how difficult the adjustment has been for the Somali community around me to access different aspects of the health system in the UK. Initially I was unaware of the different dynamics at play, especially in regard to barriers in accessing help. As I developed as a trainee counselling psychologist, I was able to observe and notice that these barriers stem from broad psychosocial issues. As such, my personal curiosity became an academic

one and I hoped that by improving on the current available literature I could improve the experience of the Somali refugee community in accessing mental health care in the UK. Coming into this research, my assumption was that my background would aid at different stages of the research (e.g. recruitment, interview process, analysis) as I have an in-depth understanding of the Somali culture. This assumption is further looked into in the methodology chapter where I discuss the insider/outsider positioning, and the advantages and challenges that come with it.

2. Chapter Two: Methodology

2.1 Introduction

This chapter will consist of the rationale for the study in the light of the research questions and aims. There will be an exploration of the research paradigm, research procedures, analytical strategy and ethical considerations, as well as a demonstration of the critical thinking that was used in the research process in developing a reflexive methodology.

2.2 Research Questions and Aims

Three sub-questions were developed as the research questions, presented below:

1) How do Somali refugees in the UK understand mental ill-health?
2) What do Somali refugees understand to be the available support and treatment for mental ill-health in the UK?
3) How do Somali refugees experience help-seeking for mental ill-health in the UK?

2.3 Research Paradigm

Guba and Lincoln (1994) explained that paradigms are our basic belief systems, made up of epistemological, ontological and methodological assumptions. I began to consider what type of knowledge I aimed to create, what assumptions I made about the world, and what type of relationship there was between me and the knowledge that I aimed to create (Willig, 2012). Ponterotto (2005) argues that a research paradigm aims to establish a context for the researcher's study and there are many paradigms available to be incorporated into research.

2.3.1 Ontology

Ontology is concerned with the nature of reality, what exists, and what is out there for us to know (Willig, 2012). There are numerous positions available to guide a researcher's study, such as a positivist, critical realist, or relativist position. A positivist ontology would suggest

that there is one true reality that exists and that can be measured and identified for us to know (Ponterotto, 2005). Whilst a critical realist ontology would also agree that there is a single true reality that is out there, the difference is that this reality is mediated by how others make meaning of it and the social context of both the participant and the researcher (Bhaskar, 1975). Therefore, it could be argued that both a positivist and critical realist ontology would seek to find a single reality, albeit through different means, given the chosen methods and methodology (Guba & Lincoln, 1994; Ponterotto, 2005). However, I felt that these two ontological positions did not fit my understanding of the nature of reality and assumptions I held about the world and what I aimed to create (Willig, 2012).

This led to an exploration of a relativist position that describes the existence of multiple realities instead of a single true reality (Guba & Lincoln, 1994; Ponterotto, 2005). The relativist position is based on several factors, such as an individual's environment and experiences, their perceptions, and even how the researcher and participant interact during the study (Ponterotto, 2005). This ontological stance aligned with the aims of the study by attempting to explore multiple realities rather than a single reality of the phenomenon of mental ill-health. Therefore, the study adopted a relativist ontology and as such assumed that there are multiple realities and several understandings when trying to access what people think about mental ill-health and mental health services.

2.3.2 Epistemology

Epistemology is primarily concerned with the nature of knowledge, what is possible for us to know and what we know (Willig, 2012). As with an ontological stance, there are numerous positions one can take in terms of epistemology. A fundamental aspect that influenced which epistemology would best fit this research was being mindful of how I viewed the relationship between participants and researcher (Ponterotto, 2005). I attempted again to explore the numerous positions, such as a positivist, critical realist, or relativist one, in the context of an epistemological stance. The positivist position would assume that any researcher bias would result in the study being flawed and less objective (Ponterotto, 2005), whereas a critical

realist position would assume that the researcher might of course have some influence over the study, but that it would be fundamental that the objectivity of the study was not comprised, with strict guidelines in place to protect against this (Ponterotto, 2005). These two positions seemed to ignore the fact that in order for me to capture and produce the knowledge from the participants, I indeed needed to be involved in capturing their socially constructed realities by engaging in an influential exchange in the research process (Ponterotto, 2005). Therefore, it was not essential for me as a researcher to seek the quality of the experiences or even a true reality; what was essential was to understand how participants talked about their experiences or the nature of the world (Willig, 2013).

Therefore, the study adopted a social constructionist epistemology. This means that to access the knowledge we are seeking, we need to look at what participants are saying, how they describing it to us as researchers, and be mindful in our thinking about how participants have learned to talk about the phenomena of mental ill-health and mental health services (Burr, 2015). By adopting a social constructionist epistemology there is an assumption that the social/psychological world is socially constructed, and that the role of the researcher is to deconstruct participants' realities. The researcher will be looking at how participants use language to talk about mental ill-health, how language is socially available to them, and whether there are any consequences arising from these constructions (Willig, 2013).

2.3.3 Cultural competence in research

A key element in carrying out this study was to ensure I was conducting culturally appropriate research. I was aware that the study required engagement from a marginalised and oppressed group in the UK. Therefore, I endeavoured to produce research that was culturally sensitive and respectful of the Somali community in the UK. Historically, many have argued that there is a deep history of marginalised groups in the world being 'researched' but not being involved in the development of research (Mafile'o & Walsh-Tapiata, 2007). More recently there has been a focus on the need for culturally sensitive

approaches to be employed and that subsequently the issues faced by those potentially being ‘researched’ are considered (Cram, 2009). This approach can allow communities that take part in research to benefit from this involvement rather than being the recipients of potential harm (Cram, 2009). Papadopoulos et al. (1998) developed a model for creating culturally competent practitioners. This can be observed in Figure 1, which demonstrates the four concepts: cultural awareness, cultural knowledge, cultural sensitivity, and cultural competence (Papadopoulos et al., 1998). This model was adapted by Papadopoulos and Lees (2002) to address culturally competent research. I will provide a description of how I have demonstrated the four concepts in the study.

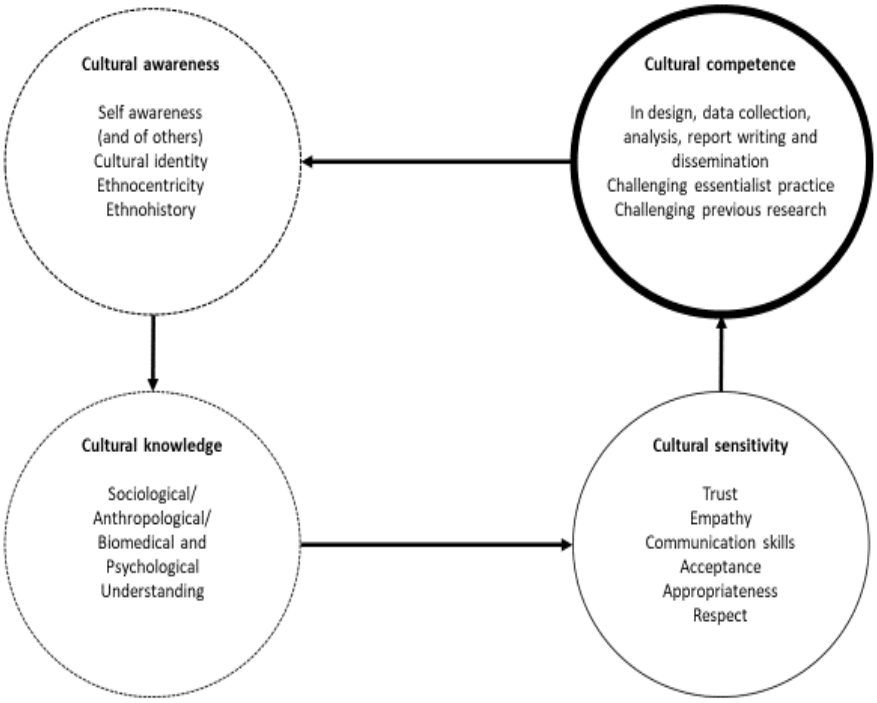

Figure 1. Concepts of Cultural Competence of Research. Papadopoulos et al. (1998).

The first concept that I addressed was cultural awareness. This promotes reflexivity in the researcher. Papadopoulos and Lees (2002) argued that the researcher needs to explore and confront their values and how they have been socially constructed. Before commencing with this research, I did reflect on my cultural background, values, and how these might interrelate with the potential participants. I pondered how coming from a Somali background

similar to that of the potential participants might influence the research process. I reflected that it could be beneficial in relating to potential participants, but that it could also activate stigma within participants. I was aware from my own experiences within the culture that discussing the phenomenon of mental ill-health in the Somali community is taboo. Therefore, I reflected that my presence in the interviews might initially make it daunting and could potentially hinder participants in fully discussing mental ill-health. Furthermore, I reflected on the differences between participants and me, such as the fact that the participants would have come to the UK as refugees while I was born in the UK. So, despite sharing a Somali heritage there might be differences in how acculturated we were in terms of British culture. Moreover, my position as a trainee counselling psychologist would create differences between the participants and myself, as this position influences my perceptions just as much as my Somali heritage. By allowing myself to engage in a reflexive process I was able to be tentative in not imposing my values onto the cultures of the participants (Leininger & McFarland, 2002). I explored and researched more about Somali history and culture despite feeling that I knew my own culture; I was aware that it was important to examine it further and explore the available literature and research. This process deepened my understanding and connection to Somali culture. Furthermore, I explored literature around being a refugee and experiences related to this. This process of engaging with my values and culture as well as those of the participants allowed me to begin the process of being more culturally competent in research.

This led me to the second concept, which was cultural knowledge. Papadopoulos and Lees (2002) argued that it is important to engage with people from different cultures to explore differences and similarities and that knowledge can be discovered through many different disciplines. The way I was able to engage with this in the research was by examining the similarities and differences of the care received from the NHS within different cultural groups, not just the Somali community, and the disparities this may perpetuate. This exploration allowed me to consider several factors, such as power relations in society and

health care, socio-economic status, length of stay in the UK, and gender. Papadopoulos and Lees (2002) suggested that by this process a researcher avoids practising essentialism in research.

The third concept of cultural competence in research is cultural sensitivity. Papadopoulos and Lees (2002) argued that cultural sensitivity can be achieved when participants are viewed as partners and power relations are contested. They emphasised that it is important to offer participants choices and that there should be a focus on building trust and respect. Patel (1999) suggested that community brokers should be utilised when researchers are attempting to include ethnic minority communities in the research. I was able to reach out to four Somali community leaders in London and get their input and advice on how to recruit participants. They allowed me to use their community centre spaces to conduct the interviews, as many suggested that this would be a better and more homely venue for participants than a room at City, University of London. Some of the community brokers suggested I bring refreshments such as tea, coffee, pastries and fruit. They stated that this may make the interview process seem more like a conversation so that participants could feel less nervous. They also highlighted that it is part of the Somali culture to host guests with refreshments to make them feel welcomed. Also, I was able to share the interview schedule with some community brokers. Through their consultation, I made amendments to the interview schedule to make it more sensitive. I also attended Somali community events such as the Somali week festival in London. I have been a regular attendee of the festival, however, this year I was able to hand out my recruitment flyers there. Kauffman (1994) suggested that matching researchers and participants with the same cultural backgrounds may increase participation and allow for beneficial conditions. However, even when such matching occurs, there are other factors to be aware of such as power relations, socio-economic status, length of stay in the UK and gender (Douglas, 1998). Hammersley and Atkinson (2019) suggested that a way for researchers to prevent

over-identification and over-affinity with participants from the same ethnic background was to embrace an insider/outsider position.

Lastly, the fourth stage of cultural competence in research is cultural competence itself. This stage is concerned with combining and applying all the cultural awareness, knowledge and sensitivity gained from the other three stages. Papadopoulos and Lees (2002) argued that an essential element at this stage is to acknowledge and confront racism and any other methods of discrimination. I have mentioned in the previous three stages how I attempted to make the research process culturally competent. I worked with community brokers in discussing the phenomenon of mental ill-health and treatment in the UK. I collaborated with community brokers in the development of the interview schedule and recruitment process and discussed with them my lack of fluency and confidence in conducting the interviews in the Somali language. I also discussed my financial limitations in hiring interpreters and transcribers (Papadopoulos & Lee, 2002). This opened up a helpful discussion about how this would close off the research to a group of people that might not usually have the opportunity to be involved in this research and be heard. This was a particularly difficult subject to grapple with. I agreed with the community brokers that I would include this conversation in the research write-up and make future recommendations about the importance of opening up the research to involve more groups of the Somali community in the UK. Furthermore, I was able to allow participants to use and feel comfortable using Somali terminology for things that could not be explained in the English language. Participants were able to explain the Somali terms they used in the interviews. Papadopoulos and Lees (2002) argued that the dissemination and reporting of findings should be inclusive. I will demonstrate how I have attempted this in the later sections of this chapter.

2.4 Methodological Considerations

This study will adopt a qualitative research approach as this research is concerned with meaning. The research question aims to gain answers through deconstructions and

possible explanations of the phenomenon which for this research is mental ill-health and mental health treatment in the UK Somali refugee community (Willig, 2013). McLeod (2015) argues that historically, quantitative research has dominated research in counselling and psychotherapy. This has helped in identifying patterns, comparing groups and interventions, as well as in making causal links (McLeod, 2015). However, qualitative research provides a different perspective where the quality of the participants' experience is captured and there is an emphasis on understanding the implications of this (Willig, 2012). This research is concerned with how Somali refugees in the UK understand and experience mental ill-health and mental health treatment in the UK, how they make sense of it, and whether there are any consequences in terms of their constructions of mental ill-health and mental health services arising from it.

Furthermore, qualitative and quantitative paradigms make different assumptions about the nature of knowledge; for example, a more positivist stance will assume that the researcher can be objective in studying the object or participant (Guba & Lincoln, 1994). However, by understanding my position as a British-Somali with a maternal family that arrived in the UK as refugees I feel that my values/interpretations, as well as those of the participants, cannot be ignored. There will inevitably be a dynamic interaction between participants and the researcher in the research process (Ponterotto, 2005).

2.4.1 Rationale for Thematic Analysis (TA)

Once the research questions and research paradigm have been developed the next stage of the research process is to select appropriate methods for data collection and analysis (Willig, 2012). I was drawn to a Thematic Analysis (TA) research method as with this method the subjectivity of the researcher is viewed as important in the processing of analysis (Braun & Clarke, 2006). In addition, TA is viewed as a method rather than a methodology, which allows there to be some theoretical flexibility and independence (Terry et al., 2017). TA can fit with a constructionist, essentialist, realist or contextualist (critical realist) epistemology. As the research adopted a social constructionist epistemology, I explored how the ontological

and epistemological position, TA, and the research question all fit together coherently from a theoretical perspective. By adopting a TA method with a constructionist framework there is an assumption that experience and meaning are socially produced rather than innate within individuals (Braun & Clarke, 2006; Burr, 2015). Therefore, the focus will not be on individual psychologies but rather on making sense of the sociocultural and structural contexts that allow the individual participants' stories presented in the research (Braun & Clarke, 2006). The role of the researcher is to deconstruct the participants' realities. This method and philosophical framework fit nicely with the research question. I will be looking at how participants use language to talk about mental ill-health, how it is socially available to them and whether there are any consequences arising from these constructions (Willig, 2013). I am researching a marginalised group in the UK and I am interested in how they have made sense of their experiences of help-seeking for mental ill-health and mental health treatment as well as their understanding of it.

There are several thorough accounts of how to execute a good-quality TA (Braun & Clarke, 2006; Willig, 2013), and the two approaches that I considered employing were Braun and Clarke's (2006) six-step guide to TA and Fereday and Muir-Cochrane's (2006) TA hybrid approach of inductive and deductive coding. Despite the similarities between the two approaches, Braun and Clarke (2006) do not encourage using a codebook and promote a more organic and flexible approach to coding. They argue that employing a codebook can lead to superficial codes and instead advocate a data-driven approach (Braun & Clarke, 2006), whilst Fereday and Muir-Cochrane (2006) advocate a hybrid approach that will combine a data-driven inductive approach with a deductive a priori template of codes approach. Both approaches of TA have comprehensive steps, as Fereday and Muir-Cochrane's (2006) method involves six stages of data coding adapted from two approaches of TA combined, whilst Braun and Clarke's (2006) approach involves six stages of data analysis, as follows:

1. Familiarisation with the data, which will involve re-reading and listening as well as making initial notes or ideas.
2. Coding, which comprises identifying and labelling patterns in the data.
3. Searching for themes, which means that the different codes are organised into plausible themes.
4. Reviewing and refining the themes across the coded data and entire dataset.
5. Defining and naming the themes to ensure road mapping.
6. Writing the report and weaving together a narrative, drawing conclusions across the themes and providing evidence of the themes.

The chosen method was Fereday and Muir-Cochrane's (2006) hybrid approach to TA over Braun and Clarke's (2006) approach to TA, for the reasons described above. I felt that it was important to include a codebook as this would allow the inclusion of previous literature related to the research question on Somali refugees' understanding and experiences of mental ill-health and mental health services in the UK. This would allow for previous literature with marginalised groups to be used to potentially contribute to further understanding leading to change. Furthermore, Fereday and Muir-Cochrane's (2006) hybrid version of TA also allows for the flexible and organic approach to coding advocated by Braun and Clarke (2006). TA was the best possible analytical method for this study because it is a valuable approach in understanding people's views and experiences, which can improve the existing literature (Braun & Clarke, 2014). The current study explores both Somali refugees' views on mental ill-health and available support and their experiences. Moreover, TA can provide flexibility in interpreting the data and this has allowed for a hybrid TA whereby existing knowledge can be utilised and built on. Furthermore, TA can provide a systematic and robust framework for coding qualitative data. It is a valued approach for applied research such as this. As mentioned by Braun and Clarke (2014), TA is often adopted

beyond academia and can be valuable in practice arenas and policy developments as it is also accessible to those who are not part of the academic community.

2.4.2 Fereday and Muir-Cochrane's (2006) hybrid approach to Thematic Analysis

The chosen method was Fereday and Muir-Cochrane's (2006) Thematic Analysis hybrid approach of inductive and deductive coding. Fereday and Muir-Cochrane (2006) used Boyatzis's (1998) data-driven inductive approach and Crabtree and Miller's (1999) deductive a priori template of codes approach. This method of identifying, analysing and reporting patterns/themes can make for a bridge between inductive and deductive, descriptive and interpretative approaches in TA (Willig, 2013). To utilise both inductive and deductive coding effectively facilitates consideration of the types of meanings brought to the themes: latent or manifest, depending on whether the researcher is analysing with an empathic or suspicious approach. The inductive and deductive approaches to TA are characterised by whether you are reading bottom-up, directly from the data (inductive) or making interpretations of the data by using a theory or literature (deductive). By combining inductive and deductive approaches the researcher can potentially gain meaningful and comprehensive insights (Willig, 2013).

For the a priori template of codes approach a codebook is developed which can be based on a preliminary search of the text, the research question, relevant literature and/or a theoretical framework (Crabtree & Miller, 1999). The process of coding is the act of seeing something or recognising a significant event or moment and coding it within the process of interpretations (Fereday & Muir-Cochrane, 2006). The present research developed a codebook through a preliminary search of the text, the research question, and relevant literature, guided by my epistemological stance of social constructionism. Fereday and Muir-Cochrane (2006) used social phenomenology as both a theoretical framework and methodology, and this was highlighted in the themes captured through TA. There is no obligation to select a theory when employing TA, but it is important to be clear on what is guiding you in the formation of the themes developed (Willig, 2013). TA can allow for a story

to be told of what is emerging from the data, and thematic maps can highlight the relationship between themes (Braun & Clarke, 2006).

2.4.3 Limitations of Thematic Analysis

This view of TA described above, that it is theoretically unbounded, may be seen as both an advantage and a limitation, as it means that the researcher needs to engage in a fair amount of theoretical reading. In addition, as TA has the (debatable) reputation of being easy to conduct, the researcher may underestimate the importance of the having an epistemological stance (Willig, 2013). However, TA's theoretical flexibility means the researcher may be more well-informed about different epistemological stances as they must decide on which one will guide their research. Once the researcher becomes immersed in the data and continuingly engages, this can yield more rich data that goes beyond the surface level (Terry et al., 2017). Therefore, analysis can be viewed as a more creative than technical process. To ensure that Thematic Analysis is adhered to with rigour and quality, Braun and Clarke's (2006) 15-point checklist criteria for good Thematic Analysis was observed in this study.

2.4.4 Critical comparison of other methodologies

At the start of the research process three methodologies were contemplated as potentially appropriate for the study. These were Interpretative Phenomenological Analysis (IPA), Grounded Theory (GT) and Thematic Analysis (TA). Below the other two methodologies will be explored.

2.4.4.1 Grounded Theory (GT). GT and TA could be considered to be more aligned with the social constructionist approach that will be adopted in the study, which is why GT was initially observed as a potential methodology. Birks and Mills (2011) described that there have been many versions of GT that present with different procedures since it was first developed, and many take a realist approach. However, there are social constructionist versions of GT (Charmaz, 2014) that were considered before deciding on a hybrid TA approach. Charmaz (2017) described that a constructivist GT allows the researcher to

recognise their influence over the data and the dynamic interactions with the participants, as the researcher is able to acknowledge the multiple roles and realities in play within the engagement of the data. It could be argued that a constructivist GT, unlike more traditional versions of GT, promotes the researcher to adopt a reflexive stance in exploring their values and how these have been socially constructed, and how this influences their interactions with participants and the actions the researcher takes throughout the research process (Charmaz, 2017). Charmaz (2014) added that a constructivist GT would need to be aware of the historical and social/psychological conditions at the time the research was being conducted, since a constructivist position assumes that the world is socially constructed and that the role of the researcher is to deconstruct these realties through meaning, language and actions (Burr, 2015). Nevertheless, despite the resonance with the philosophical framework, GT aims to produce a theory of the phenomena under study which would not be appropriate for the research questions in this study (Willig, 2013). The aim of this study is to understand how participants use language to talk about mental ill-health, how it is socially available to them and whether there are any consequences arising from these constructions. In addition, the study will explore how they have made sense of experiences of help-seeking for mental ill-health and mental health treatment, and their understanding of it. Therefore, theory production would be an inappropriate aim for this study. GT avoids engagement with current theories (Engward, 2013). GT could have been adopted if there were no relevant past studies on the topic of migration, access to mental health, stigma and barriers to accessing services. As explored in the literature review, there is existing literature on this topic, and past studies have been dedicated to that area. The aim of the study is to build on the existing literature and go beyond it, through the process of exploration and analysis within a TA framework. As such, GT was excluded because this current study is not concerned with the search for a new theory; rather it is concerned with being guided by the existing literature as an initial step to build further on what is known.

2.4.4.2 Interpretative Phenomenological Analysis (IPA). IPA was briefly considered

as an alternative methodology for this study. It focuses on capturing the quality of an individual experience in considerable detail (Willig, 2013). IPA is inclined to be idiographic, with small sample sizes, and homogeneous samples (Smith et al., 2009). Furthermore, it emphasises that the researcher may not have direct access to the participants' reality and that through interpretative engagement with the data, there is effort required to unpick these lived experiences (Osborn & Smith, 1998). Therefore, the analysis produced by the researcher will be their interpretation of the participants' lived experience, a process known as the double hermeneutic (Osborn & Smith, 1998). There is a series of systematic steps in IPA to facilitate this interpretative engagement of identifying and clustering themes individually and then across cases (Willig, 2013). Nevertheless, IPA is deemed more appropriate with a phenomenological approach to knowledge (Smith et al., 2009), and may not be as suitable to a social constructionist epistemology. It was deemed that IPA would not be appropriate for this study, since as the study progressed it became apparent that the participants involved may not have personally experienced mental ill-health but rather had others in their lives experience it, which had contributed to their understanding of mental ill-health and treatments, in addition to experiences of help-seeking. Therefore, this study was not concerned solely with the lived experiences of participants and IPA was not seen as compatible choice for this study.

2.5 Procedures

2.5.1 Sampling considerations

This study adopted a qualitative research design using purposive sampling. Ten participants were recruited and interviewed to determine some level of patterned response or meaning in the dataset. Furthermore, a snowball sampling recruitment technique was employed as more potential participants were recruited in addition to those already taking part in the study. A sample size of ten or more participants for a qualitative professional doctorate study utilising Thematic Analysis is recommended for this approach (Terry et al., 2017).

2.5.2 Inclusion and exclusion criteria

The inclusion criteria consisted of:

- First-generation Somali refugees. This means individuals born in Somalia who subsequently emigrated to the UK. The proposed study included refugees, meaning those who have fled conflict and persecution. Therefore, the criteria included all forced migrants from Somalia who entered the UK. It did not matter what stage of the asylum process the potential participant was at; some might have already gained citizenship
- Proficient in speaking the English language. This avoided the use of translators and the implications that could have on confidentiality

The exclusion criteria consisted of:

- Participants under the age of 18
- Second-generation Somalis
- Participants who had been diagnosed with a severe mental illness, as the study did not want cause further distress to a vulnerable group

2.5.3 Participants

Ten participants (five male and five female) who identified as Somali refugees took part in the study. Demographics were collected during the interview and can be found in Table 1 below. Pseudonyms were used to protect the anonymity of the participants. The age range for female participants was 28-51 and 31-63 for male participants.

Participant pseudonym	*Sex:*
Hamza	Male

Ali	Male
Yusuf	Male
Maryam	Female
Liban	Male
Filsan	Female
Sagal	Female
Ayan	Female
Faisal	Male
Fadumo	Female

Table 1: Participant demographics.

The study aimed to recruit twelve participants, however, due to coronavirus restrictions in the UK, two participants were unable to be interviewed. The two potential participants felt they could not offer their time because of the ongoing pandemic. In addition, the community centres I recruited from were closed due to coronavirus restrictions. I was able to empathise with the two potential participants and thanked them for their time. I liaised with my supervisor and ended the recruitment stage with ten participants.

2.5.4 Recruitment strategy

Papadopoulos and Lees (2002) emphasised that cultural sensitivity can be achieved when power relations are contested and there is a focus on building trust and respect. In addition, Patel (1999) suggested that community brokers should be utilised when researchers are attempting to include ethnic minority communities in the research. I was able to reach out to four Somali community leaders in North West/West London and to receive their input and advice on how to recruit participants. I was invited to speak at the community centres on separate occasions when the Somali community leaders had gathered some of their

community members for existing groups or activities that took place on the days in question. I was able to explain the study to each of the groups and answered their questions about the study. The Recruitment Advertisement (**Appendix A**) was distributed during these group sessions and within the Somali community centres after I had gained permission from the community leaders. Somali community leaders were emailed a copy of the recruitment advertisement. During some of these group sessions, potential participants shared their contact details and we were able to arrange for when they would be available for a phone screening call. Potential participants had a choice to participate or not by contacting me using the posted details or by going through a Somali community leader to access my details.

I also attended Somali community events such as the Somali week festival in London. I was able to talk to some people at the event about the study and distribute the recruitment flyers. Even though there was no successful recruitment from this method, I was able to share ideas and receive more insight about the current issues that some of the Somali community members report with regard to the phenomenon under investigation.

2.5.5 Data collection

2.5.5.1 Stage 1: Pilot phase. The Interview Schedule (Appendix B) was also reviewed by Somali community leaders, who had many years of experience as community leaders. Through their consultation, I made amendments to the interview schedule to make it more culturally sensitive. Two participants were used for a pilot study to identify whether the questions were suitable and to ensure the feasibility of the study. The two participants were recruited through word of mouth within the Somali community, and they went through the correct process of the initial phone screening. The two participants were provided with the recruitment flyer, participant information sheet and gave informed consent. They met the inclusion criteria and felt more comfortable to be interviewed in one of the Somali community centres near their homes. The outcome of the pilot interview influenced changes in my style

of interviewing (Majid et al., 2017).

