

**Somali male refugees:
Perceptions of depression and help-seeking**

Sophie Rae

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Abstract

Background: In recent years, research has started to draw attention to the notion that Western biomedical concepts of mental illness such as depression may not be recognised, understood or treated in the same way across non-Western cultures. Research has begun to reveal the differences in how mental illness is conceptualised across non-Western cultures, highlighting the prominence of social and contextual factors in contrast to the Western biomedical view. This has implications not only on a global scale, but also for diverse populations living under the Western mental health system. The UK Somali community has been identified as a cultural group who rarely access psychological services, despite high rates of mental health diagnoses such as depression. In particular, Somali men are said to be at increased risk of suicide and frequently present in tertiary care, yet there is little research to explore how they understand concepts such as depression.

Aims: The purpose of the current study was to explore how Somali male refugees in the UK understand and perceive the Western concept of depression, alongside their views on coping and professional help in the UK.

Method: A constructivist grounded theory approach involved the use of twelve Somali male refugees in the community. They were interviewed with the aid of a vignette across three focus groups, with eight who participated in subsequent semi-structured interviews.

Results: Findings suggest that 'depression' appeared to be a result of the difficulties associated with migration, portrayed as an overall 'sense of disconnection'. The 'health' of the community appeared to link to the 'health' of the individual; highlighting the collectivist appraisals of self-worth. Help-seeking from Western professionals was portrayed as rare, and were conceptualised as lacking awareness of the needs of the Somali community in relation to their difficulties.

Conclusion: These findings highlight the importance of taking into account social and contextual factors, supporting the argument for a bio-psychosocial approach when making decisions about depression as a diagnosis. These differences in the way depression is conceptualised has implications for Western models of therapy, while indicating a need for counselling psychology to consider a move towards community-based work when working with these populations.

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Glossary

DSM	The Diagnostic and Statistical Manual of Mental Disorders
ICAR	Information Centre for Asylum and Refugees
ICD-10	International Classification of Diseases
UNDP	United Nations Development Programme
UNHCR	The Office of the UN High Commissioner of Refugees

Foreword

My interest in this topic stemmed from many years of working among culturally diverse populations and observing the struggle many non-Western patients experienced after being given a diagnosis that was unfamiliar to them. In one particular inpatient secure setting, what stood out for me were Somali men, a high proportion in this setting, and the experience of seeing them under the care of the Western model of mental-health. Through observation I learnt that the narratives these patients had around their difficulties were often misconstrued by professionals as “symptoms of psychosis”. As a result I began to feel a sense of frustration at the power of the Western model of mental health and its disregard for culturally-shaped beliefs. This observation ignited my interest in this area, and I soon learnt of the unfamiliarity of Western diagnoses among this community.

The concept of depression is becoming increasingly talked about in Western society. It is understood to be a future global epidemic and there is a call to acknowledge it, understand it and treat it globally based on the Western model of depression. However, this has implications for cultures where such concepts may not be recognised, perpetuating the powerful position of the Western model of mental health. This is especially relevant to refugee populations in the West, where it is felt that such communities “lack awareness” of such concepts and there are calls to educate them. It is my view that, instead, we should be exploring how these communities understand these concepts, and should be engaging with what is more meaningful and valid to the individual.

It is thus necessary, I feel, to explore what “depression” might mean to the Somali community. I have chosen to focus on men due to the scarcity of research conducted among this group. My hope is that further research will continue to explore this issue globally. This brings me to a passage I recently came across while investigating the concept of depression in Rwanda, a country that has experienced severe atrocities of war and loss. This gives a flavour of the reasons behind my research, and my drive to get such voices heard.

We had a lot of trouble with Western mental health workers who came here immediately after the genocide and we had to ask some of them to leave.

They came and their practice did not involve being outside in the sun where you begin to feel better. There was no music or drumming to get your blood flowing again. There was no sense that everyone had taken the day off so that the entire community could come together to try to

lift you up and bring you back to joy. There was no acknowledgement of the depression as something invasive and external that could actually be cast out again.

Instead they would take people one at a time into these dingy little rooms and have them sit around for an hour or so and talk about bad things that had happened to them. We had to ask them to leave.

From The Moth podcast, “Notes on Exorcism” (Andrew Solomon, 2014).

Introduction

1.1 Overview

In recent years there has been an increasing emphasis in the literature that the Western perceptions attached to what is labelled “ill” may be understood differently in non-Western cultures (Kleinman, 1988). This is particularly relevant in relation to recent movements that are pushing for the globalisation of biomedical psychiatry that is currently a dominant model of mental health in the West, and has implications for the increasingly diverse populations seen within Western mental health settings. Over the years the biomedical model has thus attracted a number of critiques, highlighting an increasing need for cross-cultural research to provide evidence against its universal application and to instead increase our cultural competence as practitioners (e.g. Kirmayer, 2001, Mills, 2014). This has also highlighted a further need: for research to explore conceptualisations of mental health across cultures with regard to their applicability across cultures.

The current chapter is divided into four main parts. To begin with, an overview of this on-going debate will be presented. Attention will then turn to a Western concept of depression and the current evidence with regard to its recognition across cultures and the need for further research. Following this, an introduction to the Somali refugee community in the UK will be given, with a discussion of the need for such research on depression within their communities in the UK. Finally, the justification and objectives of the current study will be outlined.

1.2 A Western view: The biomedical model of mental health

One model of mental health that has been particularly influential in Western psychiatry (particularly here in the UK and across Europe) is known as the “biomedical model”. The two main underlying assumptions of the biomedical model posit that: a) “mental disorders” result due to biological abnormalities in the brain (b) treatment targeting these biological abnormalities is prioritised (i.e. via pharmacological interventions) (Andreasen, 1985). This model therefore holds many implications, viewing “symptoms” of “mental-disorders” as universal and based on a view that it is possible to investigate human problems using methods of scientific investigation. For example, the use of pharmacological interventions as treatment can be designed and studied independently of context. This has been increasingly encouraged by large international health bodies such as the National Institute of Mental Health (NIMH) and the World Health Organisation (WHO), resulting in many pharmacological interventions in Western countries such as the USA (Whitaker, 2010). Furthermore, tools to assess and identify specific mental-disorders assume the objective existence of such

“disorders”, despite an individual's background, context or culture (Jasper, 1963). This view has thus become a dominant model in the West, providing the foundation for the development of diagnostic criterion and manuals, such as the most recent edition of the *Diagnostic and Statistical Manual of Mental-disorders* (DSM-V). The focus of Western psychiatry is thus primarily based on biological aspects of mental illness, seeking to “classify” or “diagnose” based on an assumption of a universal existence of symptoms and “mental-disorders”, irrespective of individual differences or context (Klerman, 1978). Thus, mental health disorders have been classified into diagnoses such as depression and schizophrenia, and are seen as biological “brain disorders” that require medication (Blumner & Marcus, 2009; Pescosolido et al., 2010). Diagnostic manuals widely used across mental health-services in many Western countries are based upon this model, its focus to classify and provide a diagnosis for the individual. Receiving a diagnosis thus implies a biological intervention as well as other standardised treatments (e.g. psychological), based on the view that “symptoms” or diagnostic criteria are universally shared among individuals.

In psychiatry, the biomedical model can be argued to hold a number of strengths. Firstly, its biological focus means that the outcomes of treatment can be measured and manipulated until a successful outcome is reached. Secondly, viewing mental-health difficulties in this way means that individuals are able to conceptualise these as “illness”, thus removing any sense of self-blame or responsibility for their difficulties, which may be reassuring for the individual. There appears to have been increased talk in the media of “mental-illness” from a biomedical standpoint in recent years, and it could be argued that this view has enabled a sense of increased openness about these issues. Together, the reduced sense of self-blame and increased openness may be serving to reduce the stigma that has surrounded the topic of mental health for decades. The research that has provided evidence for this model have thus shown successful outcomes in response to pharmacological treatment, and serves to increase our understanding of the roles of biological processes that may contribute to psychological health (e.g. Angoa-Perez et al., 2014).

1.2.1 A call for globalisation

The biomedical model of mental health has come to hold a powerful position in Western psychiatry. The WHO have claimed there are 450 million people suffering with some form of “brain disorder” worldwide, yet 40% of countries are still without a mental-health policy and 30% have no mental-health programmes (WHO, 2001). There has been a call to standardise assessment tools, diagnostic criteria and treatments globally with a “Global Mental Health Movement”, whose mission statement is to “close the treatment gap for people living with mental, neurological and substance use disorders in low resource settings” (Patel et al., 2013). The aim is to remove traditional “irrational” and

“inappropriate” treatments, and establish the “evidence-based practice” model, improving “mental health literacy” across cultures, so that Western classification systems and diagnoses are understood globally. The Western world is seen as “a powerful global north” and the non-Western world as a “receiving global south” (Bracken et al., 2012).

However, despite the current dominance of the biomedical model in mental health, critiques of the model have been ever-present, beginning with the “anti-psychiatry movement” in the 1960s (e.g. Szasz, 1961). Criticism began with the objective nature of the model and its focus on mental disorders as “brain diseases”, hence reducing individuals to a biological basis. Its use of a standard classification and diagnostic system, standardised treatments (e.g. electro-convulsive therapy) and involuntary hospitalisation, resulted in some viewing the model as “ineffective and barbaric” (Deacon, 2013; pp.848).

Critical psychiatry movements have evolved over the years (e.g. Bracken & Thomas, 2001), and the call to globalise mental health has been resisted (e.g. Kirmayer, 2001, Summerfield, 2012). As discussed below, core arguments have questioned the “evidence-base” that underlies the model, and its solely biological focus (e.g. Moncrieff & Cohen, 2009; Kirmayer, 2012).

1.2.2 The evidence-base questioned

Evidence for the biomedical model uses randomised control trials and on-going reviews of efficacy. Some research has indicated some positive outcomes for biological intervention (e.g. Cruz et al., 2011; Thase et al., 2011; Hesselgrave & Parsey, 2013), reinforcing existing theory around mental “illness” and building on them (e.g. Angoa-Perez et al., 2014). However, critiques of this research have questioned the validity of these research methodologies and the efficacy of some minimal or inconclusive evidence (e.g. Whitaker, 2010; Fournier et al., 2010; Moncrieff & Cohen, 2009; Moncrieff, 2014). In addition, due to the cost and complexity of evidence-based research, most of it has focused on high-income countries rather than low income, non-Western countries (Kirmayer, 2006; Hickling cited in Bemme & D'Souza, 2012).

These criticisms have contributed to a view held by some that the overall evidence-base for a biological basis of mental illnesses such as depression tends to remain weak (Moncrieff & Cohen, 2009; Bracken et al., 2012; White, 2013; Moncrieff, 2014). Given these concerns relating to the very existence of such biological illnesses, the ethics of administering medication with potentially long-term harmful effects for them has also been brought into question (e.g. Whitaker, 2010).

1.2.3 A loss of social context

The biomedical approach has been criticised also for its narrow focus on the brain to the exclusion of other potentially relevant factors, in particular the social context of the individual, i.e. “the immediate physical and social setting in which people live or in which something happens or develops. This includes the culture that the individual was educated or lives in, and the people and institutions with whom they interact” (Barnett & Casper, 2001, p.465). An opposing view is that biological processes amongst individuals are shared across cultures and experienced in the same way, even if they are expressed using different language and concepts (Patel et al., 2013; Okpaku, 2014). However, many have argued that by focusing only on biological processes, we are failing to take into account individuals’ cultural backgrounds and lived experiences upon which they build and understand their social realities (e.g. Kirmayer, 2001; Bracken et al., 2012).

On this basis the validity of such research is argued to be questionable, and by categorising “mental illness” based on Western constructions “fails validity, as it fails the reality of these people” (Summerfield cited in Bemme & D’Souza, 2012, p.5). For example, the use of cultural healing practices in approaching mental health difficulties are recognised as common across different cultures (e.g. Boynton, Bentley, Jackson & Gibbs, 2010), yet these practices are argued to be “inappropriate” as they do not fit the “evidence-base” protocol that is seen as essential in clinical practice in Western psychiatry (Patel et al., 2013). Having an evidence-base is argued as critical to ensure safe clinical practice and thus provides the basis to the treatment recommendations provided by the NICE guidelines. However, critiques have disputed the idea that the West has the authority to decide what counts as an “irrational” or “inappropriate” treatment, when such practices are deeply rooted in non-Western cultural and traditional belief systems (e.g. Mills, 2014).

1.2.4 A call for change

As a result of these challenges, there has been a call to change the existing paradigm of psychiatry, including a “post-psychiatry” movement (e.g. Bracken & Thomas, 2001; Thomas, Bracken & Yasmeen, 2007; Bracken et al., 2012). This has argued for a need to integrate context and environmental influences into psychiatry with a move away from the narrow focus of the biomedical model, as this implies a “uniform sameness” which misses our “vital human differences” (Thomas, Bracken & Yasmeen, 2007, p.181). In addition, an increased focus on “ethical” rather than “technological” interventions has been called for, as well as lessening the coercive power and control of psychiatry with regard to decisions about an individual’s care (Bracken & Thomas, 2001). Supporters of the biomedical model would continue to argue that symptoms of mental illness have the same biological causes irrespective of context or culture, and can thus be treated using a

standardised approach universally (Patel et al., 2013; Okapku, 2014). However, critiques of this view argue there is a need for an increased bio-psychosocial approach to understanding mental health (Thomas, Bracken & Yasmeen, 2007; Engel, 1978). The underlying assumptions of this model is that biological, psychological, and social aspects of an individual must be taken into account with regard to health (Engel, 1978), and that any “illness” cannot be reduced to a single aspect. In other words, it is argued that the social context and cultural background of an individual should be included when assessing, diagnosing or making decisions about an individual's mental health.

To explore this argument further, research has begun to draw attention to the differences in Western and Non-Western conceptualisations of mental health (e.g. Zafar et al, 2008; Chen & Mak, 2008; Pirani, 2009; De Anstiss et al, 2009). However, such research remains relatively scant, and there is an on-going need for further exploration in this field.

1.2.5 Summary

The biomedical model has become a dominant model of Western psychiatry over recent decades. Its biological focus assumes that mental disorders arise from abnormalities of the brain, implying universal symptoms and causes of mental-disorders which are shared across individuals. Treatments are hence designed and administered with the aim of targeting and treating such biological abnormalities mainly through the use of pharmacological interventions. Supportive evidence and pharmaceutical influence in support of this view has enabled its strength in Western psychiatry, although such evidence is often criticised for providing inconsistent or inconclusive outcomes.

In recent years there has been a call to globalise the biomedical model, so that diagnostic criteria, diagnoses and treatments are standardised across non-Western countries, especially for those in which mental-health literacy and treatment-pathways appear to be scarce. However the criticisms of the model's narrowness and disregard of environmental circumstances has resulted in a call to include factors relating to context and culture. The ethos of counselling psychology supports the notion that mental distress cannot be reduced to a single biological problem, and argues for caution when considering implications of diagnoses (Douglas, 2010). Instead, the practice of counselling psychology advocates a holistic view of the individual, taking into account factors such as culture and context, as this approach is seen to provide a more sufficient account of what it means to be a person in distress.

To follow, the focus of the current discussion will explore the question of “universality” with regard

to one particular “mental disorder” that has received increasing attention over the years: depression. This will begin by introducing the biomedical model of depression and the evidence thus far with regard to its recognition across cultures.

1.3 Depression: a “biomedical global illness”?

“Depression” has long been recognised as a mental health disorder in the Western world. It is classified as a “mood disorder” by the American Psychiatric Association and a “major depressive disorder” in the DSM. Diagnostic criteria include a marked loss of interest or pleasure, persistent low mood, feelings of worthlessness, changes to sleep patterns, loss of energy, significant weight changes and/or impaired functioning (e.g. social or occupational). Over the years a number of “depressive disorders” have evolved, and in the recent publication of the DSM-V a number of newly defined categories were presented, such as “disruptive mood dysregulation disorder” and “premenstrual dysphoric disorder”.

The WHO has claimed that depression will become the second biggest global epidemic after heart disease by the year 2030 (Murray & Lopez, 1995). This claim suggests that these experiences and symptoms will be experienced and recognised on a global scale. One long-held view of depression is that it is a “mental-disorder”, caused by a chemical imbalance within the brain. More specifically, this biological theory holds that low imbalances in the neurotransmitter serotonin is the primary biological cause of depression, and as a result treatment has primarily been focused on administering anti-depressants; selective-serotonin re-uptake inhibitors (SSRIs) being the most common.

Research into the effectiveness of antidepressant therapy continues to provide evidence of positive outcomes (e.g. Cruz et al., 2011; Thase et al., 2011; Hesselgrave & Parsey, 2013), and a recent review of research provided support for the theory that the serotonin system may be central to the aetiology of depression (Albert & Benkelfat, 2013). Such evidence strengthens the view that clinical depression may stem from biological abnormalities, indicating that a standardised approach to treatment may be sufficient. Despite such evidence, critics have argued that clinical research has failed to produce consistent evidence of its efficacy and it has been suggested that the Serotonin theory is “collapsing” (Moncrieff & Cohen, 2009; Rottenberg, 2010; Moncrieff, 2014). Some research has even shown evidence of elevated levels of serotonin in “depressed” individuals, disputing the theory altogether (e.g. Barton et al., 2008). Others have shown there is no or inconclusive evidence for mild to moderate depression (e.g. Fornier et al., 2010; Moncrieff & Cohen, 2009), or argued that the drug-placebo differences are minimal (e.g. Kirsh & Sapirstein, 1998; Moncrieff, 2014).

The notion that depression is solely biological in nature has thus been questioned, and raises questions about the existing evidence-base used to support a biomedical model of depression that is being pushed on a global scale.

1.3.1 Depression: prevalence across cultures

We cannot gather all distressed people in the world and put them into the category “depression”. I don’t think there is such a thing as depression, as a universal category. I think that’s a myth. At the end of the day it’s like saying people’s worlds are like colourful garments that you can strip away. (Summerfield, 2012 cited in Bemme & D'Souza, 2012, p.5).

Although various definitions of culture exist, a shared view appears to be the notion that a culture consists of “ever-changing constructs that emerge from interactions between individuals, communities and institutional practices. Individuals use the resources available in the social world to construct durable and socially valued selves” (Kirmayer, 2001, p.22). Culture is therefore argued to have an influence on how categories of emotional experiences are constructed - for example, paying attention to some feelings more than others - and on how “symptoms” are recognised (Bhui, 2004). Furthermore, culture can determine which emotional expression is socially acceptable, hence influencing how an individual may express or regulate his or her emotional experiences (Bhui, 2004).

The biomedical model of depression is argued to reflect only the Western recognition and expression of emotions, ignoring the role of culture itself in providing the context and rules that underlie complex emotions (Kirmayer, 2001). It has thus been argued that what is called “depression” (from a Western perspective) may be understood differently across non-Western cultures and societies, and even within those societies individuals can disagree about what constitutes optimal versus pathological psychological functioning (Jahoda, 1979). Critics of the biomedical model, such as Jahoda (1979) have suggested that instead “human behaviour cannot be understood in terms of isolated symptoms, but instead must be viewed in conjunction with the social norms and values of the community in which the symptoms are observed” (Asch, 1952, p.14). This is in contrast to the opposing view that although emotions may be expressed in different ways across cultures, they all relate to a common experience across individuals irrespective of cultural difference (Patel et al., 2013; Okapaku, 2014).

One major focus of this debate has drawn upon studies of refugee groups living in the West, with regard to the high prevalence of mental disorders among these communities and their low help-

seeking patterns in Western mental-health services. A refugee has been defined as a person who “owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country” (The Office of the UN High Commissioner of Refugees, 1951). At the beginning of 2013, statistics for the number of refugees worldwide was 15.4 million (UNHCR, 2013). Developed countries such as the UK host 80% of the refugees worldwide. Many refugees will have been exposed to various traumatic experiences pre-migration such as loss, separation from loved ones, torture or violence. Arriving in a new country also involves post-migration difficulties in settling in relation to housing, employment, finances and the process of applying for asylum (Bhui et al., 2003).

With the growing numbers of refugees migrating to the West, there has been considerable interest in recent years on the mental health status of these groups with a view to determine the impact of pre and post-migration factors on mental health. Research has subsequently shown that levels of psychological distress among refugee groups are higher than that of non-refugee communities (e.g. Burnett & Peel, 2001; Harris et al, 2001; Fazel, Wheeler & Danesh, 2005; Johnson & Thompson, 2008; Ellis, McDonald, Lincoln & Cabral, 2008; Turner & Herlihy, 2009; Maier, Schmidt & Mueller, 2010, Carswell, Blackburn & Barker, 2011) and this has been linked to experiences of trauma and post-migration difficulties (e.g. Carswell et al, 2011).

In particular, some research has identified depression to be one of the most common “mental-disorders” among refugees (e.g. Slewa-Younan et al., 2014; Bojic et al., 2012; Priebe et al., 2010; Bhui et al., 2006; Wittchen & Jacobi, 2005). Despite this, access to professional help-seeking has been shown to be relatively low in developed countries, and a number of research studies have examined possible reasons for this. Common barriers have been found to relate to the underlying differences in Western and non-Western cultures, in particular the stigmatisation of mental health among some non-Western communities. Misconceptions and disparities in understanding between cultures are suggested to be significant, and some studies have suggested that low rates of help-seeking among some cultures may be due to the differences in the conceptualisation of depression (e.g. O' Conner et al., 2014; Saraga, Gholam-Rezaee & Preisig, 2013; Grover et. al., 2012; Waite & Killian, 2009; Kokanovic et al., 2008; Cadassa, Lester & Zayas, 2007). This therefore raises questions about the validity of previously mentioned research which has sought to identify the prevalence rates of mental health issues such as depression amongst refugee groups, as Western terms and concepts may be misunderstood or misinterpreted (e.g. Jakobsen, Thorasen & Johansen,

2011), questioning the recognition and understanding of such terms across cultures.

1.3.2 Depression: recognition across cultures

Cross-cultural research has identified a number of distinguishable differences regarding both the expression and understanding of the Western view of depression (e.g. Yoo & Skovholt, 2001, Karasz, 2004; Lackey, 2008; Grover et. al., 2012; Patel, 1995; Peiera et al., 2007; Kokanovic et al., 2008; Waite & Killian, 2009; Ward & Besson, 2012; Saraga, Gholam-Rezaee & Preisig, 2013; O' Conner et al., 2014). Studies have used a mixed approach for investigation. For qualitative approaches, researchers have commonly applied the use of “explanatory models” (Kleinman, 1980) to investigate such differences. These are subjective accounts given by patients or clients in relation to their understanding of their illness or given diagnosis. This would typically include exploring their view of what causes their “illness”, enabling an individual’s subjective interpretation; thus incorporating cultural and contextual factors (e.g. McSweeney, 1993). Such research has been particularly useful in obtaining rich culture-specific data that elicits evidence against the notion that concepts of mental illness have a single, universal meaning (Kleinman, 1980). Others have used more direct approaches, using self-report measures or questionnaires to understand the perceived causes and favoured help-seeking approaches of participants.

A number of cultural differences have been identified with regard to the expression of depression, its perceived causes and favoured methods of healing or treatment. As Murdock (1980) concluded, following a worldwide survey of illness, the aetiology of classified illness can be divided into two major categories depending on their “natural” or “supernatural” causes. It seems that findings from current research thus far do fit into each of these categories, as described below. Attention is drawn to the differences in the perception of self, conceptualisation of “mental illness” and how it is emotionally expressed across cultures.

1.3.2.1 Differences in the perception of self: individualistic vs. collectivist cultures

One significant factor in the differences between Western and non-Western cultures that impacts on emotional expression and help-seeking concerns the contrast between individualist and collectivist cultures (e.g. Triandis, 2001). It has been argued that these “cultural syndromes” (Triandis, 1996) foster “cultural shaping of psychological reality thereby affecting customs, norms, practices and institutions” (Kitamaya & Markus, 1994, p.4). Culture is thus suggested to impact how individuals view and define themselves in relation to their social context (Markus & Kitayama, 1991).

Individualism is characterised by a sense of self as independent and attendant to one's own values and needs. Here, an individual's attitudes would take priority over social norms, behaviour would be

largely based on personal goals and interests, and the general expectation would be one of self-reliance. This type of personality has been described as “idiocentric” (Triandis, 1996).

Contrastingly, in collectivist cultures, the society or community acts to facilitate and encourage interdependent, co-operative and group-orientated behaviour. Furthermore, there is an expectation to conform to the norms of the group, group-norms are prioritised over individual goals and there is an emphasis on interdependency (Triandis, 2001). Personalities defined by these cultures have been described as “allocentric” (Triandis, 1996). These observations relate to existing literature on cultural identity. It is beyond the scope of this review to go into depth on this matter, but it appears that these differences are in line with the notion that cultural identity may be socially constructed in relation to societal norms (e.g. Goffman, 1968; Burr, 2003).

These differences have received some attention in the literature with regard to general wellbeing and differences in emotional expression, coping and help-seeking behaviours. For example, some studies have shown that individuals in collectivist cultures are less likely to seek social support if there is a belief this could disturb group harmony (Kim, Sherman, Ko & Taylor, 2006). Another characteristic of these individuals is a sense of external control, with an increased likelihood to view bad luck as a cause of stressors (Wong & Ujimoto, 1998 cited in Chun, Moos & Cronkite, 2006). There is also said to be a greater emphasis on social harmony rather than on individuation, and autonomous behaviour is said to be discouraged. However, the individualistic-collectivist paradigm has been criticised as being over encompassing of cultural differences (e.g. Bond, 2002; Berry et al., 2011), where “researchers tend to define and assess these constructs in overly broad and diffuse ways” and that is why “these constructs are described as conceptually ‘fuzzy’” (Brewer & Chen, 2007, p. 134). Furthermore, it has been argued that individualism and collectivism can be conceptualised as not only within the culture, but also within the self (Balcetis, Dunning, & Miller, 2008). A further major criticism focuses on the methods of investigation and that the scales that are used to measure for these differences and it is argued that better measurements are necessary to describe each cultural dimension (Oyserman, 2002).

Despite this, such differences are argued to be crucial and should be taken into account as part of cultural research on mental health (Oyserman, Coon & Kemmelmeier, 2002; Brewer & Chen, 2007, Papadopoulos, Foster & Caldwell, 2013).

1.3.2.2 Differences in conceptualisation: Social factors & traditional beliefs

“Mental illness” in some non-Western cultures has been identified by extreme changes in behaviours or appearance, with descriptions offered that may be more closely linked to the Western concepts of psychosis or schizophrenia. However, milder neurotic difficulties have been found to be commonly viewed not as illnesses but rather as the result of social or moral problems that may be occurring at home or within the community (Kirmayer, 2001). Such examples of social difficulties have included separation from loved ones, social isolation, unemployment and interpersonal difficulties (e.g. Karasz, 2004; Lackey et al., 2008; Kokanovic et al., 2008; Peirera et al. 2007; Grover et al., 2012; O'Conner et al., 2014). Many of these difficulties have been found to arise as a result of migration (e.g. Lackey et al., 2008). As a result, such neurotic issues were said to be commonly viewed as the result of difficulties located within the social worlds of the individuals rather than viewed as illnesses that occur outside of this context (Peiera et al., 2007; Kirmayer, 2001; Patel, 1995). The causes of misfortune or illness were found to often be externalised and linked to spirituality, rooted in traditional cultural beliefs. Examples of this have included beliefs in supernatural elements such as spiritual possession and curses such as the 'Evil Eye' (e.g. Grover et al., 2012; Patel, 1995; Peiera et al., 2007; O'Conner et al., 2014; McClelland et al., 2014).

Western psychiatry may still refer to this as what is classified in the ICD-10 as “adjustment disorder” or “situational depression”, which is suggested to occur as a result of a major life event that one may have difficulty coping with. Some studies have found that despite the role of external factors, pharmacological interventions have been found to have a positive outcome (Strain, Smith, Hammer et al., 1998; Hameed U, Schwartz T, Malhotra, 2005), thus suggesting a biological component may still be significant in the experience of such distress.

1.3.2.3 Differences in expression: “Somatic complaints”

One major finding has been the expression of physical or somatic symptoms in response to the understanding of depression. These are expressed as aches or pains across the body, commonly associated with headaches, stomach or abdominal pains (e.g. Patel, 1995; Yoo & Skovholt, 2001; Peirera et. al., 2007). This is a common phenomenon in expressions of “mental distress” (e.g. Pang, 1998; Bhugra, 1997; Bhui, 2001). It has been suggested that in contrast to the Western model, some cultures hold a belief system based on a holistic understanding of the person that does not separate mind and body (Kirmayer & Young, 1998; Chun, Moos & Conkrite, 2006). Thus, some hold a view that psychological symptoms have physical origins in the body, with the physical element being the focus of treatment (e.g. Chun, Moos & Cronkite, 2006).

However, other research has suggested that somatic complaints are symptoms of “depressive disorders” and can be treated effectively with anti-depressants (e.g. Kroenke, 2003; Grover et. al. 2012).

Although the aetiology of somatic complaints remains unclear, it has been argued that the misinterpretation of such may result in misdiagnosis, and thus the importance of eliciting a patient's explanatory model has been emphasised in order to assist with both diagnosis and a negotiation of treatment (Kleinman, 2004; Jakobsen, Thorasen & Johansen, 2011).

1.3.3 Limitations of previous research

A number of limitations regarding these studies should be noted with regard to their methodological approaches. One common limitation of the use of explanatory models has been the use of participants with a diagnosis of depression and consequent exposure to the Western mental health system (e.g. Grover et. al., 2012; McClelland et. al., 2014). This does not allow for a “lay” account of such concepts, and raises the question of how such a diagnosis may be understood in the wider community without any previous knowledge or exposure of the Western mental health system.

A further criticism is the use of the term “depression” that appeared to be used by some researchers when exploring it with participants (Kokanovic et al., 2008; Waite & Killian, 2009; O'Conner et al., 2014; McClelland et al., 2014). This has been criticised due to language disparities whereby certain terms or concepts may not exist in the participant's mother-tongue, thus imposing an objective view that such concepts exist, while for some communities or cultures this may not be the case (e.g. Waite & Killian, 2009; McClelland et. al., 2014). The validity of such qualitative approaches is thus questionable and emphasises the need for research that allows for understanding to be explored without imposing such Western concepts.

1.3.4 Summary

Research has shown a clear distinction between Western and non-Western understanding of depression. It could be argued from the literature that many cultures do not view what the West calls “depression” as “mental illness”, but instead attribute its symptoms to social, spiritual or interpersonal difficulties. Furthermore, the role of cultural norms and belief systems can impact on an individual's decision to seek help.

Such research has elicited a number of findings that suggest beliefs, perceptions and understanding of non-Western cultures which are argued to be contrary to the Western biomedical model, although

Western psychiatry may dispute this. Such differences have been found to impact on both access to mental-health services and attitudes towards help-seeking. As such, the need for further research across cultures has been argued for.

In response to this, the focus will now turn to the people of Somalia, a country which as a result of civil war has seen a global dispersion of its people. Many Somalis have thus found themselves living within Western society and may thus be aware or exposed to the Western mental health system. This prompts an interest into research that has explored how they may view or understand the Western concepts associated with this, and will be discussed in the following sections. Exploring the perceptions of the Somali population in relation to mental health assists in addressing this gap in the literature for an increased understanding of human distress across cultures. To begin with, a brief background will be given of Somalia and its people.

1.4 Somalia: a country dispersed

1.4.1 A brief history

Somalia is an East-African country located in the zone commonly referred to as the Horn of Africa. Its capital city is Mogadishu which is one of its few urban areas, and is thus largely a rural, underdeveloped country.

Somalia has a history characterised by war, poverty and famine dating back to 1969, when the country was ruled under a strong dictatorship and control over the social system resulted in conflict and bloodshed between clans. This regime came to an end in 1991, resulting in the breakdown of the Somali state and the onset of a raging civil war that is on-going. The United Nations have made several attempts to intervene, but have been forced to withdraw as a result of the deteriorating situation and increasing number of casualties.

In addition to this, Somalia has been overcome with periods of severe drought and famine, the two worst episodes occurring in 1992 and 2011. Since the beginning of the civil war, approximately 550,000 Somalis have died as a result of war, disease or famine. Almost 45% of the population have fled to other countries including the Middle East and European countries. The scattered population of Somalis across the world has become known as the “Somali Diaspora” (UNDP, 2009).

Although Somalis are scattered globally, they seek to maintain their cultural practices and continue to orientate themselves towards their home country (e.g. Utilitarian, 2010). Furthermore, Somali

communities have been identified as viewing themselves as different, and do not feel fully accepted by their host countries (e.g. Hammond et. al., 2011).

1.4.2 Family and community

Within Somali family structure, the father is viewed as the head of the household, responsible for providing an income, as well as having the position of authority in which he is seen as the decision-maker. Women tend to be responsible for day-to-day household tasks; however, rearing a child is viewed as a “project” for the whole family, including members of the extended family, and close family friends (Johnsdotter, 2007). Couples tend to have several children, as this is highly valued in the community, suggested as a way of ensuring a continuation of the family’s support system (Johnsdotter, 2007; Bentley & Owens, 2008). This shared responsibility is characteristic of Somalia’s “collectivist culture” (Triandis, 1996). As previously discussed, this culture is also characterised by its community, which acts to facilitate and encourage interdependent, co-operative and group-orientated behaviour (Triandis, 1996; Bentley & Owens, 2008). There is a close, strong, supportive relationship between the family unit and extended family (Bentley & Owens, 2008).

Religion plays a significant role in the community, and is highly prevalent in day-to-day life, with Islam seen, for most, as providing a culture and a way of life (Bentley & Owens, 2008). In particular it is seen as providing a framework for cultural norms, morals and social customs in the community, and there is a general expectation for all to adhere to this.

1.4.3 Somalis in the UK

Since the onset of the Civil War, many civilians have fled the country. In January 2014 the number was estimated as over 1.1 million Somali refugees (UNHCR, 2014). The UK is said to have one of the largest populations of Somali refugees in Europe, which currently stands at approximately 99,500 (UNHCR, 2014). Although the influx of Somali refugees has reduced over recent years, this number remains relatively high, with 11,249 having migrated to the UK in 2013 alone (UNHCR, 20). Somali communities have clustered among the major cities of the UK, such as Leeds, Bristol and Cardiff, with London accounting for 78% of the UK's Somali residents (ICAR, 2007).

Somalis migrating to Western countries hold a huge desire to find a better life and education, in order to fulfil the expectation to provide for both their immediate families and extended families back home (Tiilikainen, 2010; Johnsdotter, 2007). However, in reality the process is experienced as difficult, time-consuming and risky (Rousseau, Said, Gagné & Bibeau, 1998). In 2013, the *Economist* reported that the Somali population were among the highest with regard to

unemployment in the UK, with over 50% living in social housing. Among Somalis, failure to meet the expectations of a better life is seen as failure not only for the individual, but also for the extended family (Tiilikainen, 2010).

1.4.4 Summary

Somalia has a long history of unrest, characterised by war, poverty and famine. Since the onset of the Civil War, the UK has become home to a large proportion of Somali refugees in Europe. Many will have had experiences of loss and trauma and have fled in hope of a better life for themselves and their families. The Somali communities who settle aim to continue to adhere to their cultural practices, with regard to maintaining the collective social structure and following the norms and expectations of both their community and their religion.

1.5 Somali refugees and mental health

1.5.1 Mental illness among Somali Refugees

A number of studies have attempted to quantify mental health problems within the UK Somali community, and suggest that mental health conditions such as depression and post traumatic stress disorder (PTSD) are more prevalent in this group than among the general population (e.g. Silveira & Albeck, 2001; Bhui et al., 2003; Bhui et. al, 2006; Ellis et al., 2008). One study also highlighted concern regarding the large numbers of suicide among young Somali men in the UK, despite suicide being almost unheard of in Somalia (Summerfield, 2001), although there is little other research to support this finding.

Significantly higher levels of mental distress have been found in Somali refugee populations in the West (e.g. Silveira & Albeck, 2001; Bhui et al., 2003; Bhui et. al, 2006; Ellis et al., 2008; Mölsä et. al., 2014). Research has suggested that these rates of mental illness are linked to previous experiences of trauma, loss, separation and migration difficulties (e.g.; Bhui et. al, 2003; Bhui et. al., 2006, Silveira & Ebrahim, 1998; Ellis et. al, 2008; Turner & Herlihy, 2009; Mölsä et. al., 2014). Pre-migration factors such as exposure to war-related traumatic events, as well as occupational status before migration, were linked to high rates of depression and anxiety among Somali refugees in the West (Bhui, et. al., 2003; Mölsä et. al., 2014). Post-migration factors have included the lessened quality of life post-migration (Mölsä et. al., 2014), as well as the use of the substance khat¹ (e.g. Bhui et. al., 2003; Patel, Wright & Gammampila, 2005; Warfa et. al, 2007), which is common

¹ Khat: a green leaf shrub native to the Horn of Africa. Among communities from this area, khat chewing has a history as a social custom dating back thousands of years.

among the Somali community (especially males). Although currently debated within the literature, there is some evidence to suggest a link of khat use with the onset of mental health problems and suicidal ideation (Bhui et. al, 2003; Patel, Wright & Gammampila, 2005; Bhui et. al, 2006, Warfa et. al, 2007; Warfa & Bhui, 2010).

1.5.2 Seeking help, stigma, and silence

Despite the high rates of mental health problems in the UK Somali community, previous research has shown a tendency to under-utilise mental health services (McCrone et. al., 2005; Palmer, 2006; Ellis et. al., 2010; Maier, Schmidt & Mueller, 2010).

Treatment for “mental disorders” (e.g. anxiety, depression, post-traumatic stress disorder) has been found to be an unfamiliar concept for many Somalis. Instead, the cultural norm would be to seek help through faith healing or counselling from elders and family. Thus participating in “talk therapy” with professionals is seen as an “alien” activity within the Somali community (Baluchi, 1999; Bentley & Owens, 2008). Exposure-based therapies aimed at “working through” trauma (i.e. cognitive behavioural therapy for PTSD) have become a familiar concept in the UK; however, it has been suggested that these represent an “incomplete psychological treatment approach when working with refugee groups, due to the multiple layers of trauma experienced by these populations” (Guerin, Guerin, Diiraye & Yates, 2004 cited in Bentley & Owens, 2008, PTSD section). In one study, 76% of asylum seekers in London rated counselling as “poor” or “very poor” (Baluchi, 1999 cited in Ingleby, 2006, p.105), and non-attendance in therapy was found to be common (Schuchman & McDonald, 2004).

Despite a low tendency to access professional help from mental health services, it has been identified that Somali men fall into the statistical data that shows that men from black or ethnic minority backgrounds are three times more likely to be admitted to a psychiatric unit and be detained for longer periods in comparison to white men (“Count me in” Census, 2005). This has implied the need for research to explore difficulties within the Somali community, questioning in particular the reasons for low access but high figures of hospitalisation (e.g. Fernando, 2013).

Some identified barriers to accessing professional healthcare are a lack of community knowledge about health care and misconceptions, discomfort and stigma associated with mental health (Whittaker, Hardy, Lewis & Buchan, 2005; Palmer, 2006; Palmer, 2007; Scuglik et. al., 2007; Guerin, Abdi & Guerin, 2003; Johnsdotter, 2009; Pavlish, Noor & Brandt, 2010; Boynton et. al., 2010; Ellis et. al. 2010). Somali culture traditionally prevents a willingness to discuss mental health

issues and the Somali tradition of shamanism has suggested the communities tend to have more faith in the supernatural than in Western medicine (Scuglik et. al., 2007). In addition, mental health terms are not easily translated into the Somali language (Bhui et. al., 2006; Carroll, 2004). For example, it has been found that the words used for “severe depression” indicate “migraine” or “severe headaches” (Bhui et. al., 2006, p. 403), and it is these headaches and other somatic symptoms, such as tiredness or muscle aches, which Somalis are more likely to talk about rather than mental distress. (Scuglik et. al, 2007).

It has also been found that Somali society tends to be afraid of and conceal mental illness. Stigmatised sufferers are seen as weak-minded and hopeless and are often “chained” or locked away without hope of recovery (Schuchman & McDonald, 2004; Bentley & Owens, 2008). In one study, Somali women suggested they never go to the doctor because “we go and the doctor believes we are crazy or psychotic and that makes us crazy” (Pavlish, Noor & Brandt, 2010, p.355).

Cultural misconceptions have been identified as a major barrier to accessing professional healthcare, often resulting in discordant beliefs and unmet expectations from mental healthcare professionals (Warfa et. al., 2006; Knipscheer, de Jong, Kleber & Lamprey, 2000; Whittaker et. al., 2005; Scuglik et. al., 2007; Pavlish, Noor & Brandt, 2010, Tiilikainen & Koehn, 2011). For example, those who have not been hospitalised but are seen to suffer from mental health problems tend to stay with relatives and may only visit a healer to receive treatment and medication (e.g. Tiilikainen & Koehn, 2011). These discordant belief systems are suggested to impact on help-seeking behaviours. As a result, this has become an increased focus of the literature and research over recent years.

1.5.3 Somali beliefs about mental illness

The few studies that have been carried out in Western society have so far identified that, in contrast to the Western biomedical model, mental ill-health is often related to difficulties relating to social context and spirituality (Whittaker et. al, 2005; Carroll, 2007; Kokanovic et. al, 2008; Mölsä et. al, 2009; Arkko & Gahan, 2010; Pavlish, Noor & Brandt, 2010). The literature has highlighted that within Somali culture one is either “sane” or “insane”, and there exists no continuum in between (e.g. Bentley & Owens, 2008). This has an impact upon how other issues are perceived.

For example, extreme difficulties that would be viewed as severe psychopathology in Western culture have been commonly linked to traditional beliefs in spiritual possession or curses, or may be viewed as being “part of Allah’s destiny”, meaning they have “to be faced, whatever happens”

(Elmi, 1999; Whittaker et. al 2005; Carroll, 2007; Pavlish, Noor & Brandt, 2010). The most common spirit is known as the Jinn, which are described as spirits possessing supernatural powers, capable of controlling an individual's processes, including his or her psychological process (Carroll, 2004). Jinn are seen to be responsible for certain experiences such as auditory or visual hallucinations, loss of appetite and difficulties sleeping. In addition, any changes in behaviour may be externalised to the Jinn, including anti-social behaviours. For example, if a person is showing behaviours such as violence, screaming, crying, talking non-stop or talking to themselves, the Jinn may be viewed as responsible (Tiilikainen, 2003). The Jinn are mentioned many times in the Koran, and there are said to be different types of Jinn invisible to the eye. Other spirits are also referred to, such as Mingis and Saar, but the term Jinn may be used if it is unknown which spirit is inside the person (Tiilikainen, 2003).

Research that explores beliefs and understanding with regard to more affective difficulties that may be conceptualised by the Western model as depression is limited (e.g. Kokanovic et. al., 2008). Findings identified that these are often attributed to interpersonal relationships, and are viewed as a collective, systemic issue rather than an issue affecting the individual (as in the West) (Kokanovic et. al, 2008). Other research has shown that no words for affective disorders exist within the language, yet certain terms have been likened to them (Carroll, 2004). For example, “qalbijab” is a term identified as something similar to depression, translated as “broken heart” or “broken mind” (Tiilikainen, 2003; Wedel, 2012). However, a person suffering with this would not view it as a mental-health problem but would instead require support from others in the community. In addition, social problems are viewed as a cause, such as losing a loved one, memories of war and difficulties associated with refugee status such as unemployment (Tiilikaninen, 2003). Without support, it is suggested that emotional experiences can turn into “madness” or “waali”, which are seen as difficult to cure, and thus may result ostracism from the community (e.g. Schuchman & McDonald, 2004).

Such beliefs impact on preferred methods of help-seeking. A large body of research has shown that traditional healing, such as readings from the Koran, is the norm (Whittaker et. al, 2005; Carroll, 2007; Arkko & Gahan, 2010; Pavlish, Noor & Brandt, 2010; Wedel, 2012). This method of healing is used for both physical and mental health problems (Guerin & Guerin, 2004), ranging from milder forms of mental health problems (e.g. qalbijab) through to spiritual possession (e.g. the Jinn), while family and friends give their support. Although anyone can give readings from the Koran, it is said that it is more effective if read from by those who are closer to Allah, such as a Sheikh or Imam (Wedel, 2012). The reading of the Koran is believed to strengthen the body and soul (Wedel, 2012).

For Jinn possession, the Koran can be used as a method of exorcism. The Jinn is said to be weakened by the recitation of the Koran. This may require a Sheikh or even a large group of people to recite together. The process may need to be repeated over several weeks (Wedel, 2012) for severe problem.

1.5.4 Limitations to previous research

Although the research discussed above has identified some important findings, the validity of this is questioned with regard to the methodologies employed.

Firstly, although these studies yield important implications into the role of pre and post-migration factors on mental health of Somali refugees, the validity of such research is questioned due to the use of self-report measures where Western concepts and terms are argued to be non-translatable and thus may be misconstrued or misinterpreted (Jakobsen et al., 2011). In addition, the majority of samples were clinically-based (e.g. Palmer, 2007; Carroll, 2004), suggesting that participants were exposed to knowledge and concepts regarding the Western model of mental health. In addition, the common use of Western mental health terms in exploring these concepts assumes an objective position with less focus on how meaning and knowledge about such concepts may be constructed (e.g. Kokanovic et. al., 2008). Hence there is a need for more of a lay perspective of individuals in the community in how they understand and conceptualise such concepts.

Very few studies have been based in the UK, with a majority of research taking place in the USA, Europe and the South Pacific (e.g. Johnsdotter, 2009; Guerin, Abdi & Guerin., 2003; Guerin et. al, 2004; Mölsä, Hjelde & Tiilikainen, 2010; Arrko & Gahen, 2010). The increasing influx of Somalis to the UK, the prevalence of mental disorders and the low access rates to psychological services mean there is an urgent need to address these issues with the Somali community in the UK. Those that have been carried out in the UK so far have either been quantitative or used mixed-method approaches (Bhui et. al, 2003, 2006; Palmer, 2006; 2007). There has thus been little focus on or exploration of how Somali individuals understand mental health concepts.

In regard to existing qualitative research, a majority of studies have used mixed gender samples or focused on Somali women (Whittaker et. al., 2005; Pavlish, Noor & Brandt, 2010; Carroll et. al, 2004). There is little exploration regarding the issues that may relate solely to Somali men, considering their low access rates to mental health services, high numbers detained in hospital, and higher rates of suicide in the UK (Summerfield, 2001). Those that have focused on men have focused primarily on elders of the Somali community (Silveira & Ebrahim, 1998; Silveira &

Allbeck, 2001), suggesting there is little evidence on how younger generations may think about mental health.

1.5.5 Summary

Research into the Somali refugee community has shown there to be high prevalence rates of mental-health diagnoses within this population. It has been identified that, despite this, voluntary access to mental-health services is rare.

Barriers to help-seeking have been identified: principally, fear of stigma from the community and misconceptions around Western treatment practices. Furthermore, discrepancies in health beliefs have also been identified, in which there have been found to be clear cultural differences when compared to the Western model of mental health.

This has triggered a need for further research to explore these differences. So far findings have found a major difference in how Somalis classify mental disorders (i.e. sanity or “madness”). This has meant that, with a lack of knowledge regarding other types of Western categories, any label of any mental health difficulty has a tendency to be interpreted as extreme. Most difficulties relating to any forms of mental distress have been found to be commonly conceptualised as spiritual difficulties, in response to which the recognised practice of faith healing is sought.

The theory that depression is becoming an increasing global epidemic, as well as the move to standardise such diagnoses and treatments globally, prompts the question of how depression would be understood by the Somali community. Furthermore, the continuing influx of Somalis into the UK implies increasing clinical contact with these communities who may continue to be given diagnoses and treatment that they deem unhelpful.

Little research exists that focuses on Somali perceptions of milder labels of mental health difficulties such as depression, which is already known to be an unfamiliar concept, with no equivalent in their language. So far, existing research has shown a strong attribution of depression to social and spiritual issues, without viewing it as a “mental-disorder”. However, this research remains scant in the UK, and methodological issues have limited the ability to see how Somalis may construct knowledge about the concept.

Together, these issues suggest a need for further research into Somali perceptions of depression, in order to add to the literature with regard to the debate on the globalisation of mental health, as well

as contributing to the aim of being culturally competent practitioners.

1.6 The current study

1.6.1 Justification for the current study

Depression has become an increasingly talked about concept, alongside a belief that it is becoming a global epidemic. As a result, there are calls to raise awareness of depression as a mental illness, with a focus on encouraging people to seek help and treatment. Such discussions appear to lean upon the Western notion of depression as a biomedical disorder, which implies that its causes are directly related to a biological or “brain disorder” and can consequently be treated with pharmacological interventions. In addition, recommended psychological approaches involve a course of therapy, which is aimed at overcoming negative cognitions, emotions, and behaviours that are seen to manifest as a result of depression. This Western view implies that depression exists as a singular, universal concept, which may be experienced and recognised globally, irrespective of culture or context (WHO, 2001).

However, cross-cultural research so far has highlighted that what the Western model diagnoses as “depression” would not be recognised as such in non-Western cultures. It is argued that these different views significantly impact on how such “illnesses” are understood and subsequently dealt with (Kleinman, 1988). For example, it has been shown that some cultures lack the appropriate language to recognise “mental illness”. These emerging findings appear to add to the argument for a more bio-psychosocial view of depression, in contrast to the existing Western biomedical view.

The current study therefore positions itself in line with the argument that social and contextual factors are significant in how depression may be understood or conceptualised. It is argued that taking these factors into account will impact on the process of making decisions about diagnosis and treatment. The view of this study is that explorative research of a qualitative nature is valuable with regard to expanding our knowledge on how conceptualisation occurs among different cultural groups (Bhui, 2004; Kohrt, 2014). The majority of research regarding cultural studies of depression does appear to be in line with the Western view, assuming the existence of depression as a universal concept. This has meant there has been less of a focus on how different cultural groups construct knowledge about such concepts. The need for explorative research is seen as especially important not only for different cultures and societies living throughout the world, but also for those refugee and migrant communities who are living in the West under the care of the Western mental-health system.

One such cultural group is the Somali community, whose numbers are increasing in the UK and thus also under the care of its mental-health system. Previous research has highlighted some of the cultural differences of this community in conceptualising mental health, which have been linked to an under-utilisation of mental-health services in the West (e.g. Scuglik et. al., 2007; Pavlish, Noor & Brandt, 2010). However, mental-health research specific to Somali refugees remains scant and many studies are limited in their findings by their methodological approaches. In particular, although depression has been identified as an unfamiliar concept in the Somali language, there appears to be a lack of qualitative research that focuses on how the community conceptualises this term. There exists little research that is specific to Somali men, with more of a focus on women or research that has mixed the two. Despite low access to services, there is said to be a high number of Somali men hospitalised under the Mental Health Act, as well as a high incidence of male suicide rates among Somalis in the UK. It is therefore important to focus on this particular group.

It is hoped that the explorative approach will provide some insight into how this concept is perceived, understood and approached in comparison to the Western view. This is relevant to counselling psychology with regard to increasing cultural competence when having contact with Somali individuals in mental-health services. Although the current study can only provide a small insight, it is hoped that this may raise questions about the global application of the Western model of depression, and provide a basis for further such research. It is hoped in time that increased knowledge here may assist in our understanding of Somali conceptualisations of depression and expressions of distress, and provide greater insight into difficulties in engagement with this group.

1.6.2 Objectives of the current study

The objective of the current study is to explore how Somali male refugees in the UK understand the Western construct of depression. In particular, the study will aim to explore how it is understood, caused, and coped with. Specifically, my research questions will be:

- How do Somali men understand depression?
- What methods of coping do they perceive as helpful?
- What are their views on Western-based help?

Findings will be discussed in relation to models of health and illness which have been criticised for being ignorant of cultural factors, which currently determine the use of diagnostic tools in Western psychiatry, which in turn can determine psychological input. In particular, it is anticipated that outcomes from the study will support the notion that mental-health should be regarded in terms of

the biopsychosocial model (Engel, 1977) rather than the former biomedical model approach. This would support the argument that socio-cultural factors are significant in determining how health, illness and psychological experiences are understood (Engel, 1977). In relation to this, it is hoped that findings will contribute to discussions about the universality of psychiatric diagnoses (Kleinman, 1988), and add to the literature, improving psychological services for the Somali refugee community.

Methodology

2.1 Rationale for a qualitative approach and research paradigm

2.1.1 Rationale for a qualitative approach

The study will adopt a qualitative methodology, the objective of which is not to make predictions but to be explorative of people's perceptions (Willig, 2008). Morrow, Raksha & Castañeda (2001) suggest that qualitative research enables researchers to address issues of context, power, and voice particularly when related to marginalised peoples. This is fitting with the aims of the current study, which is looking to elicit the voices of a refugee community.

The overall design of the current study will use the Constructivist Grounded Theory approach of data analysis (Charmaz, 2006). Justifications for this choice of method are explained below.

2.1.2 Rationale for my epistemological position

It has been suggested that to ensure a strong design, “researchers must choose a research paradigm that is congruent with their beliefs about the nature of reality” which inform their research aims (Mills, Bonner & Francis, 2006, p.26). In particular, they argue, “We are all influenced by our history and cultural context, which in turn, shapes our view of the world, the forces of creation and the meaning of truth” (Mills, Bonner & Francis, 2006, pg. 26). When making this choice, a range of factors need to be considered. These are, among others, the researcher’s belief about the nature of reality, the relationship between researcher and participants, assumptions about the role of the researcher’s personal values and biases, and the choice of methodology (Ponterotto, 2005).

As researcher I take a “critical realist’ position, which asserts that diagnostic concepts such as depression “... can be examined in the context of social and historical conditions which allowed them to emerge” (Pilgrim & Bentall, 1999, p.262). The underlying notion of this position and the current study is informed by a social constructionist perspective, seeking to explore how the “theories” behind the concept are socially constructed, taking into account factors such as gender, culture, context and race (Pilgrim & Bentall, 1999). This is in contrast to more positivist approaches, which are criticised for overlooking how these factors may shape and influence the understanding or practice of such concepts (Willig, 2012).

This position fits with the view that depression does not exist as a universal concept, as assumed by the Western biomedical model of depression, and may be understood differently depending on context (Kleinman, 1980; Summerfield, 2008). This is felt to be especially relevant to the awareness that the concept of depression may be understood differently across cultures (e.g. Kirmayer, 2012; Kleinman, 1988). Significant to this approach is the researcher's role, which takes the position as a co-constructor of data rather than a distant enquirer seeking an "objective" reality.

Taking the critical realist position allows for the exploration of how social and contextual factors might influence how the concept of depression is perceived, experienced and understood for Somali men in the UK. Thus, my position is based on the premise that individuals construct their worlds under particular historical and social conditions that shape their views, actions and practices (Charmaz, 2006).

2.2 Choosing a methodological framework

2.2.1 Constructivist Grounded Theory

Constructivist Grounded Theory "assumes the relativism of multiple social realities, recognises the mutual creation of knowledge by the viewer and the viewed, and aims toward interpretive understandings of subjects meanings" (Charmaz, 2000, p.510). As such, this method assumes the existence of a real world that may be interpreted in multiple ways.

Since the development of the traditional Grounded Theory model (Glaser & Strauss, 1967), various perspectives have evolved due to the existing debate with regard to "discovery vs. construction" and "objectivist vs. subjectivist perspectives" (Corbin & Strauss, 1994; Charmaz, 2006). The original version of Grounded Theory (Glaser & Strauss, 1967) is based on the premise that categories emerge from the data (i.e. a discovery-orientated understanding). In other words, it implies that sets of social or psychological relationships already exist objectively within the world, and are merely "captured" by any researcher. Thus such models are in line with the post-positivist/realist paradigms.

In contrast, the constructivist approach, posits that the researcher constructs theory from their interpretation of participants' stories. Charmaz (2000) further highlights the active process, which occurs within socially created situations. The researcher is seen as being a co-constructor of data since factors such as their position, privileges and interactions affect it (Charmaz 2000).

This approach demands that the researcher look beyond the responses of participants and attempt to recognise the values and beliefs upon which those responses are based. Unlike traditional grounded theorists, Charmaz (2006) does not assume that data or theories will be discovered, but rather the aim is to present an “interpretative portrayal of the studied world, not an exact picture of it” (Charmaz, 2006, p.10). Rather than developing a “theory”, Charmaz argues that any researcher's finished “grounded theory” is merely a “construction of reality” - i.e. an interpretation of the studied world.

This method appears to fit most appropriately with the current study for a number of reasons. Firstly, the notion that an individual's construction of reality is based upon context ties in with the study's focus on a group of Somali male refugees in the UK, and the impact of this on the resulting data. Secondly, as the focus here is not on meaning drawn from individuals' experiences but instead how perceptions of depression are constructed, this rules out phenomenological approaches. In addition, the aim of the current study was to give participants a voice, which can be lost in discursive approaches. Furthermore, its central focus of incorporating social process as meaningful to the data is seen as fundamental in exploring how the Western concept of depression is constructed, and for this reason was chosen over discursive approaches which focus more on language rather than process. Finally, the aim of this study was to give the participants a voice, and grounded theory enables multiple voices to be heard that would likely to be lost in more discursive approaches.

2.3 My role as researcher: ensuring reflexivity

In qualitative research, the researcher, alongside participants, is engaged in producing knowledge. Thus “reflexivity” allows for a reflection on this process as a way of ensuring both rigour and quality. Being reflexive involves being aware and reflective of my position as researcher, i.e. “the class, race, gender, sexual orientation etc. (...) everyone brings their own histories, social standing and cultural background with them to all endeavours - including the process of researching.” (Rhoads, 1997, p.480).

In the majority of existing qualitative studies in this field, the researcher is often posed as “distant expert” (e.g. Carroll, 2004; Lee, Lytle, Yang & Lum, 2010). However, self-reflection on one's position is critical for both the researcher and research process as part of Constructivist Grounded Theory and its epistemological stance (Charmaz, 2006).

Therefore the following factors were considered as having a potential impact on the research

process and construction of data:

- ❖ My identity as a White British woman
- ❖ My professional role as a trainee counselling psychologist
- ❖ My experience of working professionally with the Western model of mental health
- ❖ My knowledge and exposure to the Western model of mental health
- ❖ My perception of self as an autonomous

In order to improve reflexivity, I viewed myself as a “co-constructor” of meaning, and as integral to the interpretation of data. This included keeping a record of ongoing experiences and my reactions from assumptions or biases that emerged and is expressed in the writing of my self-reflective journal (Appendix 5.4). Furthermore, I kept in contact with my Somali colleagues who served as a mirror by reflecting my responses to the process (Hill et. al, 2005; Morrow, 2005).

It is argued that it is essential to pay attention to the “critical dimensions” of the research process affected by diversity (Green et. al., 2007). These include the process of data collection, analysis and interpretation. I will therefore be documenting reflections throughout my method and analysis in my effort to be transparent about processes, which I feel impacted upon the generation of data throughout. I will draw these together in a section on reflexivity in the final chapter.

2.4 Data collection

2.4.1 Ethical considerations

Due to the cultural basis of the study, specific ethical issues were considered. Firstly I took steps to familiarise myself with the Somali background and culture (Hudson & Taylor-Henley, 2001). This is necessary when carrying out cultural-specific research (Barnes, 1996; Green, Cresswell, Shope & Plano-Clark, 2007). This involved reviewing the literature with regard to Somali culture, as well as attending several meetings run by a local mental health charity for Somali individuals in the community. Further exposure came from my experience of working with Somali men within mental-health settings. This enabled me not only to observe cultural practices, but also to recognise how my presence might impact on the process of data collection. For example, I seemed to be eliciting respect and consideration of my own needs. I reflected on this within a diary to ensure I was taking this into account during the analysis process, as well as assisting in formulating research questions I felt were culturally appropriate (Barnes, 1996). It was necessary to continue to reflect upon how my own values, biases, assumptions and experiences impacted upon the research

(Morrow, Raksha & Castañeda, 2001), and this reflexivity is commented on throughout my analysis and discussion.

2.4.1.1 Ethical approval

Ethics of the study were formally checked and approved by the University of East London Ethics Committee (Appendix 1). There was no formal process required for obtaining further ethical approval from the Somali communities involved in the research.

2.4.1.2 Informed consent

The initial consent form was presented in the Somali language in order to ensure that full individual consent was obtained (Marshall & Batten, 2003) (Appendix 2.4). I was aware that the collective nature of the community could mean that participants were unfamiliar with the individual process of being asked to give consent (Mohamed & Loewenthal, 2009), and hence this was fully explained at each step of the process.

Password-protected material, anonymised recordings and response confidentiality were important ethical procedures throughout the study. On an information sheet at the recruitment stage, and at the start of the group and the interview, participants were assured of their right not to answer questions, and terminate an interview and withdraw from the study at any time (Appendix 2.1). Participants were given the opportunity to present any particular concerns at the end of interviews and after each interview was completed, the intentions of the study were fully explained.

2.4.1.3 Anonymity and confidentiality

Prior to the interviews, participants were assured of confidentiality and anonymity both verbally and in the information sheet (Appendix 2.1). Care was taken throughout the research process to preserve participants' anonymity through the use of pseudonyms and by omitting any details specific to their identity.

2.4.2 Participants

2.4.2.1 Sampling considerations

Participants were selected through purposive sampling – i.e. the selection of a target group in a deliberate and non-random fashion, who may have the best knowledge and / or experience of a topic (Smith, 2008). Inclusion criteria were as follows:

✧ **Somali male refugees, first generation.**

This ensured the focus remained on those who are refugees who will have had experience of migration to the UK.

✧ **To be proficient in the English language.**

This was to avoid the use of interpreters, which would have added complexity to the translation and analysis process.

✧ **To have not ever accessed UK mental health services.**

This was to avoid those who may have been exposed to the Western mental health system as a patient, which could have influenced their input.

The aim of qualitative methodology is to focus on understanding a phenomenon rather than yielding results that may be “generalised”. Grounded theory requires the researcher to continue collecting data until “saturation” is reached, i.e. “the point at which gathering more data reveals no new properties or any further theoretical insights” (Charmaz, 2006, p.189). However, the time-limitations of the current study put constraints on the number of participants required to reach what might be referred to as theoretical saturation in this sense. Furthermore, an argument as to whether theoretical saturation is possible has been critiqued (e.g. Strauss & Corbin, 1998; Dey, 1999), and instead saturation has been proposed as a “matter of degree” (Strauss & Corbin, 1998, p.136), as there will always be the opportunity for new data to emerge. Therefore, rather than reaching theoretical saturation, the focus here was to “collect sufficient data to discern how research participants construct their lives and worlds” (Charmaz, 2008, p403). Thus, the goal was to continue recruitment until categories emerged that were seen to reflect participants' perceptions and provide a way of understanding them (Charmaz, 2006). This process is discussed in more detail in the ‘data analysis’ section.