2.5.5.2 Stage 2: Interview stage. Potential participants who had provided their contact details after expressing interest in the study were contacted with an initial phone screening call. During this initial call I asked potential participants whether they personally had experience with the mental health care system. If they confirmed this, I would then ask about the nature of their involvement and their mental health history. I would then explain the impact of the current study and explore with the potential participant whether it was appropriate for them to participate. If the individual were to disclose that they were experiencing a mental illness I would ask whether they had any current support, and if not, signpost them to available support. I would explain to the individual that the research might bring up topics that could distress them and therefore why it might be best to not be involved in the research on this occasion. During the call they were briefed about the study and were asked questions as to whether they fit the inclusion criteria. Potential participants were sent the Participant Information Sheet (Appendix C) to have the opportunity to gain an understanding of the purpose and aim of the study before giving informed consent. The researcher provided the participant with a copy of the Consent Form (Appendix D) after the phone call provided they met the inclusion criteria. Participants had time to consider partaking in the proposed research after the initial phone call. This allowed them to build rapport with the researcher and gave them a choice about participation in the research study. They signed the consent form on the day of the study taking place. Participants were also notified about their right to withdraw from the study up until the point of data analysis. Participants were provided with a Demographic Form (Appendix E), which asked for their age, sex and occupation to be recorded.

The consent form included a statement asking whether participants would like to be sent a summary of the findings and outcomes once the study had been completed. A lay summary of the findings/outcomes of the project would then be provided to participants who checked ‘yes’ once it became available. In addition, a snowball sampling recruitment

technique was employed as participants who were recruited from the Somali community centres recommended potential participants who would be interested in taking part in the study. Therefore, more potential participants were recruited from participants already taking part.

Individual face-to-face semi-structured interviewing was used as a method of data collection. All interviews were audio-recorded and a verbatim transcript of each interview was produced. Semi-structured interviews are the most widely used data collection method and were the primary source of data collection in this study. Interviews could have been located at City, University of London, but participants preferred the second option of having the interviews conducted in the community centres where recruitment took place. Therefore, all the interviews took place in the Somali community centres from which participants were recruited. Refreshments were provided during the interview. Ten interviews were conducted, lasting between 45 and 60 minutes. A Debrief Sheet (**Appendix F**) was given to participants after their data had been collected. Their role in the research was discussed, and how it would hope to contribute to the research. At the end of the interview participants were also given the opportunity to ask any questions or voice any concerns they had about the interview or study.

2.6 Analytic Process

2.6.1 Transcription

I transcribed all the interviews verbatim and the transcripts were checked against the audio recordings for accuracy. Braun and Clarke's (2006) 15-point checklist criteria for good Thematic Analysis was observed in this study. They argue that the transcribing process is a great way to familiarise the researcher with the data. The data was transcribed with an orthographic approach where all verbal and non-verbal utterances were written down (Braun & Clarke, 2006). Pauses, hesitations, utterances, laughter and emphases in speech were all

captured in the transcript. It was important to adhere to a high level of accuracy and quality in the transcribing process.

2.6.2 NVivo 12

NVivo 12 software was employed in the data analysis process for this study. Traditionally, the method for coding qualitative data has been to use highlighters to categorise the data (Hilal & Alabri, 2013). However, with the innovations in software technology that have been designed for qualitative analysis, some researchers are opting to use NVivo 12 for data analysis. When using NVivo 12 I felt that it allowed me to work more systematically and to obtain rigour. Before using NVivo for the data analysis I was encouraged by my supervisor to watch all the step-by-step tutorials on how to use the data. My supervisor allowed me to share what I had learnt from the tutorials and helped clear up any questions I had about the software. Through NVivo 12 I was able to import the transcripts, the codebook and then to commence the coding process on the software. Once I completed coding, clustering and identifying the themes, I was able to export the data from NVivo 12 (Hilal & Alabri, 2013).

2.6.3 Fereday and Muir-Cochrane's (2006) step-by-step procedure to data analysis

This research study followed Fereday and Muir-Cochrane's (2006) hybrid TA approach of inductive and deductive coding. Fereday and Muir-Cochrane (2006) used Boyatzis's (1998) data-driven inductive approach and Crabtree and Miller's (1999) deductive a priori template of codes approach. For the a priori template of codes approach a codebook was developed based on a preliminary search of the text, the research question and relevant literature (Crabtree & Miller, 1999). The process of coding is the act of seeing something or recognising a significant event or moment and coding it within the process of interpretations (Fereday & Muir-Cochrane, 2006). This hybrid approach can produce a comprehensive thematic description of the data (Willig, 2013). The transcripts were analysed using software NVivo 12. The six phases can be seen summarised below:

Stage 1

The first stage of analysis was to develop a codebook. Codebooks are developed by looking at the relevant literature and identifying frequencies of reoccurring statements. From this, thirteen codes were developed. The codebook was imported into NVivo 12 for analysis.

An extensive literature search was conducted from 1990 to August 2020 focusing on key terms such as 'Somali refugees', 'BAME', 'help-seeking', 'mental health', 'Somali mental health treatment', 'ethnic minorities help-seeking for mental health', 'Refugees', 'Refugee needs', 'mental health services' and 'barriers to help-seeking'. The key terms were used in several combinations, starting with databases such as City Search, PsycArticles, PsycInfo and SCOPUS, in addition to browsing journals such as *British Journal of Clinical Psychology*, *British Journal of Psychotherapy*, *Counselling and Psychotherapy*, *Counselling Psychology Quarterly*, *Current Opinion in Psychiatry*, *Journal of Mental Health UK* and *The British Journal of Psychiatry*. The rationale for the time period was to cover the period from when Somali refugees initially began to relocate due to political unrest in Somalia. This extensive literature search helped develop the codebook alongside the identification of common frequencies of reoccurring statements.

Three of the codes developed were stigma, distrust and fear of professionals, and lack of cultural representation. Stigma is described in this codebook as shame, disgrace, or any negative association towards a personal circumstance. This stigma can potentially make the personal circumstance worse or stop a person from seeking help. Distrust and fear of professionals is described as suspicion of the other which leads to lack of communication between the two groups. Lack of cultural representation is described as not having a particular population group or demographic represented in a sector such as the mental health field. The thirteen codes from the codebook are presented in **Appendix G**. The codebook also presents how many transcripts (labelled 'files' in the Appendix) the codes were found in. In addition, the number of times the codes are referenced is labelled as 'references'.

Stage 2

Following the first stage of developing the codebook, the second stage involved testing out the reliability and applicability of the codes with the first transcript of the study. I systematically went through the transcript noting the frequency of anything related to the codes in the codebook. This is presented in **Appendix H**. All the most common codes I found made sense so I did not have to seek further codes at that point.

Stage 3

The third stage involved a process of familiarising myself with each transcript, listening repeatedly to the recording, summarising the data and identifying initial themes (Fereday & Muir-Cochrane, 2006). The research questions were used to help summarise key points from each individual transcript and identify potential themes in the raw data. For example, from the first transcript the potential themes that began to emerge from this stage in the analysis were: misunderstandings, stigma of mental ill-health, different constructs of mental ill-health and representation of Somali professionals.

Stage 4

The fourth stage of analysis involved a systematic coding process working through the data line by line. This was done through the software NVivo 12. The codes from the codebook were used in this process as well as new inductive codes emerging from this systematic coding that were not captured from the codebook. These new inductive codes emerged from focusing on the two research questions that were assigned to be analysed inductively:

1) How do Somali refugees in the UK understand mental ill-health?

2) What do Somali refugees understand to be the available support and treatment for mental ill-health in the UK?

The codes that were developing during this process complemented the initial themes that emerged in stage three of the analysis. In **Appendix I** an example from NVivo 12 software of applying the code (distrust and fear of professionals) from the codebook to transcript 1 can

be observed. In addition, in **Appendix J** an example of some of the inductive codes that emerged from the data can be found.

Stage 5

The fifth stage of analysis involved a review of all the codes by connecting them, looking for patterns and identifying themes. Here I focused on the similarities and differences between and within participants, in relation to each of the three research questions. For example, some participants showed an increasing understanding of mental ill-health with greater experience and education. Some participants emphasised an increase in understanding for young Somalis who had been brought up in the UK for most of their formative years, yet highlighted that those who came to the UK as adults had to go through a process of education and experience of mental ill-health within families to increase their understanding of it. Many participants highlighted that some Somalis who came to the UK as adults may not have been exposed to education or experiences and therefore were unable to increase their understanding of mental ill-health. This is an example of how I was able to flesh out the similarities and differences between and within participants. This allowed for patterns and conflicts to be identified, which aided the process of clustering themes.

Stage 6

The final, sixth stage, of analysis was where themes were labelled and clustered. This stage was concerned with corroborating the themes. Here I attempted to justify each of the themes and evaluate how they overlapped. Therefore, I had to go back to the data, codes, and then the themes to describe how this developed. It was important that the themes gave a timeline narrative. I carefully looked at how each of the sub-themes contributed to this narrative and whether it was suitable. At this stage there were several attempts to reword each theme and sub-theme into succinct phrases to illustrate the meaning behind them. I created a thematic map to illustrate this, which can be found in **Appendix K**. It was important at this stage before the analysis began to feel confident that I could describe and justify each theme and sub-theme.

2.7 Reflexivity

This research looked at reflexivity on three levels: epistemological, methodological and personal. To increase the integrity of the research, reflexivity can be used as a tool to evaluate the researcher's self-awareness in their role in the research (Finlay, 2003).

2.7.1 Epistemological reflexivity

I will begin by looking at reflexivity at an epistemological level. A positivist stance assumes that the researcher is able to be objective in studying the object or participant (Guba & Lincoln, 1994). However, by understanding my own position as a British-Somali and having a maternal family that arrived in the UK as refugees, I feel my own values/interpretations as well as those of the participants cannot be ignored. I have aligned with the philosophical assumption that the social/psychological world is socially constructed, and that the role of the researcher is to deconstruct the participants' realities. I will be looking at how participants use language to talk about mental ill-health, how it is socially available to them and whether there are any consequences arising from these constructions (Willig, 2013). This can be important in interpreting social problems and suggesting solutions for social change/justice (Fletcher, 2017). From conducting a literature review I am aware that the existing knowledge on Somali refugees is that they do not necessary access mental health services and have strong cultural beliefs/stigma associated with mental health. It is only after considering my position as a trainee counselling psychologist that I came to understand that the approach I take in therapy is that I do not consider whether what the client is telling me is true or false.

2.7.2 Methodological reflexivity

Reflexivity was practised at the data collection stage (Finlay, 2002). Considering the reflexivity at the epistemological and personal stages, I needed to be aware of how my presence during the data collection stage could lead to an omission or false information being passed (Finlay, 2002). I wondered whether my Somali heritage might have activated stigma in the interview process as we discussed mental ill-health, as the fear of someone in

their community knowing about it could hinder participants' truthfulness due to feeling stigmatised or shamed. As mentioned earlier in the chapter, Hammersley and Atkinson (2019) suggested that a way for researchers to prevent over-identification and over-affinity with participants from the same ethnic background would be to embrace an insider/outsider position with participants.

Also, I needed to be mindful of any power imbalance between the participant and me. I found it helpful to be clear on our roles when prepping the participants and allowing them to ask questions about it. I assured participants that they were the experts in their understanding and experiences of mental ill-health, and that there was nothing wrong that they could say.

Furthermore, I was mindful that the participants who had engaged with the research were a self-selective group of people who were open to talk about mental ill-health with me. However, there were many participants who expressed that this was their first time openly discussing mental ill-health. This allowed me to reflect on how in the future I could reach people who might never even have contemplated engaging with such research, as I feel it is important that I can somehow allow as many representations of the Somali community as possible to be heard.

I was able to make use of my cultural background and reflect frequently on the concept of cultural competence in the research. My personal awareness and knowledge of, and sensitivity to, Somali customs allowed me to critically evaluate past research as well as the current research. For example, I was aware of the role gender plays in the interview process. It was important that I made use of community leaders as gatekeepers in order to keep to the respectful customs, especially in regard to gender roles. I was also sure to acknowledge the importance of hosting the interviewees, as it can be deemed disrespectful to invite someone to an event without making the appropriate preparations (i.e. appropriate greetings and refreshments). Nevertheless, each experience with a participant was different and I had to constantly be aware to not lead with my assumptions and respect the

uniqueness of each participant. There was awareness of potential power dynamics that could arise and there were instances when this was important. During the interview process some participants initially seemed nervous in expressing their opinions. Here I made sure to clarify that despite my academic knowledge they were actually the experts, and it was their experiences and views that were important. This allowed some participants to feel more at ease and less intimidated in the interview process.

Furthermore, the choice of a hybrid approach to TA complemented the cultural competence model for this research project, as the deductive approach to TA allowed previous research to be challenged through a cultural competence framework and aided in creating a codebook. The inductive approach to TA allowed the cultural competencies to be worked through in the recruitment, interview and analysis stages.

2.7.3 Personal reflexivity

Finlay (2003) states that researchers should also look inwards for any personal meanings. This research topic does invoke emotions in me such as sorrow, fear and shame. My position as a British-Somali gives me two different aspects that I identify with, one being my Somali culture that shames and stigmatises mental ill-health, and the other being my British culture which is beginning to have open discussions about mental ill-health, and where mental ill-health is less feared compared to in Somali culture. My own maternal family, including my mother, arrived in this country as refugees. I have witnessed some family members struggle with their mental wellbeing but never openly discuss it or seek professional help. I think there is a chance for more to come out of the research considering the many subjective experiences of Somali refugees. The interview, transcription and data analysis stages were difficult for me personally. Many emotions came up and it felt heavy for me to contain these at times. I was able to reflect on this in personal therapy, with my supervisor and colleagues. What helped me was the support from my supervisor in recognising the importance of working with marginalised groups in research and allowing social justice to be the focus in pushing forward with the work. I felt an enormous sense of

pressure in making sure I was doing the right thing by my participants, community, family and myself. It has been particularly difficult writing up the research during a pandemic and not being to access some of my forms of support, but I have found it helpful to keep a self-reflective journal to document my experiences and thoughts throughout the process (Josselin & Willig, 2014). Particularly, during one interview there was a moment when a participant identified with me regarding our shared Somali cultural background and voiced his hopes that young Somali professionals like myself could make a positive change for the Somali community. This moment encouraged me after the interview and again during the analysis to write in my journal. Many of my own personal thoughts were brought to the surface and noting these thoughts in my journal enabled a level of self-awareness and helped prevent any bias in the analysis.

It is important to establish where I fit in to the insider/outsider positioning, and how this has influenced the research process (Hammersley & Atkinson, 2019). My Somali heritage and having family members who came to the UK as refugees allows me to have an 'insider' positioning within the research process. This at times influenced my assumptions in over-identifying and viewing Somali refugees as a group that required support. Nevertheless, as the research progressed, I was able to focus my attention on the strengths of Somali refugees and the resources they highlighted. I was also confronted with a situation where my insider positioning activated stigma regarding mental ill-health within the participants as they were asked to share their experiences. In Somali culture such topics are considered taboo and rarely discussed, even within family structures. This may have created an initial barrier and hesitancy at the start of the interviews. Furthermore, these experiences encouraged me to be more aware and step into my outsider positioning in regard to how my insider identity could impact and activate stigma within participants (Hammersley & Atkinson, 2019). Being a researcher, trainee counselling psychologist and second-generation Somali in the UK places me in an outsider position, as I recognise that my experiences are different to those of the participants, who are first-generation Somalis in Britain. Both these positions can have

advantages and disadvantages, which is why a flexibility between both stances was taken at different points in the research process. This supported me in building and maintaining trust with the participants, which allowed them to contribute to the current study.

One experience that arose from my positioning was when I attended a Somali group in the community hosted by a Somali mental health professional. I remember that I was excited to join the group, to share the current research aims and find out whether this appealed to anyone. However, I was not received well by the Somali mental health professional, who questioned whether the research would go anywhere or be any use to the Somali community. I vividly recall him laughing at my research and the hopes I had for it. Here I was reminded of the power dynamics between an older, well-established Somali man and myself. I felt dejected to continue after that interaction as I began to question whether I could really carry out this research and whether it would be well-received within the Somali community in the UK. However, my resources for support (supervision, personal therapy and peers) and personal hopes allowed me to reflect and encouraged me to go on, and to be mindful of how my insider/outsider positioning could be perceived and what might be played out due to this. This experience was overall a helpful one as I was able to reflect, process and learn from it. It was a significant experience that encouraged me to be continually reflexive about how I interact with others at each stage of the research process.

2.8 Ethical Considerations

This research study was granted formal ethical approval from the Psychology low risk review by City, University of London on the 3rd December 2018.

2.8.1 Informed consent

Participants were made aware that they could end the interview at any point and could withdraw their data up until the point of data analysis. This right to withdraw from the research study was explained at the start and end of the study. In addition, participants needed to provide and understand informed consent, therefore an information sheet and

consent form were given to potential participants explaining the purpose and procedure of the research. Once they received this they were able to make an informed decision about whether or not to participate.

2.8.2 Confidentiality

Confidentiality was explained to participants, so that they could understand that their identities would be kept anonymous. Participants were made aware that the setting was a free confidential space, however, if the researcher felt that the participant was in danger this information would be passed on to the relevant professionals. However, this was not necessary as it did not come up. Furthermore, a full debrief sheet was given to participants after their data was collected. Their role in the research was discussed, and how it would hope to contribute to the research.

2.8.3 Emotional distress

There was a possibility that participants might become distressed through discussing their experiences as refugees and their experiences of psychological distress and mental wellbeing. The researcher explained at the start and end of the study that they could withdraw at any time. The researcher could have also informed relevant professionals if the participant expressed any risk of harm to self or others. Nevertheless, this was not required. In fact many participants expressed that this was the first time they had been heard and felt a sense of relief in being open.

It was important that I explained my role as a researcher clearly to the participants so that they were under no illusion that there would be a therapeutic intervention (Thompson & Russo, 2012). I was using some therapeutic and communication skills to facilitate the interview, especially with such a sensitive topic as mental ill-health and refugees. It was important that the environment in which the interviews took place did not impinge on the autonomy of the participants (Thompson & Russo, 2012).

Elliott et al. (1999) developed a set of guidelines to check the quality of qualitative research. The three main functions of these guidelines are to legitimatise qualitative research through methodological guidelines, to provide valid scientific reviews of the qualitative approach, and to ensure quality control in student research through appropriate selection of research methods, especially as student qualitative research is on the rise (Elliott et al., 1999). Ethically, I must also continuously engage in reflexivity when working with a vulnerable group such as refugees.

2.8.4 Data storage

The privacy of the participants was protected by de-identifying data. This was communicated with participants as there is considerable distrust in black ethnic minorities towards mental health professionals (Campbell & Cornish, 2003). Data was stored on password-protected computer files and an encrypted USB device. Audio recordings are kept for ten years as per City, University of London guidelines. Personal data forms were destroyed after the data was transcribed and analysed. Contact details of participants wanting a final summary of the research were stored on a password-protected USB drive.

2.8.5 Financial incentive

Initially, the researcher considered the option of a financial incentive for participants involved in the study, as an appreciation of their time. Therefore, the idea of a raffle for a £30 Amazon voucher was contemplated. Participants could be automatically enrolled in the raffle. However, after much consideration and research I became aware that a monetary incentive was a controversial issue, especially with vulnerable groups. Some argue that a financial incentive for 'hard to reach' or vulnerable groups can be seen as coercion or inducement and may undermine their free choice to participate in the study (Liamputtong, 2007). Therefore, I discussed the idea of the raffle incentive with some of the community brokers I was in contact with to seek their advice. They felt that on balance the raffle incentive would be a good idea in terms of valuing the participants' contributions. Moreover, the community brokers suggested I bring refreshments such as tea, coffee, pastries and fruit. They stated

that this might make the interview process seem more like a conversation and help participants feel less nervous. They also highlighted that it is part of the Somali culture to host guests with refreshments to make them feel welcomed and valued. Some researchers emphasised that such gestures show that the contributions from participants are valued and that this can help with reducing unequal power relations (Hollway & Jefferson, 2000). Therefore, it was decided to go ahead with the raffle incentive and to bring refreshments to the interviews.

2.8.6 Yardley's (2008) quality criteria

Yardley's (2008) quality criteria were applied to assess the quality and validity of the research. Research needs to be evaluated according to an established criterion. Yardley (2008) argues that to ascertain that research upholds validity standards for qualitative research it has to account for the following: 1) Sensitivity to context; 2) Commitment and rigour; 3) Transparency and coherence; and 4) Impact and importance.

1) Sensitivity to context was achieved in the current study by making sure that relevant literature was employed to develop socio-cultural sensitive research. This in return allowed participants to express their perspectives and therefore for empirical data to be created that can serve the field of psychology.

2) Commitment and rigour were a significant part of the current study as the research had an in-depth engagement with the topic, methodology and analytical process of the study. Commitment was achieved by ensuring that no steps were bypassed at any stage of the research.

3) Transparency and coherence were a central part of the study as the research endeavoured to keep clarity of the process in play, particularly through constant supervision, reflexivity and personal therapy.

4) Impact and importance in the wider field of counselling psychology and mental health care was adhered to. Throughout the research process participants were able to highlight aspects

of the socio-political climate in respect to mental health care, which is why the implications of the research emphasise these aspects for further clinical practice and research. Additional rationale for the theoretical and practical impact of the study is further discussed in subsequent sections, especially the rationale and reflexivity sections.

3. Chapter Three: Analysis

3.1 Introduction

This chapter will present the findings of the research study. Fereday and Muir-Cochrane's (2006) hybrid approach to TA was employed to analyse the ten semi-structured interviews. Through this systematic process five overarching themes emerged with subsequent sub-themes. The first overarching theme is 'Understanding mental ill-health', which comprises four sub-themes: (a) 'Stigma attached to mental ill-health', (b) 'Mental ill-health is a choice/behavioural issue', (c) 'Challenges with acculturation', and (d) 'Learning from experience: A process of change'. The second overarching theme is 'Cultural and religious beliefs', which comprises two sub-themes: (a) 'Supernatural beliefs: possession of the devil/jinn', (b) 'Faith healing'. The third overarching theme is 'Perceptions of available UK support and treatment', which comprises four sub-themes: (a) 'Unspecified support', (b) 'Discrimination and racism', (c) 'Support from a general practitioner and treatments that can be offered', (d) 'Support is only available to those that seek it'. The fourth overarching theme is 'Experiences of help-seeking', which comprises four sub-themes: (a) 'Difficulties in accessing support', (b) 'Last resort out of desperation', (c) 'Dominant Eurocentric approach: Excludes other worldviews', (d) 'Lack of cultural representation'. Lastly, the fifth overarching theme is 'The relationship between Somali refugees and professionals', which comprises four sub-themes: (a) 'Distrust and fear of professionals', (b) 'Misunderstandings', (c) 'Collaboration', (d) 'Negotiating relationships'. This is presented as a thematic map in Figure 2, below.

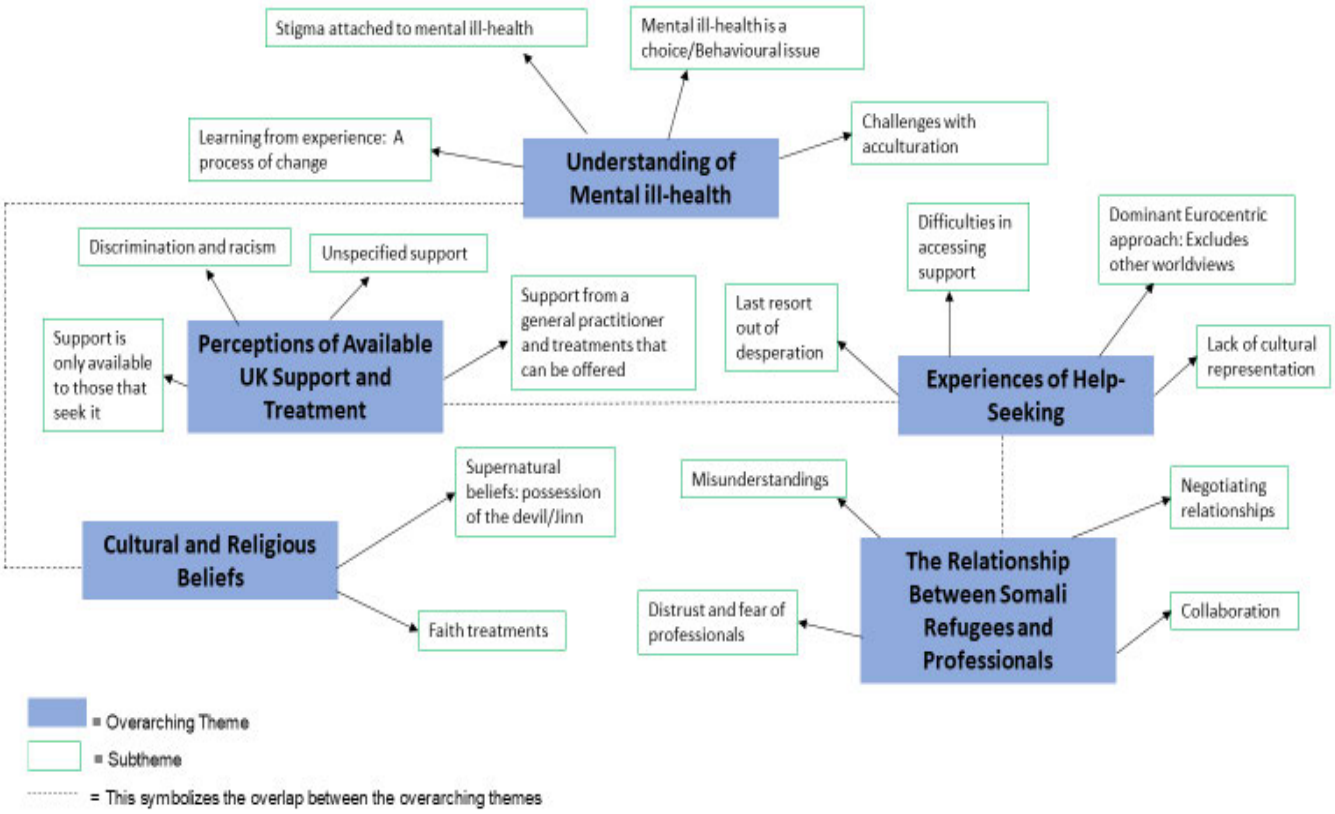

Figure 2: Final Thematic Map

This chapter presents illustrative quotations from participants' interviews included to highlight and provide evaluation of the overarching themes and sub-themes. There are more examples of the quotations used to validate the themes in Appendix L.

3.1.1 Presentation of analysis

Data extracts from the interviews with participants will be used to illustrate themes, with pseudonyms used to protect the anonymity of the participants. Pauses will be presented will be shown as […], while missing text will be presented as [ ].

3.2 Theme One: Understanding Mental Ill-health

The first theme summarises how mental ill-health is understood by participants and the assumptions underpinning it. Participants shared their knowledge of mental ill-health and the implications it has for their community. This theme captures the four sub-themes that

have contributed to participants' current understanding of mental ill-health. The sub-themes that will be explored are (a) 'Stigma attached to mental ill-health', (b) 'Mental ill-health is a choice/behavioural issue', (c) 'Challenges with acculturation' and (d) 'Learning from experience: A process of change'. This theme will share the narrative of participants' understanding of mental ill-health and learning through experience.

3.2.1 Stigma attached to mental ill-health

Many participants expressed that mental ill-health is a 'taboo topic' in the Somali community and that there is a fear of acknowledging it.

> *'when it comes to mental health it seems to me a taboo topic for our society, Somali society. Because the people don't talk, whether it is what causes it, what the effects is, how you are seeking help' (Hamza, P.1, L. 18-20)*

This extract highlights a silent and shameful association with mental ill-health, which elicits fear of exploring it or even acknowledging it. Most of the participants described a fear of being stigmatised and others finding out about their poor mental health. Ayan linked this to a fear of permanently being stigmatised and devalued as she described why her brother may have kept his struggles with mental health concealed.

> *'he didn't wanna be looked down upon, and he didn't want that sympathy…and maybe he felt like he's gonna get extra help and for the rest of our lives we would say oh leave him alone…he's got a bit of an illness' (Ayan, P.7, L. 171-173)*

This was echoed by Yusuf who described that mental ill-health can affect an individual's position in society which can then have a negative influence on their families. It could be suggested that the stigma and labelling of mental ill-health ostracises an individual and their family from the Somali community. Yusuf believes this explains why mental ill-health is 'hidden'.

'it affects the social position of the person in every society when [ ] mental health is seen as something that is not welcome in the sense that anybody who is affected by mental health is somehow umm segregated' (Yusuf, P.2, L. 46-48)

This is also reflected in a remark by Liban as he describes that the Somali culture is 'tribal' and very connected. Similarly, the importance of family and community is emphasised and the label of mental ill-health can affect this. Both Yusuf and Liban seem to infer that the Somali culture has elements of a collectivist community, and a perceived negative label has a collective and widespread effect. Therefore, Liban reflects that this may increase the fear of others 'finding out' and the implications of that.

'I'm seen as just a nutcase…nobody is gonna respect me, nobody is gonna you know…care about me' (Liban, P. 26, L. 700; 702)

The extract from Liban highlights a fear of losing respect and care from the Somali community because of mental ill-health. It could be suggested that the implications of stigma can lead to shame in the Somali community. The impact of this might be the fear of being isolated and only being seen as a 'nutcase', which suggests that there is a fear in the Somali community of moving beyond the label of experiencing mental ill-health. Six participants expressed that those suffering with mental ill-health would either bring shame to the person or their families.

'someone will label it and call them names…seventy percent of people hide it and fear it. They are scared they will tell other people, that is the biggest fear' (Filsan, P. 11, L. 256-258)

This segment further illustrates a fear of humiliation that has long-lasting stigma, even if there is recovery. The following extracts exemplify the long-lasting impact of stigma.

‘once you've had a problem [ ] there'll always be that attachment [ ] that person that had that illness [ ] that's just how I've seen it in the Somali community, that when someone has a certain illness…umm...it's like they can almost not overcome it’ (Fadumo, P. 9-10, L. 248-251)

The above extracts from Filsan and Fadumo highlight a sense of embarrassment and stigmatisation from mental ill-health. One participant expressed that she was the only family member to know of when her brother struggled with his mental health, and that she only found out by discovering his medication in his room. She describes that no one else in her family knows till this day. The burden for this participant might be keeping her concerns secret and feeling limited in how to support her brother, as her brother compelled her to not reach out to anyone. As such, the uncertainty of the situation may be a burden for the participant. It could be suggested the element of secrecy is a powerful component of the level of shame and stigma experienced by family members.

‘nobody knows about it, it's just myself [ ] he did say to me don't tell anyone [ ] he made it clear to me as in like…this is between me and you…and I just said like yeah it's OK’ (Ayan, P. 15, L. 395; 398-399)

Two other participants also described this powerful sense of secrecy within families regarding mental ill-health.

‘I was not told about my ex-husband’s mental health issues because his family wanted to hide it from me. I just thought he was aggressive and abusive and only until we were divorced I realised that it was a mental illness and his family were hiding it from me’ (Sagal, P. 7, L. 160-163)

‘I know a lot of people who are like why don't you tell your family and they say no no no. Even if the person is feeling better, they still won't tell because people will say you know a few years ago that person was crazy. So, they don't trust’ (Filsan, P. 11, L. 267-269)

The extract above from Sagal and Filsan emphasises the desire to remain hidden even within a family unit. It could be suggested that the stigma of mental ill-health can impact the decision of a potential spouse, which may account for why Sagal's ex-husband's family kept his mental ill-health a secret, despite the impact it had on her marriage. Marriage in many cultures can mean bringing together two families, in particular in a collectivist culture such as the Somali one. It could be suggested that the apprehension from Sagal's ex-husband's family might be related to feared stigma attached to disclosing mental ill-health and the implication it could have for finding a spouse.

In the below extract Sagal also highlights that Somali men and women have had to find different methods of managing the impact of witnessing the war. She differentiates that women had to keep their feelings hidden while the men used vices such as drugs and alcohol. This further emphasises an element of silence within genders. The female keeps silent through not talking about the issues while the male uses vices.

> *'But back home women saw a lot during the war and had to keep their feelings and troubles to themselves and had to be quiet or cry to themselves. But men coped with using marijuana, alcohol and got crazy from that, men did not know how to talk about their feelings or troubles' (Sagal, P. 8-9, L. 204-207)*

It could be suggested that the fear of labelling, being looked down upon, being made fun of and the overall stigma of mental ill-health within the Somali community hinders and discourages feeling safe to trust others or acknowledge what is going on. It seems this may encourage being in denial, feeling ashamed and wanting to hide mental ill-health.

The main elements that emerged from this sub-theme were: mental ill-health as a taboo topic, a long-lasting silent and shameful association with mental ill-health, the element of secrecy as a powerful component of the level of shame and stigma experienced by family members. Moreover, this sub-theme showed that mental ill-health causes families to be

ostracised and apprehensive, and this is more prominent due to the collectivist nature of the Somali culture.

3.2.2 Mental ill-health is a choice/behavioural issue

Participants in this study discussed why many in the Somali community feel that mental ill-health is a choice and behavioural issue, and how this contributes to their understanding of mental ill-health. Nine participants suggested that mental ill-health is only acknowledged when an individual is out of control, suggesting that the overt expressions of mental ill-health are more recognised in the community. For example, being 'naked' or 'nude' in public settings. All participants allude to the fact that there is different concept of mental ill-health in the Somali language, with some participants explaining that the only term in Somali to come close to describing it is 'goof walan', which means crazy/mad person. One participant compares how mental ill-health is seen according to a Somali or British worldview.

> *'the way the UK mental health is understood in the UK is a continuum situation, where 1 in every 4 people during their lifetime suffer some form of mental ill-health in their life [ ] Those are very difficult concepts among Somali community it's only for them either you are normal, or you are really mentally ill, like you are really mentally ill, there is no grey area' (Ali, P. 2, L. 27-29; 31-32)*

The extract above displays how Ali describes that mental ill-health can be a challenging concept to grasp. It could be inferred that there are differences in how mental ill-health is conceptualised between Somali culture/language and a Eurocentric framework. For example, in a Eurocentric framework there are concepts such as depression, anxiety, psychosis, whereas participants described that in the Somali language there is a clear dichotomy according to which you are either 'normal' or 'goof walan'. In the following extract Yusuf further builds on the above extract from Ali by describing that because of this view, mental ill-health is only acknowledged if the person cannot cope and that until it reaches that stage it is viewed as a behavioural issue. Yusuf emphasises that a behavioural issue can be

‘rectified and addressed’ by community and family efforts, which is highlighted in theme two: Cultural and religious beliefs.

> *‘until it reaches a certain stage. Initially they see it as a kinda behaviour problem...a behaviour problem that can be rectified and addressed’ (Yusuf, P. 5, L. 118-119)*

Four participants echoed the notion that some presentations of mental ill-health can be understood as behavioural issues and as such the individual is seen as an ‘attention seeker’, ‘bottom of the pile’ and a ‘drama queen’. The use of ‘drama queen’ appears to be as a way of suggesting that an individual is exaggerating their situation. This perhaps emphasises the dichotomy in which you are either ‘normal’ or ‘goof walan’, and where anything in the middle is a behavioural issue – the fault of the individual who as such does not require or deserve support. One participant (Liban) offered a remarkable example of this understanding that informs the view that certain illnesses are not widely accepted as others.

> *‘they wouldn't describe somebody who is depressed as mad [ ] they'll just say he's a miserable person’ (Liban, P. 14, L. 386; 388)*

Seven participants emphasised that in Somalia mental ill-health is only recognised or treated when the individual is at risk of harming others or themselves. Therefore, participants allude to the individual being ‘locked’ and ‘chained’ in the house or to a tree outside the house. One participant describes how this method seems cruel, yet compares this to the situation of UK mental health hospitals. It could be suggested that Ali is inferring that UK practices in mental health hospitals create the same cruel experience in their treatment of people with mental ill-health. This seems like a powerful comparison that may highlight why there might be some apprehension from the Somali community in the UK, as they may still hold certain views of how people are treated when experiencing mental ill-health.

> *‘The way they treated mental health in Somali was very cruel…hospitals seem like being locked away and being chained in how people were back home’ (Ali, P. 14, L. 311-312)*

Three of the younger participants, aged between 28 and 32, expressed a development in this understanding from what was understood in the family home to what they understand now as adults. It could be suggested that this highlights a generational change where one becomes more 'aware' of mental health issues over time in the UK. Maryam expressed that when she was younger, she believed her sister was making up her mental illness and that she blamed her sister for her actions, as this was how the family viewed her sister's mental illness.

> *'mental health is usually they say is done by the person to themselves because they are the one for them to blame really [ ] all that time I thought she was pretending to be ill and then after a while it hit me like when I got into my 20s that like this can't be someone pretending because it's too long for someone to pretend to be ill' (Maryam, P. 6; 7, L. 146-146; 172-174)*

Some participants echoed this by describing similar experiences with regard to what they were taught to believe about mental ill-health. Ayan describes being taught that mental ill-health means crazy or mad but now feels that the younger generation can be more understanding and empathic towards it.

> *'they'd think you're actually crazy…and that's the older Somali generation, I don't believe that the younger Somali generation would think like that [ ] I think that the younger Somali generation who's grown up in England, from the UK would be more understanding' (Ayan, P. 20, L. 528-529; 531-532)*

Another participant, aged 60, was able to express that before he came to be more aware of mental ill-health he thought like others in his community that it meant losing complete control of yourself. Perhaps Faisal had begun a process of acculturation where his understanding of mental ill-health was merging with the dominant values and customs in the UK.

> *'before I came to know more about the mental health, I thought the side of all the first sign is mental health is somebody…when somebody runs barefooted [ ] or naked,*

nude [ ]that's what I heard [ ] in my culture [ ] there's no stress, no depression, it's just mad' (Faisal, P. 2, L. 32-33; 35; 39-40)

The belief that mental ill-health is a choice or behavioural issue appears to be deep-rooted in a Somali cultural understanding and as such resonated with many of the participants. Many explained how mental ill-health is understood in the Somali language, and then described how it is now understood within their own families.

The main elements that emerged from this sub-theme were: mental ill-health is only recognised when the person is viewed as 'out of control', less overt presentations are viewed as behavioural issues and certain UK practices, although different to those of Somalia, are still experienced as harsh. Some of the participants also highlighted that there is a generational transition in how mental ill-health is viewed, suggesting that a process of acculturation is informing how mental ill-health is understood.

3.2.3 Challenges with acculturation

Participants in the study expressed that post-settlement difficulties were a potential cause of mental ill-health as the circumstances of this experience increase distress, especially in the UK Somali community. Six participants spoke of difficulties with culturally assimilating that may have heightened the development of mental ill-health. A few participants highlighted how the contrast between the collectivist Somali culture and the individualist British culture can lead to social isolation in the Somali community living in the UK.

'situations found in the UK, when someone is sent to particular place and then you know somehow, a community that was outgoing just becomes inward looking and then becomes less in contact with the community, drifting and individuals mainly men then you know can also lead to that isolation hiding from the community, not belonging to somewhere' (Ali, P. 7, L. 166-170)

Liban echoed this by sharing his own views that emphasise the difficulties with social isolation in the UK for Somalis who have been accustomed to a different way of life

previously. It could be suggested that Liban is highlighting how Somali families go beyond nuclear families and extend to other families and people in the community. It could be further understood that he may be suggesting that those accustomed to an individualistic culture are able to adapt to isolation. However, those from the Somali community find difficulty with being 'secluded' and isolated as it conflicts with their cultural and social values. A broader concept can be inferred whereby it appears that Liban is suggesting that the Eurocentric models of mental health treatment might be more fitting to an individualistic British culture rather than a collectivist Somali culture.

> *'when they're secluded [ ] it just doesn't work cause obviously they're not used to this…this is against their nature…you know [ ] it makes their condition worse [ ] people that are generally lonely will probably survive there because they're used to the loneliness [ ] but I think it's very rare to find a Somali that's not living with other Somalis [ ] majority of them are like big big families' (Liban, P. 39, L. 1058; 1060-1061; 1063-1064; 1066-1067; 1076)*

Many participants expressed that socio-economic factors were a contributing factor to poorer mental health for Somali refugees in the UK. Three participants expressed that poorer living conditions such as overcrowding, financial pressure, language barriers and lower skilled jobs (compared to previous employment in Somalia) can create pressures for parents with large families. Maryam shares her experience of having a sister with a mental illness and expresses that overcrowding in the home could have contributed to the onset of her mental illness.

> *'What is triggering it like for us maybe it was overcrowding, the noise of the house, like because there were loads of children in one place…and then you won't find anywhere to rest so maybe if they would have provided good social housing in the first place then maybe that could have been prevented' (Maryam, P. 12, L. 288-291)*

Many participants alluded to the fact that financial pressure has a negative impact on an individual's mental health. Overall, six participants expressed that socio-economic disadvantage increases psychological distress. It could be inferred that the worry of finding a job at a later stage in life in a foreign country can impact mental health, as unemployment would contribute to financial pressure and disadvantage for the individual.

> *'you come here at 50…40…you don't speak the language [ ] your qualifications are not valid [ ] you cannot go to work cause you cannot speak the language [ ] you cannot go to school cause you are 50 [ ] what do you do? [ ] becoming mentally ill…that's the easiest' (Faisal, P. 19, L. 512; 514; 516; 518; 522-523)*

One participant spoke about the complexities of navigating a new way of life in the UK. This was reiterated by two participants who highlighted the barriers in learning a new language. It could be inferred that Ayan raises an important dilemma in regard to identity. Ayan mentions how there is a barrier when you do not identify with others around you and perhaps raises the question of how Somali refugees and the UK can help alleviate these barriers.

> *'but we're here in the UK, speaking a new language, interacting with people we've never seen before [ ] they don't look like us, they don't talk like us…it was completely a different barrier' (Ayan, P. 24, L. 644-645; 647-648)*

Two participants noted that culture clashes between first-generation Somali parents and their second-generation Somali British children could cause immense distress. This connects with the previous sub-theme in Section 3.2.2 where it is suggested that a generational change is affecting the level of awareness towards mental ill-health. It could be suggested that there are differences in how Somali parents and their second-generation children balance the two cultures and therefore this may cause tension within a family unit. Filsan emphasises this below by suggesting that children seem to have culturally assimilated into British society while their parents seem to be attempting to hold on to their Somali values, beliefs and behaviours.

'There is a major culture clash because in our culture you listen to your parents advice and say ok and do as they say. But in this country the child can say excuse me no, they can do what they want, and the parent feels helpless and left out. But if the parents have power, then they will feel less stressed' (Filsan, P. 5, L. 101-104)

Filsan goes on to explain the implications of this below, as not only are the parents struggling with holding on to power, but their children are battling with living within two cultures and as a result their mental health suffers. There is a constant tension between family dynamics and beliefs but also different paces of transition within generations.

'Now young people even need mental health support because a lot of them they can't cope with what is going on between living in two different cultures' (Filsan, P. 5, L. 104-106)

Ali and Faisal spoke of Somali refugees feeling like failures after they migrated to the UK, as before some may have been in well-paid jobs and educated in their country, whereas by moving involuntarily to the UK, they are dealing with unemployment and low-paid jobs. This may problematise the identity of a Somali man as provider for the family unit.

'being a failure [ ] being the first in the family I am supposed to be responsible for the family, and then suddenly realising you do not have the money to provide, unemployed' (Ali, P.7, L. 171-173)

This is echoed by Faisal who suggests that an adult restarting in a new country and attempting to build themselves up from the bottom may put pressure on their mental health and the ability to cope with the strain of these circumstances. Faisal believes this is one of the reasons that contributed to his brother's mental ill-health as his brother felt 'useless' and powerless in not being able to provide for his family like he did back home in Somalia.

'all of a sudden [ ] he just run around, looking for jobs [ ] different kind of jobs [ ] and then he found all of them very hard…and there is nothing else he can do so he remained, and through that he became stressed (Faisal, P. 24, L. 651; 652; 659-660)

Both Ali and Faisal expressed that this is particularly difficult for Somali men as they feel as if they are losing their status and restarting again. Thus, they have increasing worries about their family's future and their future as individuals.

> *'he feels that he is absolutely useless [ ] he is not helping his children, he is not providing anything [ ] and then he became mentally ill' (Faisal, P. 25, 667; 671; 673)*

Six participants were vocal about the experience of the civil war in Somalia contributing to mental ill-health.

> *'they went through a war in their childhood and they could have been stepping over dead bodies you know and that can trigger it and freeze back in time and the past can trigger it' (Maryam, P. 2-3, L. 49-51)*

> *'the generation that first came into the UK [ ] who suffer with mental health issues [ ] it's probably post trauma [ ] they witnessed wars and death and and all sorts of things [ ] that not many people can handle' (Liban, P. 16, L. 429; 431; 433; 435-436; 438)*

Even though participants vocalised that the impact of experiencing war was a high contributing factor for mental ill-health in the Somali community, others emphasised that not knowing or having spaces to resolve and talk about these horrific experiences had left people in distress and many could not manage anymore. However, they expressed that when Somali refugees migrate to the UK the impact from war is put on the back burner as there are more pressing concerns relating to post-settlement difficulties. As such it appears that the challenges with acculturation dominate pre-migratory trauma concerns from the war in Somalia.

> *'Somali people have not had a place to talk about their experiences which is why they get mad, because they kept kept kept it in and at the end of the day they get to such a level that you can't help them. Maybe all they needed was someone to talk to and to share their experiences of their father, mother, brother or sister being killed.*

These thoughts have never gone away they just have kept it quiet' (Filsan, P. 14-15, L. 359-364)

This sub-theme summarises how Somali refugees experience post-settlement difficulties and acculturation. The elements that emerged were: difficulties with restarting life stages that were already completed in Somalia, difficulties with merging the Eurocentric mental health practices with the collectivist Somali culture, socio-economic factors contributing to poor mental health, intergenerational tension within families highlighting different transitional stages of integrating the Eurocentric model, and post-settlement difficulties prioritised over the pre-migratory trauma.

3.2.4 Learning from experience: A process of change

Many of the participants spoke of learning about mental ill-health from experience and a process of change in their understanding of it. The process of change they alluded to was that there was continuous learning about mental ill-health due to life experiences in the past, present, and potential continuous learning in the future. Most participants expressed how at first they had a lack of understanding and awareness of mental ill-health. However, they described how their perceptions of mental ill-health had changed over the years due to education and experience in the UK. Nine participants were keen to share how their understanding of mental ill-health had evolved. Sagal highlighted how she was unaware of her ex-husband's mental health issues as she did not know what mental ill-health was.

'If I were more educated at the start I would have picked up on his problems and would have understood it, but I was not educated enough then (laughs)' (Sagal, P. 8, L. 183-185)

Sagal further highlights that she had to educate herself as she did not speak English and the Somali community around her did not speak about mental ill-health as it was viewed as 'goof walan' (crazy). She came to the UK as an adult and she shared the ways that she had gained awareness of mental ill-health, and which had shaped her understanding today. It

can be implied that by being impacted by her ex-husband's mental ill-health, and her learning and adopting of Eurocentric models, Sagal was able to add another dimension in her understanding of the difficulties experienced.

> *'I learnt this all from Somali medical professionals that are on our TV who explain mental illnesses in the community. So, I was learning from these tragedies and how the doctors were explaining what the real issue [ ] I learnt this all from BBC Somalia, VOA Somali radio and other Somali media sources. I also watch English news too like BBC, but I prefer it in my own mother tongue. It really hits home more when it is in your own language' (Sagal, P. 10. L. 239-244)*

> *'I am not scared of anything because I am now one of the people who is educated to know about these things' (Sagal, P. 5, L. 126-127)*

Sagal describes above a sense of empowerment while sharing her journey of learning about mental ill-health, highlighting that she learned through Somali media and radio where Somali medical professionals explained mental ill-health. She expresses that learning in the Somali language impacted her more. Similarly, Maryam, who arrived in the UK as a young child, expresses that when she was younger, she just wanted to run away and abandon everything due to her sister's illness. As mentioned in Section 3.2.2, Maryam felt her sister was pretending to be ill but then later in her twenties concluded that someone cannot be pretending for that many years. She recognises that her views have changed dramatically, especially now that she works with Special Needs children and adults. She feels that she can now use her experiences in these situations at work. Maryam further emphasises that the older members of her family have changed as they would now take someone to the GP if they had mental health difficulties, whereas before they would have kept the person hidden at home.

> *'my views have changed a lot! Now if I see a mentally ill person because I work with special needs children and special needs adults even...So I can put it towards my…*

my work as well [ ] if the person is getting aggressive, if the their mood has changed [ ] you get to pick it up easier because you had first-hand experience...and umm it helped quite a lot and I do advise the community as well to be more confident and not to just keep it to themselves' (Maryam, P. 9, L. 215-220)

Furthermore, Maryam feels there has been a change in her generation in terms of understanding mental ill-health. She believes it is important to give information on mental ill-health as it helps others to not hide or feel ashamed, and may stop the next generation from suffering and provide them with confidence. Maryam emphasises that a few years ago she would never have been able to take part in a study like this, discussing mental ill-health, and thinks this is a great step for her.

'I wouldn't imagine talking about it, it's like a few years ago when I actually found out that there is mental ill-health and it might sometimes not be diagnosed as you think. It just won't go away even if you think the person is pretending, or just a drug addict, or alcoholic or whatever so I just don't think like that anymore. So, it is a great step to be talking to others' (Maryam, P. 14, L. 352-356)

Both Sagal and Maryam describe different turning points in shaping their understanding of mental ill-health. It could be argued they show a sense of pride in their development. Many other participants described several pivotal moments that increased their awareness of mental ill-health.

'the reason I worked with mental health projects is because my brother's illness [ ] I began working with places [ ] small community-based projects in mental health [ ] I attended so many seminars, trainings [ ] about mental health issues [ ] then I became educated on it (Faisal, P. 4, L. 83-84; 88-89; 91-92; 94)

Ali highlighted this by expressing the steps he took to understand and cope with his wife's mental illness.

'I decided to take a counselling course [ ] I think this gave me a lot of ideas which helped me and gave me small skills to understand what the problem is and how you treat people, how you talk to them… you don't shout with them you don't fight with them you're just listening, how to keep doing it to cool down and be patient with the person' (Ali, P. 11, L. 252-256)

From the participants' accounts, it could be considered that experiencing others close to them who have experienced mental ill-health encouraged them to gain awareness and seek further knowledge/education. Others, meanwhile, expressed that the process of change came about by progressing into higher education or developing into adulthood.

'as you grow up and you get more knowledge, more experience in life…at one point I used to think mental health is just somebody that's completely lost it [ ] you begin to realise that mental health is more than [ ] just completely losing [ ] your sanity' (Liban, P. 10; 11, L. 262-264; 282-283)

'I would say when I started studying [ ] till higher education [ ] because that's when you start…real life starts to hit you a little bit' (Ayan, P. 4, L. 82; 85)

This sub-theme summarises interwoven ideas of how Somali participants experienced their changing view of mental ill-health. Many participants described how education and experience have impacted their understanding and willingness to learn more about the Eurocentric models. It could be suggested that participants were able to add another dimension to their understanding of mental ill-health. Also, some participants highlighted the significant impact of learning through Somali media sources in the Somali language. Overall, many participants expressed how learning had given them a sense of pride.

3.3 Theme Two: Cultural and Religious Beliefs

The second theme captures another element that has contributed to the understanding of mental ill-health for Somali refugees in the UK. Therefore, this theme links with the first theme 'understanding of mental ill-health'. Theme two will explore cultural and

religious beliefs such as the possession of the devil/*jinn* and black magic, which is called '*sixir*' in the Somali language. In addition, it will explore what are deemed to be appropriate religious and cultural methods of treatment for these beliefs.

3.3.1 Supernatural beliefs: Possession of the devil/*jinn*

Seven participants spoke of spiritual or supernatural beliefs that can resemble or be mistaken for mental ill-health. Some expressed Somalis as being 'very superstitious people'.

> *'Somalis are generally spiritual people [ ] very focused on their religion and they would say [ ] you've been possessed by the devil' (Liban, P. 18; 19, L. 500; 502; 504)*

Another participant highlighted the association between mental ill-health and the belief of being possessed by the devil/*jinn*.

> *'you know when you think of mental illness sometimes you think [ ] someone's like being possessed...like you know for example Somalis, you'd think that if something's wrong with someone, if they're acting a certain way, there's like a devil inside them' (Ayan, P. 4, L. 104-107)*

Ayan's account could be highlighting the focus on religion when things are unexplainable, and behaviours become concerning. Similarly, Yusuf emphasises that once the obstacle of the devil/*jinn* is separated from the individual's body, order is restored in the individual.

> *'Once the jinn leaves the body the person comes to...ummm...to be a normal' (Yusuf, P. 6, L. 155)*

There seems to be a consensus among the seven participants that possession of the devil/*jinn* is a religious belief that is often used to describe when an individual is 'mentally ill'. Two participants argued that there is another supernatural belief, called '*sixir'* in the Somali language. They expressed that '*sixir'* can resemble mental ill-health and possession of the devil/*jinn*. However, the causes of '*sixir'* were described differently by the two participants.

'they say oh, I've got sixir on me, somebody's did this on me [ ] you know, somebody's done voodoo on me [ ] it's obviously the parents and the old generation are telling them [ ] you've got the evil eye' (Liban, P. 20, L. 555; 557; 561-562)

Here Liban emphasises that '*sixir'*, or 'voodoo' as it can also be known, is something that is done to someone by another person. He expresses that it is like an evil eye. This could be understood as malice or envy from a person that brings harm, suffering or bad luck to an individual. Simultaneously, Yusuf further expresses an example of '*sixir'* that shows that even objects can be used to place someone under a spell that can cause them harm.

'sixir [ ] will not be resolved until a source of the cause is identified [ ] maybe a necklace you are wearing [ ] that somebody gave you [ ] which is a problem, the moment that necklace is thrown away [ ] you feel fine, and people will never know until...umm...that's done' (Yusuf, P. 23, L. 617-618; 620; 622; 624; 626)

This sub-theme summarises three main points: how superstitious beliefs can resemble mental ill-health, how possession of the devil/*jinn* is associated with mental ill-health and how '*sixir*' (voodoo, curse and evil eye from someone else) can also resemble mental ill-health. These supernatural beliefs appear to be relevant views held by Somali communities.

3.3.2 Faith healing

Seven participants highlighted that the recitation of the Quran is effective at treating mental ill-health-related issues, as well as any other troubles in life and possession of the devil/*jinn*. In the Somali culture and Islamic faith some participants argued that most situations are 'associated with religion'. One participant described that she used to believe that mental ill-health was not a reality and could be cured by her faith as her parents taught her.

'parents would say oh you know…make sure you read a lot of Quran, it'll help you calm down…so that's why I used to think oh…mental illness is like…maybe not a thing, and maybe it can be cured by like religion or something like that...but nothing

else, I didn't think it was a...thing that was affecting a lot of people' (Ayan, P. 3, L. 54-57)

This is echoed by two participants who highlight that religious healing is the only viable option within most Somali communities, and that it is a cost-effective alternative. This possibly highlights a financial barrier and assumption that treatment in the UK may not be as cost-effective as 'spiritual healing'. It could be suggested that more information on available treatment in the UK is needed to be distributed to the Somali community.