2.4.2.2 Recruitment

Accessing the Somali community can be difficult, thus I made use of Somali colleagues, to ask their advice and begin the process of recruitment. This process is described below.

- Contact was made with a Somali colleague by email, and an information sheet was sent to him outlining the purpose of the study (2.2). This colleague was asked as to how to proceed in recruiting a group of Somali men.
- This colleague offered to recruit several men from his local community, and information

sheets were passed to them. No contact was made with participants prior to the focus group.

- Following the first focus group, all participants were invited to take part in semi-structured interviews, (but were not obliged to). Three participants agreed and contact was made with them separately to organise these.
- For the second focus group, another Somali colleague was approached by email, and information sheets and invitation letters were passed to several men in his local community.
- This colleague recruited five men for the second focus group, and no contact was made between myself and participants prior to the focus group. Subsequently all were invited to attend interviews and four of the five men agreed to do so.
- All contact with the participants was made via the Somali colleagues, and details such as places, times and dates were negotiated through them.
- The same process was repeated for the third focus group via the second colleague. This consisted of three participants, two of whom subsequently agreed to meet individually.
- A total of 12 participants were recruited, and their demographic details can be seen in Table 1.

Table 1: Participant demographics

	Name	Age range (years)	Occupation	Range of time in UK (years)
Focus group 1	Samuel	40-49	Bakery worker	20-25
	Mustaf	40-49	Religious leader	20-25
	Moses	40-49	Charity worker	20-25
	Oliver	40-49	Charity worker	20-25
Focus group 2	Ali	20-29	Student	10-15
	Hasan	40-49	Taxi driver	20-25
	Yusuf	40-49	Store shift manager	20-25
	Ibrahim	40-49	Counsellor	20-25
	Ahmed	40-49	Mental health support worker	15-20
Focus group 3	Jibriel	30-39	Accountant	5-10
	Hussein	50-59	Accountant	20-25
	David	50-59	Community worker	15-20

2.4.2.3 Setting

Participants were seen at a variety of convenient settings where confidentiality could be assured. These included counselling rooms in NHS healthcare settings and private rooms in local community centres.

2.4.3. Materials

2.4.3.1 Use of Vignettes

Vignettes are a commonly used tool in qualitative research (e.g. Hill, 1997; Hazel, 1995). They have been defined as being “stories about individuals, situations and structures which can make reference to important points in the study of perceptions, beliefs and attitudes” (Hughes, 1998, p. 381). They are used in qualitative research for a number of purposes, mainly as an aid to elicit interpretations, judgements and information with regard to a situational context (Barter & Renold, 1999). They are commonly used across focus groups and individual interviews (e.g. Wilkinson, 1998), and examples often include moral dilemmas or topics that are sensitive in nature (Finch, 1987; Hazel, 1995).

For the current study, the use of a vignette was employed as a tool for a number of reasons. Firstly, talking about personal difficulties or mental health issues is a sensitive issue within the community. This tool allowed participants to listen to a story that depicted the Western concept of depression (Appendix 3.1) and invited them to actively communicate their views and perceptions of what was occurring in the story. It was hoped that participation in the vignette was viewed as less threatening, while facilitating discussion and helping to strengthen the rapport in the group (Hazel, 1995). In addition, this process enabled participants to have control over what stage they chose to participate in, if at all (Neale, 1999). Lastly, it enabled a multi-method approach, in which the information elicited within the focus group was later explored in the individual semi-structured interview, an approach that has been found to be successful (e.g. Wade, 1999). The use of vignettes has become increasingly popular in social research, and has been used in similar cross-cultural studies on depression (Karasz, 1995; Cabasa et. al., 2007; Lackey et. al., 2008).

Issues of diversity were taken into account when formulating the vignette and interview questions. A Somali colleague was asked to review the vignette and determine if it was culturally relevant. It is argued that within grounded theory, acknowledging diversity is crucial throughout the research process. (DeVault, 1995).

2.4.3.2 The use of a Dictaphone

After consent was obtained a Dictaphone was used to record all interviews (Appendix 2.2). Following interview completion, all recordings were downloaded onto a password-protected computer and subsequently deleted from the Dictaphone.

2.4.4 Procedure

2.4.4.1 Using a multi-level approach

The interview process used a multi-level approach, involving a combination of focus groups and individual interviews. This is a widely used approach, which has many advantages (e.g. Lambert & Loiselle, 2008). For the current study, there are a number of advantages in using this approach. Firstly, the follow-up interview allowed for specific components of the initial group narrative to be explored in more detail. It also allowed a space for participants to elaborate on their personal attitudes and beliefs, which may or may not have been shared within the initial group (Rothschild & McDermott, 2000), making this method especially appropriate for addressing a sensitive topic. Charmaz (2006) advocates the use of multiple interviews over time, regarding this as a way of obtaining deeper insight into a participant's worldview, and the issues, which appear important to them, and suggests that such insight may not be gained from a single interview. Despite the combination of the two approaches, it was important to observe each method as a separate phase of data collection.

The process occurred in stages, as illustrated below (figure 1). Focus groups took place first and following this all participants were invited to attend an individual interview. For example, five participants took part in focus group 1, and three volunteered to be seen for a follow-up individual interview. The process was then repeated for focus groups 2 and 3. Table 2 gives details of participant numbers at each stage. To follow is an overview of each of these stages, and the reasons these were felt to be appropriate for the current study.

Figure 1: Stages of data collection

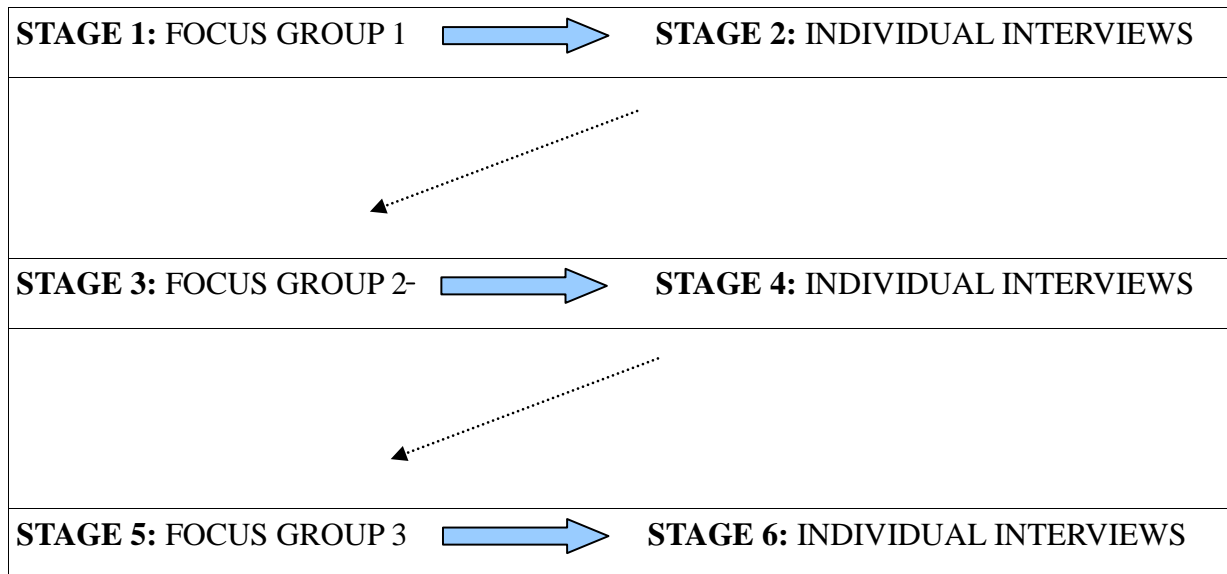

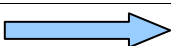



Table 2: Stages and numbers of participants

FOCUS GROUP NO.	Number of participants		Semi-structured interviews: No. of participants
1	4		3 (Samuel, Moses, Oliver)
2	5		3 (Ali, Yusuf, Ahmed)
3	3		2 (Hussein, Jibriel)

2.4.4.2 Focus groups

Focus groups are used to explore peoples' knowledge and experience of a topic. They are said to “reveal dimensions of understanding that remain untapped by other methods” (Kitzinger, 1995, p.299), draw on a multiplicity of opinions, and open areas of dissent and debate. It has been suggested that focus groups are the most appropriate and ethical way of investigating hard-to-reach groups such as the Somali community (e.g. Mohamed & Loewenthal, 2009). They are said to be particularly suited to cross-cultural research, for example, in exploring how meanings are constructed across languages (Kitzinger, 1995; Watkins-Mathys, 2007).

One aim of the focus group was to build rapport with participants, while gathering an initial breadth of data. This allowed for initial data collection as befitting the Constructivist Grounded Theory approach, which began a process of theoretical sampling (Charmaz, 2006). Data was analysed and refined following each focus group as a way of informing which data to explore in subsequent interviews.

The focus groups ranged between five participants (focus groups 1 and 2), and three participants (focus group 3). Although focus groups are commonly suggested to have between six and twelve participants (Krueger, 1998; Morgan, 1997), it was felt that the specialised knowledge of the participants was better suited to smaller focus groups (Krueger, 1994; Morgan, 1997).

The vignette was read aloud to participants at the beginning of the focus group. The vignette provided an external reference point that assisted the participants in “warming up” and making them feel comfortable in the group (Kitzinger, 1994 p.107). The vignette described a man showing symptoms and behaviours in line with criteria for the DSM-IV definition of depression (Appendix 3.1). The term “depression” was not used, to avoid influencing how participants responded. The participants were then asked a number of questions, to elicit their perceptions of what may have been happening to the character in the story, any factors they felt may have caused his behaviour and any help or coping mechanism they felt might be required (interview schedule in Appendix 3.2).

Throughout the process, the use of questions was minimised and instead a focus on using active listening skills. This allowed the participants to do most of the talking, enabling them to take control of the narrative so that the discussion could move in directions that were unanticipated but significant to the participants (Rothenberg & McDermott, 2000). Following the group discussion all participants were invited to take part in an individual interview, although this was not obligatory.

2.4.4.3 Semi-structured interviews

A semi-structured interview is a commonly used method in qualitative research. It is defined by its flexible and fluid structure, based only on a loose interview guide covering topics or themes of interest. This is in contrast to structured interviews, which contain a sequence of questions to be asked in the same way of all interviewees. The semi-structure allows for flexibility in how and in what sequence questions are asked, and is shaped by the interviewee's own understandings as well as the researcher's interests.

Participants who agreed to take part in an individual interview were seen on a separate occasion, with the aim of providing greater depth to the group data previously collected. The data from the focus group thus initially shaped the follow-up individual interviews, allowing the two methods to interact to produce richer data (Morgan, 1996).

It was important and useful to note when individual responses differed from the group setting. For example, it was observed that at times within the focus groups certain members who appeared to represent more powerful or respected positions within the community often impacted upon the dynamics. The individual space therefore enabled an opportunity for the participant to speak without the presence of such dynamics (Rothenberg & McDermott, 2000).

2.5 Data-analysis

Charmaz (2006) advocates a method of analysis that allows researchers to view the researched phenomena in the same way as participants in the research area see it. These techniques can be changed during the research process to suit events occurring in the field (Charmaz, 2006).

Charmaz (2000) argues that the focus should be on meaning, action and process. She states that the result is rarely presented as a theory, but instead a “story about people, social processes and situations” (Charmaz, 2000 cited in Glaser, 2002, para 15). The analysis reflects both the participants' and the researcher's way of thinking.

Below is a brief description of the general steps that were involved in the analysis. It is suggested that when using this approach, researchers “need to go beyond the surface in seeking meaning in the data, searching for and questioning tacit meanings about values, beliefs, and ideologies” (Mills, Bonner & Francis, 2006, p.31). To enrich data, I positioned myself as ‘co-producer’ to the emergence of data (Charmaz, 1995), accepting my role in adding to the “description of the situation, the interaction, the person’s affect and [their] perception of how the interview went” (Charmaz, 1995, p.33). My role as a co-constructor of the data is reflected upon throughout the analysis.

2.5.1 Stage 1: Recording and transcription

Each interview was recorded using a Dictaphone. Following each interview, the recording was listened to prior transcription, and notes were made on the process occurring during the interview, in order to aid a feeling of being immersed within the data (Charmaz, 2006). Each interview was transcribed prior to the next interview, allowing for on-going analysis throughout the process of data collection. This process helped to guide subsequent interview questions and facilitated the

emergence of codes and categories, as required in the process of Grounded Theory (Charmaz, 2006).

When collecting data, I checked with participants throughout the process to help ensure appropriate and representative portrayals of their responses (Marshall & Batton, 2001). This was achieved mainly through summarising points and checking for clarity with participants throughout the interview process. This was done in an attempt to avoid any culturally inaccurate findings and prevent damage to the community (Herring, 1999; Green et. al., 2007).

2.5.2 Stage 2: Initial coding

Transcripts were studied line-by-line with the aim of identifying any actions or events that occurred in the data. As suggested by Charmaz (2006), “active” codes were used to help define implicit processes in the data (Charmaz, 2006). This involved focusing on what processes appeared to be present within the data, using gerunds as a way of expressing this within the coding. This enabled more of an analytical view of the data, rather than one that was merely descriptive. Furthermore, this step assisted in staying close to the data. An example of this process can be found in Appendix 5.1.

2.5.3 Stage 3: Focused coding

Focused coding allows for separating, sorting and synthesising of large amounts of data. It is described as making “decisions about which initial codes make the most analytic sense to categorise your data incisively and completely” (Charmaz, 2006, p.57).

Focused codes were identified by paying attention to chunks of initial coding and labelling them. Each focused code was written onto a separate post-it note, and these were laid out on a separate sheet. The more meaningful or frequently occurring codes were then tentatively arranged into groups or initial categories (example shown in Appendix 5.2). Writing memos aided the process of refining categories, as described below.

2.5.4 Stage 4: Memos

Memos are a technique used to direct further data- gathering and refine codes (Charmaz, 2006). This process serves an analytic purpose and can be used as next step to building on the emergence of categories. The process involved examining the focused codes and using a method of writing reflectively to document connections within the initial categories, while using the “constant comparison” method (Glaser & Strauss, 1967, Charmaz, 2006) (two examples can be found in

Appendix 5.3). This is a method used within Grounded Theory where new data is compared with existing data as a way of generating codes and categories.

2.5.5 Stage 5: Refining categories

The next step is known as “theoretical sampling”. This process involved using the initial codes to stimulate further data collection, whereby subsequent interviews were guided by previously collected data (Glaser, 1978). This process of theoretical sampling together with memo-writing supported emerging categories and defined their properties as new data was compared with existing data (Morrow 2005). Once no new data emerged, the process of data collection ceased. As a way of managing the emergence of well-established categories, the data was constantly reviewed, ensuring that new data was identifiable (Dey, 1999, Charmaz, 2006). This process was carried out until “theoretical sufficiency” was reached (Dey, 1999, p.257).

2.5.6 Stage 6: Identifying the core category

The final stage involved identifying a “core category”, viewed as a central concept that links all the categories and sub-categories together (Strauss & Corbin, 1998). This offers an interpretive answer to the research endeavour investigating how Somali male refugees perceive depression.

ANALYSIS

3.1 Overview

The analysis begins with the identification of the core category, which offers an overall interpretation of how this group of Somali male refugees conceptualised depression. This is discussed in relation to four main categories and their sub-categories. A majority of the categories and sub-categories embody the social difficulties relating to migration and resettlement as well as the conflicts and struggles as a result of the mismatch between Somali and Western cultural values, norms and beliefs. The third category in particular demonstrates the social process of the struggle for participants to grasp “depression” as a term and demonstrates the effect of the conflict between the Somali and Western influences on their understanding. The fourth category integrates these factors and addresses participants' views of coping and attitudes to help-seeking in the West.

3.2 Identifying the core category

A “sense of disconnection” was identified as the core category, as this appeared as a frequently recurring concept throughout the data. A sense of disconnection in relation to both the Somali community and UK society appeared as a result of migration. This was seen to link to the other categories, with regard to a perceived “loss of strength” and “struggle for identity” as well as discrepancies regarding professional help and unmet needs which left them “deliberating help”. “Searching for depression” further demonstrated this as a process that participants appeared to experience, in their conflicting attempts to define depression.

Figure 1 illustrates this as a theoretical model, locating the core category at the centre, showing how this links with the other four main categories. This illustrates how the loss of the sense and strength of community appeared to result in the loss of identity for the participants, and together these factors appeared to result in the dilemmas associated with the forms of help required to meet these needs. The search for depression appeared as a process resulting from all three factors. All four related to the core sense of disconnection that participants appeared to be expressing.

Arrows are used to show the direction of the proposed relationships between these. Table 3 lists these identified main categories and their subcategories.

Figure 1: The conceptualisation of depression by Somali male refugees

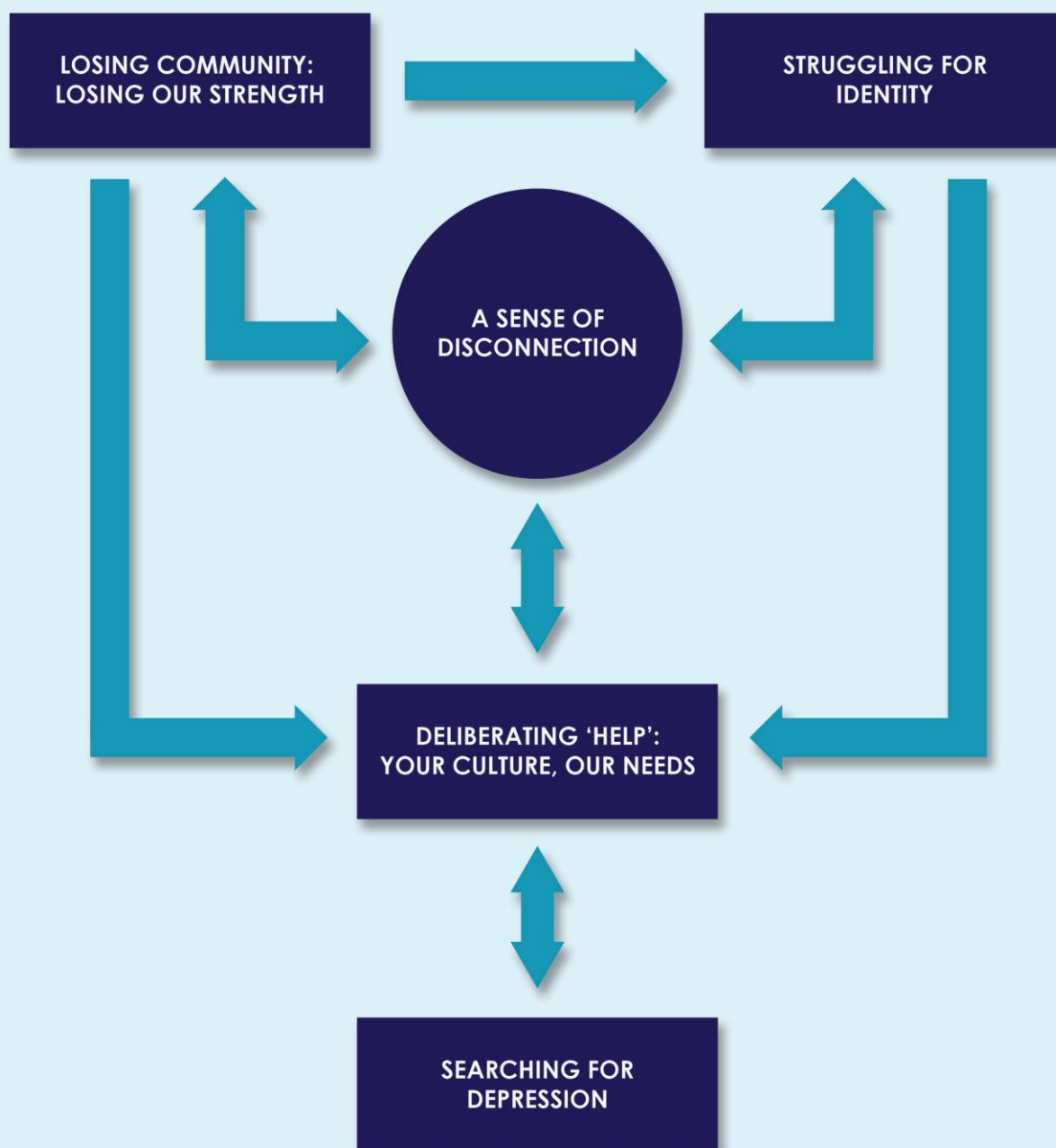


Table 3: Categories and subcategories.

Main category	Sub-category
Losing community: losing strength	<ul style="list-style-type: none">⤴ Comparing cultures: community as strength⤴ Isolation and “illness” in the Western World
Struggling for identity	<ul style="list-style-type: none">⤴ Losing status: “From the sky to the ground”⤴ Losing authority: “Here, the women have the power”
Searching for depression	<ul style="list-style-type: none">⤴ As unfamiliar: “it’s a new word in our culture”⤴ As a visible “mental illness”?⤴ As spiritual: Possession or curse?
Deliberating “help”: Your culture, our needs	<ul style="list-style-type: none">⤴ Silence in suffering: Pride and prejudice⤴ Keeping our faith: The need for spiritual healing⤴ Avoiding the Professionals: Unmet needs, labels and the “zombie”⤴ The future: Integrating but separating

3.3 MAIN CATEGORY 1: LOSING COMMUNITY: LOSING STRENGTH

I've seen someone who erm becomes depressed, you know, then erm he became eventually totally out of order, and he went home... and he become ok after a couple of months, when he's been there.. he was fine.. I don't know whether it was to do with the society around him or that he was feeling maybe homesickness, erm when he was away and living abroad.. erm he was missing something. (Jibriel, L161-165, FG3)

This category was developed to incorporate how participants constructed meaning about the roles of the community with regard to an individual's wellbeing. "Losing our strength" reflects how participants talked of the community as providing a sense of strength, protection and meaning to the individual. The focus here is on how participants referred to the impact of migration to the UK and the changes and loss of this sense of community. In particular, participants' constructs of the West embodied an increased sense of isolation and separateness from the community, resulting in an increased sense of individuality with regard to functioning and coping.

3.3.1 Subcategory 1.1: Comparing cultures: Community as strength

This first sub-category draws on participants' talk, which introduces the underlying essence of the community as being the core element which influences, the day-to-day life of the individual. Participants talked of the community as providing a sense of cohesion, belongingness, and interdependency. This was often spoken about in comparison to the lifestyle of an individual in the West.

The concept of being alone or autonomous was often responded to as unusual or negative. For example, Ahmed's description of the living environment for a single person in Somalia highlights the cultural norm of staying within the family unit, implying that the Western norm for a single person to live alone is viewed almost as an alien concept.

... if it was Somali, Somalia ... probably you wouldn't live alone you know, even if you are a single person ... for example, you might have a cousin, or brother or sister live with you ...
(Ahmed, L231-232)

Participants spoke about this sense of being integrated with the community as stemming from both the cultural and religious values of the community and providing a moral, meaningful and safe basis to live by. For example, Mustaf indicates that to be embedded within the community serves to

provide a form of protection for the individual, and that without such an individual may be vulnerable.

... to be alone is not in our religion. It's not our religion. We have a problem if we are alone. We are with people you see ... to live with people you see ... to live with someone ... (Mustaf, L100-102, FG 1)

... we haven't been created to live alone ... (Mustaf, L85)

Others such as Jibriel also spoke of religious values as providing a framework to live by which was portrayed as a way of ensuring positive wellbeing for the individual and in turn the wider community. This again appeared to highlight the role of the individual in keeping to the “path”, this seemed to ensure a safe, harmonious environment for the wider community. It again seems evident here that Jibriel's expression of the rules of the wider community appear to take prevalence over the individual. His reference to the use of “we” appears to be reflective of not separating himself from the wider community context.

We believe that if, because the religion teaches us all the right things ... you know, you will be safe if you stick on, on, you know, on the ... erm ... path ... you have to erm ... be respect to others, you have to erm ... erm work, and erm try your best, and erm you know, look after yourself, after your family, erm ... do no harm to anyone ... do not do anything that harms ... smoking, or drinking, or drugs or all this ... erm so you will be a good person ... that will really ... erm ... mentally and physically you will be a good person. (Jibriel L103-114)

Oliver spoke about the community as providing a sense of meaning and purpose to the individual, while also showing the impact of an individual's isolation on the wider group (the family), indicating that to be integrated serves the greater good of both the individual and the group as a whole. It appears that here Oliver is drawing upon certain central principles of Somali culture.

... otherwise life doesn't make any sense for a human being ... you get isolated for one hour, two hours ... because it's not a normal sense for human beings ... for being a human being with human beings ... so that is a sense of living, basically. Where if you feel isolated ... the family or you feel senseless ... (Oliver, L114-116)

Being surrounded by others and having this sense of belongingness was also spoken about as providing a source of strength and support to individuals. Participants appeared to provide a view that helping others was a community expectation and they worked with others to achieve this. For example, in response to the vignette, many participants like Ahmed spoke about the community's potential response to seeing an individual withdraw. The common response showed extended proactive group involvement in attempting to address the individual's difficulties. This illustrates the impact of the individual on the community and further underlines core communal values.

... you will have social contacts and people who can turn up any time at your house, and would care for you, and prompt you to do things ... take you, even, take you to try to do things, like your parents might, even physically, you know, tell you to have a shower, you know, and say those kind of things in a caring way ... it's proactive and the family ... cousins, even the neighbour will help you in Somalia ... (Ahmed, L234-238)

3.3.3.1 Summary

This sub-category focused on participants' accounts of the different ways in which they constructed a sense of community and its values. Overall, this seemed provide a source of strength, support, purpose and protection. The wellbeing and behaviours of an individual were shown to have an impact on the wider community, indicating the pressures on them as individuals to comply and conform to its cultural norms in order to keep its sense of cohesiveness and harmony. The way in which participants expressed themselves here also appeared to illustrate a tendency for core cultural values and principles to take prevalence over individuality.

Reflexivity: it was apparent that my role as a trainee counselling psychologist impacted upon the process I experienced: I was drawn in particular to the loss that participants spoke about which elicited feelings of empathy in me. I was thus more focused on this topic within the process of data collection in which my questions and interjections may have encouraged talk on this. This subsequently impacted upon my analysis as I was drawn to highlighting this as a key issue.

3.3.2 Sub-category 1.2: Isolation and “illness” in the Western World

This sub-category focuses on the spoken struggles of maintaining a sense of community following migration to the Western World. The focus here embodies the constructs given of the West with particular regard to the impact on the individual and subsequent links to 'illness'. The participants seemed to draw upon constructs of a typically Western lifestyle, these accounts included “isolated living”, “increased responsibilities” and “self-reliance”. Based on this understanding and

experience, the participants commonly made comparisons of individual wellbeing in Somalia and the UK.

For example, Ali's talk here incorporates constructs of the UK as isolating and having higher occurrences of negative events such as familial breakups. In comparison, he constructs life in Somalia as supportive, with rare occurrences of familial breakups or having to cope with difficulties alone.

... because when in a new country a different situation ... 'cause erm sometimes you find yourself feeling lonely ... sometimes maybe um you're isolated, family break-up, this kinda stuff, which is maybe unusual or easier back home ... So underlying issues (INTERVIEWER: So if this was in Somalia, would it be different do you think?) Erm it would be a little bit different, because in Somalia, because here, it's different, because social circumstances ... there is big families, relatives, always right in the middle of things, you know ... Here you are alone, cold weather, yeh ... so it's different ... (Ali, L41-52)

Hasan also emphasises the need for community, and talks about the search for this on arrival in the UK.

... you know ... we come where the communities are ... (Hasan, FG 2, L117)

This loss of support was spoken about as contributing to the increased pressures and struggles to cope with day-to-day life. Some participants such as Oliver commented on the increased pressures on women, viewing these as responsible for difficulties or illness.

... there are many communities in this area ... mainly women from single mums ... most of Somali women are depressed because they actually, they can't ... they can't actually tolerate this, you know Western lifestyle because they came from back home where there's no, you know, stressors, these factors. (INTERVIEWER: So is this the environment you're talking about?) The environment I'm talking about, because here, Somali women doesn't normally ... she has to everyday ... raise the children, take them to school, all of this, all of this, she is actually ... the women in this area are basically frustrated, stressed or depressed ... (Oliver, L136-143)

Participants also constructed the Western lifestyle as encouraging independence and individuality, resulting in separateness from the community and restricting the sense of togetherness. Hussein talks about the adaptation to this lifestyle as potentially harmful and sees being diagnosed with “depression” as a consequence. It could therefore be suggested that the restricted sense of community, increased individuality and self-reliance in the West may be viewed by some as resulting in an increased sense of isolation and loneliness and is thus harmful to the individual.

... I know a friend of mine ... who, whose son ... has depression. The government gave him a one bedroom flat ... you know the borough, the local authority ... he's in his 20s, living on his own, he doesn't want to come home with mum and dad and brothers ... and he's getting more depressed ... you know and that is the problem here—had this person been back home it would've been different—he would never have been this lonely ... (Hussein, L120-127)

Migration to the West was therefore portrayed as increasing the risk of developing such “illnesses”. Here, Hussein constructs depression as an “illness”, but relates this to being a consequence of the new “individualistic” “isolated” lifestyle.

... I believe, because, is it because the developing world reached the stage where these kind of illnesses are coming now, and the Western world faces this, and then people from other cultures where it was more kind of err family orientated, people staying together, that kind of illness was very rare—it was there but it was very rare ... and then here, people are very individualistic, very isolated, and that illness is starting, and that is why the Western world has seen this—they are trying to solve it, they've tried to treat it, and now they are ready to give to people who came to this part of the world and want to live like this, it could be that, and we need it. (Hussein, L385-393, FG3)

It therefore appears that Hussein's construct of illness here integrates social and environmental factors, emphasising the change to the Western “individualistic” culture and lifestyle with special implications for Somali migrants.

3.3.2.1 Summary

Overall, migration to the West was portrayed as resulting in the loss of the cohesive, supportive and protective structure of the Somali community. Participants spoke of the West as isolating and introducing increased pressures, communicating the struggle to maintain the sense of cohesiveness and protection of the community. Consequently, Western concepts such as depression were seen to

be only associated with life in the West, in which living alone away from a community-based structure was viewed as potentially harmful or damaging to the individual.

Reflexivity: I was aware how I was particularly drawn to the participants' talk of increased isolation and how they viewed this as harmful. The contrast to my own Western culture, which tends not to see the relationship between individuals and society in this way, draws my attention to it. However, in my wish to explore this further there is an impact on my data. As a sympathetic Westerner I may have prompted my participants to communicate the defects of the Western lifestyle.

3.3.3 Overall summary of category

Participants highlighted in this category:

- The Somali community is viewed as a source of strength, protection and meaning to the individual
- The Western lifestyle is isolating and more pressured for the individual
- Migration to the West results in a sense of disintegration of the community and its resources
- Depression is an 'illness' that may be a result of such negative changes in environment
- Such 'illness' is unheard of in Somalia, and attributed to the West.