'the only treatment they have is spiritual healing' (Faisal, P. 40, L. 1111)

'it's available to everybody [ ] It cost [ ] next to nothing [ ] you can ask, me or you, through others somebody can call, and even here in London we did it, people do it' (Yusuf, P. 6; 7, L. 165;167; 169-170)

Yusuf reiterates that spiritual healing such as reciting the Quran will cure the individual rather than just treat them, as he expresses that once the devil/*jinn* is drawn out through recitation the individual is cured. It could be assumed that 'spiritual healing' is a permanent form of treatment, which may account for why it is more favoured in the Somali community.

'they have to pray Quran on it so that they can be cured [ ] not treated, be cured because by reading the Quran and the [ ] jinn will leave [ ] Once the jinn leaves the body the person comes to [ ] be a normal and that's the predominant way of treatment' (Yusuf, P. 7, L. 149-150; 152-153; 155-156)

However, one participant who describes himself as a 'faithful Muslim' expresses that despite this he believes that practices such as reciting the Quran and 'electrocuting' the individual to get the devil/*jinn* out of them takes advantage of people. He feels that for some it is about making money out of vulnerable people.

'they're using the name of religion [ ] and superstition [ ] in order to make money' (Liban, P. 19, L. 519; 521; 523)

While Filsan attributes poor faith to being punished, she nevertheless says that before seeking help from others, one should turn towards Allah for help. The impact of this may be that spiritual healing is prioritised over any other support.

> *'prayer helps a lot because some people if they don't practise their religion whatever religion you have if you leave the religion of course you will get punishment and Allah said in the Quran if you need help ask me before you ask other people' (Filsan, P. 12, L. 292-295)*

There was a shared understanding of faith treatments amongst participants. However, Ayan and Liban, two of the youngest participants interviewed, expressed that despite having a strong religious belief they felt that other means of treatments were allowed. Ayan describes how faith treatments are pushed greatly by the older generation, such as her parents.

> *'so I think if I spoke about a problem, I believe they would be like conflicting opinions, but mainly from sort of people like my mum's age, my dad's age, aunties, uncles…they would sort of say something along the lines of [ ] she's not right [ ] get a [ ] religious man, a sheikh to come…maybe to speak to her...maybe [ ] she's possessed or get a devil out of her…or something like that (Ayan, P. 20, L. 546-550)*

However, Sagal, a 51-year-old mother, shows a blended view that faith and Western medicine can be used simultaneously to treat a mental illness.

> *'reading the Quran over someone is very good for them and can help heal their troubles but I think it is also good for someone to take medication also' (Sagal, P. 4, L. 79-81)*

This sub-theme summarises the role of faith in healing ailments and troubles and highlighted the following points: recitation of the Quran and faith as healing, religious healing sometimes as the only available option, some faith healers may exploit those in need, poor personal faith is associated with poor mental health and troubles, and other forms of treatments (e.g. Western medicine) can be used in conjunction with faith healing.

3.4 Theme Three: Perceptions of Available UK Support and Treatment

The third theme progresses to what is recognised to be the available support and treatment in the UK. Four sub-themes emerged from the data. Participants spoke of 'unspecified support' for mental ill-health in the UK and expressed a lack of awareness of what is available. Another sub-theme that emerged was 'discrimination and racism' that participants expected to experience in places they perceived as offering available support and treatment of mental ill-health. The third sub-theme highlighted what participants recognised as 'support from a general practitioner and treatments that can be offered'. The last sub-theme, 'support is only available to those that seek it', will highlight how said support can be reached.

3.4.1 Unspecified support

Five participants highlighted strongly that there is an overall lack of awareness of where to seek support and treatment for mental ill-health in the UK. Some participants struggled to name a specific service or support that they would turn to if struggling with their own mental health. One participant laughed at not knowing where to go, however, he suggested the GP. It could be suggested that he was not confident with his answer.

> *'I don't know if there is a place specific for mental health (laughs) is there a place? (laughs). I don't even know there is nothing that tells people about where to go. So, then when you tell the general practitioner maybe they will have some idea of where you can go, I think…because I can't think anywhere else to go.' (Liban, P. 48, L. 1314-1318)*

Liban further argues that mental health support is 'hidden' in the UK, unlike support for physical illnesses such as cancer, where information is highly publicised. He emphasises that one must actively search for available mental health support if it is needed.

'you know how cancer research [ ] on TV [ ] on the billboards [ ] mental health is more...you have to go and look for it yourself if you need it [ ] it's more hidden' (Liban, P. 30, L. 810; 812; 816; 818)

Some participants expressed that the mental health system in the UK is poor as many people do not know where to go. One participant reiterated that because of this, communities are having to fill the gap. This can be seen as a significant contrast to the situation described earlier in section 3.3.2, where seeking help through faith healers is easily accessible.

'The mental health system here is very poor and there are a lot of people that need services, but they don't know where to go [ ] For example the area where I live we don't have services [ ] because now what it is like the community people coming together and doing their own things to support' (Filsan, P. 7; 8, L. 172-173; 187-190)

Ayan echoed this further by expressing that people do not know where to go for support with mental ill-health. However, she was able to identify counselling and therapy as available treatments for mental ill-health. Nevertheless, despite identifying treatments she pointed out that the Somali community does not have the right information about the treatments as she has come across people assuming they must pay for them.

'they don't know where to go [ ] so now they make it seem as if you know…you can seek medical profession [ ] when you think of like therapy and counselling, you think of going to see someone and paying money [ ] so a lot of people were maybe deterred from going to speak to someone about a problem because they think you have to pay' (Ayan, P. 26, L. 695; 697-699; 701-702)

Both Faisal and Fadumo shared a common feeling of helplessness in not knowing where to go for support for their loved ones. They confirmed still not knowing what were the available services and treatments in the UK.

‘we didn't know where to go to be honest, we had no idea what to do [ ] and that's happens to me most of the time this…they don't know what to do…what do they do?’ (Faisal, P. 27, L. 725-726; 728-729)

‘we didn't know how to go about it, we didn't know how to get the help and umm…I think certain events led to us being directed to certain services [ ] that could help the situation’ (Fadumo, P. 5, L. 117-118; 120)

This sub-theme highlights that many participants expressed that support for mental ill-health was unspecified in the UK. This sub-theme underlined three elements: lack of awareness of where to seek support, mental health resources being not easily retrieved or known, and holding incorrect information about how services run.

3.4.2 Discrimination and racism

Five participants spoke of discrimination and racism in the available services and treatments in the UK for mental ill-health. Two participants talked about class discrimination, that the mental health system is set up to benefit the upper class at the cost of the lower class. The following segment describes how certain communities are disadvantaged, as they do not have access to equal information, treatment and education. Liban further makes a distinction between ‘first-class treatment’ and having to wait to be seen. As such, this may perpetuate a feeling of being ‘less than’.

‘people always complain about lottery postcode where people in a particular part of the country will get you know absolutely first-class treatment where others will wait for a consultant for months or...and then the situations gets worse’ (Ali, P. 14, L. 342-344)

‘those that are educated [ ] seem to be getting information now [ ] so the middle class I think it seems, be to getting a bit more information [ ] regarding mental health’ (Liban, P. 30, L. 822; 824-825; 827; 829)

Filsan echoed that particular groups of people benefit more from the mental health system and feels that it is white people who are benefiting most as they are offered the full range of services available. Filsan highlighted that Somalis are discriminated against by GPs because of their race, ethnic origin and religious beliefs. She argues that she has seen this first-hand when supporting others and feels that GPs make assumptions based on race, ethnic origin and religious beliefs and will offer services and treatments accordingly based on the assumptions they hold about that particular group of people. Filsan argues that Somali patients will be offered medication rather than services for mental ill-health. This may raise questions about how identity influences the kind of support that is offered to certain communities. Filsan alludes to there being something assumed about the Somali identity (i.e. black, Muslim, social status and gender) that prevents Somalis from accessing good treatment.

> *'People are discriminated by the GP on how they look, their colour, culture. I think white people are offered all of these services, but we are not. I have seen it as I was working with the community for the last 15 years so I've seen this and have supported people to the GP and have even argued with the GP. Sometimes I say excuse me you don't have to give the tablet where are the services don't you have services, aren't there any other offers. Then they say yeah, we don't but I know they are not going to go. Like how can you say that, excuse me! What does that mean?' (Filsan, P. 13, L. 320-326)*

In the extract below Sagal emphasises that Somalis will probably not be offered counselling or the talking therapy route but instead prescribed medication. There is a sense of medication being used as a way of silencing, as Sagal describes that health professionals are not ready to take the time to understand and listen to the Somali community's concerns. This may further increase the reluctance of the Somali community in the UK in accessing mental health care.

'Somali people who are mentally ill are offered more medication and not offered someone to talk to them like counselling or someone trying to understand them' (Sagal, P.11, L. 272-273)

Faisal echoed the feeling of racism found in the mental health system. He feels that Somali people are treated differently in mental health services when professionals do not understand their culture. He feels that professionals test all different types of treatments on them and treat them differently. He feels that the racism plays a big role from early on. It could be suggested that Faisal is alluding to the institution of mental health care as holding racist practices, as he highlights 'a lot of racism here'. There is an emphasis on how race plays a significant factor in accessing good health care.

'there is racism [ ] a lot of racism here' (Faisal, P. 23, L. 622; 624)

This sub-theme highlights the intersectionality of race, gender, social class and religion that plays on the Somali community's ability to access good health care. The sub-theme described class discrimination, professionals making wrong assumptions based on race, ethnic origins and religious beliefs, Somali people being offered medication rather than talking therapy, and treatments being tested on them and not on other populations.

3.4.3 Support from a general practitioner and treatments that can be offered

Eight out of the ten participants were able to identify a general practitioner as an available service for mental ill-health in the UK. However, the understanding of what could be offered as a treatment and the feelings towards GPs differed. Ali and Yusuf both held more positive views towards seeking support from a GP. Ali believed that people should not wait until they deteriorated, and should always seek help early on from the GP as they could be referred on for other services and treatments. Yusuf expressed that going to the GP is the best first contact as they could refer the person to psychiatrists.

'I've always said to people, don't wait, don't wait...I always advise people please, act early on. If you come across don't wait until somebody you know becomes sort of ill, if you notice anything wrong the first point of contact is the GP and they can always refer you' (Ali, P. 8, L. 183-186)

GPs are the first people who probably recognises the person is…and they can refer them to…umm…psychiatry doctors' (Yusuf, P. 16, L. 426-427)

Maryam highlights that because her family and community did not acknowledge her sister's mental illness, her sister did not receive the appropriate support. She explains that one of the reasons things are better now is because of the support of the GP. She feels that if she was struggling with her mental health she would go to the GP as it is confidential. Maryam appears to have more trust towards her GP compared to others in the Somali community. Perhaps she has had a good experience of accessing the service of her GP. However, she worries that if she was too distressed or ill to access the services of her GP, she would not know how to help herself. Maryam makes an interesting case, as she attributes her capacity to seek help to the trust she has in her GP. She emphasises the role that confidentiality plays in building this trust. Again, this point links to earlier themes where participants described the significant stigma in relation to mental health within the Somali community. As a result of the stigma in the community it appears that GP services are the only viable and available options. The implications of this point are further discussed in the discussion chapter.

'it's just better to be private first so just tell your GP and umm explain it to them. But if I can't take myself then I don't know what would happen (laughs)' (Maryam, P. 13, L. 323-325)

Similarly, Ayan describes the GP as available support for mental health, as her brother went to his GP for mental health difficulties. However, she does not have confidence in what the GP can offer, though feels it may be short-term help. Ayan expresses that she is unsure how

quickly she would get a GP appointment and worries how she could share everything that is concerning her in a 15-minute appointment. She feels that a partner could give you more insight into how you are doing, although she recognises that this is not professional advice. It appears that Ayan is unknowingly describing the shortcomings of having the GP as the sole branch of support and she hints at the importance of having a more collaborative approach where family members and professionals work together.

> *'we have a 15-minute appointment [ ] I can't really tell her everything about my life...like I use my phone, I don't fall asleep, I do this…I always straighten my hair…like I can't tell her these things [ ] but like...a partner would sort of know your routine inside out [ ] so it's more easier for them to give you a little bit of an insight but it just won't be professional advice' (Ayan, P. 14; 15, L. 381-382; 384-385; 387; 389-390)*

Faisal echoes this point by doubting the quality of support that can be provided by a GP. It appears he believes that their approach is generalised due to time constraints and so may not be a source of significant support.

> *'GP has probably seen so many different people and so, probably they don't see any [ ] maybe they don't know what to do' (Faisal, P. 30, L. 810-811; 813)*

Three participants spoke of how counselling and medication together are often offered by GPs as a viable treatment option for mental ill-health. These methods of treatments mentioned by the participants appear to be traditional Eurocentric methods. It could be suggested that these participants may favour these approaches due to their further experience and learning as mentioned in Section 3.2.4.

> *'psychology or medicine [ ] a combination of the two is probably the solution or can be the solution…but more medication leads to more addiction more you know the person becoming debilitating…the talking therapy probably people would have a better outcome but I don't have a view that one method is better than the other, but I*

think both of them have their own place to use in my view really' (Ali, P. 13, L. 319-324)

'you treat them with whatever available medication is at the time. With counselling' (Yusuf, P.10, L. 267-268)

This sub-theme looks into how Somali participants view GP services. It highlights the following points: support from the GP should be sought early on, GPs offer viable Eurocentric treatments, support from the GP is only effective in the short term, treatments offered by the GP are often generalised, which is unhelpful, and a positive outlook on multimodal forms of treatments and a collaborative approach should be sought.

3.4.4 Support is only available to those that seek it

Five participants highlighted that Eurocentric support is only available to those that seek it. Many recognise that support is out there for mental ill-health but agree that this support can only be utilised when the individual suffering with poor mental health seeks it, as this is how Eurocentric services are set up. Yusuf emphasises that no services will knock on your door and ask if you have a problem. He stresses that people need to seek help for themselves and that services only help people who seek it, whether this be a governmental or charitable organisation. He feels that it is a shame if people do not seek help as there is no financial cost with mental health services. It could be inferred that Yusuf is highlighting the missed opportunity to get free support for people in his community.

'governments do not knock on people's door and say oh have a problem? [ ] umm they never do that, because institutions help people who come to and also there quite few non-governmental…umm...charities [ ] that deal with umm...mental health [ ] so that one can seek help from...and because there is no cost involved, ehh...it will be sort of a really shameful people not to seek help' (Yusuf, P.26, L. 696; 698-699; 70; 703-704)

Hamza highlights this further when describing how he found support for his wife when her mental health was severely deteriorating. He expressed that he was struggling to help his wife and his children but that mental health professionals helped him greatly. However, he states that if he had not asked for help, he would not have received it. He actively sought help from his children's school, mental health professionals, his GP, and social workers. In this case he appeared to show a proactive approach to seeking support.

> *'if I don't ask them to seek help I would not be able to do anything because…but they helped me actually [ ] But if I didn't seek help I wouldn't get any of that' (Hamza, P. 10, L. 217-218; 236)*

Three participants expressed difficulty in understanding how someone might receive support if they did not seek it out for themselves. They expressed that sometimes the individual struggling with their mental ill-health may not want to recognise it, may deny, or hide their issues. Some participants talked about the gap in support for an individual presenting in this manner. It could be suggested that these participants had identified the barriers to seeking support for someone else and were thinking about how to get them motivated to seek help and treatments. Here these participants appeared to be asking questions about how they could best prepare and support someone in accessing services.

> *'for example like…umm...there's a situation where you knows…you think somebody might need that help [ ] but they don't see that themselves, they don't see that they need that help [ ] or they don't see themselves as having a mental health problem [ ] where do you go? cause you cannot refer that person unless they want to go to the doctor's themselves' (Fadumo, P. 7; 8, L. 191-192; 194; 196; 198-199)*

> *'he'd just disappear [ ] he say 'no, I'm not going'…the last minute…he'll say 'yes I'll come with you' and then you'll make an appointment, take to him…GP, the clinic [ ] then they'll say an appointment…the day arrives, he's gone [ ] that actually would happens a lot' (Faisal, P. 32; 33, L. 916; 918-919; 921; 923)*

This is echoed by Maryam who expresses that she feels that there is good support out there, but the problem is that the person who is ill is not able to get help for themselves. They need the support of someone else and that person needs to make follow-up appointments with the GP and be proactive. In the absence of a proactive figure the ill person may continue to suffer in silence until the situation escalates even further. It could be inferred that there needs to be an active solution for those such as brokers/gatekeepers who are supporting individuals who do not want to access services for mental health issues. These brokers/gatekeepers may actively support the ill person by chasing-up appointments but they could also help in more subtle yet fundamental ways. For example, they may positively promote mental health narratives within their own milieu, and this in return may increase a sense of acceptance and permission for the person who needs to seek support.

> *'the help the person needs they can't get it themselves somebody else has to get it for them....you see then it's just difficult the person is telling them that they are anxious, depressed and that they are this, they might tell you ok umm....you need proof that maybe the GP will just give you a certain amount of months rather than not follow up the person unless somebody else calls up for them and says looks this person is severely depressed and not well. Then they will listen but if they go there for maybe a few months again but overall it's quite good' (Maryam, P.11, L. 274-280)*

This sub-theme highlights the importance of actively seeking support to gain access to services. The main components highlighted were: there are barriers to seeking support for others who need it but are reluctant to access it, and there needs to be an active role for brokers/gatekeepers to be involved in filling those gaps.

3.5 Theme Four: Experiences of Help-Seeking

The fourth theme encapsulates the experiences of help-seeking for mental ill-health in the UK. Participants spoke of the experiences of help-seeking for family members or others who are known to them. Four sub-themes emerged and will be explored. The first

sub-theme is ‘difficulties in accessing support’ and will explore some of the barriers experienced by participants in seeking help. The next sub-theme is ‘last resort out of desperation’, which will explore how the difficulties in accessing support can lead to desperate acts to help someone. The third sub-theme is a ‘dominant Eurocentric approach: Excludes other worldviews’. This will explore how some participants expressed that the mental health system in the UK is focused on a Eurocentric approach that is unwilling to include other worldviews. Lastly, the fourth sub-theme is a ‘lack of cultural representation’, which will explore how some participants spoke of not having much representation of Somalis professionals in the mental health field and that this can have an impact on the experience of help-seeking.

3.5.1 Difficulties in accessing support

All ten participants highlighted that there were barriers in getting support from services in place to support others with mental ill-health in the UK. Seven participants agreed that language was one of the barriers in accessing support.

> *‘the big barrier is language. Let's see the people that have been here for one generation Somali community but people who have come at 40 and 50 years cannot speak the language, so that can't use services and they have a lot of issues’ (Filsan, P. 2, L. 25-27)*

This was echoed by Sagal who expressed that when her ex-husband was struggling with his mental health, she was unable to provide support as she could not speak the English language at that time. Sagal expresses her frustration with the barrier that this created for her. This is a significant barrier as it highlights a further divide whereby the process of integration to the UK has substantial limitations at a fundamental level. As language is an important element needed for communication, the absence or limitation of it can create significant daunting scenarios for anyone that may be seeking any kind of support. In addition, this may hint at a further barrier as even a fluent English speaker may find it overwhelming to speak to professionals who may use a medicalised language. This could

even be more discouraging for an individual whose mother tongue is not English. This raises important questions about the role of interpreters and the potential added difficulty that may arise in trusting them.

> *'They did not have anyone to translate at the doctors [ ] my English was poor and low. So, I could not really support anyone with the doctors but could tell when a person needed help. I was not confident to support anyone to the doctors because of language and could not express myself' (Sagal, P. 7, L.154-155; 157-159)*

Three participants spoke of the severity of an individual's mental ill-health as another barrier when attempting to seek help from the GP. Maryam suggested that it felt as if her sister had to tick certain boxes before getting the right support from the GP.

> *'if it was diagnosed a little bit earlier like when my sister was getting more talkative or something could be earlier but then at the end of the day it falls onto like ticking so many boxes just to get to a certain stage to get help' (Maryam, P. 12, L. 291-294)*

Faisal underlined that seeking help from the GP for his brother was like a 'maze'. It could be suggested that the ethical practices (Confidentiality practices) of services in the UK are experienced as complicated to understand and navigate. There is a connecting thread within the sub-theme in relation to the difficulty encountered in accessing support which appears to relate to the experience of participants feeling that the systems put in place are inefficient or unsuitable when attempting to communicate distress or a need.

> *'you don't know where to start, you don't know where it will end [ ] you don't know how [ ] to get help, and...even you can't get any information because they will say to you when you ask for it, how, when I asked how my brother was...or is, they say "oh they cannot disclose any information to me"' (Faisal, P. 6, L. 143; 145-147)*

Another barrier that four participants expressed was the resistance within families which created a difficulty in accessing support for mental ill-health in the UK. Hamza spoke of the

resistance within his wife's family and emphasised how this acted as a barrier in getting his wife support for many years.

> *'They refused me to take her to the hospital saying that our daughter she is not sick yeah…They pretend and just ignored the illness [ ] So, it was becoming worse worse worse…I was struggling very very very much to care for the children and herself. I was struggling very much and for many years' (Hamza, P. 3, L. 59-60; 62-63)*

This was echoed by Sagal as she expressed that her husband's family not only hid his illness but purposefully prevented him from going to the doctors at first when it appeared he was struggling with his mental health. Perhaps this sub-theme offers some more context to the phenomena of stigma described in the earlier themes, as it may be possible that the barrier of language creates a fear that feeds the stigma attached to seeking support.

> *'I said that he needs to go to the doctors, but he did not want others to know about it. His mother did not allow him to go to the doctors. At the time I had a little child who was four years, and everyone cherishes their life and I was slightly worried for mine because of his illness' (Sagal, P. 4, L. 84-86)*

This sub-theme highlights the difficulties experienced by Somali communities in accessing services. These difficulties include: language as a barrier, the level of severity of mental ill-health and its effects on whether an individual is accepted into a service, resistance within families, and the difficulties in navigating and understanding the practices of services.

3.5.2 Last resort out of desperation

Following on from the last sub-theme of the difficulties in accessing support, all participants described acting out of desperation as a final course of action when all other attempts for support had failed. Four participants highlighted that the police had to be called, for a variety of reasons. Liban expressed that his aunt's mental health issues were ignored and denied for so long in the family that they became severe. He explains that in regards to a close family member, the family only sought support from the police when her presentation was

critical. Liban highlighted that Somalis will only seek help when it is a crisis, which is when the person is a danger to themselves or others. He shared that when the police were called for his aunt she was finally sectioned. He explains that his family failed his aunt as they denied and ignored her illness for too long until it got so severe that she had to be hospitalised.

> *'the only time they would get help is when a police officer takes them to the...to the hospital [ ] or they're arrested outside...doing you know...behaving erratically' (Liban, P. 35, L. 952-953; 955)*

This echoed by Sagal who shared that when her ex-husband's illness escalated that his cousin had to call the police as his presentation became erratic. She explains that she had to slam the door in his face for her safety.

> *'He went to stay with his mother who he then had a fight with so then he had to stay with his cousin. His cousin then called the police and help for him [ ] His illness reached the peak and I had to slam the door on his face for my safety' (Sagal, P. 4, L. 87-88; 92-93)*

Fadumo shared the same experiences with her niece.

> *'I think where we didn't know how to deal with it at the time, we couldn't call the ambulance [ ] we would call the police [ ] and that's when we were directed to the right person for help' (Fadumo, P. 5, L. 127-128; 132; 134)*

Hamza expressed a different experience in that since professionals were not supporting his wife, he felt that out of desperation he had to get her assessed in a private hospital.

> *'so what else I was stuck so maybe that pressure gave me the idea to take her to a private hospital' (Hamza, P. 11, L, 251-252)*

Hamza highlighted that he also got his 15-year-old daughter to call mental health professionals and explain what was going on with her mother. He explained that these were his acts of desperation as he was struggling with his wife's illness for many years.

> *'I remember during the bad days [ ] I asked her…I think she was 15/16 to call the mental health people [ ] I persuade her…very strongly…if she can talk to explain what is going on in our house yeah' (Hamza, P. 16, L. 352- 353; 355)*

Ayan describes that unless she felt that she was at breaking point, she would not seek help early. This appears to coincide with others' accounts, who said they would not seek help unless it was deemed a crisis. In this sub-theme there is an intergenerational effect and a sense of old meeting new, and the responsibility that lies within the family in desperately seeking help on time.

> *'I don't think I would go to a medical professional and talk...till it get to like breaking point' (Ayan, P.13, L. 342-343)*

This sub-theme explores how the Somali participants act out in desperation as a last resort in seeking help for family members. The main points raised were: situations reaching a crisis point, involving the police in desperate situations for containment, and mental health sectioning as a desperate source of help.

3.5.3 Dominant Eurocentric approach: Excludes other worldviews

Six participants expressed their sense of a strong focus on Eurocentric culture and ideas in the mental health system in the UK which excludes other worldviews. Hamza expressed that he found that the mental health system in the UK did not understand the culture of his community and was not flexible towards it. Similarly to the previous sub-theme, the participants highlighted how there are gaps in communication. Whereas in the previous sub-theme this related to language, the current sub-theme highlights such gaps from the aspect of cultural understanding.

> '*I find it is flexible but not in my community' (Hamza, P. 15, L. 329)*

Fadumo shared that faith is important to the Somali community. She highlighted that this should be respected in the mental health system and integrated into an individual's treatment plan if it is important to them.

> *'you have to respect if they are a spiritual person [ ] that is another form of treatment that you can use all forms of treatment, not just one, and limit yourself to just one service so if you know, they want to seek spiritual healing' (Fadumo, P. 16, L. 443-446)*

Many participants expressed that the mental health system in the UK is limited and rigid. Yusuf further emphasises that there is a strong medical model focus with mental health and that everything must be scientifically proven. It could be seen that this leaves little room for other worldviews. Perhaps the participants are asking whether the Eurocentric practices could meet the Somali culture halfway.

> *'they've got limited way of doing things [ ] they can't only prescribe person with drugs [ ] that's the only tool they have [ ] the medical profession has got limited supply of armoury to deal with the issue…but that's the only one that is proven [ ] and acceptable scientifically' (Yusuf, P. 17, L. 449-450; 452; 454; 460-461; 463)*

This is echoed by Filsan who described that mental health has a negative connotation in the Somali language. She expressed that there should be consideration of this by mental health professionals. She suggests that being flexible in working around the Somali community, and using different and more acceptable terminology, engagement from this community could be increased. It could be suggested that understanding basic concepts of the Somali culture can be important. For example, using non-diagnostic language even when things look dire does not mean that the Somali person does not understand the severity of a situation but rather it is a way of keeping true with the belief that positive affirmations are important within the cultural and religious practices.

‘My community needs to talk first and to stop using the word mental health. So, changing the label to a woman's wellbeing. I think it's better when…we don't mention that name of mental health because when you mention it no one will come but if you bring a group together and talk talk talk…the you can find a lot of comfort and support’ (Filsan, P. 5-6, L. 122-125)

Six participants highlighted the differences between a Eurocentric culture and the Somali culture. Filsan argued that because of these differences the two groups would not understand each other. She highlights that this is unfortunate for Somalis who need support with their mental health.