3.4 MAIN CATEGORY 2: STRUGGLING FOR IDENTITY

... you know when you come here it's like an ocean ... you don't know where to start ...
(Jibriel, L228-229)

This category arose from the constructs participants drew upon with regard to a negative sense of self for a Somali man as a result of migration to the UK. In particular, participants related this to the changes in the roles for a Somali man in both Western society and within the family. In particular, participants focused on a loss of professional status and a change in the patriarchal role as a man within the family.

3.4.1 Subcategory 2.1: Losing Status: “From the sky to the ground”

This sub-category addresses the constructs participants drew upon in relation to losing professional status as a result of migration to the UK. This was acknowledged by a number of the participants as having a negative impact on a Somali man. Most did not share their own experiences of this but instead referred to hypothetical experiences and feelings.

Yusuf constructed meaning about his use of the word “depression” as feelings of “failure” as a result of losing professional status. He also drew on a sense of disappointment as a result of migration, and it could be suggested that migration to the UK was initially viewed as a form of escape for a better life.

Depression in Somali society ... how we see depression is like failure. When they expect something. Initially when they come to the UK, they expect to be getting a nice house, or good education, proper job ... when they eventually come here ... there's nothing, zero. So what happens ... some of the men ... they used to work higher job back home, but here they end up cleaning or driving a bus ... and ask themselves ‘why am I here?’ (Yusuf, L213-217)

Samuel also spoke about this using a metaphor of a pilot falling from the “sky to the ground”, drawing on talk about Somalia as providing a “good life”, emphasising the higher professional status it enables. In comparison, he draws on constructs about migration to the UK as having taken this professional status and good life away.

... from the sky to the ground ... That good life have gone ... you've got that person in Somali ... a doctor ... in Somalia a very nice job ... when he came here ... he's got nothing ... his profession is gone ... his life is gone ... everything is gone. So that person ... when he is going on the streets of London, he is not mentally good. (Samuel, L332-340)

Participants also spoke of the lack of status recognition post-migration, and it appeared this was portrayed to be a common experience for Somali men on arrival to the UK. Jibriel attributed a process of feeling “lost” and in “despair”.

... you know we had men who were professionals, engineers, you know doctors ... when they came over here there were no jobs erm they couldn't you know get a job for their profession erm ... that also resulted to become despair ... you know erm ... maybe sometimes lost ... (Jibriel, L53- 56).

Participants who spoke about this also drew on talk about the UK as unhelpful and ignorant with regard to assisting with employment and status. Samuel, keen to share his story, compared this unhelpful view of the UK to a more helpful view of Somalia.

I was walking around this country, when I came here, London, for seven months ... in a tie, suit, Samsonite full of different qualifications: from high school, through university. International seminars ... Speaking five different languages. When I work ... [pause] from high school headteacher, supervisor and then go to er assistant, you know at university ... lecturer in university ... that department officer ... of education ... huh. When I came here, and go to the British Counsel here, a British Counsel who came to my country, and came to my department and gave him instructions on what he can do and what he can not do ... when I came here and see those people who used to come to Somalia, to my office, working with me. When I asked him to give me a job ... he say: ‘we cannot help you.’ (Samuel, L352 - 361)

Others drew on constructs of life post-migration in the UK as overwhelming, unfamiliar and stressful. For example, Oliver spoke of the difficulties adapting to the unfamiliar environment as well as difficulties associated with resettlement such as housing and employment. It appeared here that he was expressing a sense of being marginalised from UK society.

... they still face some problems because they don't have enough experience, knowledge of this environment ... and they sometimes get distressed ... they're failure to get a job and apply for housing ... and finally they feel some sign of pressure or stress, and you can see it (Oliver, L259-261)

Samuel drew on an experience of feeling hopeless as a result of such difficulties, and expressed how he saw that accepting lower professional status was a necessity and requirement of adapting to the UK. Through his story, he spoke about locking away his professional identity and status; seeing this to be his only option.

How (is) my life is ruined now coming here with these people...what can I do? So it caused me a lot of thinking in my mind ... (INTERVIEWER: Mm ... lots of thoughts) Yeh in different ways (INTERVIEWER: Yeh) ... and then I say 'this is maybe the route that can save me' and I go through that route ... I succeeded. I succeeded in that way. And then I go back to my home ... I've got the Samsonite ... I kicked the Samsonite under my bed ... I said 'wait there until my country will be safe' and then I start from there from scratch, and became a bakery worker. (Samuel, L401-409).

3.4.1.1 Summary

This sub-category has addressed how participants drew on constructs relating to a negative sense of self as a result of their immigration into the UK. Participants experienced unhelpfulness and a lack of accommodation in particular with regard to their skills or professional status. In contrast to this negative experience of the UK, it seemed that Somalia could be seen in a more positive light, a country that in fact enabled a better life.

Reflexivity: My role as a Western-based trainee counselling psychologist may have contributed to the commonly shared sense of the participants' frustration at the immigration process. I was aware that I was encouraging the process of being heard, and as a UK citizen I felt a responsibility for their immigration experience. In this sense these emotional reactions in this process may have contributed to the construction of data, by my need to convey these issues in the analysis (e.g. Parker, 2005).

3.4.2 Subcategory 2.2: Losing authority: “Here, the women have the power”

This sub-category incorporates participants' talk with regard to the impact of migration on the sense of identity in relation to changes in the role of a Somali man within the family. Participants commonly drew on comparisons between the roles of the Somali man in the family in Somalia and the changes in this role post-migration to the UK. Participants also spoke of this as contributing to the use of khat post-migration.

Yusuf and Jibriel expressed the change for men as a loss of the “dominant” position in the family as the role of breadwinner within the household. Hence, it appeared that the loss of employment for men post-migration and the subsequent need for women to work resulted in a loss of their sense of dominance and a shift in their position within the family. The women in the family were constructed as being empowered and gaining this dominant position post-migration.

... back home ... men dominated the family ... they are the breadwinner ... they work outside, they do all these things, the woman does cleaning, cooking, all this. When you come here, you both have to work ... or if only one of you work, it's not enough. And a lot of men looking for a job here ... and women look where they can do some cleaning, and some of these things ... So they dominate how the household is run. (Yusuf, L59-72).

... at home men is the one who always the breadwinner ... you know who feed the family... erm ... they go out and women stay at home ... and they look after the children ... and erm that.. when we came here, this thing really caused a lot of problems.. in the family ... erm because it looks like the woman has been empowered ... she has control of maybe the finance side.. men has nothing. (Jibriel, L26-31).

The changes in gender roles were also seen as causing new demands. Adapting to this was portrayed as difficult for some, as described below by Yusuf.

... so what happens ... is the woman dominates the man ... ‘why don't you Hoover today?’ ‘Oh I can't do’ ... ‘you're supposed to cook today’ ... ‘cook, I don't know how to cook’ ... (Yusuf, L91-93)

These constructs of women as passive pre-migration and empowered post-migration also incorporated a common view by participants that linked women's increased sense of authority to marital separation post-migration. As Hussein states here, women were described as developing a

sense of independent assertiveness and having less tolerance

So what is missing there now is, the pressure that the mother, the wife cannot kick him out because of the community... so she is someone ... if she has a husband with her...she needs that independence...why would he be a burden on her ... who is gonna stigmatise ... there's no community which is so close-knit that he'll say 'hey... she has kicked her husband', no, no.. but there ... the whole family's there ... she's not married to this husband only, the whole family, his family, her family ... everyone ... (Hussein, L78-83)

Yusuf illustrates through his story the negative impact this has on men, describing men as highly dependent on women and struggling to cope post-separation. Furthermore, he emphasises the role of support from the community, although constructs this as meaning a lack of privacy in such circumstances.

They can't bear it ... they can't cook ... a lot of my, actually it was one of my friends ... he was in Somalia ... and he came back here with his wife. So when he came back from Somalia, within 24 hours he phoned 'Yusuf I don't have nowhere to sleep' ... and I phoned his wife she said 'no'... so he had no choice he came to my flat and he stayed with me a few weeks until he get somewhere. (Yusuf, L98-102)

A further consequence around these changes was the use of the substance khat, it was commonly spoken about as a response not only to lack of employment, but also to the increased pressures upon men within the family post-migration.

There is a substance misuse of Khat, which is one of the main problems of Somali men in this country. (Oliver, L160-161)

They don't cook, they never used to cook, unless they come here and they are forced to cook ... so what do they do ... carry on eating their khat. (Hussein, L74-76)

On one hand they want to cope, they want to get out of the house ... what happened is ... one man was telling me ... I said to him ... why don't you go to your house ... he said he get bored with his wife ... but his wife knows him well ... 'where are you ... provide me food'. So he run away. (Yusuf, L180-184)

The use of khat was usually talked about as having a negative impact on men, their wellbeing and their ability to fulfil their roles within the family home.

What happens is you go very down, down down. You are nothing, you can't provide for your family...you can't take children to school because you're tired. So there are difficulties in the house when you chew khat. (Yusuf, L257-259)

Men were thus portrayed as using khat to cope or escape from their difficulties in the home. However, a majority of the participants spoke of women becoming less tolerant of men's difficulties. For example Samuel gives a view of women as gaining "power" in the UK, suggesting that the Western lifestyle enables this empowerment.

Here, the woman have the power. If he doesn't do, she calls the Police ... out of the house. (Samuel, L499-500)

Hussein spoke of this empowerment of women post-migration as having a negative impact on the family. Here, he describes the Western lifestyle as "selfish", and "materialistic" and speaks of how the behaviour of Somali women can reflect these characteristics.

I think the selfishness of the Western world where 'I don't have anything here ... there's no interest in me, he's a burden on me ... I'm gonna kick him out' ... that kind of mentality you can see it here ... it's not the woman's fault ... because of that kind of mentality, we are here very kind of materialistic, you know. (Hussein, L86 - 89)

3.4.2.1 Summary

Overall, participants' appeared to be developing constructs of migration to the UK as having a negative impact on identity for a Somali male. In particular they appeared to be drawing on the loss of status and changes in their roles within UK society and in their relationships with their women and families. It seems that as a consequence Somali men were experiencing new and increasing pressures, which was suggested to lead to a greater use of khat.

Reflexivity: My role as a Western woman will have had an impact on the data that was generated in relation to the participants' loss of male power. The comparisons made pre and post-migration appeared to communicate a need to be recognised as having had status as men; particularly in the context of my role as a professional female. In addition, it appeared that the shared frustration and

criticism of Western society may have arisen out of a need for this to be heard by me, as a Westerner. Again this appeared to result in my own desire to convey this as a result of my own sense of responsibility as a Westerner. This process may have therefore impacted upon my desire to explore this at depth during data collection and to convey this in the analysis (Parker, 2005; Dickson-Swift, James, Kippon & Liamputtong, 2009).

3.4.3 Overall summary of category

Overall, participants highlighted:

- The loss of professional status post-migration and the negative impact on identity
- The changes of their gender role and position within the family unit and the negative impact on identity
- The West as unhelpful and unaccommodating with regard to their needs post-migration
- The Western lifestyle as encouraging individuality and the struggle to adapt to this.

3.5 MAIN CATEGORY 3: SEARCHING FOR “DEPRESSION”

It was observed throughout the process that some participants would use the terms “depression” and “mental illness” interchangeably in response to the story. The focus here is therefore on how participants were seen to construct meaning behind their understanding of these terms. Many participants demonstrated a process of their attempts at trying to fit these concepts into their knowledge and understanding about the world. This category therefore brings together the processes that occurred as a result of this, while also demonstrating the struggle that appeared present in their attempts to do this.

3.5.1 Subcategory 3.1: As unfamiliar: “it's a new word in our community”

This sub-category demonstrates the struggle for participants to understand the concept of “depression.” Although participants were observed to use the word “depression”, it was evident they found the concept unfamiliar and untranslatable and hence had difficulty in constructing its meaning. When Ali was probed about his understanding of his use of the word depression, he voiced its unfamiliarity in the Somali language and culture, seeing it as a “new disease” for the community here in the UK. His response here is vague:

Um, it's erm it's a new word in our community. Because back home there's no depression at all ... it's just here. It's a new disease for us, and it's like you're tired always? Or something.
(Ali, L156-157)

Instead, as portrayed here by Ibrahim, being given a mental health diagnosis resulted in “labelling” by the community, referring to the terms “waali²” or “madness”. It appears that Ibrahim is demonstrating the extremes of the Somali belief system, addressing the unfamiliarity of having existing “in-between” concepts.

If you, if you if the Somali community knows that you have got a mental health problem (...) they will label you ... there's a label ... ‘mad person’ (INTERVIEWER: Mad person?) ‘Waali’ (laughter), there's no word between sane or insane. (Ibrahim, L229, FG2)

Hussein expresses how the unfamiliarity of having categories of mental-health means a lack of language for such concepts, with the consequence that that a number of Western mental health

² Somali term referring to a person as ‘crazy’ or ‘mad’

diagnoses such as depression are non-translatable into the Somali language.

The thing is, if you look at the Somali language, and the Somali culture ... about depression ... mental health, schizophrenia, psychosis, bipolar disorder ... you know what is in Somali language? We have got a variety of words where none of them I would think would fit there. (Hussein, L119-121, FG3)

Some participants did attempt to manage Hussein's dilemma. One word in particular that was likened to depression is a word known as "bufus". Participants described this as a new word in the language, existing only since the beginning of the Civil War, and attributed this to those who had been in refugee camps and victims of the civil war. An individual with bufus was commonly described among participants as showing signs of "paranoia" and "acting strangely", as described by Hasan:

Bufus ... yeh because it is someone who speaks suspicious, we call bufus ... acting strangely ... yeh, acting strangely ... and he is running away from other people ... yeh you think, you seem to explain ... this as bufus these days. (Hasan, L172-173, FG2)

Ahmed however demonstrated his attempt to construct depression as a separate concept from "bufus", seeing the paranoia element as separate, making it a more extreme concept than depression.

... you know people mentioned as you said 'bufus'.. and bufus is not only depression the word bufus ... it's some people who are also a bit paranoid ... bufus that's what it is actually. (Ahmed, L89-91)

Hussein also demonstrates his struggle to fit "depression" into the language and compare the concept with other Somali terms. His expressed confusion is around the biomedical idea that the "illness" could exist without any tangible reason. Here, he is seen searching for a reason for depression.

I am honestly confused when I look at it ... is murug³ the same? Because when you say a Somali person is depressed, and I ask him 'are you depressed?' Even if that person is depressed in the Western terminology. He or she would tell me something which is external,

³ Somali term referring to a daily sadness

physical that has got some kind of treatment. (INTERVIEWER: Would there always be a reason?) Of course, yes. And that reason is not a reason which is abstract ... it is tangible, it is something which you can solve. And that is the nearest to anything related with depression ... past that and it's madness. (Hussein, L216-225).

3.5.1.1 Summary

The traditional Somali construction of mental-health as being either “sane” or “mad” meant an unfamiliarity of the categorisation of mental-health as per the Western model. Participants’ use of Somali concepts indicated a different way in which distress may be categorised.

Reflexivity: My role as a Western-based trainee counselling psychologist may have influenced the participants' use of terms such as depression, and prompted their efforts to fit the concept into their Somali language and culture.

3.5.2 Subcategory 3.2: As a visible 'mental-illness'?

This sub-category arose out of the constructs of “depression” and “mental illness”, which addressed the visible negative signs and individual behaviours, that were seen to be different or “stand out” from the community.

Samuel constructs his view of a depressed individual rather than responding to its definition. He draws upon the visible behaviours of self-isolation and withdrawal, while similarly Oliver draws upon behaviours that “deviate” from cultural norms.

Depression...the way I understand it is that when somebody was ... got er ... isolate himself from the people. Isolate himself from the people ... no shame being alone ... err he does not seek help ... everything by himself. (INTERVIEWER: Everything by himself.). Yeh ... for himself. And that is when he start talking by himself ...walking around and talking all this ... that's when specifically I can say that is the depression. (Samuel, L42-47).

I think anything that deviates us from social and cultural err you know of this main society, actually ... this illness or mental illness you can see because this person doesn't clean himself; his hygiene is basically low, he doesn't respond; he's actually isolated ... these are signs of mental illness basically. (Oliver, L16-19)

Participants similarly spoke of behaviour changes such as aggression or expressions of

unprecedented violence, which again made them stand out from the community. Here, Samuel links depression with aggressive feelings and Ali interprets violence as madness. These behaviours do not fit with the social harmony of the community.

Because what is depression and put him in that category ... he forget himself. It's because of that ... the only thing that he do is looking now to be in an aggressive way. (Samuel, L126-130)

If someone is seen as violent or if they hurt someone maybe they are a bit mad. (Ali, L245-246)

Ahmed also highlighted this as he spoke of how such visible behaviours could result in judgement from the community.

We are a community who are open to each-other, and someone who's behaving a bit or a bit suspicious (sic) way, then his friends (sic) might not use kind words, their quite harsh, and they say 'why are you feeling this way...you look like mad person'. (Ahmed, L182-184, FG2)

Ibrahim spoke about how such changes in behaviours could impact negatively on the family, whereby the family may be shamed or viewed negatively by the rest of the community.

But the biggest one is, is ... is the shame that come to the family, of the person is doing bad things ... it's not the person ... anything bad that person does ... will come back to the entire community or extended family. (Ibrahim, L542-546, FG2)

What therefore became clear was a common view of “mental illness” as visible. This appeared to parallel the Somali view of the continuum of seeing mental-health as “sane” or “mad”, with no recognition of any other categories of mental-health (as in the Western model). Most participants emphasised only visible signs of what they viewed to be “mental-illness”.

However a small number of participants commented on the Western view of other existing constructs of mental illness less extreme than the view of “madness”. Yet their view of this was that these possible forms of mental illness were hidden from the community. Yusuf highlights this here:

... they'd say 'this guy is bufus ... he is mad' ... the other one he doesn't say much so you can't

tell ... You can't see I ... this one you can see. (Yusuf, L322-323)

Hussein also shared his view of this, drawing on his experience of seeing hospitalisation as a result of mental-illness, yet highlighting the difficulties in recognising any signs prior to this.

I took to hospital two, two people who are related to me, a friend and a relative ... one to erm Royal Free, another to UCL ... and that time they were completely gone you know ... and one wanted to commit suicide, the other one refused to wash, to eat, to do anything ... locked himself in his bedroom ... so that is the minute we would know that these people have got mental illness ... but before that it's early stage, or whatever stage it is, I don't think we can know ... and I wish there would be some way we could find out about these people before they reach this stage. (Hussein, L172-181)

3.5.2.1 Summary

Participants' understanding and recognition of mental illness tended to derive from observed behaviours, which caused the individual to stand out from the community and be labelled as “mad”. Fear of such labelling and isolation could be a reason for the existence of “hidden” mental difficulties. This appeared to demonstrate a process in which participants were seen to be wrestling with their understanding of what depression “looks” like, demonstrating uncertainty of how this fits within their knowledge of mental health as a “visible illness”.

Reflexivity: Participants' responses indicated a process in which they had difficulty thinking about mental health categories. In the presence of a trainee counselling psychologist, they may have felt pressured to demonstrate some understanding of these categories. This was demonstrated by what appeared to be a need to convey Western ideas through their use of Western terminology as well as attempts to explain or describe how they understood 'depression'.

3.5.3 Sub-category 3.3: As spiritual?

In Somali culture, we believe mental illness is ... spiritual. (Moses, L182, Focus Group 1)

This sub-category developed out of participants' talk of spiritual ideas. This was common talk seen to be responsible for visible changes in behaviour and “mental-illness”. Spiritual difficulties were constructed to be the influence of supernatural beliefs in spirits such as the “Shaytan⁴” or the

⁴ The Somali term for The Devil

“Jinn⁵”; both of which were believed to have the power to take control or possess an individual.

Although few participants spoke on this topic, it was observed that they did so mainly within the group settings rather than in the individual semi-structured interviews. This was an example of a group process of knowledge and meaning construction. Only Samuel spoke on this issue at length in both the group and individual settings. “Mental-illness” was constructed as being related to the influence of spirits, as demonstrated by Moses who refers to Western concepts of mental illness.

Whether it's stress or schizophrenia or mood disorder or withdrawal or anything to do with this. As Somalis we believe that mental illness to be related with spirits. (Moses, L191-192, FG1)

The “Jinn” was constructed as a religious belief and as Ibrahim implies, belief in the Jinn is integral to the Muslim faith. The Jinn here is portrayed as taking “hold” or “going inside” the person; portraying it as an invisible spirit that takes control of the individual.

Yeh ... there is also a thing that other Muslims, Somalis believe is that can hold the person, is like Jinn ... we call it Jinn, this is like the Devil going inside the person. (Ibrahim, L265-266, FG2)

It's invisible isn't it...nobody can see the Jinn...you may get it from outside, or, from the toilet. (Hasan, L280, FG2)

The Devil Himself is a Jinn ... the Devil Himself is the biggest Jinn of all. (Ibrahim, L582-584, FG2)

Those who spoke of the Jinn / Shaytan maintained the view that they were the cause of negative occurrences in an individual's life. This extended from social problems to changes in an individual's mental state, therefore externalising responsibility away from the individual. In particular, participants were seen to attribute any negative changes or behaviours that would be deemed as 'bad' or immoral in the community to the power of the Jinn. The individual in this sense appeared to be viewed as passive and vulnerable to the powers of these external influences. Samuel gives examples of the actions and behaviours they see as being a result of the Jinn's / Shaytan's influence. It seemed that such events that fall outside of the community's strive for peaceful, harmonious

⁵ Supernatural creatures in Islamic mythology. They are mentioned frequently in the Koran.

existence could not be attributed to the responsibility of an individual.

The breakdown of the house ... the madness and everything, everything, everything ... is Jinn. Jinn is cruel. One will put you through sickness or kill you or push you to kill, and all this things...this man is with a bad Jinn. (Samuel, L654-656)

A small number of participants also spoke briefly about other spiritual beliefs, such as that which is referred to as the "Evil Eye". Hasan and Ibrahim conceptualise this as a form of curse sent from one person to another, causing negative changes or illness. This view again implies an external influence on the individual.

Evil Eye ... from someone ... from the outside ... you get the Eye. (Hasan, L287 FG2)

The Somalis believe if the person is clever ... or they're successful ... then the other people's eyes can see him, so that would change him ... and they become ill ... envy and jealousy of others. (Ibrahim, L289-292, FG2)

Mohammed, Ibrahim and Ahmed spoke of the protection of religion against Shaytan:

Whenever you are out of religion, the Shaytan comes and then it will come. (Mustaf, L83-84, FG 1)

The Shaytan will do anything he can to deviate us from the right path, and the only way we can protect it is like now, in our countries we use the term 'nuclear power', it's not a weapon to fight with, but it's a deterrent, you know to stop people attacking you. So the Koran's a deterrent ... Yeh ... The Koran's a deterrent from the Shaytan. If someone's religious, I think they would be much safer compared to if they are not religious. (Ibrahim, L625-631)

I find those who are close to God and their religion, they are those who are less vulnerable to Shaytan. (Ahmed, L652-655, FG 2)

A number of participants did not engage in group discussion with regard to this issue. Ali, for example did not participate in the group talk but in the individual session he gave a contrasting view as did Oliver. In both examples it is seen that they are separating their views from the community view.

Yeh ... I don't think ... I believe maybe um people are sometimes affected, to some kind you know, but I don't believe that much erm ... this kind of ... what people mentioned. (Ali, 60-61)

They perceive mental illness as a Jinn or evil eye or something like that. But it is the beginning of the Somali community to believe that mental illness could be basically caused by any psychological or by any psychological-related factors. (Oliver, L31-33)

3.5.3.1 Summary

The talk within this sub-category suggests that a common view of the community may be that any negative changes or strange behaviour of an individual may be deemed as the responsibility of a spiritual influence, “curse” or “possession”. This suggests that at such times an individual perhaps no longer sees themselves as in control of their actions or behaviours, but rather submissive and vulnerable to external influences.

Reflexivity: My prior knowledge of beliefs in spirituality had an impact on the generation of data here. I also recognised I was curious and very interested in exploring my participants' knowledge and thoughts on these issues. This was a construct spoken about mainly in the focus groups especially in the first two focus groups. My experience was different however when speaking to participants individually in which they either did not talk, or separated themselves from these beliefs. This separation may have been due to my Western presence as participants may have wanted to respond more favourably to the Western way of thinking. In the group setting, perhaps some participants refrained from voicing their ideas in fear of disturbing the group process. This could be another illustration of the strength of the group and its commonly held cultural beliefs. Interestingly, my interpretation during the process was this as a strongly conveyed topic, yet to my surprise during the analysis, actual data appeared to exist mainly among the focus group transcripts. For me this process demonstrated the strength and presence of such beliefs at a community or group level, and my experience of this contributed to my need to convey this within the analysis.

3.5.4 Overall summary of category

Participants highlighted in this category:

- That any mental illness is normally recognised and understood through extreme, visible signs of behaviour
- That the various forms of mental illness are often unfamiliar and unrecognisable
- The process of trying to grapple with the Western concept of depression
- That individuals appear to express the more traditional views on spirituality, for example, when in the presence of community peers.

3.6 MAIN CATEGORY 4: DELIBERATING HELP: YOUR CULTURE, OUR NEEDS

This category developed from the participants' constructions around help-seeking. In particular, the participants focused on the cultural norms that appeared to impact on an individual's ability to seek help. These included an expectation to endure difficulties, religious beliefs, and a fear of stigma from the community.

3.6.1 Subcategory 4.1: The Silence of Suffering: Pride and Prejudice

“Pride and prejudice” refers to the participants' talk around avoidance and disclosure of difficulties; maintaining pride and avoiding judgements of “weakness” in the community. It appears that an expectation of endurance exists within the community; where individuals feel a need to be seen as strong and able to remain active, as well as striving to keep harmony and order in the community.

Participants commonly expressed the difficulties of keeping information private within the community, giving the impression that an individual's business often became the business of others. Hussein here describes the process in which this occurs; giving a view that the occurrence of individual problems creates a ripple effect, thus showing the process of how an individual's business might impact upon the community. This was spoken of as a common and normal process in the community, contributing to the view of it as close-knit, yet also presented as a reason for 'hiding' individual difficulties or problems at times of feared stigma or judgement.

In Somalia there are clans, and it ... it gets from the family up to a clan, so if someone here has got any problems, he or she would share ... not only the family members but relatives and all that ... but it also goes to the whole clan ... so he could see sometimes your affairs, your issues, your illness ... is not confined to your family, it goes down to the clan leaders and clan chiefs and they know 'oh so and so has got this problem'. (Hussein, L106-111)

This lack of privacy was therefore suggested to result in a tendency for individuals to be “inhibited”, whereby the expression of feelings or difficulties was uncommon and discouraged, as described by Hussein.

In Somali culture, expressing your feelings ... whether it's even happiness, love, other emotions ... it's really inhibited. (Hussein, L155-157)

Furthermore, hiding problems within the community appeared to be linked to pride and the avoidance of being viewed as “weak”, especially for men. Yusuf expressed the pressure of feeling they must not talk:

The way they talk ... they won't tell you ... they hide it inside ... they won't talk
(INTERVIEWER: Why's that?) “ Because of pride ... pride ... they don't want people to know. (Yusuf, L297-298)

There was an indication that endurance of difficulties was portrayed as being a cultural norm and expectation. Speaking about problems was seen to be a view of weakness; especially for men, thus withholding difficulties from others was suggested to include carrying the burden of previous traumatic experiences as well as current difficulties, such as marital or family difficulties, as described by Jibriel below.

A lot of people faced a lot of killings and you know, rape and all this ... and at the same time people don't speak ... don't speak ... you know, you see the victims who are not speaking (about) (sic) what happened to them ... and that's the culture ... we don't speak. (Jibriel, L182-185)

Endure it ... yes, yes ... erm we see that person (as) weak ... if he ... you know ... especially men ... they complain ... we don't like ... (INTERVIEWER: So what might happen if that man complains ... what might the consequence be?) Yeh ... they might say 'he is weak', he's err you know the people's perception of him (INTERVIEWER: Mmm) ... and that's not good ... maybe if he wants to marry or something, they will say 'oh, he's a weak man' (laughs) ... yeh so it's bad. You know sometimes, that's why the man has to keep everything to himself ... (Jibriel, L200-208)

This was therefore suggested to have implications for the actions of the individual: avoiding disclosure of problems, denying difficulties and not seeking help from others.

Ali speaks of the denial as maintaining a confidence:

Yeh, that's normal. Not just him but it's just normal. You are in denial. (INTERVIEWER: You are in denial ... you don't want other people to know?) You say 'oh I'll be fine in a couple of days, don't worry.' (INTERVIEWER: Ok, ok ... and I wonder what that's about?) He doesn't

want people to talk about it, he doesn't want people to say he's sick, he want to have his confidence. (Ali, L220-225)

Ahmed describes the possibility of isolation for the individual who talks:

... that's what the fear is in our community ... we are a close-knit community ... even we might not know each-other, but someone will know you or someone you know, and if you talk openly with someone in the community, that person might tell someone else ... that person might tell someone else and then it will come back to you ... and then you would feel cut off. (Ahmed, L579-582)

Hussein portrays a contrasting account below, as he draws on the supportive element of the community, where you can “say whatever you feel like”. He gives this as a reason for the lack of professional-help seeking in the UK. This appears to contradict the view of “hiding” or “denying” any difficulties, as his emphasis here is on the community as a source of strength. His contrast here may be due to the group setting. In the presence of others he describes members of the community as offering help in the form of sympathetic listening and talk.

In this, in the Somali community, yes going to counselling is not something common, but again they go for counselling to me and others, and you will someone coming, not saying directly 'oh, I need counselling now', but they would start talking and that person would listen, and they exchange, and they have coffee, talk together, and you can see both of them - the guy who's needing the help and the one who is providing this help, both of them are not aware of what they are doing is counselling ... where they are giving each-other company, and this is very common ... so in the community, or social, family-orientated people, if a Somali is isolated, on his own, or her own, it's extremely rare ... very rare ... and that is maybe why people are not going for counselling, because they already have a whole community behind them, who will talk to them and say whatever you feel like. (Hussein, L373- 382, FG3)

3.6.1.1 Summary

It seems there exists a cultural norm of enduring difficulties within the community, resulting in a common tendency for individuals to be silent and 'hide' or 'deny' their difficulties. The focus seems to be on the wellbeing of the community rather than the individual. In such a context a recognition of the Western construct of individual “depression” is unlikely.

Reflexivity: The participants' talk around silence was of particular interest to me as I felt that participants were communicating the reasons for their difficulties in sharing personal stories or experience, especially in the presence of others. I also wondered if my presence as a woman was having an impact on how much they felt they could share. This may have contributed to the participants' tendency to externalise and use hypothetical situations in discussion rather than experience. This resulted in a majority of data that was not a window to individual or personal experience, but rather a more generic representation of the community experience. This process was felt to parallel the process in which individuals may function within the community - prioritising group needs over their own.

3.6.3 Sub-category 4.2: Keeping our faith: The need for spiritual healing

This sub-category developed from participants' constructs of preferred methods of treatment as traditional forms of healing. It was found that a majority of the participants prioritised the traditional view of spiritual healing when discussing methods of seeking help or treatment. This appeared to contribute to the view that an individual's difficulties are commonly linked to spiritual difficulties such as Jinn possession (as previously discussed). This was again a topic more commonly discussed in the group process, and contrasting views were talked about on an individual basis.