‘me and white people are not the same because my culture and his culture are different. So, the way he thinks he is not understanding me or the way I think’ (Filsan, P. 6, L. 147-148)

Faisal shared that during the times when he supported his brother with his appointments, he felt that the psychiatrist did not want to hear his contributions. Faisal emphasised that the psychiatrist did not want to accept Faisal’s cultural input in describing his brother’s behaviour or choices. He supports the views of the other participants that describe a rigidness in the mental health system in the UK. It could be suggested that he is highlighting the need for more culturally competent considerations from professionals. These kinds of practices may lead to significant resistance within the Somali community to access or seek support, as they may feel that the Eurocentric approaches negate part of their identity. This raises a dilemma regarding how effective support can be if the service user or their family network is not sufficiently understood.

‘they don't like see somebody else telling them [ ] especially psychiatrist’ (Faisal, P. 12, L. 307;313)

This sub-theme describes how dominant Eurocentric worldviews and practices exclude other worldviews. The sub-theme summarises that: professionals do not understand the culture of

the community, faith is not deemed important by professionals, Somali concepts of the language surrounding mental ill-health are not understood, and collaborations from family members are ignored by professionals.

3.5.4 Lack of cultural representation

Half of the participants spoke of an under-representation of the Somali population in the mental health field. Filsan expressed that mental health services will not reach the Somali community in part because of this under-representation, and that therefore language and cultural barriers will remain.

> *'Mental health services need a big improvement and need to find out from the Somali community what they would like whether that is a talking group, cooking group. They have to train a lot of young people from the community and different communities to understand' (Filsan, P. 10, L. 233-236)*

Both Hamza and Filsan emphasised the under-representation of Somali professionals in the mental health field in the UK. They highlight that representation is needed as an outsider cannot relate to Somalis and what some have been through in the war. This point may be helpful when taking into account the previous sub-themes where participants have expressed not feeling understood.

> *'The other thing is before Somali people they don't work in hospitals yeah and social services. We don't have social workers, doctors in hospitals so…this is the other thing support worker they don't have support worker before' (Hamza, P. 12-13, L. 279-281)*

> *'There needs to be more training for people in the Somali community because white people would not understand what we have gone through back home' (Filsan, P. 14, L. 351-353)*

Furthermore, Sagal echoed the views of other participants by expressing a lack of representation of Somali professionals. She shared that she was battling with the stressful

decision of whether to send her son to a specialist or mainstream school. She expressed that his teachers were advising her to send him to a specialist school for a few years to help with his speech and then go mainstream. But the Somali community did not believe in this approach. She emphasises the need for a Somali professional to offer a balanced view that she can trust. This highlights how Sagal was doubtful of professionals' advice as she did not trust in their cultural understanding of the situation at hand. This is even more important in that it brings to light the importance of offering culturally sensitive support as this may determine how support is sought or received.

> *'There are not really many Somali professionals that are around to represent us and help us. My son is diagnosed with autism and ADHD and I don't know whether to send him to a specialist school or mainstream school [ ] It would be nice if someone who was a Somali professional could advise me and give a more balanced view that I could trust' (Sagal, P. 11, L. 264- 266; 269-270)*

Faisal emphasised that reading about different cultural groups is not enough and that it is more effective and beneficial to have representation of a cultural group in the mental health field in the UK. It could be suggested that Faisal is sharing his disbelief that the current resources have so far not shown cultural competence and that perhaps trying different approaches such as increasing cultural representation might be significant.

> *'you have to be specialist [ ] on cultures [ ] they've understand very little [ ] the psychiatrist gonna see somebody [ ] from Afghanistan [ ] they might look at the Afghanistan culture a little while [ ] is that enough...just reading about it?' (Faisal, P.14, L. 363; 365-366; 368-369; 371; 375)*

This sub-theme describes the lack of cultural representation of Somali professionals in the mental health field. This section brought to the surface that: there is under-representation, those outside the Somali community cannot fully relate to or understand the community, and

there is a need for more Somali professionals as they can offer more balanced and trusted views.

3.6 Theme Five: The Relationship between Somali Refugees and Professionals

This fifth theme captures the relationship between Somali refugees and professionals as experienced by Somali refugees in the UK. Four sub-themes emerged: 'distrust and fear of professionals', 'misunderstandings', 'collaboration' and 'negotiating relationships'.

3.6.1 Distrust and fear of professionals

The data exposed that nine participants expressed a fear and distrust of Western professionals in the UK. Hamza, a 50-year-old father with a wife who has suffered from mental ill-health for several years and has nine children, presented his own fears of professionals as well as his family's assumptions.

> *'I was frightened that maybe social services were going to take my children… because always they came to me.' (Hamza, P. 9, L. 199-120)*

> *'If you say your child, or your wife or your husband have got illness mental health illness by a psychologist they don't believe.' (Hamza, P. 7, L. 146-147)*

Maryam echoed these views by expressing that her family kept her sister's mental illness hidden until she was finally sectioned. She explains that one of the reasons her family hid the illness might have been because they feared her sister being taken away from them. She explains that the Somali community fears that once professionals like the police, social services and doctors are involved, they will never get the person back. This distrust of the system appears to further fuel the fear of approaching professionals. It appears that there is a lack of understanding and perhaps lack of information on the exact procedures within mental health systems (i.e. mental health sectioning, care in the hospital and the roles of different professionals).

'Yeah if they get sectioned for example, they will say we don't know what's happening behind closed doors so…anything can be happening so they say no' (Maryam, P. 2, L. 32-34)

This is reiterated by Filsan who suggests that Somalis have difficulties in trusting outsiders. She expressed that professionals such as GPs never tell Somalis about all the mental health services available, and she is suspicious of the intentions of professionals. She emphasises that GPs offer medication straight away to Somali patients, but she would advise someone not to take the medication unless they are severely ill. It is important to note Filsan's apprehension around the discrimination she perceives in regard to professionals offering medication rather talking therapy. She appears to suggest that the use of medication is mainly offered to particular demographics, emphasising further the disparities in treatment.

'because you are Somali so they will trust you, but they don't trust no one else' (Filsan, P. 3, L. 61-62)

Sagal highlighted that Somalis tend to have a mind-set that outsiders such as White professionals will purposely drug and kill Somali patients. She states that when Somali patients are offered medication for mental health issues, they do not take it as they believe it will make them worse.

'They have a horrible mentality that white people will drug us and kill us.' (Sagal, P.3, L. 60-61)

Among participants' experiences of and views towards mental health professionals was Faisal's assertion that he felt professionals were playing God. Faisal expressed that you cannot trust mental health professionals as they cannot stand being told that they may have got something wrong. Faisal suggests that seeking support does not feel collaborative as the professionals are unwilling to take the accounts and narratives of Somalis into serious consideration, or learn from them.

'sometimes you...you cannot trust' (Faisal, P. 9, L. 228)

Some participants described the behaviour of their family members who struggled with their mental health towards mental health professionals. Hamza spoke of how his wife refused to take medication as she felt she did not need it and she was scared it would kill her. He explains that she did not listen to what the doctors advised her.

> *'sometimes she stopped medication she said I don't need…it will kill me…she doesn't listen to what doctors advise her' (Hamza, P. 4, L. 87-88)*

This was echoed by Sagal who shared that when her ex-husband was taken to the GP for his mental health issues he did not trust or believe the doctors. She expresses that this distrust stopped him for getting the right treatment.

> *'When he was taken to the doctors he didn't believe or trust them even. So, when he refused help from the doctors' (Sagal, P. 4, L. 78-79)*

These extracts from participants highlight an underlying fear and suspicion towards mental health professionals. It could be suggested that there almost seems to be an apprehension that professionals may not have an individual's best interests at heart. The sub-theme summarises that participants would keep information from professionals due to fear of the interventions they may employ. Participants expressed a fear that White professionals will severely harm them with their interventions and that they would be unable to challenge professional opinions once they are made. Lastly, participants shared that the distrust of professionals often stops the Somali community from accessing treatment.

3.6.2 Misunderstandings

Six participants spoke of how misunderstandings can affect the relationship with professionals, thus increasing suspicion and fear. Hamza expressed that despite mental health professionals helping him in the end, they nevertheless did misunderstand the Somali culture. He highlighted that during the assessment process for his wife there were a lot of misunderstandings which made it very difficult. He expressed that this meant that the

assessment process took years. He felt that the GP and mental health professionals did not understand, which is why he took his wife to be assessed at a private hospital.

> *'The other day after I came back to the GP and said she has problems call the mental health (professionals) can you come to me to help my wife and she said that we assessed her before yesterday and she has been ok this is the assessment she has no problems and we cannot force (emphasises word) her to take her to a hospital, they asked her can you go to the hospital with me and she said no I don't need it…so what else I was stuck so maybe that pressure gave me the idea to take her to a private hospital.' (Hamza, P11, L. 247-252)*

This extract from Hamza highlights the sense of urgency in getting his wife support. It appears he felt professionals were unable to provide it, as they did not understand him – he attempts to describe why cultural stigmas might mean his wife may not be answering honestly. Hamza suggests that Somalis can also contribute to the misunderstandings. It could be inferred that professionals might be unaware of cultural variations of distress and the impact of stigma in relating to Somali populations.

> *'there's always help but…Somali people I think they it make worse for misunderstandings' (Hamza, P. 11, L. 238-239)*

This is echoed by Faisal who described an example of how Somali culture can be perceived differently by professionals who do not understand the culture. He expressed that when he would take his brother to the GP, there would be misunderstandings with the GP, who assumed his brother was well. But Faisal emphasises that his brother was withholding information. Faisal stresses that the family of the patient should be included in their treatment to help clarify some of the misunderstandings.

> *'they say don't speak for him please, he say 'I'm okay...no problem'…'he say he's okay…look no problem he's ok'. That what the GP said' (Faisal, P. 28, L. 749-751)*

Sagal argued that Somalis may present differently than expected to professionals but that this is due to cultural reason. She highlighted that this does not mean they are not dealing with issues.

> *'We are Africans and we hold in our pain and are strong people.' (Sagal, P.10, L. 257)*

The sub-theme described how misunderstandings between professionals and Somali refugees can increase fear and suspicion. This section summarised that professionals may be unaware of cultural variations of distress and stigma that could impact how Somalis present their distress. Also, it was highlighted that there is a need to involve family members in order to have a full account of the dynamics of a situation, as there may be ambivalence from the party seeking support.

3.6.3 Collaboration

Nine participants emphasised the need of empowering others to have choice about the care they receive and working together with professionals to get the right care. Ali suggested that if mental health professionals work on creating more mental health awareness in communities then community members will feel empowered enough to share their preferences. He suggested that this is a way for the two sides to understand each other and collaborate.

> *'It's just really about getting that message across....what services are available, how to access them you know barriers facilitating and breaking the barriers like language, culture if those kind of things that can help the community to feel confident enough to say what their preferences are. Those are the very important things we need to understand and collaborate on.' (Ali, P. 14, L. 350-354)*

This was echoed by Yusuf, as he described that professionals may work within a framework but if they look at the patient as an individual this can enhance personalised care.

'to deal them within that framework, but as an individual.' (Yusuf, P. 42, L. 1140-1141)

Nevertheless, Ayan encourages personalised care but believes that professionals may feel it creates a great deal of difficulty and trouble. Ayan also appears to allude to a systemic issue whereby the NHS may not have the resources to offer personalised care. It is also possible that this notion may fuel the sense of discriminatory treatment whereby Somali people do not receive good treatment when seeking help.

'I believe that if you're gonna give sort of a tailored advice to someone, you have to see if it's gonna work first and then you have to make sure that...follow-up, see how it goes but within the NHS in general, I feel like it's a very onerous thing to do, try to tailor everything specifically to someone, always had follow-up appointment' (Ayan, P. 9, L. 242-245)

Faisal highlighted that collaboration is needed for families of patients with a mental illness. As he expressed feeling isolated from his brothers treatment plan.

'but it's the way they treat with carers, with the people who are fully looking after them [ ] and...that's not good, they are not part of it, the therapy that that person receives, there should be, their families should be included.' (Faisal, P. 11, L. 277-278; 280-281)

Although Hamza struggled to get that initial access to support/treatment for his wife, he did demonstrate in the extracts below that he was able to collaborate with professionals once his wife was in treatment as this appears to have finally allowed him to be seen and heard. Therefore, he was able to provide an explanation for his wife's perceptions towards mental health hospitals.

'I know my wife when she is becoming sick...I avoid somethings [because] I know she has got phobia if she goes to the hospital…so I asked them if we could meet

somewhere else not in a mental health…not in the hospital' (Hamza, P. 13, L. 295-296; 299-301)

'I asked the mental health services if they can treat her with the home treatment so this helped me I asked them if they can send a team to come to her home so they can give her treatment' (Hamza, P.13, L. 299-301)

This sub-theme describes that collaborations between professionals and the Somali communities can empower others and resolve misunderstandings. Further suggestions from the sub-theme were greater mental health awareness in the Somali communities and a push for personalised care. Some participants raised concerns about how personalised care would be viewed by professionals who are used to working in a particular framework.

3.6.4 Negotiating relationships

Eight participants highlighted a need to find mutual understandings and better relationships between Somalis and mental health professionals in the UK. Hamza suggested that the mental health field needs to recruit more Somali professionals to bridge the gap and connect Somalis with mental health professionals and services. Hamza highlighted that there is a big language barrier for Somali people and that if there are Somali professionals this will help set up needed flexible services.

'If they understand the professionals Somali professionals in the field maybe they will get help to understand the culture, the illnesses, and to set up some kind of flexible services.' (Hamza, P.13, L. 291- 293)

'Some more Somali people working there I think that will help…You know making that bridge…To connect them to each other.' (Hamza, P. 15, L. 333; 335; 337)

Filsan argued that the Somali community has difficulties in trusting outsiders. Therefore, she suggested that there should be research on this to help train professionals on how to work with the Somali community and maybe then gain more trust from the community.

'I think if we do a lot of research on how we can help them and then we can train professionals how to work with the community then maybe people will work and trust them more.' (Filsan, P. 3, L. 62-64)

Filsan further expressed that community support is more flexible and can allow people to exchange experiences, feel more connected, socialise, and learn new skills. It could be suggested that they might be a need for more community organisations in order to involve more Somali people.

'people have to come together. Things like workshops help. We have to see how things can work for different people you can't use the same things to help people if they are different, we should work with people.' (Filsan, P.14, L. 345-347)

Yusuf suggested that another means to increase mutual understanding and create better relationships between Somalis and mental health professionals in the UK would be to use platforms such as Somali television and YouTube. He highlighted that there are many means of communication available to increase awareness of help-seeking for poor mental health.

'you've got so many means of communication [ ] Somali televisions [ ] you've got YouTube, which is available to anybody [ ] so making use of all this means of communication and increasing that awareness of the people, on mental health as a disease, and not as something to be ashamed of is not their cause, is not something you did' (Yusuf, P. 42, L. 1146, 1149; 1151; 1158-1160)

Some participants hope that the younger Somali generation in the UK will make a change in representing the needs of Somali refugees, as this generation has been able to acquire a greater understanding of Western constructs.

'At the moment sometimes I saw young people alhamdulillah coming…to the field…Some of them social workers, some of them teachers, some of them doctors everywhere you go you see young people…Learning here yeah, that were born here

maybe growing up here and coming to the field so they get help.' (Hamza, P. 13, L. 281-282; 287-288)

This sub-theme highlights the reflections of the Somali participants in regard to how services could improve their relationship with the Somali community. The participants suggested a need to recruit more young Somali professionals to bridge the gap between professionals and the Somali community. Furthermore, the participants suggested that more research needs to be conducted in the Somali community and non-Somali professionals need to be trained on how to work with the Somali community. Lastly, they suggested utilising Somali media source to create awareness of mental ill-health and to educate Somali people on how to seek help.

3.7 Conclusion

This analysis chapter has presented the most salient themes from the research study. The next chapter will present these key findings in relation to the existing literature.

4. Chapter Four: Discussion

4.1 Introduction

This chapter will present the key findings of the present study in relation to the research questions:

1) How do Somali refugees in the UK understand mental ill-health?

2) What do Somali refugees understand to be the available support and treatment for mental ill-health in the UK?

3) How do Somali refugees experience help-seeking for mental ill-health in the UK?

This chapter will begin with a discussion of the five themes that emerged from the analysis and relate these to the existing literature. This will hope to inform the present study and build on the existing literature. This will be followed by a critical evaluation of the present study that will highlight its limitations and strengths. The clinical implications of the present study for counselling psychology and other mental health services and clinicians will then be considered. This will then lead onto suggestions for future research. The chapter will conclude with overall reflections on the research process.

4.2 Understanding Mental Ill-health

This theme answers the first research question: How do Somali refugees in the UK understand mental ill-health?

Participants expressed how they understood mental ill-health and the implications it has for their community. Participants expressed that mental ill-health is regarded as a taboo topic in the Somali community. The role of stigma has been heavily evidenced to be a contributing aspect to how mental ill-health has been perceived by different populations, especially BAME communities (which includes the Somali community) (Whittaker et al., 2005; Shefer et al., 2013). Participants expanded on the role of stigma and the provenance

of it in their community. The level of shame and secrecy of mental ill-health seemed to be a powerful component linked to stigma. The implications of this shame and secrecy within the Somali community regarding mental ill-health are that it leaves those with mental ill-health with limited options for seeking support, as there would be some mistrust of external individuals and even individuals within their own family or community network. This creates a dilemma as seeking support for mental ill-health will be potentially stigmatising, which therefore may lead an individual to decide to not seek support. This highlights that the implications of shame and secrecy of mental ill-health would need to be considered in any new developments that aim to help the Somali community access mental health care, as this seems like a prominent barrier. Perhaps this is due to the fact that less overt presentations of mental ill-health are seen as behavioural, with only the more overt, 'out of control' presentations seen as serious illness in the Somali community. Participants expressed that the only term in Somali to come close to the meaning of mental ill-health is 'goof walan', which means crazy/mad person. It could be suggested that a community-based participatory research (CBPR) approach would help create a partnership between Somali community members, researchers and organisational representatives, and allow for all to share their expertise to co-create and co-produce knowledge to help the Somali community (Jull, Giles & Graham, 2017). Co-production can be practised in different approaches, for example, I am working with a Somali organisation in London that aims to develop a community-based mental health model that would work better for the community and to develop links with partners that can support the community. Somali community members are actively involved in leading the process by sharing their needs and helping to develop a programme geared to the needs of the community it serves. This project is a Somali-led women's project. More resources are needed to include Somali men in the programme.

Some of the participants highlighted that the understanding of mental ill-health is linked to behavioural issues, for example, being viewed as a 'drama queen' highlights that the individual is seen as choosing to behave in a certain way rather than having issues with

their mental health. It could be suggested that this might illustrate cultural, religious and social norms of how to act as a Somali Muslim. As mentioned in the introduction, Somali identity is linked to the Islamic faith. A central element in the Islamic teachings is to lead a modest life, which is termed as *'Hayaa'* (Nurbaeti et al., 2020). Although there is limited scientific research on this term, it is an important religious belief and custom that Muslims strive for (Mohammed, 2014). A similar concept emerges in other BAME communities that follow the Islamic faith where *shame* is identified as one of the barriers to accessing mental health services (Pilkington et al., 2012). Nurbaeti et al. (2020) conceptualise the term 'Hayaa' as a driver in maintaining modesty and honour to keep people away from shameful or indecent actions, behaviours and words. As such, if mental ill-health is viewed as a behavioural issue or choice in the Somali community, it could be seen as being immodest, shameful or lacking 'Hayaa'. 'Hayaa' is an integral part of the lives of Muslims and having a lack of 'Hayaa' could be interpreted as having a weak faith, which displeases Allah (Mohammed, 2014). This may also explain why participants also mentioned a fear of families being ostracised and isolated from the community as the shame and stigma is long-lasting, and the family may be perceived to have lost its honour.

Markova and Sandal (2016) state that religious leaders are seen as a source of support for families dealing with mental ill-health issues or any other troubles. It could be suggested that mental health providers could collaborate with Islamic religious leaders to reduce the stigma associated with mental ill-health and the assumptions that mental ill-health is behavioural or the result of weak faith. This can be an important aspect in reducing the level of stigma and shame associated with mental ill-health as informed religious leaders, who hold positions of trust and respect within the Somali community, can have significant impact.

Participants expressed that in Somalia mental ill-health is only recognised when someone presents as a risk to themselves or others. As such, participants highlighted that people are chained and locked up to reduce the risks, though they understood this to be a

cruel form of treatment. Participants compared these cruel approaches to those of UK mental health hospitals, suggesting that the sense of isolation and restriction in such hospitals brings about the same level of distress. This point highlights the significant impact of hospitalisation in the UK for BAME communities. Perhaps this links back to the aspect of stigma associated with being labelled with a mental health diagnosis and consequently being isolated from the community (DeFreitas et al., 2018).

Many participants discussed the stressors experienced after resettlement in the UK. These stressors included difficulties with learning a new language, socio-economic disadvantage, unemployment, poor living conditions such as overcrowding, and unresolved pre-migratory trauma. Similarly, Jorgenson and Nilsson (2021) highlighted that the combination of post-settlement difficulties and pre-migration trauma can contribute to mental health issues, therefore making the process of acculturation difficult. Participants expressed the tensions experienced with regard to culturally assimilating to the British culture, which differs from Somali values and customs. Acculturation has been described as a process where individuals and groups experience cultural, social and psychological change (Berry, 2005). These changes occur due to contact between culturally dissimilar groups (Jorgenson & Nilsson, 2021).

Participants also described a further element beyond acculturation – a tension that arises from the intergenerational disparity in acculturation whereby younger Somali generations have integrated more aspects of the new dominant culture (UK) compared to the older generation (Berry, 1997). As mentioned by the participants, the different levels of acculturation can cause significant strain within a Somali household, with the push and pull between a Somali collectivist culture and a British individualistic culture. This supports Phillimore's (2011) claim that lack of support, too much change, and pressure to acclimatise in a short amount of time can cause acculturative stress, but also highlights Berry's (2001) stages of acculturation strategies which emphasise that a lack of integration or assimilation can lead to separation or marginalisation. A significant finding from the current study

suggests that participants are indicating that the differing acculturative strategies between the older and younger generations are to account for some of the stressors within households. Some participants positioned the older generation within the separation strategy stage whilst suggesting that the younger generation is positioned between the assimilation and integration stages.

Phillimore (2011) suggests that a person becomes more vulnerable to mental ill-health when there are pressures to acculturate within a short period of time. There are significant aspects to this point that can be built upon. Firstly, it raises the importance of allowing time to pass for the process of integration of Eurocentric values to happen more organically. Secondly, it highlights that perhaps the younger generation of Somalis are at a later stage of acculturation. Lastly, it shows the strain inherent in merging the collectivist culture with a more individualistic one, as participants highlighted that mental health practices are more suitable for those from an individualistic culture. Participants suggest that maintaining Eurocentric practices and not acknowledging the role that collective cultures play will not meet the mental health and cultural needs of the Somali communities. The current findings are in line with a similar study conducted in Australia where the researchers acknowledged the role of collective community values within Somali communities and the impacts this has on the effectiveness of mental health practices (Bailes et al., 2006).

Nevertheless, participants also suggested that some views of mental ill-health are changing within the Somali community. Although the participants initially suggested that the older Somali population has challenges with acculturation strategies, they also highlighted how Somalis, including some older Somalis, have been able to add another dimension to their understanding of mental ill-health through education and personal experience. Participants expressed how personal family experiences of mental ill-health have impacted their understanding and willingness to learn more about the Eurocentric models, while some younger participants expressed that the process of change came about with progression into higher education or developing into adulthood. Some participants expressed that one of the

sources that aided their understanding and learning were the Somali TV and radio programmes, delivered in the Somali language. Similarly, Dietrich et al. (2006) found that media can influence attitudes towards mental ill-health. This seems to be a significant finding from the current study, as the process of change that was expressed by participants appeared to give them a sense of pride, and that through these pivotal moments they were able to increase their awareness of mental ill-health. It is important to focus on this process of change reported from participants and on how others in the Somali community may be able to progress in this way. Another significant finding is that delivering information through Somali media sources in the Somali language may be a way for mental health providers to initiate this process of change for others within this community.

4.3 Cultural and Religious Beliefs

Participants articulated that cultural and religious beliefs were another element that had contributed to their understanding of mental ill-health. They described that when something is unexplainable, and behaviours become concerning such as mental ill-health, the Somali community conceptualises it through religious beliefs. This draws attention to the epistemological and ontological paradigms of ‘knowing’ and ‘understanding’ in terms of how Somalis may adopt a concept of mental ill-health. Studies on BAME communities have found that religion and cultural beliefs are the dominate narrative to explain the concept of mental ill-health (Freeman et al., 2013; Rabiee & Smith, 2013; Whittaker et al., 2005).

The current study highlighted that spiritual or supernatural beliefs can resemble or be mistaken for mental ill-health. This chimes with other studies that acknowledge the importance of some religious practices to the conceptualisation of mental ill-health (Ghiasi & Keramat, 2018; Kamal et al., 2013). Some participants also mentioned that they now have a blended view whereby they hold the narrative of spiritual and supernatural beliefs but also understand that there might be other explanations due to increased awareness of Western concepts. Nevertheless, participants explain that the spiritual and supernatural beliefs are

either possession of the devil/*jinn* or being the target of '*sixir*' from others (voodoo/evil eye). As mentioned earlier, the Somali concept of mental ill-health sees spiritual beliefs as an explanation of the phenomenon (Qamar, 2013). Consequently, in the Somali community, religious practices are considered to be the healing cure for mental ill-health and possession of the devil/*jinn* (Ateeq et al., 2014). Furthermore, participants articulated that recitation of the Quran is effective at healing any troubles, including mental ill-health and possession of the devil/*jinn*. Ghiasi and Keramat's (2018) systematic review also expressed that there is a positive effect on reducing anxiety from listening to recitations of the Quran. This could be compared to the effect of meditation, which is widely practised in Eurocentric models in treating mental ill-health (Hilton et al., 2017).

The younger participants in the study expressed that although the younger generation veers towards Western forms of treatments, it still holds its Islamic faith as a major component of identity but believes that the older generation continues to promote faith healing as the only viable resource. Contrastingly, the older participants suggested that they hold a blended view just as do the younger participants. This contrast may be due to participants having self-selected to participate in the study – they may have had a common experience that has 'forced' them to reconcile the realities of mental ill-health in this context. Therefore, they appear more willing to share and be involved in discussing mental ill-health, illustrating an apparent level of acceptance of the situation. This links back to the points raised in Section 4.2 where personal experience and exposure can increase awareness and understanding of other concepts of mental ill-health as well as the interest in participating in studies such as the present one. This intergenerational contrast mentioned by the participants is a similar concept to that highlighted by Lui (2015) who described that different generations would hold cultural values differently. The findings from this current study illustrate why religious leaders from the Somali community are approached for mental health concerns, as the concept of mental ill-health adopted by Somalis is heavily influenced by religion. Therefore, this strengthens the arguments for involving religious leaders in mental

health services in the UK to improve access. The current study has highlighted that some participants feel faith should indeed be prioritised when seeking support.

4.4 Perceptions of Available UK Support and Treatment

The findings from the current study demonstrate that there is an overall lack of awareness of where to seek support and treatment for mental ill-health in the UK. Participants further expressed that mental health support is 'hidden' in the UK, unlike for physical illnesses such as cancer, where information is highly publicised. Nonetheless, in 2010 there was a "Time to Change" anti-stigma campaign in the UK which aimed to improve public knowledge and attitudes towards mental ill-health (Time to Change, 2010). Henderson et al. (2016) who evaluated the "Time to Change" anti-stigma campaign between the years 2009 and 2015 found that it improved public knowledge and attitudes. However, in line with the findings from the current study, the "Time to Change" anti-stigma campaign initially did not have the same improvements with the BAME population (Time to Change, 2010). However, when Black champions were introduced to the campaign, there was a reduction in stigma in the Black population (Time to Change, 2010). The findings from this campaign suggest that there is a need to collaborate with BAME communities to increase awareness of mental ill-health. However, participants from the current study still report a lack of campaigning and that mental health support is 'hidden'. It could be suggested that members of the BAME community all have their own different cultural values and agendas, and therefore mental health campaigning is needed specifically to address the Somali community using Somali community members. As one paper from Codjoe et al. (2019) suggests, partnership between mental health services and Black faith communities can increase access to services, improve experiences of services and promote mental wellbeing.

Many participants articulated that they perceived the mental health system in the UK to be poor, as they believed that many people do not know where to go to receive support. Weatherhead and Daiches (2010) suggest a similar finding when exploring how BAME Muslim populations in the UK view mental health services. In line with the current study,

Weatherhead and Daiches (2010) reiterated that BAME Muslim populations need services to be more accessible and visible. Ten years on from that study, participants are still highlighting that due to not knowing where to seek help or access services they often fill in the gap with already existing knowledge. Participants described in their interviews that this existing knowledge of mental ill-health is often drawn from cultural and religious beliefs. The notion of 'filling the gap' seems to reinforce the earlier finding that Somali communities rely heavily on religious and cultural beliefs (Section 4.3). This point raises an awareness that perhaps religious beliefs are heavily relied upon not only because of historical knowledge but also due to a lack of awareness of mental ill-health and what is available and known (Weatherhead & Daiches, 2010). For example, some participants were able to articulate that counselling is an available resource but were unaware of how the mental health service is structured in order to access it. They further highlighted that due to this, communities are having to fill in the gaps. This chimes with Kohrt et al. (2018) who describe that lack of awareness of mental health services can lead to poor access. Perhaps this highlights the need to fund more studies and community-based resources such as encouraging professionals to participate in more community social events and when possible providing services within Mosques and community centres. As suggested by Kohrt et al. (2018), to address gaps in mental health services will require collaboration with community services and community-based programmes. This will allow mental health services to identify and assess their capacity to improve acceptability and to ascertain accessibility.

Another key finding within this theme is in relation to the discrimination and racism highlighted by participants. They described that the Somali community does not receive the 'first-class treatment' that White populations receive and that often Black patients are offered medication rather than talking therapies. The belief that perceived discrimination can hinder access to services is a notion also highlighted by Memon et al. (2016). Similarly, Bhui et al. (2003) describe how BAME participants are more likely to be offered prescribed medication in comparison to their White counterparts. Participants also articulated that GPs hold

erroneous pre-existing assumptions about Somalis based on their race, religion and culture which impacts their access to treatment. Participants suggested that because of these assumptions they are discriminated against and some resources are hidden or not offered. For example, Ghali et al. (2013) describe how certain embedded prejudices about Black people have informed mental health services and also criminal justice systems whereby Black people in need of support are regarded as 'dangerous' and needing to be detained rather than offered more sensitive and targeted support. Furthermore, Raghavan and Jones Nielsen (2021) emphasised that it has been widely evidenced in over 50 years of research that Black and other ethnic minority communities are disproportionately at higher risk of worsening mental health disparities. They shared that this evidence has shown that these groups experience more adverse pathways to care, which include more contact with the criminal justice system and police, higher rates of involuntary admission and treatment, and poorer longer-term outcomes overall compared to White British people (Raghavan & Jones Nielsen, 2021). What's more, Raghavan and Jones Nielsen (2021) suggest that during the COVID-19 pandemic these mental health inequalities have been further significantly exacerbated. Allwood and Bell (2020) add urgent recommendations such as emergency funding from policymakers to mental health services and that local government should be supported to engage with community and third sector organisations to co-produce knowledge with specific populations that are facing mental health inequalities. They further suggest that services be funded to adapt to be more culturally responsive (Allwood & Bell, 2020). The Royal College of Psychiatrists Report (2018) emphasises a deep-rooted institutional racism in mental health services such as unfair treatment of Black people on secure mental health settings and a misunderstanding of the experiences of Black and ethnic communities. It could be suggested that the COVID-19 pandemic has not only exacerbated these inequalities but also turned attention on policymakers to increase funding to allow those facing such inequalities to have a chance of receiving good mental health care (Raghavan & Jones Nielsen, 2021). The findings highlight how the intersectionality of race, gender, social class and religion appears to play on the Somali community's ability to access

good mental health care. This highlights the need to continue the work of demystifying the different prejudices that professionals and institutions hold but also the need to promote agency within Somali communities by sharing information about the possible services and treatments so that they can make a more informed choice about the required support.

Nevertheless, some participants were able to identify GPs to be available support for mental ill-health and expressed that support should be sought early on. However, some participants articulated that support offered by GPs is often generalised and only effective in the short term, which is unhelpful. This appears to be similar to the findings from Loewenthal et al. (2012) who found that Somalis and South Asians in the UK feel that their GPs are unable to address and understand their concerns and needs.

Another key finding of this current study is that participants emphasised the barriers to seeking support for others who need it but are reluctant to access it. For example, participants highlighted that sometimes the individual struggling with their mental health may not want to recognise it, may deny, or hide their issues. This is in line with a study from McCabe and Leas (2008) who found that generally people with mental health issues are often reluctant to seek support, which leads to under-diagnosis and higher mortality rates. The current study emphasises the need for there to be an active solution for brokers/gatekeepers who are supporting individuals who do not want to access services for mental health issues, and an active solution is needed to tackle these issues (Mclean et al., 2003). For example, if informed religious or community leaders were brokers/gatekeepers this could be the active solution that is needed to motivate and encourage those who are reluctant to seek support. Such brokers/gatekeepers could potentially best prepare and support an individual or their concerned family members in accessing services.

4.5 Experiences of Help-seeking

Whilst the previous themes focused on the views and concepts of participants, this theme articulates their experiences. The findings from the current study highlight the

experiences of help-seeking for family members or others known to them. Participants articulated that there are barriers to getting support from services in place to support others with mental ill-health in the UK, such as resistance within families. This is similar to Shefer et al. (2013), who found that opposing views within families can act as a barrier to an individual seeking support from mental health services. They further argued that this resistance can be due to the stigma surrounding mental ill-health (Shefer et al., 2013). This appears to link to theme 4.2 where it was suggested that the Somali community tends to hide and deny mental ill-health out of shame. Pavlish et al. (2010) further support this as they found that Somali women have silent worries about their mental health that they would not share within their community or with mental health providers, illustrating that their views towards mental ill-health often inform their experiences.

Furthermore, some participants expressed that when they supported family members to go to the GP, the family member had to meet a certain threshold of severity of mental health concerns, and that this acted as a barrier in accessing mental health services through the GP. Guerin (2004) also emphasised that Somali participants hold the view that mental illness is reserved for severe and untreatable cases (Guerin, 2004). This could perhaps account for why some Somalis feel discouraged to seek support and highlight certain structural issues in mental health services in this regard. This finding from the current study could suggest that there is a need to review primary care services, which are often the gatekeepers in accessing specialised mental health services.

Some participants expressed that language was a barrier in accessing mental health services. Aggarwal et al. (2016) conducted a systematic review of 23 studies on BAME communities and barriers in accessing mental health services. They highlighted a need to tailor language and communication to the client's preference to improve accessibility. In addition, Bhattacharyya and Benbow (2013) suggest that language barriers are one reason why services are under-utilised by BAME communities.

Another barrier highlighted by participants were the difficulties in navigating and understanding the practices of services. For example, a point was raised in regard to confidentiality and how this can often make family members feel isolated from the process and possible care plans. This point highlights a possible dissonance with what a Somali family may be accustomed to, where issues are a collective experience. It raises the question of how to improve communication with services, the client and the families involved. Perhaps the implementation of simple guidance in the form of leaflets highlighting practices and their importance might reduce the feeling of being disconnected to the process.

Linking to the previous point, it appears that as a result of feeling unheard, participants have had to endure situations getting to a crisis point before knowing how to act. Participants describe having to employ the help of law enforcers in order to restrain and at times section family members. This is concordant with Appleby's (2008) study which evidenced that there are disproportionate high rates of admissions and sectioning with ethnic minorities from police intervention. Moreover, Jeraj et al. (2015) describe how different BAME groups have experienced seeking support at a crisis point. Some of their findings align with what the participants have described in the present study when they conveyed that the police are often contacted as an act of desperation as all previous attempts for support have failed. Similarly, issues with accessing services at earlier points appeared to be the catalyst for further deterioration and police involvement (Jeraj et al., 2015).

Furthermore, participants explored another barrier to accessing services and the use of police involvement in a crisis as a last resort when they highlighted that Eurocentric support is only available to those that seek it. Many recognise that support is out there for mental ill-health but agree that this support can only be utilised when the individual suffering with poor mental health seeks it, as this is how Eurocentric services are setup. This can be a difficult situation to tackle as at times individuals find it hard to access services independently to report and recognise symptoms of mental ill-health (McCabe & Leas, 2008). Another central finding within this current study was that participants experienced

mental health services to hold dominate Eurocentric narratives. Participants found that services were rigid and not culturally sensitive. In addition, they reported that when services attempted to consider culture this was done in an inept and too generalised way. The findings from this study are supported by Tucker et al. (2011) who reported that there are links between how clients perceive providers' cultural sensitivity and how well they adhere to interventions recommended by those providers. They emphasised the importance this has on health behaviours and outcomes, and therefore suggested the significance of having a model that is patient-centred and culturally sensitive (Tucker et al., 2011). Furthermore, participants expressed that at times professionals did not seem to place enough importance on faith and the role of family, which can often discourage Somalis from seeking support. From earlier points made, participants emphasised the importance of intersectionality whereby it can be inferred that the language that professionals adopt should take into account religious and cultural terms/values. These concerns raised by participants are shared by Sue (2001) who expressed that monocultural policies and practices create invisibility for other diverse cultural groups. Similarly to Sue (2001), the current study endorses the cultural competence model to be extended whereby knowledge, skills and awareness are nurtured.

As Tucker et al. (2011) emphasise, it is not enough to just 'know' about a culture; you also have to demonstrate a 'sensitivity' towards the culture's needs. Perhaps participants highlighted the lack of cultural representation of Somali professionals in the mental health field as a way to underline the limited knowledge, skills and awareness of cultural competence and sensitivity of the existing professionals in the mental health field. One study emphasised the importance of having cultural representation within services in order to reduce the barriers and enhance care pathways, as a means to bridge the gaps in the understanding of the role of culture and race within mental health (Sass et al., 2009). For example, some participants expressed that more Somali professionals are needed in mental health as they would be able to provide a more balanced and trusted view. It could be

suggested that Somali professionals in the mental health field could help to promote cultural sensitivity and competence towards the Somali community within their services, for example by promoting training and workshops for other professionals.

4.6 The Relationship between Somali Refugees and Professionals

Participants raised a significant point within this theme when they expressed a sense of apprehension with regard to the ethos of professionals. Some of the participants expressed a sense of fear and worry that the professionals might not have their best interests at heart and might offer inept care. This is a well-documented finding within BAME communities who they share a sense of distrust towards the health care systems (Keating et al., 2002; Rabiee & Smith, 2013). These apprehensions contribute to the attitude Somalis and other BAME communities have in relation to mental health services and the professionals that deliver them (McLean et al., 2003). The participants expressed a similar view to McLean et al. (2003) that some of the distrust is based on the racial mistreatment they expect from professionals.

Looking closely at the data, participants described how misunderstandings between Somali refugees and professionals have increased distress, fear and suspicion. For example, one of the participants recounted how the assessment process for his wife took years due to misunderstandings between her and professionals. The process to recognise her mental ill-health became lengthy, which forced the participant to get his wife assessed at a private hospital. The misunderstandings mentioned by this participant were shared by others in the study. Participants described that these misunderstandings are due to professionals failing to recognise cultural stigmas, being unaware of cultural variations of distress, and lack of transparency on the part of Somalis due to shame and stigma. Similarly, other studies highlighted that there are cultural variations in expressing and help-seeking for distress and applying a Western concept to individuals from BAME communities allows for misunderstandings to arise that can prevent effective support (Biswas et al., 2016;

Fernando, 2014; Gopalkrishnan, 2018). Perhaps involving family members can mediate these misunderstandings that participants highlighted from their experiences.

On the other hand, participants articulated that collaborations between professionals and the Somali communities can empower others and resolve misunderstandings. One study shared the same views and suggested the need to present a more positive view of mental health care to BAME communities by linking with community groups and local leaders (Appleby, 2008). Furthermore, as mentioned earlier, Codjoe et al. (2019) emphasise the need to collaborate and co-design acceptable programmes with cultural sensitivity and competence that will reach BAME communities. Participants articulated the need for greater mental health awareness directed towards the Somali community. Vahdaninia et al.'s (2020) systematic review suggested that mental health services designed for BAME communities are practicable and achievable, following a community-based research study. Vahdaninia et al. (2020) emphasise the importance of mental health services designed for BAME communities not being based in settings such as clinics but rather in community centres and schools to reduce the stigma that hospitals carry for certain cultures. Participants in the present study also expressed the need for mental health services to be more inclusive. This is in line with findings from Kovandžić et al. (2011) who suggest the need to provide more holistic and socially conscious care in mental health services.

Lastly, participants suggested ways to improve access to mental health services and collaboration with professionals. Similarly to previous research and points made earlier, participants voiced a need for more cultural representation from young Somalis as they were seen to be able to bridge the gap between the Somali community and professionals (Sass et al., 2009). Moreover, the participants emphasised a need to train non-Somali professionals to improve competency (Sue, 2001). Participants also added that more research should be carried out within Somali communities on how to improve training programmes for professionals and Somalis (Pratt et al., 2017). Pratt et al. (2017) showed how training Somali community health workers in delivering CBT improved acceptability and promoted a positive

view of mental health for the Somali participants. Furthermore, participants in the study reported significant improvements in mood, stress reduction, anger management and gained skills in problem solving (Pratt et al., 2017). Participants also mentioned the importance of adopting media as a way to increase awareness of how to seek help for mental ill-health, highlighting the use of YouTube and television (Dietrich et al., 2006).

4.7 Strengths and Limitations

4.7.1 Strengths

A significant strength of this study was that it aimed to explore how Somali refugees in the UK understood mental ill-health and the available support and treatment as well as how they experienced help-seeking. Current literature highlighted the high prevalence of mental health issues and barriers to accessing mental health care within the Somali refugee community (Bhui et al., 2006; McCrone et al., 2005). However, the existing research on this population was generated mostly from other countries such as the USA, Canada, Finland, Norway and Australia. This study was able to address a particular problem within the Somali refugee community residing in the UK by heightening our understanding of the prevalence of mental health issues within the group and barriers to accessing mental health care. Moreover, the study deepened our understanding of what is happening with the Somali refugee communities and multiple generations of this community. Therefore, this study was able to offer a novel understanding of their perceptions and experiences of mental ill-health and mental health care.

Another strength of the study was its methodological consideration of conducting culturally appropriate research. The study adopted the ‘Concepts of Cultural Competence of Research’ model which addresses four concepts that demonstrate how to conduct culturally competent research (Papadopoulos et al., 1998). The four concepts of the model were: cultural awareness, cultural knowledge, cultural sensitivity and cultural competence (Papadopoulos et al., 1998). This approach allowed the development of research that was

culturally sensitive and respectful of the Somali refugee community in the UK. The aim of the study from the beginning was for the Somali refugee community partaking in the study to benefit from it rather than it causing potential harm (Cram, 2009). This process meant that there was active engagement of reflexivity throughout the process in relation to culture, power relations and identity. Moreover, there was an active avoidance of practising essentialism in the research process but instead a push to seeking cultural knowledge. Therefore, participants were viewed more as partners and power relations were often contested (Lee, 2001). During the research process trust and respect was earned via Somali community brokers (Patel, 1999), which allowed participants to trust and respect the researcher. Somali community brokers were involved in the design of the interview process, development of the interview schedule and the recruitment process. This allowed participants to join a study that was aiming to be accepting, welcoming, sensitive and respectful. Furthermore, Kauffman (1994) expressed that matching the cultural backgrounds of the researcher and participants may allow for beneficial conditions, and this may have benefitted the current study.

In addition, the chosen method of a hybrid approach to TA allowed the inclusion of existing literature related to the research question in developing a codebook, while also allowing for a flexible and organic coding approach to be utilised (Fereday & Muir-Cochrane, 2006). A strength of this process could have been that it potentially produced a comprehensive and meaningful understanding (Willig, 2013). Also, the study allowed for both genders to be evenly represented as well as a diverse age group ranging from 28 to 63 years.

4.7.2 Limitations

One limitation of the study could be that the participants who self-selected to participate in the study had a common experience that ‘forced’ them to reconcile the realities of mental ill-health. Therefore, they may have appeared to be more willing to share and be involved in discussing mental health, illustrating a level of acceptance of the situation. This may not be

generalised to those in the Somali refugee community residing in the UK who are not presently as accepting of mental ill-health. This study highlights that there is a need to engage Somali refugees in the UK who are not as accepting of mental ill-health, as their voices may have not been heard directly. However, participants in the current study were able to offer a window onto what these voices may sound like through sharing their experiences of family members and other members of the community who were not as accepting of mental ill-health. The study also highlights strategies that could engage them in the process of change described by the participants in the current study.

Another limitation of the study could have been that the recruitment process was strenuous and slow. This may have been due to the distrust in the Somali community towards professionals, the topic of mental health, research, and other poor experiences with professionals (Lee, 2001; Rabiee & Smith, 2013). Therefore, as mentioned earlier, it was important to build trust and respect with Somali community brokers and participants. This involved contacting and visiting different Somali community centres, joining groups there to further explain the study, and spending considerable time on designing the interview schedule in settings with brokers. It took over a year to develop these relationships and finally recruit participants. Despite the long period of time, it was important to follow a natural process in gaining and building trust and mutual respect.

As a final possible limitation, holding the same Somali cultural background as the participants may have activated stigma in the interview process as mental health is a stigmatising topic in the Somali community. The key findings from this study highlighted that the level of shame and secrecy of mental ill-health seemed to be a powerful component linked to stigma in the Somali community. It is important to reflect on how this may have impacted the interview process and whether participants were able to fully share all of their perceptions and experiences related to mental ill-health. This may be the reason why participants were able to share the experiences of others, whether this be family or friends, rather than their own experiences. There were moments in some interviews when certain

participants hinted at how their own mental health had been impacted by the experiences of others. However, participants were never pushed to go beyond what they were willing to disclose as simply sharing a snippet was a meaningful experience for them personally. This was often brought up in the reflexive process and the attempt to embrace an insider/outsider position with participants (Hammersley & Atkinson, 2019).

4.8 Implications for Clinical Practice and Future Research

4.8.1 Implications for clinical practice

The findings of the current study have significant implications for clinical practice. The study highlighted several issues within mental health services, mental health professionals and the overall health care structure. The study highlights potential areas to be addressed in order to increase service delivery, utilisation and sensitivity. In addition, the study suggests how to offer services that tackle the fears, anxieties and suspicion of the Somali refugee community. The issues and suggestions are as follows:

1. Mental health providers could collaborate with Islamic religious leaders to reduce the stigma associated with mental ill-health and the assumptions that mental ill-health is behavioural or a sign of weak faith. Informed religious leaders could have significant impact as they hold trust and respect within the Somali community. Involving religious leaders in mental health services in the UK can improve access in the community. As discussed, faith is a central element in the Somali community. Informed religious or community leaders as brokers/gatekeepers could be the active solution that is needed to motivate and encourage those who are reluctant to seek support, as they could potentially best prepare and support an individual or their concerned family members in accessing services.
2. The implications of shame and secrecy regarding mental ill-health in the Somali community should be considered in any new developments that aim to help the community access mental health care, as this seems like a prominent barrier. This

could mean external mental health providers or community organisations being more sensitive to using less stigmatising language when delivering mental health awareness, for example, using the term ‘emotional well-being’ rather than ‘mental health’.

3. The process of change reported in the study highlights a need to engage others in the Somali community who may be able to progress in this way. Therefore, delivering information on mental ill-health and services through Somali media sources and YouTube in the Somali language may be a way for mental health providers to initiate this process of change for others in the Somali community.
4. The COVID-19 pandemic has taught us many new ways of delivering support, such as via social media. The importance of language in talking about mental health is key, as is making use of culturally familiar and relevant conduits. These new ways of supporting could be used to reach and support the Somali community.
5. Mental health campaigning is needed specifically to address the Somali community using Somali community members.
6. Funding of more community-based research within the Somali community about how to improve training programmes for professionals and Somalis is needed.
7. Encouraging co-production can empower the Somali community to work from within to meet their needs. Furthermore, a community-based participatory research (CBPR) approach would help create a partnership between the Somali community members, researchers, and organisational representatives, and allow for all to share their expertise to co-create and co-produce knowledge to help the Somali community.
8. Professionals need to branch out of mental health service settings and engage with community-based resources, participating in more community social events and when possible providing services within Mosques and community centres. This requires collaboration with community services and community-based programs.

This will allow mental health services to improve their acceptability and to ascertain accessibility.

9. There is a need to continue the work of demystifying the different prejudices that mental health professionals and institutions hold but also to promote agency within Somali communities by sharing information about all available services and treatments so that the community can make a more informed choice about the support it requires.
10. There is a need to review primary care services that are often the gatekeepers in accessing specialised mental health services, as the intersectionality of race, gender, social class and religion appears to play on the Somali community's ability to access good mental health care.
11. There is a need to improve communication with services, the client and the families involved. Perhaps the implementation of simple guidance in the form of leaflets highlighting practices and their importance may reduce the feeling of being disconnected to the process.
12. There is a need for more cultural representation from young Somali professionals as they can be seen to be able to bridge the gap between the Somali community and mental health professionals Recruiting Somali professionals in the mental health field could help to promote cultural sensitivity and competence towards the Somali community within mental health services. This might be done through promoting training and workshops for non-Somali professionals.

4.8.2 Recommendations for future research

Following on from this study are some recommendations for future research that focus further on how Somali refugees in the UK understand and experience mental ill-health and mental health services. The first recommendation is an issue that was highlighted in the methodology chapter (2.3.3) with regard to the fact that interviews were not conducted in the Somali language due to a lack of fluency and confidence on the part of the researcher, and

not being able to fund interpreters and transcribers. Somali community brokers were involved in the design of the interview process and the researcher discussed that the implications of not interviewing in the Somali language would make the study inaccessible to those members of the Somali refugee community not fluent in the English language. Therefore, it is important for future studies to involve more groups from the Somali refugee community not fluent in the English language, so that their voices can also be heard.

Another recommendation is to look more to the second-generation Somali community in the UK, as participants referenced them as being able to bridge the gap between the Somali refugee community and mental health services and professionals. Many intergenerational differences were highlighted in the study and this may be a direction further studies could follow.

Finally, it could be suggested that community-based participatory research could be an appropriate methodology to next employ when partnering with the Somali refugee community. This would help to increase knowledge and understanding of how mental ill-health could be integrated into policies, interventions and social change for the Somali community.

4.9 Overall Reflections on the Research Process

There were many motivations that guided me in researching the Somali refugee community. Throughout my life as a second-generation Somali I have witnessed how mental health is talked about and managed within my family and some parts of the community, and how it influenced my perception over many years. It was silent yet mighty with its influence. As I began working in the mental health field, I noticed that I had no interactions with the Somali community despite working in a London Borough that was home to a large Somali community. As I gained this opportunity to conduct research and potentially have influence, it was important to address the Somali refugee community.

I have felt encouraged and motivated in the research process by supervisors and colleagues who have shared similar interests in lifting up marginalised groups in society. The research journey has impacted me greatly and the participants have left me truly inspired. I understand the difficulties in talking about mental ill-health, especially when from a BAME background. However, participants have shown great courage in sharing their insights and experiences. Some even expressed that they had never had the opportunity to talk about how these experiences affected them. A particular moment that has been hard to forget was when one participant expressed after the interview that he had never discussed the impact of his brother's mental ill-health with anyone despite now being 60 years old and that he felt his voice did not matter. It was during these moments that I was reminded about the significance of this work and how important it was to truly allow the voices of the participants to be heard and not be lost in the research process. This allowed me to be mindful in my approach when capturing and analysing the data.

One of the challenges during the research process was the lengthy recruitment process. However, I was able to build many connections during the process that still remain valuable today, as the Somali community leaders also wanted to remain in touch and were happy with the idea of disseminating the findings in their centres. This process has activated a desire to pursue work that can influence social change.

Another challenge during the research process was the pandemic and how it affected recruitment, as participants who initially agreed to participate had to withdraw due to the inevitable difficulties and hardships that came with the pandemic. Moreover, the community centres where I had recruited and interviewed participants had gone into lockdown just like the rest of the country. It was particularly difficult working on the writing-up process during the pandemic as the uncertainty, fear and isolation often clouded other priorities. But I was often reminded of the importance of this work and it has been worth it. The research process has opened my eyes to the experiences of some Somali refugees in the UK.

4.10 Conclusions

This research has looked at how mental ill-health and available treatment is understood by Somali refugees living in the UK, as well as how they experience help-seeking. The findings from the present study corroborated those of the existing literature and several new insights were also gained to add to the literature on the Somali refugee community in the UK. The present study highlighted the process of change expressed by participants and how pivotal moments in their life opened them up to increasing their awareness of mental ill-health. The study emphasises how we can empower the Somali refugee community, as well as how the Somali community can empower themselves from within to meet the needs of the community through co-production. Moreover, this study has shown the effects of oppressive practices and systemic and structural problems that highlight the inequalities in mental health care, as a prominent finding was how the intersectionality of race, gender, social class and religion appears to play on the Somali community's ability to access good mental health care in the UK.

This study is of value to the field of counselling psychology, as it offers insight on how to improve access and utilisation of mental health services in the UK. This includes psychological therapies that may not be as accessible to BAME communities. The findings of the current study have significant implications for clinical practice and offer potential suggestions on how these may be addressed in order to increase service delivery, utilisation, cultural competence and sensitivity towards the Somali community in the UK. As counselling psychologists, we need to move towards a more reflective stance as cultures are in constant evolution (Woolfe (2016). This study has been able to share power and provide voice, which fits the ethos of counselling psychology (Goodman and Kirkwood, 2004). The hope is that this study can engage in furthering the development of anti-oppressive practice in the mental health care system in the UK. The findings of the study will be disseminated in several ways. A lay summary in a PowerPoint presentation will be created and shared with participants who checked 'yes' in the consent form to receiving a summary of the findings

and outcomes once the study had been completed. The PowerPoint presentation will also be disseminated to the Somali community organisation that I am working with and shared with the community and their partners in the area. There have been talks about disseminating the findings to the Somali community centres from which I recruited participants. This research and the findings can have relevance beyond the counselling psychology field as participants were able to bring a wide range of social issues to this research, from housing, migration, challenges with acculturation to discrimination and racism. Participants were able to show how all these issues, such as overcrowded housing, interlinked and were related to mental ill-health. Therefore, this research is also relevant to reports such as Jones and Mullins (2009) who suggest that housing services for refugee communities are better delivered and targeted when Refugee community organisations are involved in co-production and that these partnership initiatives can influence local and national policy.

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Appendices
Appendix A: Recruitment Advertisement

Department of *Psychology*
City, University of London

PARTICIPANTS NEEDED FOR RESEARCH IN EXPLORING HOW SOMALI REFUGESS IN THE UK PERCEIVE AND EXPERIENCE MENTAL HEALTH AND TREATMENT

We are looking for volunteers to take part in a study of
Somali refugees' perceptions and experiences of mental health and treatment after migration.

As a participant in this study, you would be asked to: be available for the initial phone call which should take no longer than 15 minutes. Then if appropriate for the study you will need to take part in the 90 minutes interview with the researcher.

Your participation would involve *2* sessions,
each of which is approximately *15* minutes for the phone screening and 90 minutes for the interview.