Spiritual difficulties were commonly constructed as spiritual possession or the Evil Eye (as described in the previous category), but correspondingly spiritual religion is necessary for treatment and healing, as described here by Ibrahim.

... the Koran will kill this kind of things ... Evil Eye and all this. So yes, spiritual is very very important factor of treatment. (Ibrahim, L267-268, FG2)

One first step in treatment or healing spoken about were readings from the Koran. Talk around the Koran portrayed it as a "cure", describing it as a powerful tool in the healing process. Ibrahim demonstrates this here, as he talks about the preference of being taken to a Mosque to be "cured".

It is very common, and we believe, and I think as all Muslims believe, that there is a cure ... that there are some verses of the Koran that tells us there is a cure in the Koran.

(INTERVIEWER: There is a cure?) Yeh. So people will erm prefer the mentally-ill person to be taken to a Mosque, and then the Koran would be read to him. (Ibrahim, L259-261, FG2)

Although Ahmed was in favour of the Western mental health approach, in part perhaps because of his employment in mental-health services, he continues to be in agreement with the group's talk of prioritising spiritual healing, seeing this as being a powerful tool by itself and as having a positive psychological impact on a person:

Just purely reciting Koran on them and if that helps them then, for me you know, without knowing mental health system and mental health, I would have agreed with that, and I agree with them now as well ... it's purely reciting Koran on them and if that will help psychologically ... (Ahmed, L35-38)

However, it was clear that some were uncertain about which model of treatment to prioritise. For example, at times Oliver appeared to be in favour of the Western medical approach to healing for mental health difficulties and saw traditional religious beliefs as a barrier to accessing treatment:

I think Somalis have the wrong basic understanding of spiritual healing when it comes to errr ... mental illness. They often use spiritual healing instead of going straight to other medical people like psychologists or psychiatrists because they over-use it ... because of their understanding, basically. They perceive mental illness as a Jinn or evil eye or something like that. (Oliver, L28-33)

Ali also separated the concept of a mental breakdown from other factors such as family problems or addiction. In the next quote he is challenging, with a little irreverence “and this kind of stuff” the traditional acceptance of the Jinn causal factor.

But maybe most of these men who complain about Jinn and this kind of stuff ... but in the case of Omar, maybe it's different. (INTERVIEWER: Ok ... is that something that's changed for you? So when you say you don't really think much about these things, is it something you used to think, maybe before, and that's changed, so you never really thought about those things?) It's not something that's changed but it's something I believe, because most of the men who have this kind of mental breakdown are not complaining about Jinn or something. But this could be family problem, addiction. (Ali, L63-70)

While Hussein is in some agreement with a need for the medicalised view of treatment, he also maintains a need for the community to keep their traditional methods of healing. He portrays such rituals or methods of healing as an integral part of the culture “back home” and refers to a loss

among many women.

Yes, we need that psychiatric medication, and yes, the Somalis need their Jinn...doing out or drumming it ... whether it's mingus⁶ or Koran ... and here now what you can see is back home maybe, a woman in her 50s may have some kind of illness which is now we turn it to mental health, but there we would say 'she has got mingus', and she would go to a group of people who are beating a drum, giving her some alcohol through a perfume, and she drinks that, and some popcorn, and she'll be fine. You know, and now, many of these women are missing that kind of err ... of treatment. (Hussein, L393-400, FG3).

3.6.2.1 Summary

This sub-category has focused on the constructs of healing as spiritual, with a majority of participants portraying this to be the preferred method of healing. However, it was also clear that some separated the concept of “mental-illness” from spirituality, acknowledging that some difficulties derive from social factors where methods of treatment could be medical. However, as stated already, belief in the power of spiritual healing was evident among most of the participants. It could thus be argued that participants constructed mental illness as a Western problem and separate from Somali traditional beliefs.

Reflexivity: The differences in how participants spoke around this issue may have again been reflective of their response to my role. It was again apparent that the traditional methods of healing were spoken about more widely among the focus groups, and uncertainty was expressed more individually. Again, my Western position may have impacted upon how participants responded on an individual level, or confusion here may be reflective of the participants' difficulty in integrating Western understandings of mental illness and treatment into their existing knowledge of the world.

3.6.3 Subcategory 4.3: Avoiding the Professionals: Unmet needs, labels and the “Zombie”

This subcategory embodies the participants' constructs around seeking professional help in the UK, in particular their engagement with GPs. This includes a view of GPs as lacking awareness of cultural background, trauma and social factors relating to Somali refugees, as well as a fear of diagnosis and medical treatment. Seeking professional help was thus commonly associated only with physical health problems.

⁶ Other forms of spirit that may bring illness by possessing their victims

Some participants described GPs as having a lack of awareness of the needs of Somali and other BME communities. In particular, as Oliver states here, GPs were portrayed as failing to take a holistic view of the patient into account and being ignorant of the background of the patient such as experiences of trauma. He presents the limitations of the Western model and its focus on physical symptoms and its disregard of other background factors. He contrasts the needs of Western and Somali patients, highlighting a view that GPs may fail to recognise the needs of the “new” Somali patient, in particular their stress from previous trauma and the significant social changes resulting from migration.

Even GPs are not aware sometimes of psychological ... GPs focus only on other factors ... more focus on this. Minority communities and BME communities have their own psychological trauma and troubles, and they need themselves to be sensitive to psychological side of the treatment. (Oliver, L368 - 370)

I would expect the GP in (UK town), who works with my country's refugee community ... who are new to this country ... who has no basic idea of around their area ... their GPs would be very aware of a lot of the biological and genetic you know, symptoms, but not taking technical and psychological you know symptoms into account, basically. Because he's normally with UK residents; white people ... my country's all the way from Africa, who have difficulties, who are traumatised by civil war ... who have many stresses ... who have got fear every time ... when it comes to housing ... applying at the job centre ... job searching, you know all the way. (Oliver, L375 - 382)

A majority of participants spoke about the fear of being labelled as “mad” by the Somali community. For example, Samuel discussed this, and held the view that help-seeking from a professional was enough to be labelled and ostracised by the community.

The problem is not the doctor. The problem is the people: ‘oh, he went to go to see a doctor ... or a psychologist. Anyone who goes to a psychologist is ‘mad’ ... so we don't approach him, we run away from him’. That is the main problem that the Somalis have got. (Samuel, L233-235)

Hence, being seen to seek professional help for such was viewed as a way of contributing to being labelled as “mad” by the community. It also seemed that participants feared being labelled this by the GP. For example, Samuel explains this and compares the safety of attending for physical health-

care to that of mental health-care.

Let's say somebody has cut his head/hands and he needs a doctor to cure it ... or his health ... he doesn't see it that way ... that if you mentally have got a problem, that you can ... that the doctor can save you or bring you in a position ... so what they say we can mend that person.... if he go there to see that doctor and say that 'I'm not normals, sometimes I don't sleep, my head is thinking, all this doctor'... he don't say that. If he say that, the doctor say to him 'this man is mad'. (Samuel, L220-227)

Seeking professional help voluntarily for mentally-related health difficulties was therefore spoken about as an unfamiliar, feared and unhelpful process. Common constructs of recognised Western professional treatment for mental illness included hospitalisation and being administered injections. Some participants seemed to believe that Western methods for treating mental illness could be extreme and have a “zombie” effect on an individual. It seemed that this has impacted on the community's view of Western treatment for mental health difficulties as extreme, and participants such as Hussein spoke of the community's fear of using such medication.

I think it's also important to mention the Somali community, and the assumptions that we have is like, people will tell you like 'Oh, don't go to the hospital, because they will give you medication that will make you a zombie. Yeh, so 'don't go to the doctor, never go to the doctor'. That's why you see people come very late to the hospitals, because the family and friends who supposedly take them to the hospital, have prevented them from going to the hospital. (Ibrahim, L191-193, FG2)

Professional help-seeking by Somalis was therefore nearly always spoken of as being for physical health difficulties only. In contrast, as Ali describes, Western help-seeking in the UK system is frequent for both physical and mental symptoms.

... here you've got, anytime you feel something, whether physically or mentally, and I think there is something you had when you were a child, the way you grow up, the awareness ... I'm not sure in the case of Omar, but we don't go to ... usually, unless you are very sick. (Ali, L116-119).

... the patient will talk to the doctor about their pain ... where the pain is. And for them, the pain is the headache, or the stomach-ache, or their shoulders, or wherever physical. But they

will not say to the doctor, 'oh I think I need help ... with mental health'. (Ibrahim, 338-389, FG2)

Here Hussein talks about the difficulty in recognising possible prior symptoms of “madness”. It is interesting that he speaks from the point of view of others around “the young man” i.e. the community.

The issue is ... before this person reach the stage where it's complete madness ... how would they figure out ... how can you get that out from a Somali young man ... that he is going onto complete madness...how would one find out? Err ... what are the symptoms ... how would we know that this person, surely after a month he will have some kind of nervous breakdown. (Hussein, L275-278)

3.6.3.1 Summary

This sub-category drew upon the participants' talk around professional help-seeking. UK professional health services were constructed as unfamiliar, unhelpful and to be feared. Hospitalisation and extreme forms of treatment appeared to be the commonly viewed processes of treatment relating to mental health difficulties, and there was a general fear of being labelled. Accessing professional help was compartmentalised for physical health problems and the expression of somatic symptoms only.

Reflexivity: My role as a trainee counselling psychologist with a perceived association with the Western mental health system may have impacted upon how participants spoke about professionals in this context. It appeared that participants were keen to express their views about a UK health system in which they felt unheard and marginalised. This appeared to trigger my own empathetic responses, as well as touching on my own reasons for carrying out this study. These reactions subsequently led to further inquiry, thus generating more data.

3.6.4 Subcategory 4.4: The Future: Integrating but Separating

This sub-category is focused on the participants' talk of a need to “bridge the gap” between the Western and Somali view to mental-health. This drew upon the participants' expressed wish to “educate” the community and medicalise the notion of mental illness, to encourage a view of it as “curable”, while also emphasising the importance of keeping their cultural and traditional beliefs. Some participants referred to there being a “lack of knowledge” in the community about the Western model of mental health. Some emphasised the need for the community's exposure to the

concept of mental health as an “illness” and curable. Ahmed expressed how he was helped to change his perception by his experience of working in the mental-health field.

I think mental health is the same as physical health ... you know someone who's had problem ... breathing problems, or cancer ... or yeh, that's how I view now ... it's an illness ... mental health itself now is different categories ... there's levels, and some people might recover quickly; some not, some people need medication, some need psychological therapy. (Ahmed, L393-398)

However, the importance for the community to keep their “traditional” values was emphasised, highlighting the unfamiliarity of UK medicalised approaches and professionals. Ali in particular emphasised the importance of keeping these traditional values. He also sees the Western model as being accessible only perhaps for those more educated:

Yeh erm people are different ... some people are very traditional and that's not enough. For Example, most of the people come because of civil war and from rural areas which never go to school or never see a proper health-centre and this kind of stuff ... so it's very hard for them. (Ali, L267-269)

Oliver states that to “break” or “change” such traditional beliefs would be difficult, indicating that imposing the Western system may contribute to the community feeling marginalised.

Because this goes back to our traditional background ... we don't have any psychologists or psychiatrists ... healing them spiritually was the only way to deal with mental illness ... that is the root of our basic understanding and position (...) because of their background ... this is apparent...so it takes a long time to break ... to change. (Oliver, L39 - 41).

There appeared to be a consistent agreement for the use of “Somali experts” in order to facilitate the integration of the Western model into the Somali community. However, Hussein’s view here highlights the perceived difficulty in the integration of cultures, indicating that the differences in language and culture create a barrier and a sense of distrust (which he communicates to me also).

I don't think it will be that easy, but I have a feeling that if there are or there'll be Somali-trained mental health experts ... that would somehow break the barrier. If someone like Ahmed, who has got more knowledge, who is trained as a psychiatrist or mental health expert,

goes to the Somali community and they see this person who can converse with their language, tell them 'use these words in a different way', a way that they can understand, I think that would be helpful, and that would put this barrier away ... If it was from a Westerner like you coming in and explaining these words, I think the wall will always be there. (Hussein, L332-342, FG3).

However, Yusuf suggests that the specialist knowledge given by a Somali expert within the community could help to reduce anxiety about such stigma. However, he highlights that the cohesiveness of the community could still impact on an individual's ability to be open with them.

What we need to do is ... I don't know how we'll do it ... but recruit Somali colleagues ... train these guys ... but if they know I was from their community then they won't talk to me ... but if they know that person is specialised. (Yusuf, L328-329)

3.6.4.1 Summary

It seemed that although participants expressed a need for increased understanding barriers against integration of the two cultures appear to remain. These barriers seem tied in with the lack of cultural awareness in both communities as well as issues of trust. In order that their mental difficulties in particular be helped the individual Somali person seeking help needs to be understood in relation to their background and culture. A wish to understand the UK system and society appeared important to most of the participants.

Reflexivity: Similarly as in the previous sub-category, it is felt here that participants may be communicating their disappointments and differences in their needs in response to the presence of my role. Furthermore, it felt that participants were communicating their sense of distrust in response to my role as a Western-based professional, and wanting to make the sense of distinction between our cultures clear.

3.6.5 Overall summary of category

Participants highlighted in this category:

- The difficulty of sharing personal experiences or divulging difficulties to others
- A cultural expectation to 'endure' difficulties
- The priority of more traditional methods of healing
- The view of Western professionals as unhelpful, untrustworthy and unaware of their cultural needs
- A desire to understand the Western system while maintaining cultural identity.

3.7 Summary of analysis

The core category was identified as “a sense of disconnection”, which appeared to relate to result as a consequence of migration. This appeared as a common occurrence across all categories; offering an overall interpretation of how depression was conceptualised.

“Losing community, losing strength” drew upon participants’ talk of the community, which was constructed as providing a source of strength, support and protection as well as a framework for individuals to live by. Participants appeared to mourn the loss of some of this, viewing Western society as individualized, isolating and pressured, as well as being responsible for the disintegration of community values and roles.

“Struggling for identity” embodied the talk of identity difficulties as a result of the migration to the West of Somali men. This included the conflicts arising from the increased pressures of migration in relation to a different sense of self and responsibility in the struggle to maintain identity in the home, community and the wider UK society.

“Searching for depression” related to the process in which participants were seen to be drawing upon their cultural language and knowledge in an attempt to understand and integrate the Western term “depression” into their world. This included the conflict for participants between drawing upon traditional constructs relating to cultural norms and spirituality and attempting to understand depression as a “mental illness”. Differences in an individual’s construction of meanings were observed when the individual was in a group or separated from a group; this was yet another example of the strength and power of others in the community over the individual.

“Deliberating help: your culture, our needs” highlighted the conflict between the cultural norms for Somali men, the influence of the wider community and the traditional beliefs rooted in religion and culture. The cultural norm of silence in relation to individual difficulties contributed to a lack of recognition and understanding of mental illness in Western terms such as depression. Their own limited language with regard to non-physical symptoms tended to be extreme e.g. “mad” and hence unfamiliar Western approaches to treatment were misunderstood, feared and criticised.

Consequently there was a failure, often deliberate, to access or receive help which could present a dilemma for health professionals. There was an acknowledgement also of a continuing belief in the importance of traditional spiritual healing. Thus while a desire to improve their understanding of the UK health systems was voiced, a need to hold onto cultural ideas and identity was emphasised.

Discussion

4.1 Overview

This chapter will consider and discuss the key findings in relation to the research questions and previous research, and explore their implications for counselling psychology.

4.1.1 Summary of key findings

This study aimed to explore how Somali male refugees perceive and understand the Western concept of depression, while addressing preferred methods of coping and views on Western professional help. Findings suggest that symptoms and behaviours which, for the Western model, would depict “depression” were interpreted by Somali men as the result of migration, portrayed as an overall sense of disconnection. Participants were seen to question the concept of depression as existing in their home country, as the tightness and wellbeing of the community was indicated to be a protective factor to the individual. However, the weakened ties of the community following migration made the concept more recognisable. Help-seeking from Western professionals and services was portrayed as rare. Fear of being labelled and subsequent treatment, and the stigma associated with this, were identified as reasons for this lack of help-seeking. Western professionals were conceptualised as lacking awareness of the needs of the Somali community in relation to the social difficulties associated with their status as refugees. Finally, maintaining cultural identity was expressed as important to the community and, while there was a need to have more of an understanding of the Western mental health system, staying close to their cultural beliefs and practices was emphasised.

4.2 “Depression”: an unfamiliar concept in Somalia

Findings appear to show that the concept of “depression”, as defined by Western psychiatry, was portrayed as an unfamiliar concept to participants when speaking about life in their home country. The inter-connectedness and strong ties within the community were portrayed as providing wide support, a sense of belonging and a framework for an individual to live by. This was evident in participants' emphasis on the fact that individuals would rarely live alone, with wider family networks providing daily support. In particular, the role for a man within the family was portrayed as breadwinner, rarely involved in household tasks, yet holding a position of authority.

To be embedded in the community and to adhere to cultural norms was portrayed as being a protective factor against difficulties. This was evident in participants' talk of living by religious and

moral norms, and being active members of the community. To stray from such norms was seen as potentially contributing to difficulties for the individual, with possible judgement and exclusion by the community. Previous theories of collectivist cultures suggest that being socially accepted is dependent on fulfilling group expectations, with the aim of maintaining social harmony (Triandis, 1996; Markus & Kitayama, 1991; Bhugra, 2004).

Talk regarding religion and spirituality occurred mainly among focus groups, indicating that these are factors deeply rooted in the framework and belief systems of the community. Participants were seen to externalise the causes of misfortune or “mental illness” as spiritual difficulties (e.g. the Jinn), as identified in previous research (e.g. Mölsä, 2010). This not only highlights the importance and presence of such beliefs within the community, but also has implications for potential misunderstanding in Western-based health settings.

Participants were seen to struggle with the term “depression”, with some associating this label with more severe presentations, describing it as “madness”. Thus mental illness was understood only as a polarised concept (i.e. sanity or madness) and milder forms were unfamiliar. This seemed to contribute to a fear of being labelled “mad” by professionals or others in the community. Some participants attempted to fit the term “depression” into their existing language, but with uncertainty, questioning whether this could be likened to a sadness (“murug”) or paranoia and talking to oneself (“bufus”).

Despite the notion that “depression” itself appeared unfamiliar to participants, the use of these terms (murug and bufus) suggest that similar concepts or experiences are in fact apparent and recognised as idioms of distress existing in Somalia (Carroll, 2004). This brings to the forefront the difficulties associated with what Kleinman refers to as a “category fallacy” – the assumption that categories of mental illness and their symptoms are universal and recognisable across cultures (Kleinman, 1988). The participants’ use and distinction of these terms suggests alternative ways of categorising experience (Kirmayer, 2006), although others may argue that although expressed differently, suggest a universality of symptoms (e.g. Patel et al., 2013; Okapku, 2014).

Although “murug” and “bufus” may not equate to the Western diagnostic criteria of “depression”, it still indicates a form of distress that participants were able to identify as existing in their home country. By attempting to distinguish between these forms of distress only takes away from the reality of what is being spoken of here - i.e. the existence of human distress, existing both in Somalia and here in the UK. However, it is the “categorisation” of these difficulties that makes it

seem unfamiliar to the participants; emphasising this as an unhelpful system which is not, in fact, recognisable globally (Kleinman, 1988; Kirmayer, 2006). This strengthens the counselling psychologist, diagnosis and its criteria are not central to our work, and instead our ethos is to work holistically with the individual.

4.3 “Depression”: a reality in the West

A key finding showed male Somali refugees in the UK understood depression as a new concept and contextualised it in relation to their migration difficulties. As in previous research, participants spoke mainly about these difficulties rather than their previous experiences of trauma or loss (Gorst-Unsworth & Goldenberg, 1998).

Through the participants’ portrayal of the UK as isolating, the strength of the community and their roles within it were seen as being weakened. Other factors appeared to relate to the difficulties in fulfilling roles within the community. This appeared to relate to unemployment, the loss of professional status, challenges to masculinity and disruption to family relationships. The causes of participants’ distress were thus seen as external. This is in line with previous research into the Somali community, in which depression was conceptualised as a result of social and structural environmental changes (Kokanovic et. al., 2008).

In line with previous findings, changes in context and environment were identified as significant stressors (Chun, Moos & Conkrite, 2006; Warfa et. al, 2012). The loss of status and changes to gender roles were portrayed as threatening a sense of masculinity, and many participants spoke of the increased likelihood of conflict within the family and potential marital separation as a result of these difficulties. Furthermore, the inability to fulfil the roles required of a man within the family and community appeared to result in a sense of failure, impacting on self-esteem. This links with previous theories relating to self-esteem among collectivist societies, which have suggested that not fulfilling group expectations may result in greater levels of guilt, shame and pessimism (e.g. Chiu, 1993; Kitayama, Markus & Matsumo 1995). The impact of negative social events on self-liking is thus suggested to be stronger for individuals in collectivist societies, indicating a particular sensitivity to psychosocial factors (Tafarodi & Walters, 1999).

A poor fit between personality and cultural demands is suggested to impact on successful adjustment to a new country and viewed as a potential risk for psychological health (Caldwell-Harris & Ayçiçeği, 2006). This theory is referred to as “personality-culture clash”, and has been identified as a common experience among refugee communities (Ward & Chang, 1997; Bhugra,

2004; Caldwell-Harris & Ayçiçeği, 2006; Triandis & Trafimow, 2001). In line with these findings, it is suggested that, for Somali individuals, the interdependency and the high value placed on others' opinions may clash with attempts to increase autonomy and independence in the UK (Caldwell-Harris & Ayçiçeği, 2006).

4.4 A view on coping

The act of expressing emotionally-based difficulties was portrayed by participants as uncommon and discouraged. To do so was judged as “weak” by the community, and instead a norm of enduring such difficulties was commonly referred to. The focus here on the community judgement appeared to highlight the need to maintain a sense of being positive, strong and active within the community, while maintaining social harmony.

It appeared that decisions around coping related to the sense of self within the wider community, thus seeing any individual decision or strategy as impacting upon others. This was emphasised in participants' talk of enduring difficulties and the discouragement of sharing problems with each other. On the other hand, a sense of being interdependent at times of crisis or difficulties, through individuals reaching out for practical help from others, was highlighted. This supports previous findings of a recent review on collectivist societies and coping, which revealed how individuals tend to focus on modifying their thoughts and feelings, e.g. through cognitive avoidance, while also involving the support of the wider community (Lam & Zane, 2004; Kuo, 2013).

In relation to the increased levels of conflict within marital relationships, participants portrayed a sense of passivity when coping with these difficulties, rather than confronting them. This was evident in the way participants spoke of the women as making decisions around separation. For men in particular, avoidance and passivity seemed to be common ways of coping. These findings relate to theories around models of collective coping, such as “sociocultural theory”, which posits that coping strategies tend to be based on maintaining social dependence and harmony within the community (Chun, Moos & Conkrite., 2006; Aldwin, 2007). As such, passivity and avoidance, as opposed to using “problem-solving” strategies, are suggested to be common among collectivist communities (e.g. Bjorck, Cuthbertson, Thurman & Lee., 2001; McCarty et. al, 1999).

Furthermore, the use of khat is indicated here as another form of coping and “escape” from the increased stresses following migration. This also suggests passivity in coping, and is in line with previous literature which has suggested that the increased use of khat within refugee populations is a response to migration stressors (e.g. Griffith et. al., 1997; Nabuzoka & Badhadhe, 2000; Patel, Wright & Gammampila, 2005; Bhui & Warfa, 2010).

These coping methods are found to be in contrast to individuals from Western cultures, where autonomy is emphasised and difficulties lessened through the use of problem-solving strategies (Markus & Kitayama, 2001; Kuo, 2013).

4.5 A view on Western help: fear and unmet needs

Seeking professional help for emotional difficulties was described by participants as feared and uncommon. This fear appeared to be attached to stigma from the community as well as the view of professionals as unhelpful, untrustworthy and unaware of their cultural needs.

Fears of seeking professional help included the fear of being labelled as “mad”, the fear of subsequent treatment, and the fear of being judged by the community. Because emotionally-based problems were commonly seen as “madness”, being given any label or diagnosis of mental-health related difficulties was spoken of as resulting in such a judgement by the community. In line with previous findings, this stigma was a common fear (Papadopoulos, Foster & Caldwell, 2013), and the close-knit nature of the community suggested it was not possible to seek professional help in private.

The act of seeking professional help from a GP appeared to be for physical health problems only. Participants spoke of only expressing somatic-based complaints. It was suggested that emotional difficulties were commonly suppressed and were not seen by the participants as appropriate for health-care providers. Rather, there appeared to be a need for the individual to maintain a positive sense of self in the community in order to avoid potential judgement (Triandis, 1995).

Seen as being ignorant of cultural differences and the participants’ experience of war, trauma and migration difficulties, Western professionals were spoken of as untrustworthy and not meeting their needs. In addition, the wider UK society was also perceived as unhelpful in acknowledging their difficulties, resulting in a sense of being marginalised. The area of refugee communities’ dissatisfaction with GPs has received some attention in the literature, and it has been suggested that GPs may hold a difference in attitude towards refugee groups (Jones & Gill. 1998; Bhatia & Wallace, 2007).

Treatment for mental-health related difficulties was seen in terms of being hospitalised or receiving extreme forms of potentially harmful treatment such as injections. These views appeared to stem from both the experience of seeing others in the community receive such treatment and the lack of their experience of seeking help for milder difficulties.

The lack of trust in Western professionals resonates with other studies, one of which showed a link between distrust and dissatisfaction of care provision between black African patients and Asian and white providers (Benkert, Peters, Clark & Keves-Foster; 2006). As trust between patient and practitioner has been shown as a consistent predictor of health outcomes (e.g. Chavez et. al., 2004), this has implications for a patient or client in a health-care setting where cultural mismatch may occur.

4.6 Context and culture matter: against universality

The findings from the current study highlight the influence of cultural factors on the conceptualisation of depression. In particular, the subjective interpretations of the “depressive-like symptoms” in this study raise questions about the medicalisation of such issues, thus adding to the argument against the biomedical model of depression and movements to globalise such concepts. Little reference in the current study was made to biological factors and instead the focus was on context and social factors, which is in line with wider research across cultures where notions of depression have been found to be disregarded as “illness”. Instead, such difficulties are seen to be located in the social worlds of family and community (Patel, 1995; Kirmayer, 2001; Lackey et. al., 2008; Kokanovic et. al., 2008; Peirera et. al. 2007; Grover et. al., 2012; O'Conner et. al., 2014). One major finding was the importance of the collectivist nature of the community, and how this impacts on self-identity, self-esteem and emotional well-being. Such findings provide a critique of the Western model, which assumes individualism and a perception of self that focuses on individual cognitions, emotions and behaviours. Thus it is argued that the Western model may overlook broader social or systemic issues (Kwok, 2003). In addition, the importance of traditional belief systems in conceptualising misfortune, illness and methods of healing were highlighted as a necessary aspect of Somali culture. This again has implications for movements to remove what may be considered “inappropriate” methods of “treatment” raising the question of who should make such decisions.

These findings have therefore shown how the impact of cultural differences may shape the assessment of stressors, expressions of distress and ideas around coping. The study has drawn upon findings that question the idea of medicalising such difficulties. Participants seemed not to interpret these difficulties as illness but attributed them to the upheaval of their social worlds.

For Somali men, key findings related to experiences of migration and the difficulties they experience as a result of the changes relating to the collectivist, patriarchal structure of the community. Previous research in regard to depression across other cultures has identified similar

findings (e.g. Kokanovic et al., 2008; Karasz, 2006), suggesting that these factors may be relevant across other cultures - particularly those of a similar structure (e.g. Karaz, 2005). Changes in specific gender roles have also been found to be relevant across other African cultures, especially in regard to the spoken loss of masculinity as a result of migration to the West. Although it is premature to make any conclusions at this stage, such similarities and difference identified warrant a need for further research to explore this.

These findings therefore highlight the importance of exploring the meaning behind such presentations before medicalising them (e.g. Summerfield, 2008; Thomas, Yasmeen & Bracken, 2007; Bracken & Thomas, 2001), supporting the argument for a more bio-psychosocial model for depression, as suggested by previous critiques (e.g. Thomas, Bracken & Yasmeen, 2007). An individual cannot be reduced to biology, and social and contextual factors need to be considered when assessing, diagnosing or making decisions about treatment (Bracken & Thomas, 2001). This in turn has implications with regard to movements that are seeking to standardise diagnoses, diagnostic criteria and treatments globally. The current study shows that concepts such as depression are not readily recognised among some cultures, and differing perceptions of self can impact on how individuals consider such issues. This in turn raises questions about medicalising such difficulties, especially when working with individuals who have experienced atrocities of war, loss and the upheaval of migration.

4.7 Strengths and limitations

4.7.1 Strengths: original contribution to knowledge

The study has addressed a gap in the literature, with its focus on Somali male refugees in the UK and how they construct meaning and knowledge behind the Western concept of depression. This appears to be unique in its methodology and its aims, especially with regard to the sole use of lay Somali men in the community who have experienced life both in Somalia and in the UK. Findings have thus elicited factors which appear specific to Somali men, and how these might impact both on their roles in the immediate family and the wider community. This gives further insight into how such changes impact on men emotionally and the struggles to express such as a result of the constraints set by cultural norms. These findings have highlighted how such differences conflict with the Western model of depression and recommended practices of help or ‘treatment’ available in the UK.

The combined use of focus groups and semi-structured interviews is unique with regard to researching this cultural group. This has enabled insight into how the process of group compared to individual exploration may impact upon the research process, giving an indication into the strength of the community with regard to its impact on how the individual may behave, also emphasising the differences.

The use of a vignette without the use of Western terms is also unique as a method compared to previous research, which has commonly imposed Western concepts to prompt understanding when carrying out research. This approach thus elicited findings on how such was understood without the influence of the Western model and a provided a view on its relevance in their understanding.

Although the study gives insight into factors that are specific to the Somali community, these may also have implications for other cultural groups in the West who adopt similar collectivist approaches to living. In particular, findings have demonstrated how cultural norms can impact on both emotional expression and understanding, which may be in contrast to the Western approach.

4.7.2 Limitations

As with any qualitative method, findings from the current study are not concerned with generalisability. Rather, the use of Constructivist Grounded Theory and the focus on the co-construction of data means that the findings are one of multiple possible interpretations (Charmaz, 2006). Furthermore, the decision to use a grounded theory approach will have influenced the

findings, as the focus requires the researcher to answer specific research questions. Thus throughout the process, interview questions were adapted with the aim of refining and saturating data that served to answer these questions. This means that certain aspects of the data will have been missed that other methods may have addressed, such as Foucauldian discourse analysis (Foucault, 1972), which may have given further insight into how power relationships impact on the discourses Somali men use around depression.

A number of issues regarding the sample need to be considered. My use of colleagues within my sample meant their exposure to the Western mental health system may have influenced their responses. Furthermore, it will have impacted on their interactions with me during data collection (as discussed within the reflexivity section). Although participants were not service-users, some of them helped to facilitate a “Mind” community project, which meant they had prior knowledge of the Western model of mental health. This will have subsequently impacted upon their awareness and understanding of terms such as depression. Furthermore, the recruitment via colleagues resulted in a majority who had been in the UK for over twenty years, who were highly educated and in employment. Thus the sample may not be representative of those who are relatively new to the UK, where a different set of data could emerge.