In appreciation for your time, you will be automatically enrolled in a raffle. The raffle will be a £30 amazon voucher.

For more information about this study, or to volunteer for this study,
please contact:
Hayat Hussein (Researcher) or Jessica Jones Nielsen (Research Supervisor)
(Department of Counselling Psychology)
at
Email: *hayat.hussein@city.ac.uk*

This study has been reviewed by, and received ethics clearance
through the Research Ethics Committee, City, University of London.

If you would like to complain about any aspect of the study, please contact the Secretary to the Senate Research Ethics Committee on [redacted] or via email: [redacted]

City, University of London is the data controller for the personal data collected for this research project. If you have any data protection concerns about this research project, please contact City's Information Compliance Team at dataprotection@city.ac.uk

Appendix B: Interview Schedule

1. How did you get to the UK and how long did it take you to get here? How long have you been here?

2. How would you describe mental health? How do you think that happens?

3. If you or someone you know have a mental health issue, What do you think about seeking help? Where do you go? How do you go about it?

4. Before moving to the UK did you see others with mental health problems?

5. What do you think about how mental health issues are managed in the UK? What do you think about the mental health care system in UK? Have you had any experiences with this?

6. How would/do you manage your mental health needs in the UK? Would you discuss it with anyone?

7. If anyone in your family had an issue with their mental health, how do you think your family would respond? How do you think your community would respond?

Appendix C: Participant Information Sheet

Title of study: An Exploration of How Somali Refugees in the UK Perceive and Experience Mental Health and Treatment: A Thematic Analysis

Name of principal investigator Hayat Hussein (Research Student)**,** Jessica Jones Nielsen (Principal Supervisor)

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

The research will aim to explore UK Somali refugees' perceptions and experiences of mental health and its treatment. Individual interviews will be conducted and should not take longer than 90 minutes.

Why have I been invited?

- *First generation Somali refugees (born in Somalia)*
- *Proficient in speaking the English language*
- *Aged 18 years and older*

Do I have to take part?

Participation in the project is voluntary, and you can choose not to participate in part or all of the project. You can withdraw at any stage of the project without being penalised or disadvantaged in any way.

It is up to you to decide whether to take part. If you do decide to take part, you will be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason.

What do I have to do?

An initial short phone call with the researcher. This is to see whether you fit the inclusion criteria of the research and if you feel comfortable to take part.

To attend an audio recorded interview that should last for roughly 90 minutes. The questions will consist of how you experience and perceive mental health and treatment as a Somali refugee and how you have dealt with these experiences.

What are the possible disadvantages and risks of taking part?

The questions asked will involve potential difficult times such as life as a refugee and any psychological issues that have affected you. This may cause you discomfort or distress during the process.

What are the possible benefits of taking part?
This research will hope to identify what would be helpful for the Somali community in the UK to work with mental health services. As well as practitioners understanding how counselling psychology can be culturally sensitive to non-western coping strategies.

What will happen when the research study stops?

The records will be stored, usually 10 years at City, University of London. Audio recordings from the interview will be destroyed.

Will my taking part in the study be kept confidential?

- The researcher (Hayat Hussein) and principle supervisor (Jessica Jones Nielsen) will have access to the research data
- Audio recordings will only be accessed by the researcher and destroyed once transcribed
- Personal data will be kept confidential
- The identities of the participants will be kept anonymous. It will be explained to the participant that this is a free confidential space however if the researcher feels that the participant is at risk of harm to self or others it will be passed onto the relevant professionals
- No data will be shared with outside organisations
- The records will be stored, usually 10 years at City, University of London

What should I do if I want to take part?

If you are interested in taking part in the study, please contact the researcher Hayat Hussein to arrange an initial phone screening to discuss whether it is appropriate for you to participate. You will then be sent over a consent form to read and will sign this on the day of the interview.

What will happen to results of the research study?

Once the study has been analysed and the results are anonymised you will be able to request a copy of the results summary from the researcher Hayat Hussein. This research may be published in the future, and anonymity will be maintained

What will happen if I do not want to carry on with the study?

You will have the right to withdraw from the study at any point and there will be no penalty resulting from this.

Who has reviewed the study?

This study has been approved by City, University of London Research Ethics Committee

Further information and contact details

Hayat Hussein (Research Student) - hayat.hussein@city.ac.uk
Jessica Jones Nielsen (Research Supervisor) - jessica.jones-nielsen@city.ac.uk

Data Protection Privacy Notice: What are my rights under the data protection legislation?

City, University of London is the data controller for the personal data collected for this research project. Your personal data will be processed for the purposes outlined in this notice. The legal basis for processing your personal data will be that this research is a task in the public interest, that is City, University of London considers the lawful basis for processing personal data to fall under Article 6(1)(e) of GDPR (public task) as the processing of research participant data is necessary for learning and teaching purposes and all research with human participants by staff and students has to be scrutinised and approved by one of City's Research Ethics Committees.

What if I have concerns about how my personal data will be used after I have participated in the research?

In the first instance you should raise any concerns with the research team, but if you are dissatisfied with the response, you may contact the Information Compliance Team at dataprotection@city.ac.uk or phone [redacted], who will liaise with City's Data Protection Officer [redacted] to answer your query.

If you are dissatisfied with City's response you may also complain to the Information Commissioner's Office at www.ico.org.uk

What if there is a problem?

If the research is undertaken in the UK if you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through City's complaints procedure. To complain about the study, you need to phone [redacted]. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: .....
……
You could also write to the Secretary at:

[redacted]
Research Integrity Manager
Research & Enterprise
City, University of London
Northampton Square
London
EC1V 0HB
Email: [redacted]

City holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study, you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Thank you for taking the time to read this information sheet.

Appendix D: Consent Form

Title of Study: *An Exploration of How Somali Refugees in the UK Perceive and Experience Mental Health and Treatment: A Thematic Analysis*

Please initial box

1	I confirm that I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records.	
	I understand this will involve:	
	• be interviewed by the researcher	
	• allow the interview to be audiotaped	
	• complete questionnaires asking me about my age, race, gender, ethnicity and occupation	
	• make myself available for a further interview should that be required	
2	This information will be held by City as data controller and processed for the following purpose(s): Public Task: The legal basis for processing your personal data will be that this research is a task in the public interest, that is City, University of London considers the lawful basis for processing personal data to fall under Article 6(1)(e) of GDPR (public task) as the processing of research participant data is necessary for learning and teaching purposes and all research with human participants by staff and students has to be scrutinised and approved by one of City's Research Ethics Committees. I understand that the following special category data will be collected and retained as part of this research study: [- *racial or ethnic origin, political opinions, religious or philosophical beliefs]* City considers the processing of special category personal data will fall under: Article 9(2)(g) of the GDPR as the processing of special category data has to be for the public interest in order to receive research ethics approval and occurs on the basis of law that is, inter alia, proportionate to the aim pursued and protects the rights of data subjects and also under Article 9(2)(a) of the GDPR as the provision of these personal data is completely voluntary.	
3	I understand that any information I provide is confidential, and that	

	no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.	
4	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.	
5	I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on City complying with its duties and obligations under the General Data Protection Regulation (GDPR).	
6.	I agree to the arrangements for data storage, archiving, sharing.	
7	I agree to the use of anonymised quotes in publication.	
8	I agree to take part in the above study.	
9	I would like to be sent a summary of the findings and outcomes once the study has been completed.	

_____	_____	_____
Name of Participant	Signature	Date

_____	_____	_____
Name of Researcher	Signature	Date

Appendix E: Demographic Form

Demographics

1. Age: What is your age?

   ……

2. Gender: What is your gender?
   a. Male
   b. Female

3. Occupation: Are you employed? What is your job if you are employed?

   ……

Appendix F: Debrief Sheet

DEBRIEF INFORMATION

An Exploration of How Somali Refugees in the UK Perceive and Experience Mental Health and Treatment: A Thematic Analysis

Thank you for taking part in this study. Now that it's finished, we'd like to tell you a bit more about it.

This research was carried out to explore how Somali Refugees in the UK perceive and experience mental health and treatment. Interviews were conducted to gain in-depth rich detail of these experiences, giving a voice to a marginalised group. The research could potentially support our understanding and identify ways in which Somali refugees cope with migration and settlement in the UK. The study findings could provide a better understanding of how Somali refugees manage their mental health, and enhance service delivery and aid mental health practitioners to design more effective and culturally sensitive mental health treatments for this group.

If the research might have raised concerns for you, please contact the researcher Hayat Hussein (hayat.hussein@city.ac.uk), the support lines provided below or contact your GP.

- *Mind- 0300 123 3393*
- *Samaritans- 116 123*
- *SANEline- 0300 304 7000*

We hope you found the study interesting. If you have any other questions please do not hesitate to contact us at the following:

Hayat Hussein (Research Student) - hayat.hussein@city.ac.uk

Jessica Jones Nielsen (Research Supervisor)- jessica.jones-nielsen@city.ac.uk

Ethics approval code: *[ETH1819-0223]*

Appendix G: Codebook

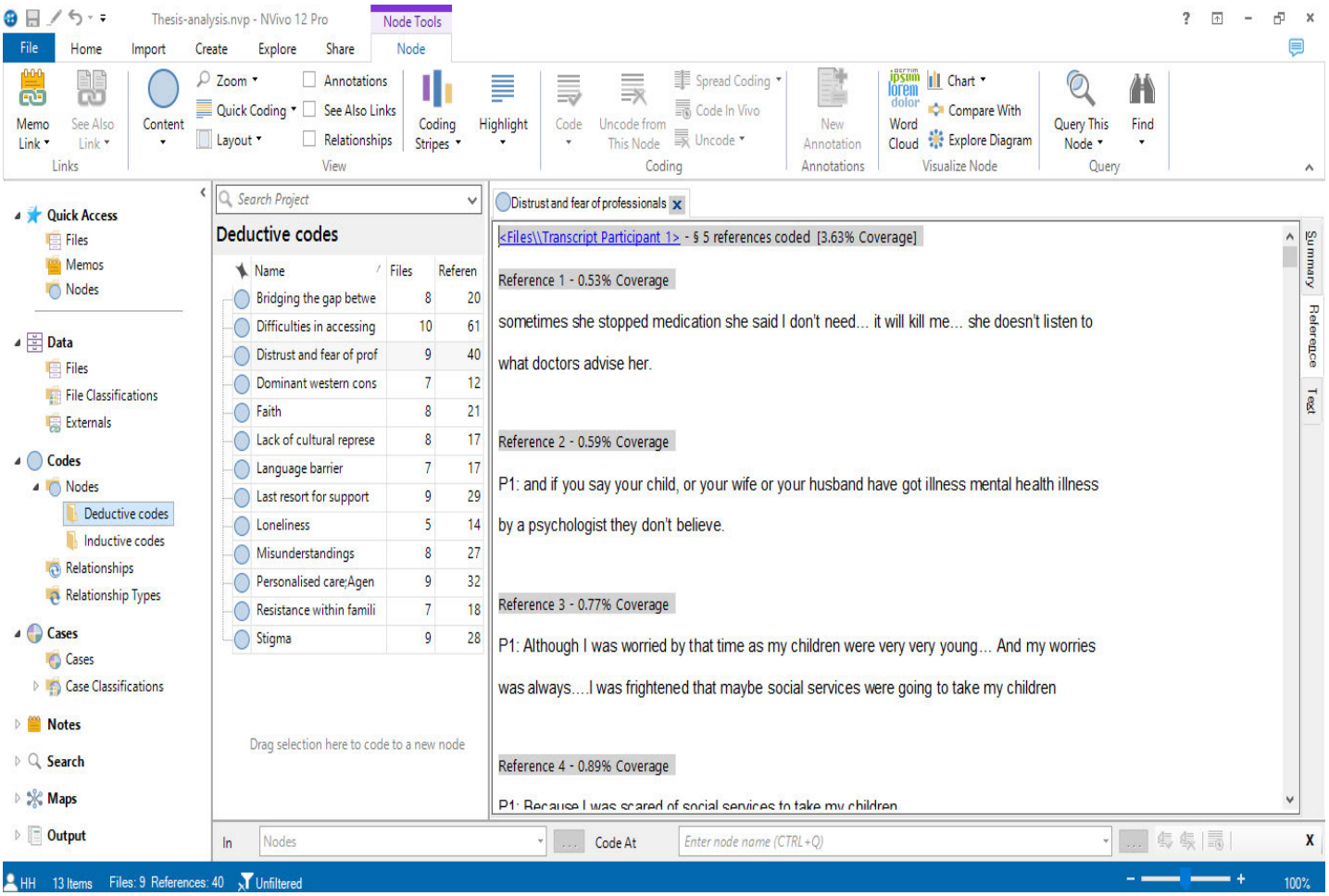
Name	Description	Files	References
Bridging the gap between cultures	Bridging the gap between cultures is described as two cultures with differences attempting to find mutual understandings and relationships.	8	20
Difficulties in accessing support	Difficulties in accessing support is described as barriers in getting support from services that are in place to support others.	10	61
Distrust and fear of professionals	Distrust and fear of professionals is described as suspicion of the other which leads to lack of communication between the two groups.	9	40
Dominant Western construct	Dominant Western construct is described as a strong focus on Eurocentric culture and ideas which excludes other worldviews.	7	12
Faith	Faith is described as strong belief in religion based on a strong spiritual conviction.	8	21
Lack of cultural representation	Lack of cultural representation is described as not having a particular population group or demographic represented in a sector such as the mental health field.	8	17
Language barrier	Language barrier is described as experiencing difficulties in communication due to individuals speaking different languages originally.	7	17
Last resort for support	Last resort for support is described as a final course of action when all other attempts for support have failed.	9	29
Loneliness	Loneliness is described as an individual experiencing isolation and a lack of connection with others.	5	14
Misunderstandings	Misunderstandings is described as failing to understand someone or something correctly.	8	27
Personalised care; Agency; voicing preferences	Personalised care; Agency; Voicing preferences is described as empowering others to have choice about the care they receive. Therefore, allowing others to express what matters to them.	9	32
Resistance within families	Resistance within families is described as families refusing to be open to cooperate with each other in making decisions.	7	18

Name	Description	Files	References
Stigma	Stigma is described as shame, disgrace, or any negative association towards a personal circumstance. This can potentially make the personal circumstance worse or stop a person from seeking help.	9	28

Appendix H: Frequency of Codes Identified in Transcript 1

A priori code	Frequency
Distrust and fear of professionals	17
Stigma	16
Personalised care/Agency/Voicing preferences	13
Misunderstandings	12
Bridging the gap between cultures	11
Dominant Western construct	10
Last resort for support	10
Loneliness	9
Resistance within families	7
Difficulties in accessing support	6
Lack of cultural representation	5 *These codes are frequent in other transcripts
Faith	5
Language barrier	5

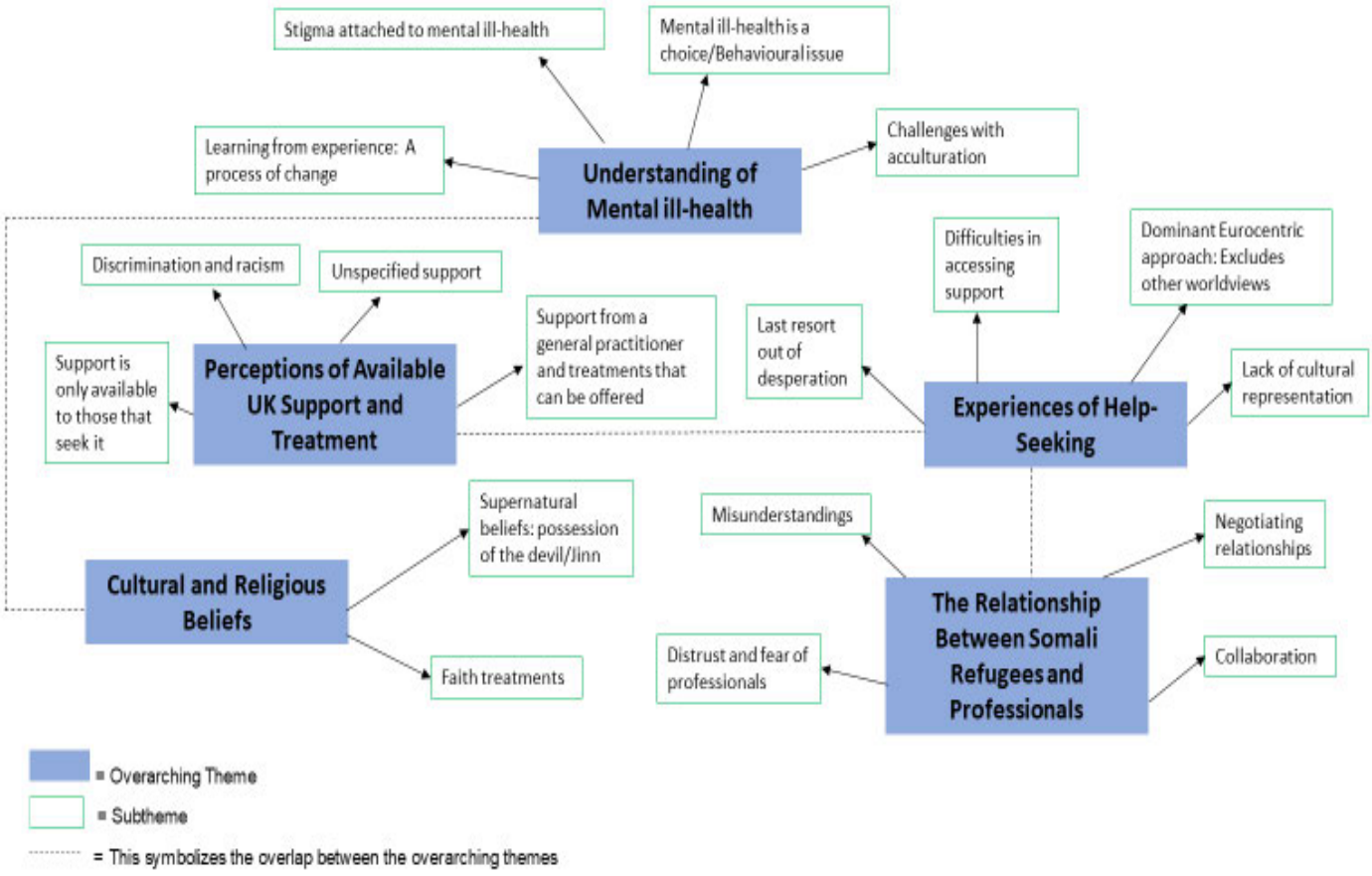
Appendix I: NVivo 12 Software Example



Appendix J: Example of Inductive Codes

Name	Description	Files	References
A change of environment helps	This describes that a change of environment can aid in treating an individual dealing with mental ill-health.	2	5
Adds pressure to the family	This describes that mental ill-health can impact family members negatively.	9	30
Available support relieves the family	This describes that available support and treatment for mental ill-health in the UK can provide relief for family members who are negatively impacted by their family members' mental ill-health.	2	2
Behavioural issue	This describes that mental ill-health is a choice and that the person has control of their actions – that mental ill-health is a behavioural issue.	6	22
Combination of psychology and medicine as treatment	This describes that integrating psychological and pharmacological treatments provides positive outcomes in treating mental ill-health.	3	5
Culture clash	This describes a conflict arising from cultural differences in Somali and British culture.	5	14
Desire to remain hidden	This describes an individual who wants to keep their problems out of sight from others.	7	31
Differing opinions within the Somali community	This describes that there are many conflicting opinions within the Somali community regarding mental ill-health.	7	18
Discrimination and racism	This describes being treated differently because of race, and that the result could mean not being offered available support from professionals.	5	6

Appendix K: Final Thematic Map



Appendix L: Code names with supporting quotations

OVERARCHING THEME	CODE NAMES WITH SUPPORTING QUOTATIONS
THEME 1: 'UNDERSTANDING OF MENTAL ILL-HEALTH'	Desire to remain hidden *Liban: 'if they have their problem...they are probably hiding it from me so I wouldn't know'* *Sagal: 'When the man gets married only his family and mother know but they hide it from the new wife. The mother won't admit that there is something wrong with her son even though she knows he has some issues'* *Ayan: 'it's quite hidden and brush under the carpet'* Culture Clash *Hamza: 'the other thing is when we come to this country or Europe or you know America when we came out…ermm there's a difficult…you know the way of life…there's a mix up'* *Filsan: 'back home everyone helps you like the neighbours, you got family, you got friends and the country is free and you don't worry about anything. You talk to each other back home but in this country you don't you don't even know who your own neighbour is. But in back home it's free the door is always open until you close your door at midnight'* *Ayan: 'but we're here in the UK, speaking a new language, interacting with people we've never seen before [ ] they don't look like us, they don't talk like us…it was completely a different barrier'*
THEME 2: 'CULTURAL AND	Traditional ways of healing *Yusuf: 'Ruqyah is a is reading certain specific verses of the Qur'an on the patients in a voice that they can hear'*

RELIGIOUS BELIEFS'	*Maryam: 'Just read Quran on them, you just take care of them yourself, don't take them outside'* *Filsan: 'read the Quran, get closer with Allah and pray. Ask Allah to help you when you wake up in the middle of the night, keep asking because I can see it is not mental'* <u>Spiritual causes</u> *Liban: 'sometimes a lot of the things, the only explanation is faith [ ] know what I mean? Life...sometimes the only explanation is God'* *Ayan: 'you'd think that if something's wrong with someone, if they're acting a certain way, there's like a devil inside them'* *Sagal: 'You hear stories that people say when people are mentally ill, they are possessed by the devil and they don't even take the person to doctors so how do they expect them to get better'*
THEME 3: 'PERCEPTIONS OF AVAILABLE UK SUPPORT AND TREATMENT'	<u>Unspecified support in the UK; lack of awareness of available support</u> *Fadumo: 'that was the most important thing for us, and we didn't know where to go at first'* *Liban: 'in the UK, in mental health crisis…emm…but technically, I don't think it's publicised, it's not in our education system as I said'* *Faisal: 'no information…no way…no guidance'* <u>Only offered medication</u> *Liban: 'the only thing that they have there is just to inject them or give them some sort of medicine to calm them down, that's it'* *Filsan: 'the doctor will only give tablets, they never offer the services available, a GP should offer services before they give*

	medication' *Faisal: 'they put you on medication, behaviour changes, your complete different person'*
THEME 4: 'EXPERIENCES OF HELP-SEEKING'	<u>Dominant Western construct</u> *Yusuf: 'the medical profession has got limited supply of armoury to deal with the issue…but that's the only one that is proven [ ] almost…and acceptable scientifically [ ] and…whatever is outside of that is…is a chance'* *Filsan: ' we are different with our cultures so they need more, that's why it's very very important because they cannot…for example, they say we do a workshop for mental health they got music and this this. But for us it won't work for us in that way. For us we have to talk talk talk but this country if you have music or this it is fun for them. So, they will never really understand us'* <u>Language barrier</u> *Fadumo: 'even I don't have that much knowledge…my knowledge about it is limited so I'm thinking people who are in our community are…you know…English is not their first language and they are not fluent at speaking English and they're not…how are they gonna know?…if I'm not…even aware about it'* *Ali: 'breaking the barriers like language, culture if those kind of things that can help the community to feel confident enough to say what their preferences are'* *Filsan: 'they never understand the language, they cannot speak the language so then they can't go'*
THEME 5: 'THE	<u>Distrust and fear of professionals</u>

REALTIONSHIP BETWEEN SOMALI REFUGEES AND PROFESSIONALS'	*Ali: 'Came across situations of members of family taking back certain family members back home to Somalia where there is absolutely nothing. Rather than seeking treatment in the UK, they would rather take the patient back to the war zone to seek treatment'* *Maryam: 'doctors, the police and all that getting involved...and then the social workers getting involved...they are just scared they might not get that person back'* <u>Misunderstandings</u> *Hamza: 'No they don't like to understand the culture of the community…the culture of the community'* *Maryam:* 'the communication wasn't so great between the health providers and myself' *Liban: 'yeah, it's a shame, I think with the…what we need to understand…the difference between the Western culture and the Somali culture'*

Section B: Combined Case Study and Process Report

Idealised care and compassion: Professionals and mothers

Hayat Hussein

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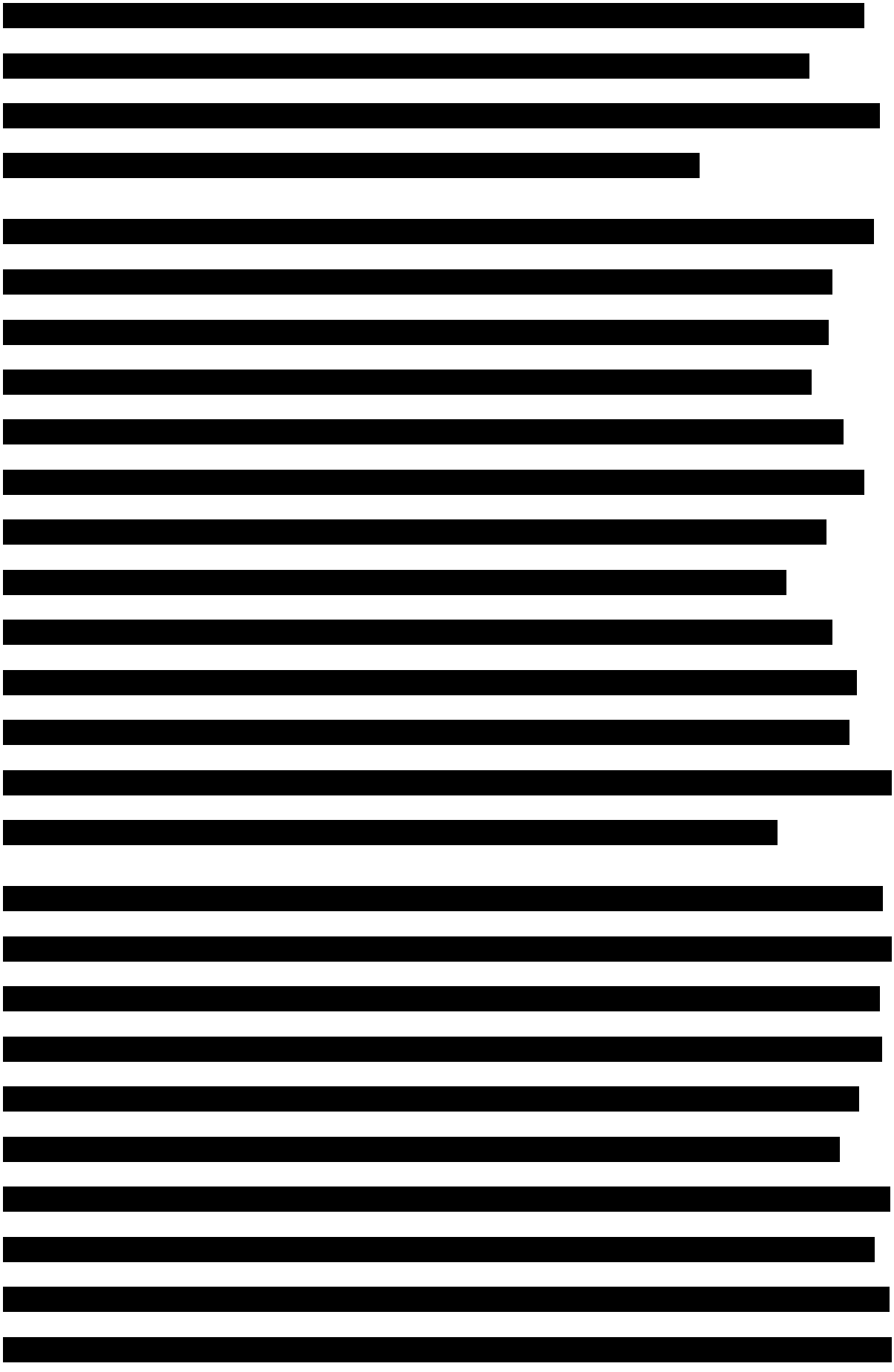