There were a number of logistical constraints that will have impacted upon the data. Firstly, some difficulties in the English language may have resulted in translation problems for both the participants and myself, resulting in the use of words or terms that may have been misconstrued. Difficulties in understanding at times also emerged when conducting interviews and transcribing, resulting in inaudible bits of data which were subsequently lost. Secondly, the time constraints between the collections of data may have impacted upon the application of theoretical sampling. More time may have allowed for further theoretical sampling to help strengthen categories (Charmaz, 2006). Finally, the construction of data within a focus group and then in the semi-structured individual interviews will have been different. However, I attempted to embody this process within my analysis and demonstrate the important comparisons between these processes.

4.8 Evaluating quality

A range of different criteria used to evaluate qualitative research have been put forward by a number of different authors (Henwood & Pidgeon, 1992; Guba & Lincoln, 1994, Denzin & Lincoln, 2000), which are often dependent upon the epistemological position of the research. The criterion that was felt to be important for the current study draws upon guidelines developed by Henwood & Pidgeon (1992), which is a good fit with constructivist grounded theory. I begin by also including specific issues, which are deemed relevant to the current study with regard to specific aspects of my methodology.

4.8.1 Ensuring fair representations

There is a concern in qualitative research about whose reality is represented in the research, and a difficulty has been suggested in delivering fair representations of participants' experiences (Denzin & Lincoln, 2000). As a result, in terms of improving “fairness of representations” I monitored accuracy throughout the interviews by checking how well my interpretations reflected my participants' responses (Taylor, 2001; Ballinger, 2006; Finlay, 2006). However, there is little need for such a scientific, rigorous process of reaching a consensus about meaning, as the study is concerned with exploring how meaning is constructed among the participants.

4.8.2 Avoiding a loss in translation: no interpreters

A further factor that appears rarely considered in cross-cultural research is the use of interpreters/translators (e.g. Carroll, 2004; Whittaker et. al., 2005), which raises methodological issues around how the meaning behind concepts is conveyed in such research (Temple & Edwards, 2002). It is argued that any individual involved in the research process influences the data, thus it is necessary to view interpreters as integral to the generation of data (Temple & Edwards, 2002). The current research therefore avoided the use of an interpreter in order to avoid adding a further layer of complexity when constructing meanings in the data (Temple & Edwards, 2002).

4.8.3 Keeping close to the data

The stages of coding facilitated in staying close to the data, and part of this process is the identification and use of quotations that demonstrate how and why categories emerge and link together.

4.8.4 Documentation

Providing a “paper trail” is necessary in showing evidence of the research process (Charmaz, 2006). In order to ensure this I have given examples of data in the Appendix to demonstrate the process of

analysis, showing how this developed from initial coding through to focused codes and categories (Appendix 5.0).

4.8.5 Theoretical sampling and negative case analysis

As befitting to grounded theory, the interview schedules and topics for discussion were adapted throughout the process of data collection, in order to assist in the development of any emerging categories (Appendix 3.2).

By using the constant comparison method I was able to identify any data that appeared to differ or diverge from the rest. Categories were developed in order to include these and to demonstrate the dilemmas that emerged as a result.

4.8.6 Transferability

This criterion is compared to that in quantitative research, which is referred to “generalizability” (Henwood & Pidgeon, 1992). However, the aim of the current study was not generalisability; but in line with Constructivist Grounded Theory, aimed to represent how participants from a specific cultural context construct meaning and knowledge.

4.9 Reflexivity as researcher

In this section I will be drawing together my reflections on how my presence as a white, Western woman, as well as my role as a trainee counselling psychologist impacted on the process and the data. I will include my reflections on how the roles, race, class and gender of both my participants and myself may have impacted upon the data. In particular, these elements will have impacted on our tendency to unite or distance ourselves throughout the process.

Firstly, the requirement to carry out a preliminary literature review together with my previous experience of working alongside Somali men influenced my prior knowledge as well as resulting in a potential against the Western medical model of mental health. This meant I was especially tuned to participants' talk around difficulties regarding their views of Western professionals, impacting upon some of the introjections and questions asked around this subject.

The assistance of my Somali colleagues and their motivation to assist and participate suggested that they may have been responding to my role as a trainee psychologist, and viewed me as a resource for hearing the issues of the community and communicating them to the professionals. It thus felt that their motivation to engage was driven by a need to be heard.

A further reflection is with regard to the observation of the participants' little reference to their own experiences. Although the concealment of difficulties has been suggested to be entwined with cultural norms, it could also be argued that my position as a Western woman may have contributed to creating a barrier to openness about own experiences (Twine & Warren, 2000).

My reflective diaries show that I was also aware that my participants' responses to me as a trainee counselling psychologist may have been motivated by a desire to demonstrate knowledge around the Western model of mental health. This was evident through their use of Western terminology, as well as through their dilemmas around which approach to treatment to prioritise. Such discourse was observed more in individual interviews with participants who had worked within the mental-health service (Ahmed and Oliver), and it was felt that it appeared especially important for them to be affiliated with me as a fellow practitioner within the field. Previous research suggests this is a process which occurs when individuals want to be affiliated with the other (Hutsinger & Sinclair, 2010), and hence this may have occurred with these particular participants.

A final reflection concerns the notable difference in how some participants were seen to present themselves on an individual level away from the group. This appeared to demonstrate a process in which participants were expressing a need to be seen as validated by the wider group, while also seeking a sense of distinction from the group (Turner et. al. 1987; Brewer, 1991). Furthermore, my presence for some may have been seen as somehow threatening or created a sense of distrust, thus influencing a change in attitudes or beliefs away from the wider group (e.g. Branscombe, Wann, Noel & Coleman, 1993; Jetten, Postmes & McAuliffe et. al., 2000).

4.10 Implications for counselling psychology

Key findings from the current study highlight factors such as connectedness within the community and religion as essential to wellbeing, as well as the reality that individuals from Somali communities are unlikely to voluntarily seek psychological help. These challenges present an overall challenge to the practice of counselling psychologists when it comes to working with the Somali community, and potentially other refugee populations where the sense of community is as essential to wellbeing and access to services is low.

Important implications here are the questions raised about the universality of depression as a concept. This is a relevant finding across all cultures, highlighting the importance of working holistically, a premise already relevant to the ethos of counselling psychology. However, this is becoming increasingly difficult for example, in the current NHS climate in which there is some pressure to focus on the reduction of depressive “symptoms” through, for example, cognitive-behavioural therapy.

The current study has also highlighted and added to the literature a distinction between the perceptions of self-identity among collectivist societies in comparison to individualistic Western societies. This therefore has implications for the Western model of mental-health. It raises questions about the validity of standardised tools, assessments and contemporary research, which are based on the Western assumption of the “independent” view of self. Challenging the assumption that individuals have a view of themselves as autonomous. However, in line with previous research the current findings argue that such parameters do not capture a picture of the individual whose perception of self is tied in with acceptance from the wider community (Kirmayer, 2012).

Furthermore, the differences in understanding of terminology and “symptoms” present a challenge the usefulness of assessment tools when working across cultures due to the language barriers and unfamiliar or unknown “symptoms”. These are argued to potentially result in misdiagnosis or a misinterpretation of behaviours and may be unhelpful. This emphasises the ethos of counselling psychology in the importance of a holistic approach, especially in the face of current pressures in the NHS where diagnosis and symptoms are frequently focused on. This also highlights the importance of increased cultural competence for practitioners, and the narrow focus of Western models of therapy in working with human distress across cultures. More specifically, tools used to assess outcome measures of therapeutic practice should be sensitive to differences between individualistic and collectivist constructions of identity. These could include domains of assessment that would capture the areas of life that provide a valid and meaningful outcome measure. For

example, the current study highlights the importance of an individual's active role within the community (Kokanovic et al., 2008; Kirmayer, 2012), indicating that it would be culturally appropriate to take into account the impact on this when working with Somali individuals.

In regard to intervention, one suggested major implication for counselling psychologists may require a significantly more active process, such as partaking in assisting with community development post-migration, bringing together those who share the same culture, language and interests. This may affiliate with the community psychological approach, in which a continuous outreach process may be required, and focusing on those who may feel isolated. This is a growing field in psychology, and is based on the premise that understanding the social settings and systems of which individuals are a part can help to improve their well-being in the community (Orford, 1992; Dalton, Elias & Wandersman, 2001; Sanbourne, 2002). It is based on a core principle that intervening at a community-based level can be a preventative strategy, as it aims to remove the barriers to wellbeing (Sanbourne, 2002). Its work involves the members of the community in designing, implementing and evaluating any community-based intervention, aiming to remove the “us and them” mentality.

In relation to refugee communities, it has thus been argued that community psychology could work to assist refugees in gaining a sense of control over their environment (Webster & Robertson, 2007). This relates to the sense of powerlessness communicated by the participants in the current study. It has been argued that movements should be made to address wider social inequality at a community level and not just focus on compassion and empowerment at an individual level (Seedat, 2001; Webster & Robertson, 2007). Such movements have been implemented through the use of “partnership projects”, with clinical psychologists working alongside volunteers to enhance social networks and support (e.g. Savcic-Sanders, 2003). These interventions could be viewed as a preventative strategy rather than purely reactive, which is especially important for the Somali community due to apprehension around help-seeking and the lack of awareness about services. In this way, individuals would be treated as active survivors rather than passive victims, giving them a voice in society.

These approaches could also assist with overcoming the barriers against those who may be working to 'educate' such communities about mental health, and also enable them to maintain their sense of cultural identity and practice. In addition, this would also help to raise awareness of available services, and would enable further research into factors contributing to marginalisation and resilience in the community. It could be argued that counselling psychologists should move from a position of

“expert” to working alongside the individual and their community.

As identified, individual therapy is an unfamiliar approach to the Somali community. In line with previous suggestion, one approach may be to portray the notion of therapy differently, again presenting a challenge to the usual practice of counselling psychologists (e.g. Harris, 1999; Schweitzer et al., 2014). For example, therapy may also involve initial support with social and practical matters. Previous case studies have also identified the importance of other factors such as encouraging better skills for expression and increasing self-awareness, such as through narrative approaches (e.g. Harris, 1999; Schweitzer et al., 2014). This may present a challenge to counselling psychologists working in the public sector, where the current pressures of the NHS may require a more structured approach such as cognitive behavioural therapy (CBT) where such a focus may be missed. As CBT focuses on modifying individual cognitions or behaviours, its effectiveness may also be questioned, as the notion of focusing on such concepts may appear as alien or unhelpful to individuals. Instead, it is argued that exploring the cultural narratives behind the meaning around such difficulties should be integrated into any therapeutic work (Kirmayer, 2012). Such encounters are perhaps more applicable in secure settings in the NHS such as tertiary care where Somali patients are present in greater numbers.

The increasing diversity of refugee populations in the wider UK community has implications for the roles of counselling psychologists and their involvement in the field of community group psychology. In reference to the Somali community, it is suggested that this could involve liaising with Somali volunteers in assisting them to run such groups. Findings from the current study have highlighted the need for the tightening of their community ties. The aim could thus be to strengthen the sense of community and work towards gaining a sense of empowerment to address their specific difficulties (Seedat, 2001). As a result of the implementation of such projects, it has so far been found that the social support networks seem to be a protective factor for such communities (Allodi, 1989). This adds to the need for this to be implemented at a wider level, and the need for further research (Webster & Robertson, 2007).

The findings also have implications on a wider level in relation to how the field of psychiatry and psychology can medicalise distress suffering, implying medical or technical solutions rather than viewing these as normal responses to stressors. This suggests that other diagnoses, which are common to refugee populations such as post-traumatic stress disorder (PTSD), may be unhelpful and invite Western treatments which may unhelpfully displace culturally-shaped methods of help. Furthermore, this also raises questions about the biomedical model of depression and whether

diagnosis is helpful both across all Western and non-Western cultures.

Overall, it could thus be concluded from the current study that such findings significantly challenge the role of counselling psychologists, suggesting the need for a change in the way decisions are made about assessment and treatment.

4.11 Future research

The findings that highlight the impact of culture as well as social and cultural factors merit the importance of further research into this field. In the current climate of increasingly diverse populations in the West, it appears important to continue with such research among different cultural groups.

As this research was restricted to Somali men, a natural step may be to repeat such research among women in order to explore how they conceptualise difficulties connected to their specific roles within the family and community. In addition, the use of recently arrived refugee communities in the UK would highlight the issues that are most salient at that time, benefiting practitioners working with these groups.

This research raises important questions regarding the globalisation of mental-health and strengthens the importance of continuing such research globally. For example it would be beneficial to carry out such research within Somalia and to highlight how constructions across different contexts may differ.

Overall, working cross-culturally has become an integral part of the role of counselling psychologists and should therefore have significance within our work. As the ethos of counselling psychology is to work holistically, this alone merits the need for further research in understanding cross-cultural conceptualisations of mental health. Furthermore, such research also highlights the importance of encompassing the individual and cultural differences that arise within our work, and being critical to diagnoses and any related assumptions these can bring.

5.0 Summary and conclusion

This research has sought to explore how Somali male refugees in the UK understand the Western concept of depression and their views on subsequent help-seeking. The focus arose from current debates in the literature regarding critiques of the Western biomedical model of depression with regard to its universal application across cultures.

The core category, given as an overall theoretical interpretation, was identified as a “sense of disconnection” following migration. This subsequently impacted upon views of coping, mainly with regard to the endurance of difficulties and a preference to traditional methods of healing. Little reference was made to a “biomedical illness”, and instead the focus of social and contextual factors appeared to support the need for a bio-psychosocial model of depression. Hence the global relevance of a Western biomedical model of mental-health in the context of our individualised Western culture should be questioned.

These findings have implications with regard to the models of therapy that are currently “prescribed” for working with depression. For example, the identified differences in how individuals base their sense of self-worth within the context of the community raises questions about the benefits of working at an individual cognitive level in such instances. If anything, the current study has highlighted how individuals are used to addressing issues as a collective rather than on an individual basis. The little reference to “illness” and focus on social and contextual factors also questions the relevance of trying to improve “mental-health literacy” across cultures.

Although findings may be cautioned as a result of this being a small-scale qualitative study, they do highlight that differences appear to occur in how difficulties or diagnoses may be conceptualised across cultures. These findings raise a number of important questions for the role of counselling psychologists, forcing us to consider deconstructing our roles and methods of practice. As counselling psychologists, we follow an ethos of working holistically, thus further cross-cultural research is necessary to assist us in broadening our understanding, as well as considering how this may impact on our work with these communities.

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APPENDICES

APPENDIX 1: ETHICAL APPROVAL

Appendix 1: Ethical approval

ETHICAL PRACTICE CHECKLIST (Professional Doctorates)

SUPERVISOR: Rachel Tribe

ASSESSOR: Ian Tucker

STUDENT: Sophie Rae

DATE (sent to assessor): 18/05/2012

Proposed research topic: Somali Male Refugees: An Exploration of Psychological Well-being

Course: Prof. Doc Counselling Psychology

- | | |
|--|-----|
| 1. Will free and informed consent of participants be obtained? | YES |
| 2. If there is any deception is it justified? | N/A |
| 3. Will information obtained remain confidential? | YES |
| 4. Will participants be made aware of their right to withdraw at any time? | YES |
| 5. Will participants be adequately debriefed? | YES |
| 6. If this study involves observation does it respect participants' privacy? | NA |
| 7. If the proposal involves participants whose free and informed consent may be in question (e.g. for reasons of age, mental or emotional incapacity), are they treated ethically? | NA |
| 8. Is procedure that might cause distress to participants ethical? | NA |
| 9. If there are inducements to take part in the project is this ethical? | NA |
| 10. If there are any other ethical issues involved, are they a problem? | NA |

APPROVED

	YES, PENDING MINOR CONDITIONS	
--	-------------------------------	--

MINOR CONDITIONS:

Strictly speaking participants should have the right to withdraw their data at any point, not just up to three months post interview.

Make it clear that anyone who would like to take part in a semi-structured interview after focus groups has the opportunity, so process of selection does not discriminate.

REASONS FOR NON APPROVAL:

Assessor initials: IT

Date: 7/6/12

RESEARCHER RISK ASSESSMENT CHECKLIST (BSc/MSc/MA)

SUPERVISOR: Rachel Tribe

ASSESSOR: Ian Tucker

STUDENT: Sophie Rae

DATE (sent to assessor): 18/05/2012

Proposed research topic: Somali Male Refugees: An Exploration of Psychological Well-being

Course: Prof. Doc Counselling Psychology

Would the proposed project expose the researcher to any of the following kinds of hazard?

- | | | |
|----|--|----|
| 1 | Emotional | NO |
| 2. | Physical | NO |
| 3. | Other
(e.g. health & safety issues) | NO |

If you've answered YES to any of the above please estimate the chance of the researcher being harmed as: HIGH / MED / LOW

APPROVED

YES		
-----	--	--

MINOR CONDITIONS:

REASONS FOR NON APPROVAL:

Assessor initials: **IT** Date: 7/6/12

Please return the completed checklists by e-mail to the Helpdesk within 1 week.

SCHOOL OF PSYCHOLOGY

Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.



School of Psychology Professional Doctorate Programmes

To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,

Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

Stratford Campus, Water Lane, Stratford, London E15 4LZ
tel: +44 (0)20 8223 4966 fax: +44 (0)20 8223 4937
e-mail: mno.davies@uel.ac.uk web: www.uel.ac.uk/psychology



The University of East London has campuses at London Docklands and Stratford
If you have any special access or communication requirements for your visit, please let us know. MINICOM 020 8223 2853



APPENDIX 2:

INFORMATION AND CONSENT FORMS

2.1: Information sheet

PLEASE TAKE PART IN MY STUDY!!

I WORK IN PARK ROYAL CENTRE FOR MENTAL HEALTH, AND I SEE MANY SOMALI MEN WHOSE UNDERSTANDING OF THEIR PROBLEMS CAN BE VERY DIFFERENT TO HOW WE HERE IN THE UK MIGHT UNDERSTAND THEIR DIFFICULTIES.

I FEEL IT IS IMPORTANT FOR PROFESSIONALS HERE IN THE UK TO HAVE MORE OF AN UNDERSTANDING IN THE CULTURAL DIFFERENCES IN UNDERSTANDING.

WITH YOUR HELP MY YOU CAN ADD TO OUR UNDERSTANDING, WHICH WOULD IN TURN HELP TO INFORM HEALTH PROFESSIONALS HERE.

I AM THEREFORE WANTING TO CARRY OUT SOME FOCUS GROUPS SO WE CAN DISCUSS THIS.

PLEASE READ THE INFORMATION AND LET ME KNOW IF YOU WOULD BE INTERESTED TO TAKE PART BY CALLING ME ON 07734 652480.

WHO I AM LOOKING FOR

If you are male and have lived in both Somalia and here in the UK, and can speak English without the need for an interpreter.

HOW LONG WILL IT TAKE?

It should take no longer than one hour.

Refreshments will be provided.

Please contact me on 07734652480 if you are willing to take part.

Thank you very much for your time.



UNIVERSITY OF EAST LONDON

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

The Principal Investigator(s)

Sophie Rae
Email: u0917934@uel.ac.uk
Telephone: 07734 652480

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate a research study.

The study is being conducted as part of my
Professional Doctorate in Counselling Psychology at the University of East London.

Project Description

The objective of the current study is to explore how Somali male refugees in the UK understand mental health.

As a participant, you will be invited to take part in a focus group. During these, the researcher will be asking some open questions with regard to your understanding of certain difficulties people have.

You will not be pressured to talk about any difficult personal experiences or anything that may cause you discomfort. However, if you find yourself feeling upset or distressed after these interviews, you will be offered further support to cope with this.

Confidentiality of the Data

Recordings will address participants by their first names only, and will be downloaded and kept on a password-protected computer, of which only the researcher will have access. Transcripts will be anonymised (will use pseudonyms) and all material will be kept on a password-protected computer (and only the researcher will have access). Recordings will be destroyed at the end of the study, but anonymised transcripts will be kept for up to 3 years on a password protected computer, for the purpose of potential publication at a later stage.

Disclaimer

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason. [Include if relevant to you: Should you withdraw, the researcher reserves the right to use your anonymised data in the write-up of the study and any further analysis that may be conducted by the researcher.

Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Please retain this invitation letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor [Dr. Rachel Tribe, School of Psychology, University of East London, Water Lane, London E15 4LZ. Telephone: (0)20 8223 4553 Email: r.tribe@uel.ac.uk]

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Tel: 020 8223 4493. Email: m.finn@uel.ac.uk)

Thank you in anticipation.
Yours sincerely,
Sophie Rae

2.2 Consent form for participation



UNIVERSITY OF EAST LONDON

Consent to participate in a research study

I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

.....

Date:

2.3 Consent form for recording

Consent Form: Recording

1. I understand that the group / interviews will be recorded with the use of a Dictaphone, and that only the persons involved in the project will hear the recordings.

☐

2. I understand that the data from the recording will be downloaded onto a password-protected computer on site, and that it will be destroyed once the project is complete.

☐

3. I agree to be recorded for the purpose of the project.

☐

Name of the Participant: _____

Signature: _____ Date: _____

2.4 Information sheet in Somali

FADLAN KA QAYBQAADO DARAASADDAYDA!!

ANIGU WAXAAN KA SHAQEYAA XARUNTA PARK ROYAL CENTRE EE LOOGU TALAGALAY CAAFIMAADKA DHIMIRKA, OO WAXAAN ARKAA RAG BADAN OO SOOMAALI AH OO FAHAMKA DHIBAATOYINKOODU AY AAD UGA DUWANAAN KARTO SIDA ANNAGA OO AH DADKA HALKAN UK KU RAAGAY AAN U FAHMI KARNO DHIBAATOYINKOODA.

WAXAAN DAREENSANAHAY INAY MUHIIM U TAHAY INAY HAWLYAQAAANNADA HALKAN UK JOOGAA AY FAHAMID DHEERAAD AH U YEESHAAN KU KALA DUWANAANSHAHA DHAQANKA EE FAHAMKA.

ADIGA OO NA CAAWIYA AYAAD WAX KU BIIRIN KARTAA FAHAMKAYAGA ARRIMAHA, TAAS OO IYADU KA CAAWIN DOONTA INAY HAWLYAQAAANNADA HALKAN JOOGAA WARQAB NOQDAAN.

SIDAA DARTEED WAXAAN RABAA INAAN SAMEEYO KOOXO AHMIYAD-SAAR (FOCUS GROUPS) SI AAN UGA WADA HADALNNO ARRIMAHAN.

FADLAN AKHRISO MACLUUMAADKA OO ANIGA II SOO SHEEG INAAD JECESHAHAY INAAD KA QAYBQAADATO ADIGA IGA SOO WACA TALEEFANKA 07734 652480.

AYAAN RAADINAYAA

Haddii aad tahay qof lab ah oo aad ku noolayd labadaba Soomaaliya iyo halkan oo UK ah, oo aad ku hadli kartid Ingiriisiga adiga oo aan u baahan turjumaan.

ILLA INTEE AYAY QAADANAYSAA?

Ma ha inay qaadato hal saac in ka badan.

Cabbitaan fudud ayaa la bixin doonaa.

Fadlan aniga igla soo xiriir 07734652480 haddii aad rabto inaad ka qaybqaadato.

Aad ayaad ugu mahadsantahay waqtigaaga.



JAAMACADDA EAST LONDON

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

Cilmi Baaraha(yaasha) Ugu Sarreeya

Sophie Rae

Iimayl: u0917934@uel.ac.uk

Taleefanka: 07734 652480

Oggolaanshaha Ka Qaybqaadashada Daraasadda Cilmi-baarista

Ujeeddada warqaddani ayaa ah in lagu fidiyo macluumaadka aad ugu baahan tahay inaad go'aansato inaad ka qaybqaadato darasad cilmi-baaris.

Daraasadda waxa lagu socodsiiyayaa iyada qayb ka ka mid ah Shahaadayda Doktooretka Hawlyaqaanimo ee La-talinta Cilmi-nafsiga aan ka qaadanayo University of East London.

Sifaynta Mashruuca

Ujeeddada daraasadda haatani waa in la ogaado sida Soomaalida qaxootiga ah ee labka ah ee jooga UK ay u fahmaan caafimaadka dhimirka.

Ka qaybgale ahaan, waxa lagugu marti qaadi doonaa inaad ka qaybqaadato koox ahmiyad-saar ah. Muddada lagu guda jiro arrinta, ayuu cilmibaaruhu ku weyddiin doonaa qaar ka mid ah su'aalo furan oo ku saabsan fahamkaaga dhibaatooyinka qaarkood ee dadku la kulmaan .

Adiga lagugu dirqiyimaayo inaad ka hadasho wixii kasta ee shakhsi ahaan kula soo kulmay ee xumaa ee kaa welwelsiinya. Hase ahaatee, haddii aad isku aragto dareen kacsan ama isku-buuq leh kaddib waraysiyadan, waxaa lagu fidin doonaa taageero dheeraad ah si aad ula qabsadto arrintan.

Asturnaanta Xogta

Cod duubidda ayaa ka qaybqaatayaasha u yeedhi doona magacooda hore kaliya, oo la soo dejisan doonaa laguna hayn doonaa kombuyuuter erey-fure lagu ilaalaiyo, oo kaliya cilmi-baaryaashu marin u haystaan. Qoraallada ayaa qofka garashadiisa lagu qarin (ayaa la siin magac been ah) oo dhammaan waxa kasta ayaa lagu hayn doona kombiyuutar erey-fure lagu ilaaliyo (oo kaliya cilmi-baaraha ayaa marin u haysan doona). Codka la duubay ayaa la baabi'in doonaa dhammaadka daraasadda, laakiin qoraallo aan magaca qofka aan la garan karin ayaa lagu hayn doonaa illaa 3 sano kombiyuutar erey-fure la ilaaliyo leh, iyada oo ulajeeddadu tahay daabac suurtagal ah mustaqbalka waayo dambe.

Afeef

Waajib kuguma aha inaad ka qaybqaadato daraasaddan mana aha inaad u dareento in lagugu qasbay. Waxaad xaq u leedahay inaad ka baxdo wakhti kasta. Haddaad doorato inaad ka baxdo daraasadda waxaad sidaas u samayn kartaa bilaa dhibaato adiga kaa soo raacda iyo aniga oo aan la iga rabin wax sabab ah. [Raaci hadday adiga ku khuseyso : Haddaad ka baxdo, cilmi-baaruhu xaq ayuu u leeyahay inuu ku isticmaalo xogtaada aan qofka la garan karin marka la qorayo daraasadda iyo wax kasta oo falanqayn dheeraad ah oo laga yaabo inuu socodsiiyo cilmibaaruhu.

Fadlan xor u ahow inaad aniga iweyddiiso su'aalo kasta oo aad qabto. Haddii aad raalli ka tahay inaad sii wadato waxa lagu weyddiisan doonaa inaad saxeexo foom oggolaansho ka hor ka qaybgalkaaga. Fadlan u hayso warqaddan martiqaad tixraac ahaan.

Haddii aad ka qabto wax su'aalo ah ama welwel ah oo ku saabsan sida daraasadda loo socodsiiyay, fadlan la xiriiir, fadlan la xiriiir kormeeraha daraasadda [Dr. Rachel Tribe, School of Psychology, University of East London, Water Lane, London E15 4LZ. Taleefanka: (0)20 8223 4553 Iimayl: r.tribe@uel.ac.uk]

ama

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Taleefan: 020 8223 4493. Iimayl: m.finn@uel.ac.uk)

Mahadnaqa ayaan kuu sii horraysiinaya.
Si daacadnimo leh,
Sophie Rae

2.5 Consent form for participation in Somali



JAAMACADDA EAST LONDON

Oggolaanshaha ka qaybqaadashada daraasadda cilmi-baarista

Waan akhristay xaashida macluumaadka ee ku saabsan daraasada cilmi-baarista oo waxa la isiiyay nuqulkeeda oo aan haysto. Nooca iyo ujeeddooyinka cilmi-baarista ayaa la ii sharxay, oo waxaan helay fursad lagaga wada hadlo faahfaahinta, aniguna aan ku weyddiiyo su'aalo ku saabsan macluumaadkan. Waan fahmay waxa la soo jeedinayo oo habraacyada aan anigu lug ku yeelanayo waa la ii sharxay.

Waan fahmasanahay in ka qaybgalkayga daraasaddan, iyo xogta gaarka ah ee cilmi-baaristan, ay si aad u xasilloon u asturnaan doonan. Kaliya cilmibaaraha(yaasha) ku lug leh daraasaddan ayaa marin u lahaahn doona xogta aqoonsiga leh. Waxaa la ii sharxay aniga waxa dhici doona marka daraasadda cilmi baaris la dhammaystiro.

Aniga ayaa halkan ku oggolaanaya si xor ah oo buuxda inaan ka qaybgalo daraasadda oo si buuxda la iigu sharxay aniga. Haddaan bixiyay oggolaanshahan waxaan fahamsanahay inaan xaq u leeyahay inaan ka baxo daraasadda waqti kasta dhibaato aniga igu timaad la'aanteed iyo aniga oo aan la iga rabin wax sabab ah. [Raaci hadday arrinta khuseyso: Waxa kale oo aan fahamsanahay in haddii aan ka baxo, u cilmi-baaruhu xaq u leeyahay inuu ku isticmaalo xogtayda aan qofka la garan karin marka la qorayo daraasadda iyo wax kasta oo falanqayn dheeraad ah ee laga yaabo in laga yabaa inuu socodsiiyo cilmibaaruhu].

Magaca Cilmi-baarahaFAR QORAALKA WAAWAYN

.....

Saxeexa Ka Qaybqaadashada

.....

Magaca Cilmi-baarahaFAR QORAALKA WAAWAYN

.....

Saxeexa Cilmi-baaraha

.....

Taariikhda:

2.6 Consent form for recording in Somali



Foomka Oggolaanshaha: Duubitaanka

1. Waxaan fahamsanahay in kooxda / wareysiyada la duubi doono iyada oo la isticmaalo Dictaphone ah, oo kaliya dadka ka mashruucan ku lug leh ayaa maqli doonaan cod duubitaannada.

☐

2. Waxaan fahamsanahay in xogta laga keeno cod duubitaanka lagu dejin doonoo kombuyuuter erey-fure lagu ilaalaiyo oon yaal goobta, oo xogta la baabi'in doonaa marka mashruuca la dhammaystiro.

☐

3. Anigu waxaan oggolahay in cod la iiga duubo ujeeddo ah mashruuca.

☐

Magaca Ka Qaybqaataha: _____

Saxeexa: _____ Taariikhda: _____

APPENDIX 3:

VIGNETTE & INTERVIEW SCHEDULE

3.1 Vignette

You are worried about your friend, Mohammed. He has not left his house for the past couple of weeks. You have seen him briefly only once or twice and he has looked quite dirty in his appearance and did not smile when you said hello. He looks like he has lost weight. You called around to his house yesterday but he did not answer the door. You know he was home because your saw his lights were on.

3.2 Topics for discussion during interview

Gather interpretation of vignette - e.g. how would explain what is happening with Mohammed?

Suggested methods of help / coping - e.g. what might you suggest he should do?

View of Western professional help - e.g. What do you think about getting help from a doctor?

3.21 Examples of additional questions in follow-up interview schedule

Some people have talked about the possibility of there being a Jinn ... what do you think about that?

Some people have talked about changes in gender roles ..., what do you think?

APPENDIX 4: TRANSCRIPT EXAMPLES

Appendix 4.1: Focus Group 2

R: Ok..right, so I read the story now..if you can't understand me just tell me. Ok so imagine you have a friend...and we call him Omar..ok? And you have noticed just recently that Omar has not been coming to things he would normally come to, so some community activities, you haven't really seen him much...ok. In fact you've noticed that Omar is not really leaving his house at the moment, ok? You try and ring him..he's not really answering the phone, and yesterday you saw him, and he looked a bit scruffy, yeh he looked like maybe he'd lost a bit of weight..a little bit dirty, and you tried to say hi, but he pretended not to see you. Ok so if this man, Omar, was in your community, what do you think would be happening with Omar..would you have any ideas of what you think might have caused this behaviour or what might be going on with him? Any ideas?

Ali: If he looks weird and different then there is something wrong with him...maybe something happened..erm..like some problems...erm erm which erm maybe he has family problems or relationship problem..so that's why he cut off all the people around and friends..

R: Mm-hmm

Ali: So erm...the first thing..I would need to contact his close family and ask them, 'have you seen him' um and explain um the thing I er notice, and how he cut off all our contact..

R: Ok, so maybe something to do with family problem..

Ali: Yeh....so...yeh

R: Ok. Good. So other people in my last group mentioned that as well..maybe some family problems. Erm anyone else..?

Yusuf: It could be financial as well..

Ok..

Yusuf:...for example...don't know about the weight loss, but, all I can say is that he needs to talk to you, you know...sit down with him and ask 'what happened?'

R: mm-hmm

Yusuf: He might not tell you the first time, but if you insist, not push him, but in a way he can come out if he needs, and then you can contact his family, and ask what happened to him, and before you jump to conclusion, you need to ask 'what's going on?' So once we get that, then we can (....).. that there is

something wrong, the way he's coping, the way he talk, the way he behave, these are all the things we ask

Hmm. So you would contact his family?

Yusuf: First I would talk to him..You'd first talk to Omar, and if he didn't tell me, then I would contact his family, his relations, friends..those he knows..

R: OK..

Ali: Erm, you cannot jump to conclusions, unless you know his background, so you have to.. someone who knows his background and how he has been before in the community and...or it could be something that happened a long time ago that affects him in his life now..

R: Ok, something that might have happened before

Ali: Yeh

R: Ok..something he maybe thinks about now

Ali: Yeh

R: OK. Great.

Ibrahim: I think someone who has been a close friend and then erm suddenly has distanced himself from you, and then you saw him in the picture you have given now, erm the first thing actually for me would be to say 'hello' um and then to ask him, in the Somali sense 'Omar, what is going on with you? You look different' That's what Somalis, how Somalis come to eachother, yeh..'what's happened, what's happening?'. He might speak and tell you something, and then within that conversation you find out something's wrong, but the assumptions that Somali's have..the first assumption that might come, I don't know if Omar is married or is single or have a family or not, but for example if he has got a family, the first assumption that would come to my mind would be 'oh , maybe a family problem'.

R: Ok

Ibrahim: Yeh

R: And if he was not married?

Ibrahim: If he is not married, the assumption is...it depends how you know the person, if the person for example has been a person that has got a habit, a bad habit like chewing Khat, the substance that Somalis chew..

R: Ok..

Ibrahim: ...drinking alcohol...erm all the assumptions come you know he might be overdoing this kind of habit...he might be doing ...he might be chewing khat...um but definitely I would try to talk to him...

R: Ok...great. So it sounds like some of you would actually try and ask him what was wrong...

Ibrahim: Yeh

R: OK

Ibrahim: I'm following an experience like this, because I come back from Somalia, there was a friend..we were born in the same place, so we did know eachother in our childhood..but he lives far away from me in London...and he used to call me when I was in Somalia...and when I came. And one day he decide we meet. And when I met, it became clear to me that something's wrong with this man...I went to his flat, he's living on his own, um and then he opened up, and he tells me that he has got enemies, that he has got people after him, people are talking, and that the family have got a knife...and I have to take him to the GP and then to hospital, and the man was put in hospital, so (laughs) I have first-hand experience

R: Mmm. Wow that sounds like that was really difficult for him

Ibrahim: Yeh

Hasan: I agree with many..most of them, most of what they say. But what I add is maybe he's a lonely man...he's a single man..in need of a relationship or wife or relationship..so maybe that is what cause the problem.

R: Mmm

Hasan: But you have to ask him, talk to him first...

R: Ok...

Hasan:...what his problem is..then you will find out, then maybe you can find something...

R: Do you think Omar would be...when you ask him what is wrong, do you think he would be open with you straight away?

All: No

R: No? What do you think he would do? So first time you ask him:'Omar what's going on with you, you seem different?'...

Yusuf: I think he would be denying it..

R: He would what sorry?

Yusuf: He would be denying it

R: He would be denying it

Yusuf: Yeh

R: He'd pretend everything was ok

Yusuf: but you'd keep asking him

R: You'd keep asking him, so is that what you would do, you'd keep approaching him, even if he doesn't want to talk to you...?

Yusuf: Yeh

Ibrahim: The problem with the Somali community is the understanding of people who have mental health problems..the Somali community does not understand.

My friend – he came to..he approach people – other friends, other relatives – but when he talks about his feelings, um the people have said to him: 'who are you?'

When people ask 'who said that to you? Do you think you are a celebrity or something? You are not that important'. You know, they don't understand. And the reason that he opened up for me was because I accepted the way that he came to me. I didn't say nobody's talking to you, I didn't say 'nobody's your enemy'..

R: Mmmm

Ibrahim: You know. I have to create a relationship first, but most of the Somali community will confront the person..

R: Mmmm

Hasan: but then this person's mentality, this is the reality, that's his experience.

R: Mmmm

Ibrahim: And that isolates the person..our culture is not isolating the person - even if you're not married, you will come to the coffee shops, you will have a lot of friends, we are not the kind of people who are private..

R: Mmmm

Hasan: You know, we come where the communities are..

R: Yeh

Ibrahim: ..so it is unlikely the Somali person will feel isolated or not talking to people. But because when they have the problem, their experience will put them off from talking to people, and being close to them.

R: Ok. It's actually really interesting that some of you talk about being isolated because that is something that was very much talked about in the last group that I

did with the people from Harrow. They talked about being alone and how that's very unusual in the Somali community. And I wonder what else, I mean, you say people would still come to coffee shops. So if Omar is not coming to coffee shops, and he is alone, how might people view him?

Ahmed: For me, I totally agree with that Yusuf said, and I'm someone who knows a little bit about mental health and mental illness..

R: Mmmm

Ahmed: and in terms of this scenario, Mr. Omar, it is clear to me if I knew him, that something has gone wrong, and my first assumption is probably he's feeling a bit depressed or that there is something wrong, or there is family problems here or back home, and er as Yusuf said, even a single person you see on the streets, you would say hello to each other, even if you don't know anyone, you know. If you see someone look like Somali, we greet each other.

R: Mmm

Ahmed: And for someone who you know many years, if they cut off from you then it would be clear that there is something wrong, and that this gentleman needs help. And probably sometimes it's difficult as well to approach his family. Maybe the family is part of the problem, but I would ask first, and try to be helpful and kind. But in my experience, I had a relative of mine who arrived in this country in 1998, and he was untreated until God knows, many many years, and I was the one he hate the most, because I knew a bit about mental health and I said to him 'let me take you to the GP', but er the day he was sectioned and assessed, the first person he want to speak to was me, he give my telephone number to the doctors and he said 'I want to speak to Ahmed', and er then I went to him, but it was after he had medication and slept well 3 days after, that he realise I was the first person he could trust, and when I spoke to him the first thing he said to me was 'can you come and visit me and bring Somali food?'..

R: Ok...

Ahmed:...that's what I did and yeh the road from there, it was difficult, because of the confidentiality as well, and also current climate of mental health system is difficult even to get someone in our Somali community help, because I know there is a bit of.....mainly here in UK we stress about the risk, and if this unwell client is a risk to others, to himself, then he would be getting support immediately, but when this problem's building up, and if you try to help for them,

then that's hard in this country climate and the change in mental health service, and it happened too many year. Social workers for example, when I said 'Please, this guy is my uncle and he needs help', and the first thing he was saying to me was 'he doesn't want you now', 'yes, he doesn't want me now, but when he's better, takes his medication and I'm the first person he likes and he trusts, but it's only when he doesn't take treatment that he sees me as the enemy, and part of the conspiracy.

R: I mean, it's interesting you talk about mental health, and you use words like depression, because I wonder if I was a Somali person, would we use words like that?

Ahmed: No, no. You see.... we have terminologies which I think our...because in Somalia we have a civil war, more than 23..in some places nearly 30 years, and we haven't developed in psychiatric terms, in terms of that and psychological terms. But these days we say someone who's paranoid we call 'bufus'..

R: Bufus?

Ahmed: Bufus..yeh because it is someone who speaks suspicious, we call bufus...

R: Ok

Hasan: Acting strangely...

Hasan: Yeh, acting strangely...and he is running away from other people...yeh you think, you seem to explain this as bufus these days...

R: Ok

Hasan: Yeh you must know the person first before...

R: You call him that..?

Ahmed: No no, you say that 'you are experiencing these symptoms, of bufus'..

R: Ok...

Ahmed: Yeh, but you will say that you are bufus, although, you know the places that Somali people chew khat..

R: Yeh

Ahmed: Erm, we are a community who are open to eachother, and someone who's behaving a bit or a bit suspicious (sic) way, then his friends (sic) might not use kind words, their quite harsh, and they say 'why are you feeling this way. You look like mad person'..

R: Ok..

Ahmed: between them... while they are chewing, in the coffee shop, so those are the terminologies we maybe use, and then that person might cut off from the community then, and isolate - hide out from everyone that he knows..

R: Because of what people are saying about him?

Ahmed: That's right..

Ibrahim: I think it's also important to mention the Somali community, and the assumptions that we have is like, people will tell you like 'Oh, don't go to the hospital, because they will give you medication that will make you like a zombie

Others:(laughter).. 'zombie, zombie'

R: Zombie?

Ibrahim: Yeh, so 'don't go to the doctor, never go to the doctor'

R: Ok

Ibrahim: That's why you see people come very late to the hospitals, because the family and friends who supposedly take them to the hospital, have prevented them from going to the hospital..

Hasan: (Inaudible)

Ibrahim:. Because the assumptions of the Somalis is that...I worked with a family, when I was working in the Tavistock Clinic...and I was working with this family, and there was a child who was having some kind of disability..

R: Ok..

Ibrahim; and he will (inaudible)...and the mother will say, if you don't eat the food, I will take you to the doctor, and the doctor will give you injection..

R: Ah, ok, injection?

Ibrahim: Yeh, so 'the doctor will give you a needle...if you don't go to school I will take you to the doctors'. That child has grown up with the feeling that doctors are very dangerous people

R: Wow

Ibrahim: Very dangerous Because the last place

R: So is that, would you say that...so for example, like that child who grows up with that belief, would that be something that would be quite common among the community about doctors?

Yusuf: It's a taboo, especially when it comes to mental...mental health

R: Ok

Yusuf: It's a taboo, so if you go...

R: So if you went to the doctors..

Yusuf: Yeh

R:...and they gave you some medicine or something, then people would...what would people say about you if you went to the doctors?

Ibrahim: If you, if you if the Somali community knows that you have got a mental health problem..

R: Mmm

Yusuf:...they will label you..there's a label...'mad person'..

R: Mad person? What word do they use..is it 'Waali'?

Ibrahim: Waali (laughter), there's no word between sane or insane...

R: No, ok so you are either sane or insane

Ibrahim: Someone will say 'Oh'..someone who wanted to marry, for example, this girl or this boy, and 'Oh, her father had a mental health..her father was mad, so her children will be mad...you have to run away from this family!'

R: Ahhh..so it's like people think if one person is mad, then if they have a child, that child will inherit the madness?

Ibrahim: Yeh, so there is all this...you know the isolation of the person with the mental illness....

R: Ok...

Ibrahim: and to deny people..not only the person, but the family..the extended family..people will deny and say 'Oh he don't have a problem'..

R: They would pretend that that person was ok..

Ibrahim: Yeh

R: With the family though, so say with that daughter..would her family..even though they deny and pretend she's ok, would they also distance themselves from her...do you think?

Yusuf: Not the family itself, but outside the family..

R: So the family themselves..

Yusuf: They hide...they hide

R: They hide as well..so the whole family are affected

All: Yeh

Ibrahim: Stigma, stigma...

R: Ok. In the last group I spoke to as well, they talked quite a lot about er religious factors, spiritual factors, and I guess I just wondered what your views on

that were...and again, I want you to tell me as if I am Somali...so if we were all sat around, chewing some Khat, talking, what would we be saying about Omar? Would there be any religious factors we would think about?

Ibrahim: It is very common, and we believe, and I think as all Muslims believe, that there is a cure...that there are some verses of the Koran that tells us there is a cure in the Koran...

R: There is a cure?

Ibrahim: Yeh. So people will erm prefer the mentally ill person to be taken to a Mosque, and then the Koran would be read to him...on him...that we believe will take away what they call 'ishlah'...er...

Ahmed: Yeh, evil eye

Ibrahim: Evil eye

R: Evil Eye...is that like a curse?

Ibrahim: A curse..Yeh...there is also a thing that other Muslims, Somalis believe is that can hold the person, is like Jinn..we call it Jinn, this is like the Devil going inside the person, and the Koran will kill this kind of things...Evil Eye and all this. So yes, spiritual is very very important factor of treatment.

R: Do you think that would be something..so say again we're all sat around, we're talking about Omar, we notice he's being a bit strange, would the spiritual er....conversation about the Jinn for example, would that be one of the first things you think people would talk about? Or would it be more 'I wonder if something is wrong in his family?'

Yusuf / Ibrahim: First, first...

R: Ok first thing..we think 'ok, maybe there's a Jinn'. Because there are good Jinn and bad Jinn...?

All: Yes, yes

R: Ok...I've heard this and erm and again, in the last group they talked quite a lot about what might cause a Jinn? But I would like to see what your views on that are? What might contribute to somebody suffering with bad Jinn? Would there be any causes of that?

Hasan: It's invisible isn't it...nobody can see the Jinn...you may get it from outside, or, from the toilet...

R: Yeh

Hasan: ..especially the jinn is the dirty area, so you might get from that area

R: Mm-hmm

Hasan: Or maybe someone...Eye..Isha..

Ahmed: Evil Eye

Hasan: Evil Eye...from someone..from the outside..you get the Eye

R: Ok

Ibrahim: For example, erm, the Somalis believe if the person is clever...

R: Hmmm

Ibrahim: Or they're successful..then the other people's eyes can see him, so that would change him..and they become ill..

Ahmed: Envy and jealousy of others..

Ibrahim: Yeh, and not only this, even someone love him to much, some person, they say for example, in the Somali love stories, you know...

Ahmed: Yeh, the man, God, went inside the girl....

R: Ahhh ok

Ibrahim: It's not a story I personally believe, but some Somalis believe if someone loves someone, whether they're male or female...

R: Mm

Ibrahim:...the Evil Eye can go to that person...

R: Ok

Ahmed: The Spirit of the man will go inside the girl...first first...that is what they believe, yeh

Ibrahim: yeh, but I don't believe...

Ahmed: Yeh...

R: Ok, but some people do..?

Ibrahim: Yeh, a lot of people do...very common

Ahmed: For me, just being in the mental health field, and I think there's some psychological help they can get from the Koranic verses and of course, as a Muslim person I believe you know, Koran is cure, can cure people, but the way I take it is like physical health...if someone got you know, TB infectious, then you might need that person to read Koran on her or him, but also need to see a doctor. And need medication. And that's how I see mental health problems. Of course, this person needs medication, needs psychological therapy or talking therapy, but if then on top of that, and a scholar or the Imam reads Koran on that person, it's no harm. But erm especially, we have seen back in Somalia there is more

problems. We see some people, they are not scholars, but they claim to be a scholar..to survive and to get money...

R: Ahh

Ahmed: And typical, they con people, and they will say 'I can cure mental health', and then he will attract every person in the community and then even, the people they bring the first day he or she might be having a little problem, but when that person recite Koran, or hit on the feet or or...

Ibrahim: inaudible

Ahmed: Yeh some traditional....yeh....will mix some plants....will make that person who came for help even worse...and I've seen and I've heard a lot when I went back to Somalia. And er for me....if this person...Koran helps...of course take to the Scholars that we know...

R: Mm-hmm

Ahmed: ...but also seek help with the doctors..and I have listened to a lecture from a famous doctor recently...and he was talking about one of the scholars...a very well respected Somali scholar...who was saying 'of course, if someone has a mental health problems...it's like physical health'...

R: Mmmm

Ahmed:...we will seek both. Let me take to the doctors, and also recite Koran...and I'd say that's my view...

Yusuf: One of the reasons we have Somalis and difficulties...there is no doctors in Somalia...who specialise..no psychiatrists...none. I was listening last week...they were saying 220 nurses in the whole of Somalia specialise in mental (health)..

R: Wow

Yusuf...and there is no psychiatrists, no doctors, no therapists...people have no choice, so they have to go...

Hasan: ...traditional...

Yusuf: Traditional...and there is a group..exploitation..they do what they want. They claim to be doctors...so they take anyone, that's the reason. We don't have no-one who specialise...maybe 1 or 2 in the whole region..

R: I wonder even if there were more, would people go and see them?

Yusuf: They would, they would. Because traditionally we used to go to the Mosque, Sheikhs....but when we have a doctor we go, but there is no doctors...

Ibrahim: But in reality..I think I am privileged to live...when we had a government in Somalia..so people used to go to psychiatric hospitals when we had a government in Somalia, but when? When it's too late. When the person's in the street. You know, when the person...it's too late to be cured..they try the Koran, they try the Jinn, they tried Mingus, they tried everything, and the last resort was the doctor.

R: The doctor...because like you said earlier, if you go to the doctor, that's taboo?

Ibrahim: Yeh

R: So maybe this is why I'm wondering...even if there were more doctors...how easy would it be for people to...a person like Omar..would he actually want to go to the doctor, you know? Or would it be just when it's 'too late'?

Yusuf: I think...I was in Somalia a few years ago..and there was a doctor..he came from Canada...and they were saying 'that doctor will come that day'. And there was a queue from all the regions..

Ibrahim: Was he a psychiatrist?

Yusuf: Yeh..and he was giving free medication..

R: Mmm

Yusuf: But the medication that was given was mainly..I think it was to make you calmer and sleep medication...2000, 3000 was in queue for a week. So what I'm saying is, if they had a choice, they will go to doctor, but there is none. They have no choice. There's no nurse specialists, no doctors..

R: And what about here in this country? We obviously have many doctors...

Ali: The first problem we have is we are afraid to contact our GPs...because if you have that contact he may not recognise the symptoms of this kind of disease. Even I can't remember myself the last time I visit my GP..

R: Yeh

Ali: So that's why we have difficulty to go to the doctors..

R: So there's something about they may not...a difficulty in understanding?

Ali: Understanding

R: So you talk about something...and I mean, say Omar was to go to the doctor, what kind of things might he say to the doctor?

Ali: Erm, how he feels.

R: Ok, would he...

Ali: Not the, you know the sickness, but the behaviour, how he behaves.

R: Ok

Ali: How he is erm..yeh. So only the symptoms.

R: Ok. I only ask that because sometimes I have observed here, that our patients talk a lot about headaches, physical symptoms..

Ibrahim: Ah yeh...

R: So they are here, not because of their headaches, obviously...

Ibrahim: I think that is what I wanted to say...the patient will talk to the doctor about their pain..where the pain is.

R: Mmm

Ibrahim: And for them, the pain is the headache, or the stomach ache, or their shoulders, or wherever physical..

R: Yeh...

Ibrahim: But they will not say to the doctor, 'oh I think I need help...with mental health'..

R: Mmm

Ibrahim: You know..

Ali: Only when you have physical health problem...that's the old perception...

R: So the doctor is for the physical...

Ibrahim: Exactly...

R: Not for anything else...

P: Non, no, no

R: Ok...

Ahmed: And to add to that, I think even our well-educated Somali community members, and when it comes to mental health, they refer it as a neurological problem, rather than psychiatric problem...

R: Ok...

Ahmed: You know, that's erm...even if they see for themselves they have a mental health problem, they don't sleep for 4 days...and some would say there might be some mental health problem, they would said 'oh, I feel you know I am sick neurologically'..

R: Ok so like a problem with your brain..

All: Brain, yeh, yeh, yeh

Ahmed: Rather than psychiatric terms...and that's the main actually we use all of our Somali. Whoever is mentally ill, will go to the doctor or scholars and saying

that 'I have got a neurological problems', and that doctor would mainly be the GP who will prescribe some medication that will calm them down rather than..even for them, those doctors might not explain deep down , in their level of understanding what mental health problem is..they just dish some diazepam medications for a week or 2 to help them. And as soon as they sleep well for a few days with the medication, their own perception will be "oh, I'm cured..."

R: I see...

Ahmed:...and I'm fine..", and that's it..

R: I see, so the medicine that helps you sleep, like sedatives...

Ahmed: Yeh, sedatives...

Ibrahim : I think that would be in Somalia, I think the question was, what is preventing people here, to seek help?

Ahmed: Yeh....again....

R: That's ok, I'm interested in both, here as well...I guess we have many doctors here...and like we've said..

P : That's for physical pain, that's why you go to the doctor

R: You go for your physical pain?

Ps: (acknowledge this)

R: And....but there's also something maybe about not being understood?

P : Exactly.

Ibrahim : I think what is preventing people from going to the doctor...the biggest fear is the confidentiality...

R: Ok

Ibrahim: Because we are an oral society...anything happens to someone, we tell everybody..like spread it..

(others laugh)

Ahmed: We are a very tight community..

Yusuf: Very tight community...

Ahmed: We know eachother....if you don't know someone, you'll know someone who knows him...

R: Yeh...you all talk!

Ibrahim: Yeh so...the stigma of the mental illness.. and the lack of confidentiality, and the culture of talking about other people..

R: Mmmm

Ibrahim: I think that would be the main reason to prevent people seeking medical help...

R: So like you were saying before, Yusuf, like you're all saying..the taboo of actually going to the doctor because...even if it's not the doctor telling people, people will know that person went to the doctor..

P : Yes

R: Even here

Yusuf : Years ago I took a lady to her GP, so I was helping her, and the doctor was asking questions.. "did you sleep well?" ...and she said "why do you wanna know my sleep? Do you think I'm mad?" (laughter). That's a taboo. She hadn't slept for weeks and weeks. So I had to tell the reality and said 'no, she hasn't slept '. So I took the medication and in a week she was alright. But the taboo is there. She said "am I mad, am I mad?" So we have carved that fear. Fear.

R: So it's like if there's anything different, so say you are having problems sleeping, there's a fear, that means you're mad.

Yusuf: Yeh

R;...there would be no other explanation...

Yusuf: Yes

R: Wow. Ok..this is all so interesting. Erm.....I think, I wonder if people would think, if we come back to Omar, would people think there would be anything dangerous about Omar? That he might be violent? Do you think people would think that? Again, say we're sat talking about Omar...

Yusuf: Yep

R...would we be saying that?

Ibrahim: Unless er.....unless people see him, for example, in a suspicious way, like er being verbally violent..

R: Mmmm

Ibrahim...you know or.....carrying some weapons, like knife or something, people would not immediately think he was dangerous to society.

R: Ok..

Ibrahim: Um I think....and the people would read the papers, and the people who are the lay people, who do not read papers, who do not understand very well what's going on..so these Somali people, will depend on the information they get from the Somali people..

R: Ok...

Ibrahim: So the Somali person will not read the paper...sometimes when I see our culture, compared to the English person, when they are broke, they say 'oh I don't have 50 pence to buy a paper'...the Somalis would say I don't have 50 pence to have a cup of tea"...we don't read, you see. But we know everything. Why? If one person reads, he will tell 20 people.

R: I see, ok.

Ibrahim: So this is what people...each one of them will tell..will go coffee shop, and tell everybody this.

R: Ok...

P : We are all oral isn't it...

R: Oral?

P : Or verbal...

R: Verbal..verbal?

P: Very verbal

R: Very verbal? It's very nice...

P: No..(laughter)

R: I can see why maybe it has problems but I think its very nice...English people, we all do our own thing..you know? Erm ok, but I guess..just coming back to this thing, if people had decided that Omar was mad, and were calling him a mad person, would they think, again...they hadn't seen him carrying a weapon or anything, but would people think "oh maybe he is a bit dangerous..he might be violent"

Ahmed: Yeh...our community, always, mental illness and violence that's true...that goes together...

R: They go together..

Ahmed: Always...if they see someone and their own understanding:"this person is mad"..

R: Mmm...

Ahmed: ...they'll say 'he's a violent and dangerous person'..they see that. That picture, they get it from that person.

R: Mmm..

Ahmed...and err for me, I always say to them:"actually it's the other people who see themselves sane who are the dangerous ones. Sometimes this mentally ill person, they provoke...

R: Mmm

Ahmed:...they make them angry...they call them names..and it would be in self-defence that he would retaliate or she would retaliate...

R: Mmmm

Ahmed: and that they would say:"see..I told you..she or he was mad"..and that's how I see it...

R: Yeh. I have heard from some of the other people that people might laugh at them...

P : Yeh..

R:...or call them names...like you said...sometimes throwing things?

Ahmed / Yusuf: Yes yes (muttering)

R: Ok..and I know that in Somalia, I don't think..I don't know if it happens here, but in Somalia, because it was on the news the other day..there was a special programme..

Ahmed: Channel 4

R: Yes.

Ahmed: Did you watch it?

R: I did. And I saw they chained up a man, because they thought he was mad. And he was going to stay chained up in the shack. Erm but I assume that does not happen here...?

Ahmed: Here, they don't chain. But, you know if they could do they might lock them in their house and they might not even allowed to leave the house, I haven't seen, I haven't heard that someone's done that but I have suspicion of that, yes. Because, we, our loved ones, we protect our people and if our young ones is unwell then they prefer keeping them in the house rather than wandering on the streets..

R: Hmmm

Ahmed: ..and again, I haven't heard or seen, but that's what I suspect some communities might do..

R: So to keep them hidden?

Ahmed: Keep them hidden, yeh.

R: Do you think keeping them inside is..more to keep them in so people don't er...because of the stigma? Or is it more to protect that person?

Ahmed: Both, both, both

R: Ok

Ibrahim: But the biggest one is, is...is the shame that come to the family, of the person is doing bad things..it's not the person..

R: Mmmm

Ibrahim...anything bad that person does...will come back to the entire community or extended family..

R: Ok...

Ibrahim: You know, if the person..and and also this is how it is back home. If someone, for example, erm kills someone, you know er..you know someone from his clan had been murdered, who doesn't know what happened, who might not be in the same place, but is simply related to the criminal, you know, to the murderer, that's how Somalis (inaudible)..so these kind of (behaviours)...they bring them here, but in a different level..this is the shame that this person brings..

R: Ok...

Ibrahim: We're not going for him..it's everybody..

R: Ok

Ibrahim: So they have to protect, they have to keep that safe..

R: So like the person..so say someone did kill somebody, would there be an automatic assumption that that person is mad?

Ibrahim: Is mad

R: Ok

Ibrahim: Unless there is errrr...an argument or something...otherwise it would be the person was mad...

R: Mmm

Ibrahim: And it's easier if the person was mad, because then (there would be) no retaliation after that..

R: Ok..

Ibrahim: Yeh..but if the persons aren't saying that, then they'd get angry and kill somebody..yes there would be a fair chance of retaliation

R: So the whole family suffer?

Ibrahim: Yes

R: Ok...erm I won't keep you for much longer

Ahmed: You're fine, you're fine

R: Tis is very interesting...I guess I've..yeh...I just wondered if there were any other things...if we were talking about Omar...you know maybe if there was a Jinn..just coming back to the Jinn..

Yusuf: Yeh

R: I'm still getting to grips with it myself and my understanding...some people in my last group talked quite a lot about the Shaytan, the Devil, and the Jinn, and I guess I'm still trying to get clear about er the difference...is the Shaytan, the Devil,, who causes you to have a bad Jinn? Or is the bad Jinn also the Shaytan?

Ibrahim: The Devil Himself...

R: Yes..

Ibrahim: ..is a Jinn

R: Ok

Ibrahim: The Devil Himself is the biggest Jinn of all

R: Ok..

Ibrahim: And then it is the Devil that is responsible for anything bad that a person does..

R: Ok

Ibrahim: For example, the person kills someone..

R: Mm-hmm

Ibrahim: ...We'd blame the Shaytan..

R: Ok..

Ibrahim: ...the person who commits adultery...we blame the Shaytan

R: Ok..

Ibrahim: ..so anything bad

R: It's the Shaytan..

Ibrahim:...it's the Shaytan...

R: Ok...and do you think that...I wonder what your view is on this, because I had someone in my group last time who said that we are vulnerable to the Shaytan if we have no attachment to God...if we fall away from our religion, but this person was a Sheikh, so a very religious man, and I guess I wondered what your views on that were, if they were different or if that's how the general perception is..if we

fall away from our religion..maybe we don't pray as much as we're supposed to, for example, whether or not that would be a reason for the Shaytan?

Ibrahim : Umm..I have a very clear opinion, but I want people to say before me..

R: Ok..

Yusuf: I think um...religious keeps us knowing all these things..

R: Mmm

Yusuf: When we believe as a Muslim, if you follow Allah, you are more likely to be safe. For example, if you pray 5 times a day...

R: Mmm

Yusuf: ..you are avoiding things like drugs, chewing Khat..from all these things you will be safe. If you don't do it and don't pray, it's easier to do bad things. That's what I'm saying. It's a barrier..

R: Mmm

Yusuf:...as long as you keep your religion, but once you stop doing one thing then you start doing something else..crime, drugs...

R: So you're more vulnerable to doing things that are not good for you..ok. I ask this too because here (at work), often I hear Somali patients say "I am a good person, what have I done wrong, why is this happening to me? Am I being punished?" So I guess this gets me thinking..so I guess I'm wondering if this is a general belief..

Ibrahim: This is...in the Koran it says that the Shaytan is the enemy of mankind, and Shaytan want to take us to Hellfire..ok? And Allah wants us to go to Heaven, but Shaytan wants us to go to Hellfire. And He wants to take us with him, and the Shaytan will do anything he can to deviate us from the right path, and the only way we can protect it is like now, in our countries we use the term 'nuclear power', it's not a weapon to fight with, but it's a deterrent, you know to stop people attacking you So the Koran's a deterrent.

R: Ok..

Ibrahim: Yeh? The Koran's a deterrent from the Shaytan. If someone's religious, I think they would be much safer compared to if they are not religious.

R: Ok, ok

Ali: I think um mental health is a disease like other diseases...

R: Mmm

Ali.. but the problem is outside they don't believe that mental health is like other diseases, and they will take spiritual guidance and something like that...

R: Ok

Ali: ...and we need to educate and be erm you know told that this is like other diseases, and that's why people go to spiritual guidance, but they still don't understand...

R: So it's a lack of understanding...and maybe seen as incurable..

Ali: Exactly, yeh..