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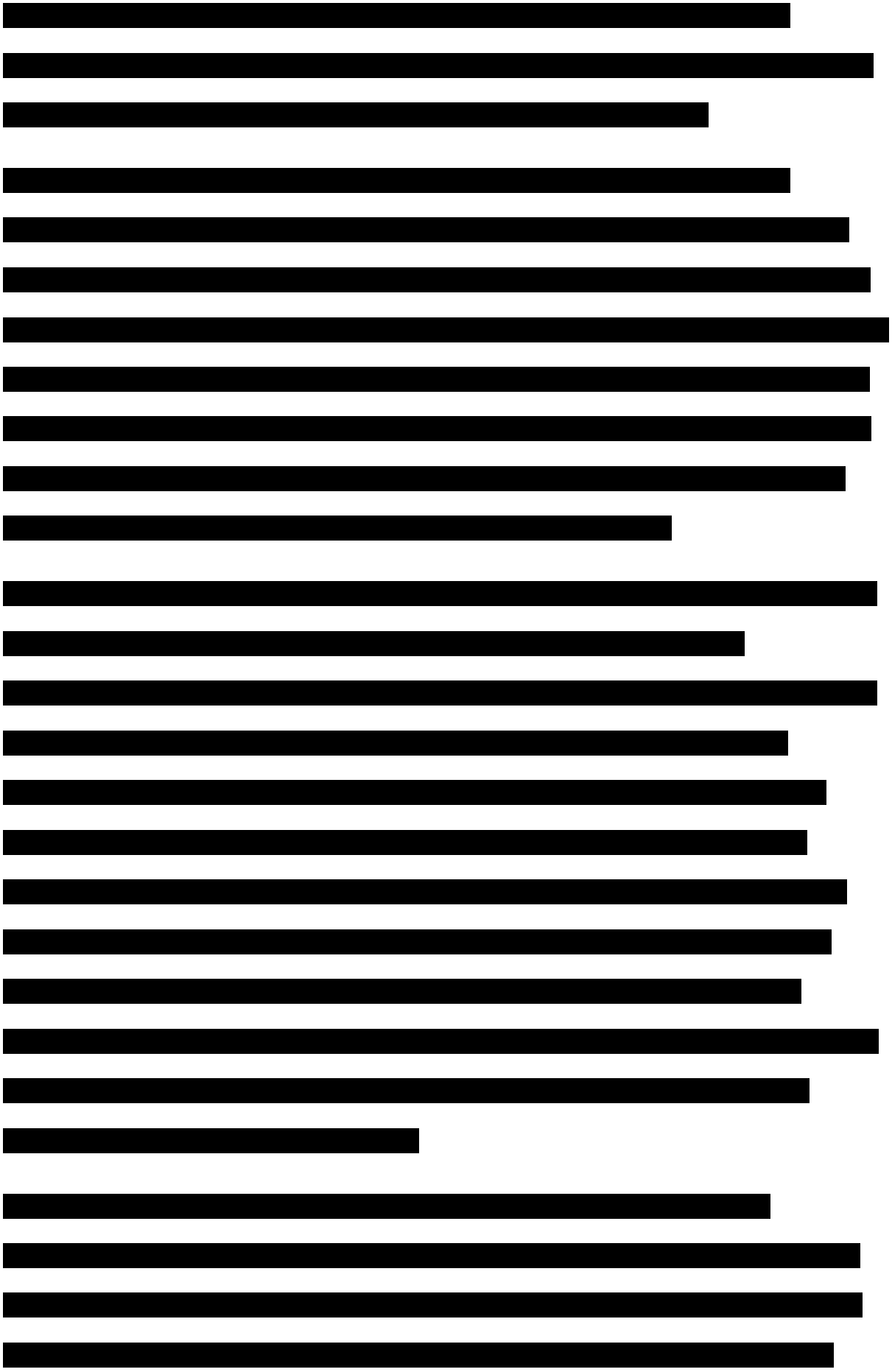

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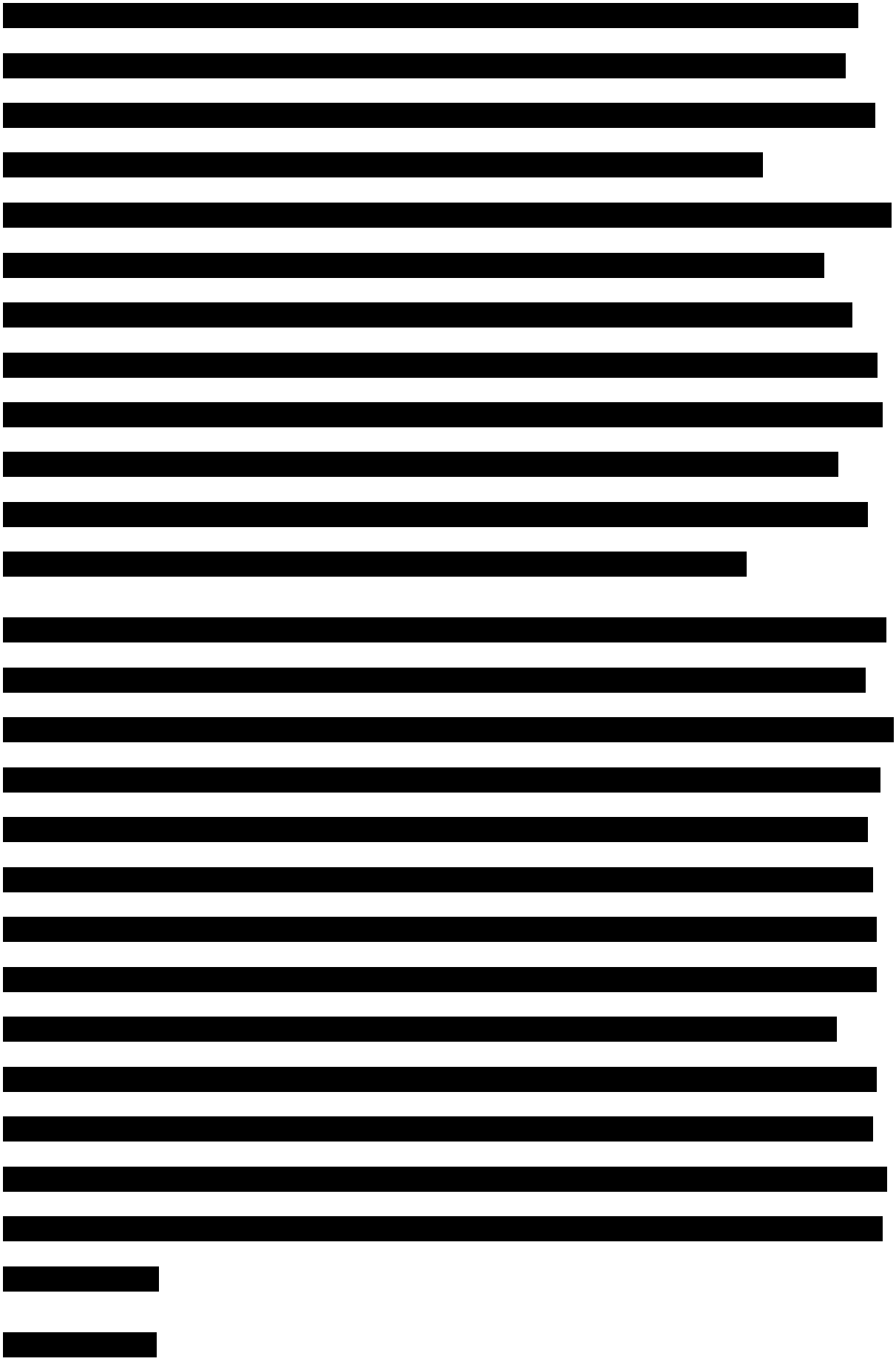

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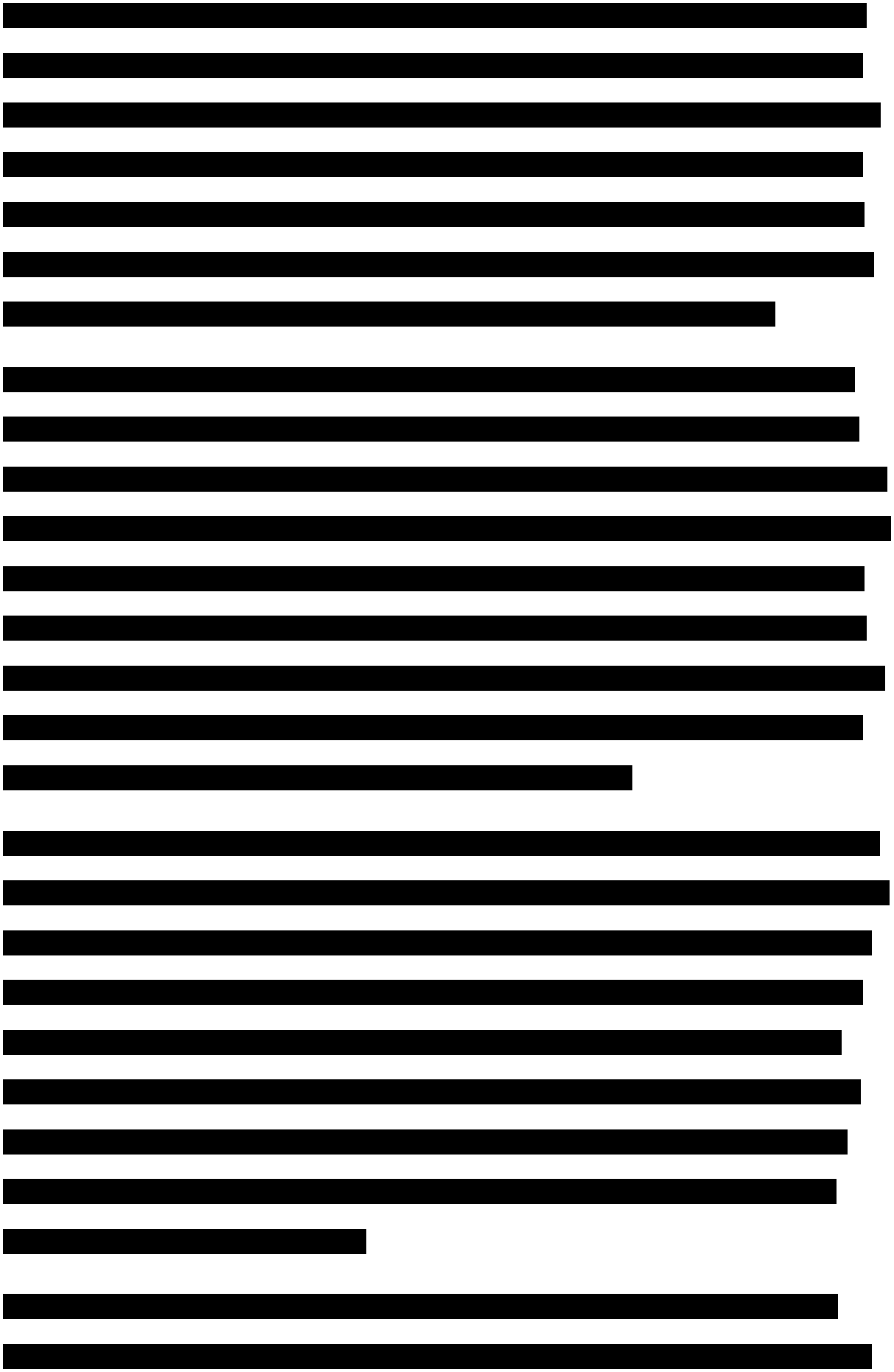

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Section C: Publishable Paper

The dynamic relationship between mental health professionals and Somali refugees living in the UK: From a Somali refugee perceptive

Formatted according to the author guidelines for the *Journal of Health and Social Care Community* (see Appendix A)

The dynamic relationship between mental health professionals and Somali refugees living in the UK: From a Somali refugee perceptive

Hayat Hussein and Jessica D. Jones Nielsen[1*]

1 Department of Psychology, City, University of London, Northampton Square, EC1V 0HB. Email:

Jessica.jones-nielsen@city.ac.uk

*Correspondence concerning this article should be addressed to Jessica Jones Nielsen, Department of Psychology, City, University of London, Northampton Square, London EC1V 0HB, United Kingdom. Phone: +44 (0)20 7040 8755, Email: jessica.jones-nielsen@city.ac.uk.

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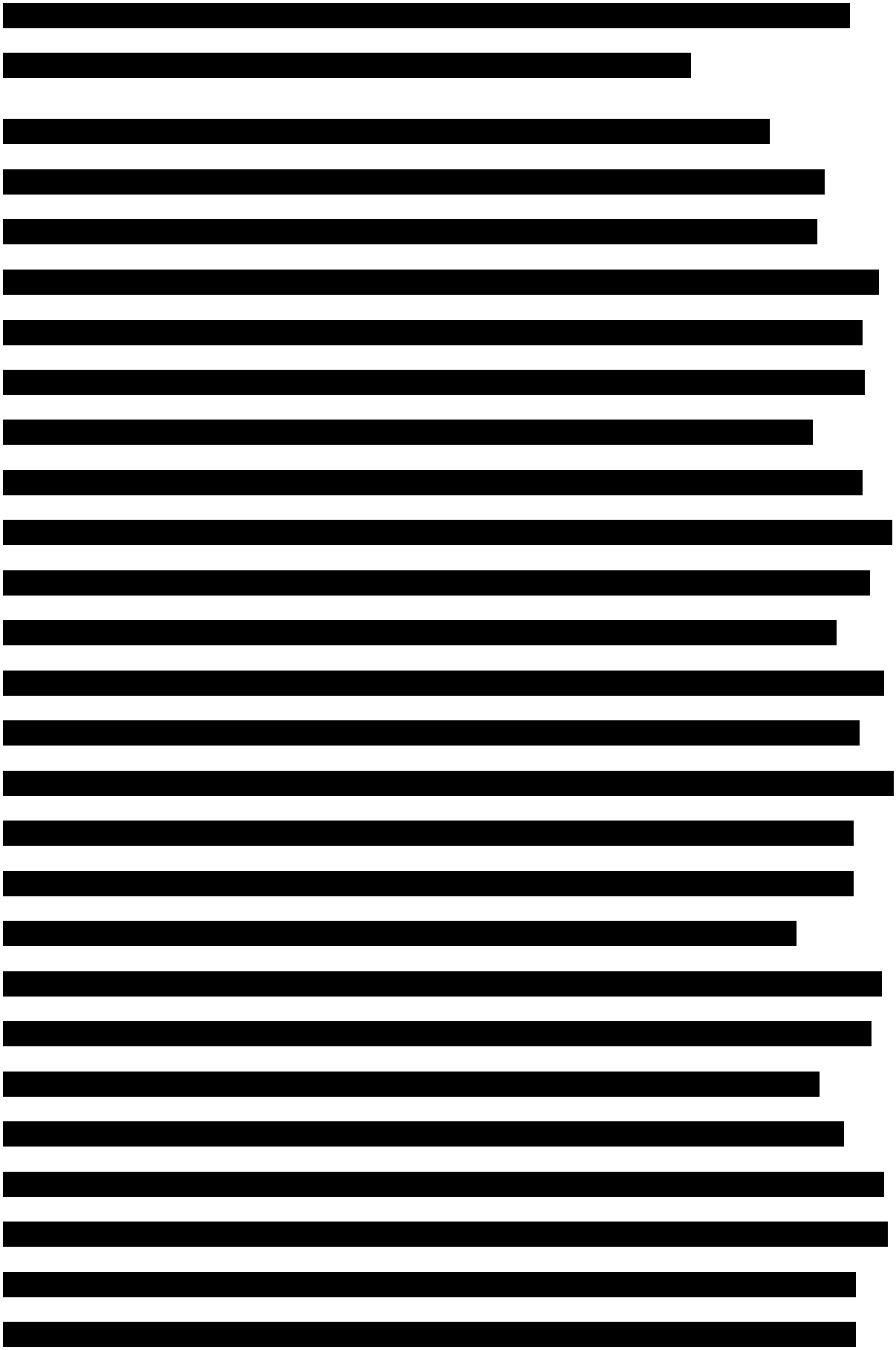

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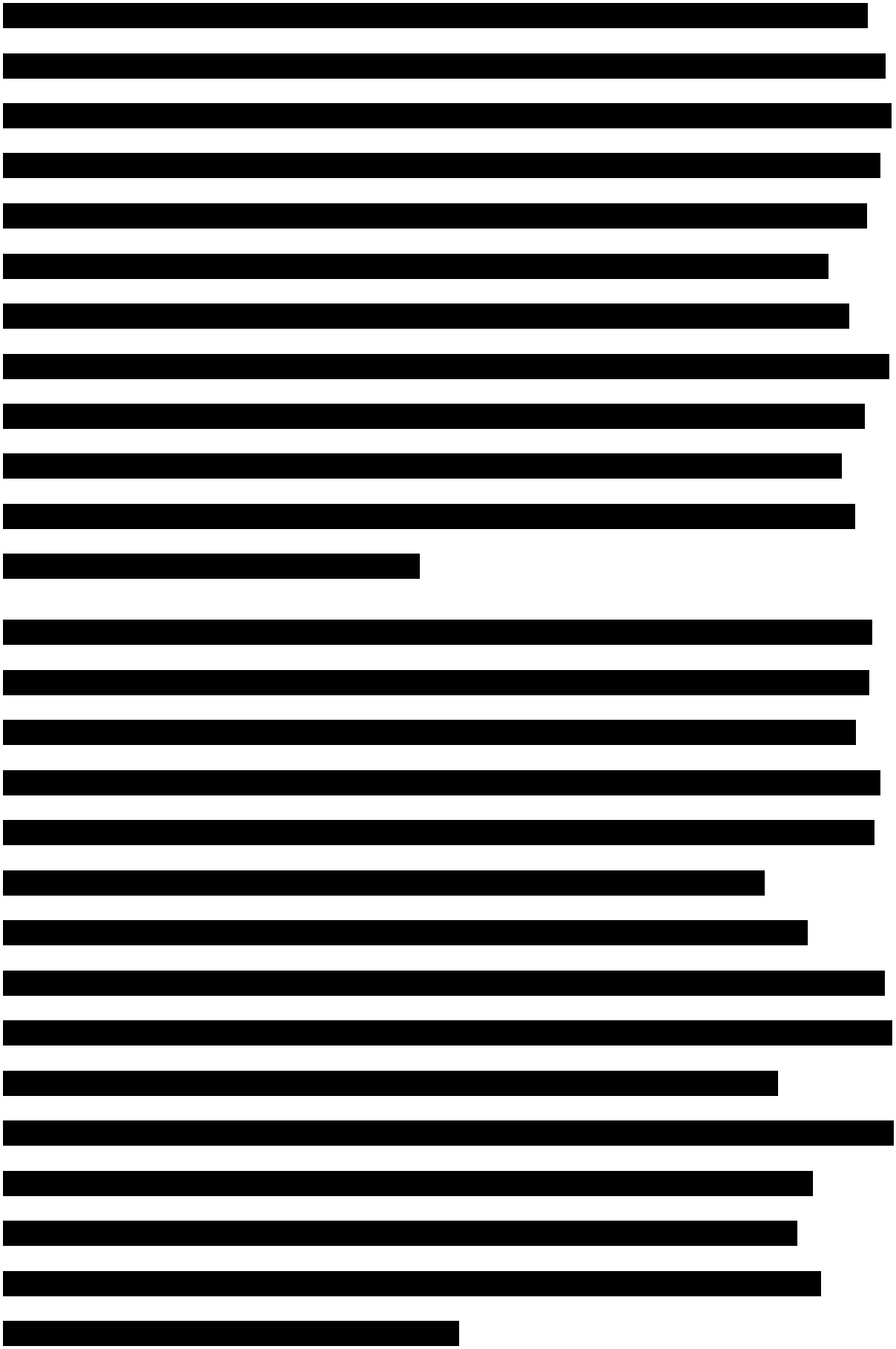

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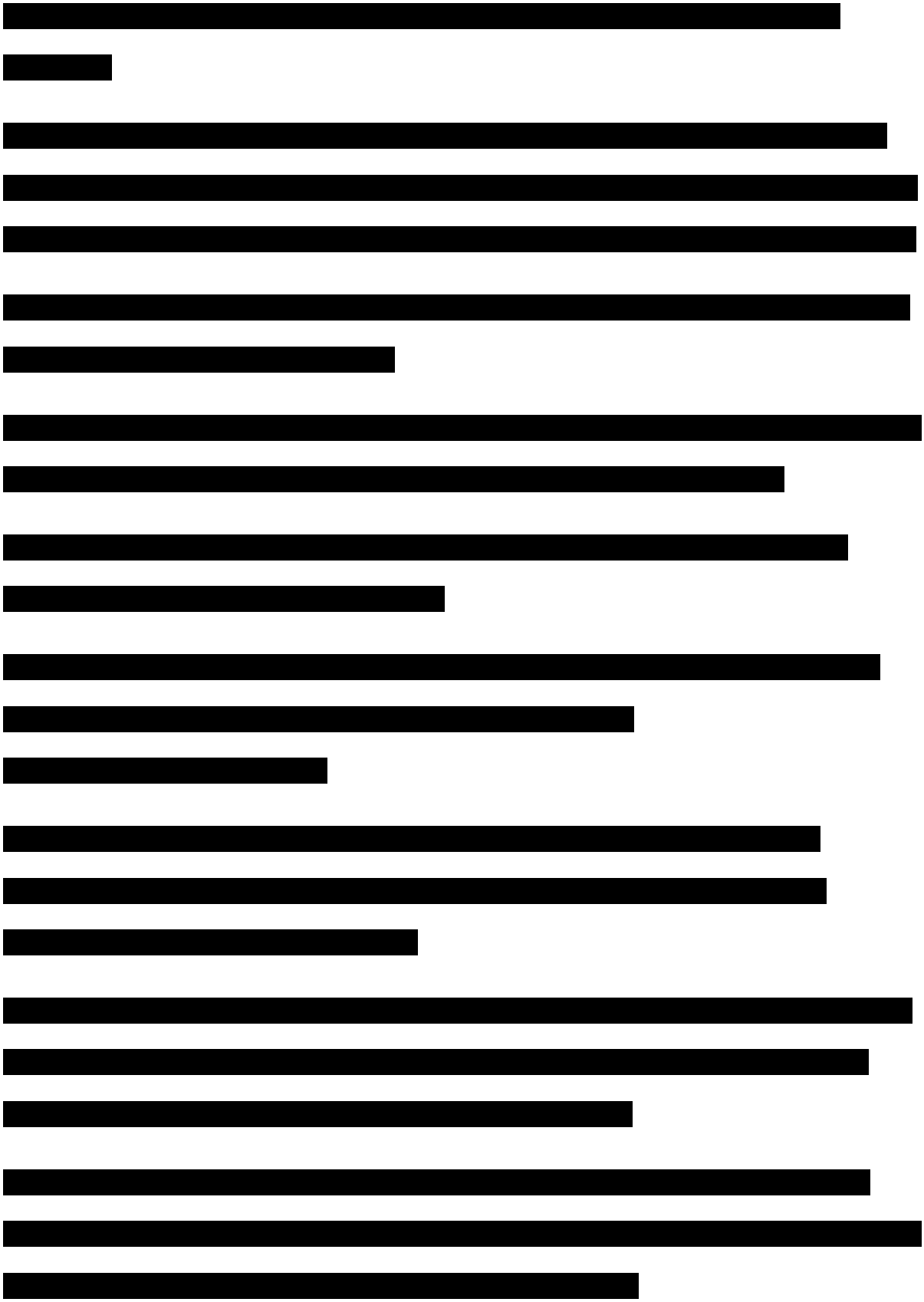

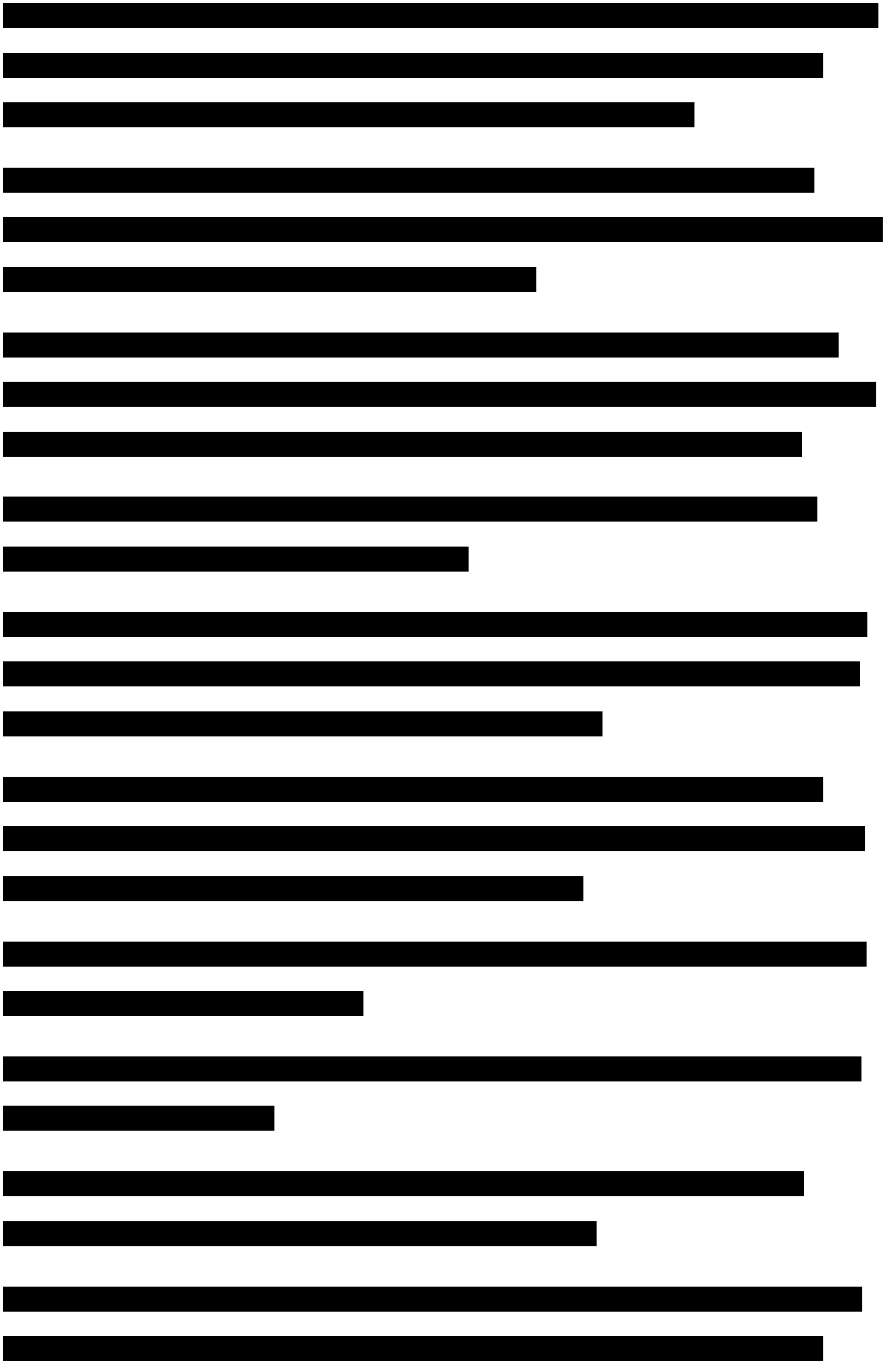

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