Ahmed: Ok for me, knowing a bit about mental health, erm I totally agree with you, belief comes first. If someone is a Muslim, you know we believe our religion guide us in the right path to go to Paradise, and for me seeing and working with Muslims clients, I find most difficult clients who recover is those who drink and use drugs..for me as mental health worker I understand, sometimes they will take those drugs and alcohol to numb or self-medicate, but what happens is when they take drugs and alcohol, they even feel shamed and guilty because they read Koran, and the way Prophet Mohammed taught us to be in a right path, and then for me I find it more difficult to support those ones...

R: Mmm

Ahmed:...you know, but of course, in mental health's illness, like physical illness, and I have seen, I don't know if you have seen, even scholars, Muslim scholars who have mental illness I have seen, who talk to themselves and feeling paranoid, and yes, it's an illness but I find those who are close to God and their religion, they are those who are less vulnerable to Shaytan..

R: Ok...so it's a protective factor..

Ahmed: It is protective

Ibrahim: So there are a group of people..nothing to do with the Somali community, but my personal belief is they have got mental illness. The people view them as religious people, we call them Sufi, ok? The people who are called Sufi, they sometimes do strange things, things that for me, are clear mental deficiencies..

R: Ok..

Ibrahim: they do..for example, they talk (about) something impossible..

R: Ok...

Ibrahim: someone will tell you, 'I'm here today, but when I done my prayers, I was in Mecca..' they tell you this. So although these people are religious people, still they have a mental illness..

Ahmed; Yep

Ibrahim: In Somalia, it's not because you are a good Muslim that you cannot be mentally ill..no no that's nonsense..you can be as good as anyone else..

Yusuf: ..but at the same time have a mental health problem..

R: So the word you use is 'Sufi'?

Ahmed: We would call them Sufi, but for me, Sufi is a sect of Islam, which have their own..but in Somalia, those who use the right term, I think they are 'grandiose' people..

R: Ok...

Ahmed:...they might study Koran and read Koran, and they know a bit of Koran...then they become mentally ill, they become grandiose..

R: Ok...

Ahmed: ..and then they will come to lay people who come for their help, and they make them believe that yes, 'at 4 o'clock I was in Mecca on a pilgrimage, and now I come back...and in the afternoon prayer I will go to Mecca again, and do prayer and come back'. But for them, clearly to me, yes they are grandiose people, they misguide other lay people..

R: So they talk about things which are impossible..

Yusuf / Ibrahim / Ahmed: Impossible, yes..

R: And this is why you might for example, see that person as not well mentally, because they talk a lot, grandiose, so they err pretend they have very special abilities..

Ahmed: Powers, yes, yes. Special powers.

R: Ok. But it's interesting that there is a term for that sect of people...

Ibrahim: Yeh, Sufi, yeh.

R: Ok..very interesting. Listen I think we should wind down now...ENDING

Appendix 4.2: Ali

R: So just to kind of remind you of the things we were talking about in the group..I think you probably remember I read you guys this very short story about a man..

P1: Yeh...

R: And I called him Omar..and then I asked you all what you thought might be going on for him..

P1: Hmm

R:...so your views. Now what's really important for me is I know that I'm white and I'm English and it might..sometimes when I've spoken to people I feel like perhaps they want to tell me what they know about how mental health and things are understood in this country. But what I'm interested in is how you view things...so there's no right or wrong, it's me just exploring with you really. I think you were the first person to speak in the group..

P1: Ah ok

R: You are number 1 (laughter). Ok...and when I first read you the story, you said one of the first things...do you want me to read you the story again?

P1: Yeh yeh yeh

R: Ok. So. So imagine you have a friend. Ok, we'll call him Omar. Ok and we imagine this is here in the UK. Ok. And you are a friend of Omar's and you notice you haven't really seen much of him in the community..he seems to have disappeared. And the things he used to come to he's stopped coming to. And you've sort of noticed that he doesn't seem to be leaving his house much at the moment. So you try and call him on the phone but there's no answer. And you've tried to call him a few times but he's not answering. And you did see him the other day and he looked a little bit scruffy, and like he might have lost a little bit of weight, and not really looking after the way he looks much. You feel like there's been a change in him and I suppose my questions to you were if this man was your friend, what would you think be happening with him. What would your thoughts about him be?

P1: Um, I think my first reaction would be um I need to reach him, talk to him, and ask him where he's been the last couple of days, and what happened to him. And sometimes if he not answer or rejecting my approach, maybe I try to get his family or very close friends about how he was doing..

R: ok...

P1: Something like that..

R: I remember you all mentioned that actually about reaching out to the family if he wasn't telling you. One of the things you also said in the group was you, without talking to him first, I think I said to you well what would you think might be happening, and you were the first person to speak and you said maybe there were some family problems..

P1: Um....here when they come to a new country there are different problems um when they come to a new country or a new culture..

R: Yeh...

P1: ..cos erm or maybe family problem, so they can figure out what happened to him.

R: Ok..so that's nice because it sounds like you can reach out.

P1: Yeh yeh. Erm...because when in a new country a different situation..

R: Yeh...

P1: Cos erm sometimes you find yourself feeling lonely...sometimes maybe um you're isolated, family break-up, this kinda stuff, which is maybe unusual or easier back home..

R: Yeh..

P1: So underlying issues

R: So if this was in Somalia, would it be different do you think?

P1: Erm it would be a little bit different, because in Somalia, because here, it's different, because social circumstances..there is big families, relatives, always right in the middle of things, you know..

R: Hmmm

P1: Here you are alone, cold weather, yeh..so it's different...

R: Ok..so people make more of an effort here

P1: Yeh, more social network here..

R: Ok,ok..good. There was quite a bit of talk in the group about and really interesting for me to hear..about erm people's different views on the cause of Omar's problems. You also mentioned it could be financial, but as we talked in the group there was some talk about some religious and cultural beliefs as well, such as 'well if he's having problems there might be a Jinn' or someone may have cursed him, things like that..do you remember that?

P1: Yeh..I don't think..I believe maybe um people are sometimes affected, to some kind you know, but I don't believe that much erm...this kind of..what people mentioned...

R: Ok, so that's fine...

P1: But maybe most of these men who complain about Jinn and this kind of stuff..but in the case of Omar, maybe it's different..

R: Ok...is that something that's changed for you? So when you say you don't really think much about these things, is it something you used to think, maybe before, and that's changed, o you never really thought about those things?

P1: (Pause) it's not something that's changed but it's something I believe, because most of the male who have this kind of mental breakdown are not complaining about Jinn or something. But this could be family problem, addiction...

R: Addiction?

P1: Yeh

R: What kind of things might they be addicted to?

P1: Well sometimes people might use erm (pause) erm..they use erm Khat and if you are addicted to some Khat, it's different from here..the weather, the situation, you know you're underground, like it really affect your health and mentally erm, so I think most of the young people who are in the mental institution here, they have used this kind of drug..

R: Ok...

P1: And isolated from other society...

R: So they might use it more?

P1: Yeh, exactly. And maybe it causes them to use other hard drugs, which cause them more damage..

R: Ah I see...so because they use that they might also use other drugs too..

P1: Yeh, yeh

R: And when use say, cos I know a little bit about Khat, that you chew it, I know it can be recreational...

P1: Hallucination...

R: Ah I see

P1: I never used it, I never tried it, I hear about people...hallucination. you are good, you're doing this and then next morning you cannot wake up, you're paralysed, you've lost your energy and everything..

R: Ok...

P1: Absolutely..

R: Ok, so someone like Omar..it could be he is chewing too much Khat..maybe family problems..: You mentioned being alone as well, because here you're more isolated..

P1: Um because if you don't know the culture, and don't speak the language so sometimes it's very hard..

R: Yeh...ok ok. With Omar though, if he was before ok, and then something changed, do you think it might be because of reasons like that..maybe khat, maybe family problems..

P1: It depends...I'd need to understand what he was doing before, how was he before, what kind of relationships he had..so without all these I can't..

R: It is hard, yeh. I guess my interest here is what the assumptions would be, of other people, even if they don't know him very well, but they know him to say hi to, but they don't know him that well. And what people would think. So it's fine, like I said there's no right or wrong here, it's really..

P1: Yeh, I understand.

R: Yeh

P1: Also it could be expectations people come with...and then in reality, sometimes people come (inaudible)

R: Yeh, ok, that's great. Erm I think as well we talked a little bit about help, what would be helpful in terms of helping Omar to be better. And I know you've said talking to his family, finding out what's wrong, and we had a discussion in the group about doctors, and that it can be quite difficult for Somalis to go to the doctors sometimes...

P1: We never used to go doctors, because you go to the doctor when you are really sick..

R: Physically sick?

P1: Physically sick, but here you've got, anytime you feel something, whether physically or mentally, and I think there is something you had when you were a child, the way you grow up, the awareness...I'm not sure in the case of Omar, but we don't go to..usually, unless you are very sick..

R: Unless you are very very sick..and why would that be? Why would you not go? What would stop someone going do you think? Do you think they'd think they need to go?

P1: Um....

R: Would Omar think he needs to go to the doctor?

P1: For physical illness, he needs to go to the doctor. He needs to see a doctor and talk to him and tell him his problems, but I don't know..

R: Do you think he would think that though? Do you think he would think 'I need to go to the Dr' or just other people think he needs to go..?

P1: If I were his friend, for example..

R: Yeh

P1: Um I would want him to go to the Dr, definitely.

R: Do you think he'd want to go?

P1: Um I don't know Omar (laughs), maybe he wants to go

R: The only reason I ask that is because I know there was a bit of a conversation about when you go to the Dr everybody knows you've been to the dr. So I'm wondering if you're not really physically unwell, and people know that, and they know you've been to the Dr anyway, that they'd talk about that. They'd talk about the fact you went, and they might think..

P1: Um yeh, yeh, if you've been to the doctor..'how's he doing, what doctor say, what about the illness you had'..and this kind of stuff..

R: Yeh. So I'm wondering if that would be a reason for people not to go...if everyone's talking..but..it's difficult

P1: Yeh, it's difficult, you can get more cautious. And people are not enjoying to talk about their illness you know.

R: Yeh..I think you even said in the group that when people go to the doctor they tend to just talk about physical..

P1: Yeh..

R: Like headache..

P1: Stomach hurting...

R: Stomach hurts..

p1: Pain..

R: Yeh, rather than if they're feeling...

P1: Stressed...depression..

R: Yeh. When you use words like depression, how do you understand it? I guess I'm very curious to know what..what does that word mean to you? If someone was to say, 'that person's depressed', how would you understand it?

P1: Um, it's erm it's a new word in our community. Because back home there's no depression at all...it's just here. It's a new disease for us, and it's like you're tired always? Or something...

R: Ok, yeh

P1: Um, you don't feel well?

R: Mmm-hmm

P1: Um (pause), maybe sometimes you don't wanna talk to other people, or you not feeling ready to talk to them or..so these are I think the symptoms..

R: It's just, yeh, and I find it very interesting because I'm aware that back home it's not something that's very recognised..

P1: Yeh

R: You're either sane or you're crazy..

P1: Yeh

R: So if someone was feeling those things you've talked about, and they're not familiar with depression, what might they think is going on for them or what might other people think?

P1: Um...they say 'oh I'm tired...I've been asleep all day I'm tired'..I don't think they see until they become, you know, very serious...yeh

R: And what would be very serious?

P1: Um..when you see how he or she is acting, strangely..

R: Ok, I see..

P1: And looking bad, sometimes..

R: OK...

P1: Yeh

R: So there's an idea that maybe if you leave it, it gets worse..?

P1: Yeh

R: And maybe you start acting strangely?

P1: Yeh

R: And you also..which I found really interesting to hear about, you all did talk to me about certain words in Somali language...like the word 'bufus'?

P1: Yeh, that's a new word

R: It's a new word?

P1: It was only used from 20 years ago..so this is the new..

R: New term?

P1: New term, yeh exactly

R: So if somebody, like Omar, left feeling this way and it got worse and started acting strangely, would he be seen as someone, would he be seen as someone experiencing bufus?

P1: If you erm avoid other people and change dramatically, too much stress, paranoid, he get bufus, yeh, he's become weird

R: He's become weird

P1: Yeh..

R: I see, ok

P1: It's a real negative meaning, yeh

R: Yeh, yeh, and if that's the case, do you think there is any help for him then?

P1: Yeh, yeh, definitely. If you go to see the dr.

R: And so what would the doctor do that might help him?

P1: Erm, I think there give sometimes, tablets?

R: Tablets?

P1: Yeh, and they help him to sleep

R: To sleep..?

P1: Yeh and this kind of stuff..

R: Ok...ok. That's really interesting, because I know we touched on some of these things...what about talking about what's going on? So as you're aware you probably know that here in this country we have things like counselling and therapy..and I wonder what your views are on that?

P1: Yeh, I think it's very useful, because it helps people to talk. Erm...discuss the issues with the dr..

R: Do you feel that it would be quite hard for someone like Omar or anyone in the community to go and have counselling?

P1: Yeh, because they are not used to it so it is hard to get used to...you have appointment with counsellor, you have appointment with therapy blah blah...and maybe he doesn't believe it's going to be helpful. You have to be very courageous to go to this..

R: Yeh. And I know as well there was a discussion that someone like Omar might be denying things...

P1: Yeh, exactly, yeh..

R: ..even when his friends ask 'are you ok, what's happening", he might say 'I'm fine'

P1: Yeh, that's normal. Not just him but it's just normal. You are in denial.

R: You are in denial..you don't want other people to know..

P1: You say 'oh I'll be fine in a couple of days, don't worry'

R: Ok, ok...and I wonder what that's about?

P1: He doesn't want people to talk about it, he doesn't want people to say he's sick, he want to have his confidence

R: Do you think it's different for men and women? Do you think women would be the same?

P1: I think women talk more to eachother

R: Ok..ok, yeh. Erm there was a little bit of discussion as well about..so just to be clear actually, going back, when you feel that's it not about Jinn or curse or anything like that, and just because others in the group talked about having some spiritual healing, where he might have parts of the Koran read to him, what do you think about that?

P1: I believe Koran is also part of healing..

R: Yeh..

P1:..but also medicine is also helpful..

R: An you did say from hearing about Omar it doesn't sound like it might be spiritual it might be more to do with family..I wonder if you do separate that maybe there are some people who perhaps there is a Jinn, and there are some people where there isn't a Jinn and they just have problems..

P1: I think he has other problems..I cannot come to conclusion about whether there is a Jinn but there are other related issues..

R: Ok, ok..erm so depression - tired all the time, maybe not wanting to talk...and if you leave it it might get worse and act strangely and if you leave it what do you think might happen?

P1: Erm...pause...it get worse..that's possible.

R: Do you think if you left it that person might become a but dangerous?

p1: Erm it get worse and worse it might yet.. if someone is seen as violent or if they hurt someone maybe they are a bit mad..

R: So it sounds like your views are a little bit different, but that's ok..

P1: Yeh I have different opinions, and I think erm how I feel and how I see is maybe different from other people

R: What do you think has impacted on how you see things, do you think it's because of being here?

P1: Definitely, definitely, definitely..since I've been here a long time in the West, and I see different through education and experience..this has contributed to my understanding..

R: Ok..ok, so just being here and seeing..I think one of the big things that came out was that back home these things may not be seen as curable or that you can't treat..and since being here people see it more like a physical illness..

P1: Yeh, definitely

R: Have there been any other things while you've been here..anything in particular that's helped changed your views?

P1: You know this kind of mental illness is taboo in our society, and they don't talk about it, it's a closed topic, and that's why if people have awareness of this and openly discuss things, I think that would be very very helpful

R: Hmmm

P1: Just a majority of people have mental illness or depression..they are used to them and there are cures and awareness of this kind of stuff

R: So it sounds like maybe in the West people are different

P1: Yeh erm people are different..some people are very traditional and that's not enough. For example. Most of the people come because of civil war and from rural areas which never go to school or never see a proper health centre and this kind of stuff..so it's very hard for them

R: Of course

P1: So it's complicated

R: Absolutely and that's what I'm curious about the change of coming from Somalia to the UK, and having all these services, all these people talking about mental health

P1: Definitely

R: Do you think this has an impact on the community in being more open about it or do you think there are still quite a lot of people who are still very closed and don't wanna talk about

P1: Yeh yeh yeh, they don't want talk about it. They're still very traditional..

R: Very traditional..

P1: very traditional and is taboo in our society.

R: Hmmm

P1: And sometimes they feel shame you know, if they've got a mental illness, cos other people talk about it and have no understanding..even if they don't know if there's a cure or not, so they keep to themselves

R: And this is why I wonder about someone..if Omar was real, you know..this is why I ask about him, if he was a real person in the community erm yes you've said he'd probably deny that anything's wrong...would he be shut out of the community, maybe if people saw him as not well or a bit strange?

P1: They'd say he's crazy

R: They'd say he's become crazy

P1: And the other thing, people won't go to the hospital because they think it make them zombie..yeh (laughs)

R: Oh yeh

P1: They don't want to go to a psychiatrist..

R: Because the medicine makes them like a zombie

P1: A zombie, yeh (laughs)

R: but say, the way you've talked about depression, for example....I mean would you say that's somebody who's maybe a bit mad or not? When I ask you how you understand depression...if it was those things, would other people still look at him and think 'he's a bit mad'

P1: Yeh, yeh

R: And what in particular would it be that he'd be doing that would make them think he was mad?

P1: If you come and leave your shoes at home, for example, or maybe your clothes are a bit weird, for example..

R: Your clothes are a bit weird?

P1: Yeh...

R: And what if it's just that you don't leave the house much?

P1: Sorry?

R: What if it's just you're not really leaving the house much?

P1: Exactly

R: Would that be something that people think 'oh he's gone a bit mad, he's stopped'..

P1: No, no, no...most of the people they don't know..only close family, erm maybe find out you've been in the house

R: But it doesn't sound like it would take much for other people to think the person was mad..

P1: Hmmm

R: Maybe they wear the wrong shoes, the wrong clothes..

P1: Yeh...

R: Maybe if they look a bit scruffy?

P1: Yeh, exactly, yeh

R: If they look a bit different..?

P1: Yeh, exactly

R: Do you think a lot of it is about the way you look as well..your image, your appearance?

P1: Yeh, yeh..If it's different from how you looked before..they may say 'oh maybe he's not well...'

R: Ok, ok..that's really interesting. and I know erm, yeh so for that person, we again talked about how they might hide away as they don't want others talking..

P1: Yeh

R: Erm...and in this country, there was some talk in the group about how families might try and protect someone, that if they felt there was someone in their family..so say Omar, his family felt that other people were talking about him, they might keep him at home...?

P1: Yeh, yeh, yeh..because we are in a community of controversy...that's why..

R: Ok..I won't keep you much longer..guess I wanted to ask you about Khat, actually, as you mentioned it. How do you feel about the ban that's coming up?

You know they are making it illegal - do you think it's good or bad?

P: Yeh (pause)..Khat..I don't like it

R: You say you don't use it?

P1: No..

R: Is that because you...it seems like quite a common thing for Somali men to do..

P1: Yeh yeh you're right

R: What keeps you away from it?

P1: Erm the environment here is different than back home..

R: So it's not as good here? Or...what do you mean by that?

P1: The climate is different, for example, it's hot and warm...and time is different...maybe people back home chew before sunset, and evening, and here it's different...they sit in a very small room - maybe 10 persons, so it's not healthy..

R: Ok..

P1: And it's rough sometimes as well...and maybe it causes more problems again

R: With the view you have about how someone may be addicted, it can be quite harmful to them..is that something you have seen with other people? Have you had experience of seeing other people?

P1: I hear it

R: Ah, you hear it..

P1: They mix it with different type of...

R: Ah, other drugs?

P1: They want to get higher and higher

R: Ok...so what do you feel about this ban then?

P1: You know, sometimes it's easy to ban but sometimes create more problems..

R: Hmmm

P1: Like smuggling..people are committing more crimes..

R: It sounds like a big deal for the community..

P1: Yeh, it's a big deal..but anyway, no-one is perfect, so if people want to chew they'll find another way..

R: Yeh..ok erm..so if Omar was your friend, what would you think about him?

P1: Again, it would depend on his background. Because maybe when he came to this country, maybe he came during the Civil War, maybe he had baggage, so nobody knows his background..

R: So you mean maybe things happened to him...

P1: Like trauma?

R: Yeh...do you know much about how trauma can affect someone?

P1: Erm I don't know but anyway it's causing a lot of problems sometimes..

R: how much do you think that's recognised in the community - like when bad things happen, how it can affect someone

P1: I don't think that is recognised..because we are a community with prejudice..you know erm..traditional

R: So it sounds like everyone tries to keep a good happy...

P1: Yeh...

R: Front?

P1: Yeh

R: And even though they might have lots going on for them, they just keep it closed..

P1: Yeh..

R: So having to be quite strong all the time?

P1: Yeh

R: That must be very hard?

P1: Yeh, that's tradition..even if you aren't well you have to tell that you are well and fine incase to avoid, you know..

R: To avoid people talking about you?

P1: Yeh

R:...and maybe shutting you out?

P1: Yeh..so it's hard..it's a hard job (laughs)

R: Yeh, yeh..that must be hard..but maybe here in this country...

P1: They need awareness, they need erm community awareness and erm education and so on

R; Do you think that would actually work?

P1: Maybe for the younger generation, I don't know

R: So to talk to the younger generation, for example, about how things affect people...

P1: Yeh

R: Ok..thank you so much for coming...(ending).

APPENDIX 5: STEPS IN ANALYSIS

5.1 Example of initial coding: “Hussein”

FG 3 P1 (Hussein)	Initial Code
R: Hello Hussein. Thank you for agreeing to take part in this interview. So I just wanted to go over some of the things that we talked about in the group, and to gain your view on some things that other people have said...	
P1: Yes...what kind of things have others talked about?	
R: From the men I've spoken to, some men have talked quite a lot about the changes in the family, when coming to this country, and how women in the family gain more power in someway..	
P1: Yes	
R: Because they have more responsibilities...so this is what some of the men I've spoken to already...	
P1: More responsibility or...they have this kind of responsibility back home, even...	
R: It's the lack of support perhaps they have here...	
P1: The men or the women?	
R: The women...that's what they talked to me about...for example someone said to me, in Somalia, a woman would have help with her family to look after the children...	
P1: Yes	
R: Whereas coming here, if the man is not there...	
P1: Yeh, that's right	
R:...they are alone looking after the children..	
P1: Yes, yes, yes	
R: So things like that..	
P1: Yes	
R: What's your view on that?	
P1: Ok..it's true, that women who are here..who don't have any family	

members, or other Somali neighbours to come and support them..but how would that have any connection with men's mental health?	
R: Because...this is what people have told me...so it would be good to get your view...so err some men have talked about how..because of that, in the family..what happens is if the man for example is finding it difficult to get a job..	
P1: mm-hmm	
R: Or..if he is spending lots of time out chewing khat..not really around..	
P1: Mm-hmm	
R:..to support her..the woman may become frustrated and some people have talked about how they will throw them out, and say 'I've had enough..you have to leave'..	
P1: Mmm-hmm	
R: ..and the men have nowhere to go, although they stay with friends, or other people..but they feel very lost because there's a family break-up..and that that doesn't happen so much maybe in Somalia, because everything is very different and maybe they have a job, and the woman has more support, but here because of problems here, the woman becomes frustrated and maybe less tolerant...erm so that's what's some people have talked to me a little bit about..so the way it impacts on men, is that if there is a family breakdown..and they are thrown out of their homes..	
P1: Yeh, yeh that's true. That is true that er men..who...were chased out of their houses by their wives..	
R: Mmm	
P1:..and there's a err...they don't say these kind of words nowadays..but they would say is 'he was give the black bag...the rubbish bag'...	Empowering women
R: Ok...	
they put his clothes in and they put is outside and they say (snaps fingers) 'you can go now'	Empowering women

R: OK	
P1: ...and yes there are men who have a nervous breakdown through that...it is true...errr...but it's not only that...when one of the wives are kicking her husband out..he's already on the road to depression or whatever because of what he was doing..he was chewing khat constantly..	<p>Using western terms</p> <p>Drawing on factors which lead to marital separation</p> <p>Linking khat use to depression</p>
R: mmm	
P1: ...yeh..he's worthless, he's useless he's not productive and on top of that he's not used to looking after kids..if they were married there from Somalia, you know..but many of these were married here..they know that..it is their responsibility..if they are not working, I think it's not very common among people who started their family here..	<p>Linking loss of status to loss of responsibilities</p> <p>Linking loss of responsibility to Worthlessness</p> <p>Stating difference between cultures: seeing different gender roles in West</p>
R: mmm	
P1: ...but for those who are from Somalia..because there, the husband was the breadwinner, the husband was the head of the house..when they came here the whole thing was turned...she is getting her welfare maybe..he is not getting anything, or he is getting...erm they are together and she is managing it..if he's not working and she wanted him to do a lot of work at home to look after this kid..and then he starts maybe chewing khat because he wants to forget this and doing this all the time with the kind of feeling that he's nothing here..yes maybe that can create err mental health issues..yeh..it is true..	<p>Cultural norms: Stating expected gender roles</p> <p>Viewing men as head of the house</p> <p>Stating changes in gender role</p> <p>Men losing power in family</p> <p>Linking khat use to coping for men as result of powerlessness</p>
R: And that's less likely to happen in Somalia..family breakdowns in that way..?	
P1: You know why..it's not that men are still breadwinners..I went there to Somalia and I was observing this kind of family breakdown in this country and what happened..there's no government..there's no permanent employment there..it is the women who are productive there...they are either doing some trade, they are selling khat...ironically...	<p>Seeing women as more productive in Somalia</p>
R: Mmm	
P1: .or..vegetable or fruit stalls...they have a small shop or I think they do	<p>Viewing women as breadwinners in Somalia</p>

different kind of businesses...so they are the breadwinners...	
R: Ok...	
P1: The women are the breadwinners...now the men are there doing absolutely nothing...they don't have to support the children because they are family members who are doing this...they don't cook, they never used to cook, unless they come here and they are forced to cook..so what do they do...carry on eating their khat...	<p>Viewing women as more responsible in Somalia</p> <p>Viewing men as less responsible in Somalia</p> <p>Linking collectivist culture to less responsibility (for men)</p>
R:Mmm	
P1: So what is missing there now is, the pressure that the mother, the wife cannot kick him out because of the community..so she is someone..if she has a husband with her...she needs that independence...why would he be a burden on her..who is gonna stigmatise..there's no community which is so close-knit that he'll say 'hey...she has kicked her husband..'..no, no..but there....the whole family's there...she's not married to this husband only, the whole family, his family, her family..everyone..I don't know maybe there's this kind of sympathy...mother's there, or wife is there...they feel for the husband and they can see 'oh he used to be something...now there are no jobs...at least I can manage to bring in some money...' whereas here, I think the selfishness of the Western world where 'i don't have anything here..there's no interest in me, he's a burden on me..I'm gonna kick him out'..that kind of mentality you can see it here..it's not the woman's fault..because of that kind of mentality, we are here very kind of materialistic, you know..there, maybe she'll be very considerate and look at him and say 'I can understand..he used to be someone who would help us all..now there's no government, there's no opportunity, there's no employment here, I have to put up everything and carry on'..maybe that would be the case..here when they have that kind of thing, then the mental issues starts as we said, yeh.	<p>Stating community power in Somali impacting on women's power</p> <p>Comparing west and Somali culture: marriage and power</p> <p>Stating community power in Somalia</p> <p>Comparing west and Somali culture: Seeing west as selfish</p> <p>Comparing west and Somali culture: Describing negative influence of West on women</p> <p>Comparing west and Somali culture: seeing west as materialistic</p> <p>Comparing west and Somali culture: Describing negative influence of West on women</p>
R:Mmm..you talked actually in the group quite a lot about err, well I felt that what you were saying, you were talking quite a lot about the differences between our cultures, in terms of what we call 'collectivist culture', which is Somali community, where you are altogether, in Somalia, and tight-knit, and nobody's alone..whereas here we call that more of an individualistic culture, where it's more about you being alone, unless you have friends and family, but essentially there's more focus on	

yourself, rather than yourself being part of a group..	
P1:mmm-hmm	
R:...and I felt you were talking quite a lot about that and erm..and sort of saying this is why there are more problems in this culture, because people are more isolated..	
P1: Yes, they are, they are more isolated..and that isolation, yes it has created this problem, and there because of being...you know, sometimes it's not only even the family, or the family members..I don't know whether you know, in Somalia there are clans..and it it gets from the family up to a clan, so if someone here has got any problems, he or she would share..not only the family members but relatives and all that..but it also goes to the whole clan..so he could see sometimes your affairs, your issues, your illness..is not confined to your family, it goes down to the clan leaders and clan chiefs and they know 'oh Mohammed has got this problem..' and they might read some prayers for him or her you know, and then one feels, 'ok, 6000 people know more about me, they know more about my health, my wellbeing..'..not only that..your money, your material world, so they can come in, although they take whatever you give them, but still they feel like you are part of them and whatever you have is theirs and whatever they have is yours, and everything, and that might be, maybe that is helping a lot about many people not having a mental problem back home...here it's totally different..	<p>Comparing West and Somali culture: west as more isolating</p> <p>Comparing west and Somali culture: collectivism and lack of privacy</p> <p>Comparing west and Somali culture: collectivism and lack of individualism / isolation</p>
R: Mmm	
P1: I know a friend of mine..who, who's son..has depression. The government gave him a one bedroom flat..you know the borough, the local authority..	Drawing on experience of young man in UK
R: Mmm	
P1:...that depressed child now, he's in his 20s, living on his own, he doesn't want to come home with mum and dad and brothers..and he's getting more depressed, more psychotic..you can see him, he's getting worse, and his situation is becoming worse..you know and that is the problem here - had this person been back home it would've been different - he would never have been this lonely..	<p>Linking separation from family / isolation to problems</p> <p>Likening depression and psychosis</p> <p>Comparing west and Somali culture: Blaming Western culture for isolation</p>
R: Yeh..	

P1:...you know, now living in a one bedroom flat, somewhere in errr Islington or Finsbury Park area..you know, on his own, with neighbours, they don't talk to eachother..he doesn't want to get, to come home and talk to his mum and dad because he grew up in this country and he took on this kind of culture..	Seeing western culture as isolative Comparing west and Somali culture: impact of growing up here
R: Mmm	
P1:...and er his situation is really depressing..not only to him but to the family and even relatives, and they see..they can't help their son there, he locks himself in there and that's it, so..you know...there are many issues like that which is really....sad when you see in this community...mental health problems, I don't know if someone did some kind of statistic of Somalis who've got mental issues, in London, or in UK..do we know that?	Collectivism: individual problems impacting on family / group
R: I think there has been some research..	
R: Some people have talked to me about when they go to a Dr...or if somebody goes to a Dr, they are more likely to talk about physical symptoms..	
P1: Mm-hmm	
R:...rather than how they're feeling..	
P1: Mm-hmm	
R:...and often the understanding I have is that is because people don't want to talk about how they're feeling incase they are seen as crazy, or because they find it hard to talk about those things..so instead they may say 'I have headaches..I have pains..' so then the Dr will do lots of physical tests but find nothing wrong..	
P1:Mmm..you know and that created this kind of problem where, I saw in my community, in Barnet, where Somali patients go to their GP and start complaining about this physical illness, and they were prescribed some psychiatric drugs..we've seen it and I could not believe my eyes when I saw..this woman or this man who is healthy and fit...because they went there several times complaining about joint-aches, can't sleep properly...and they were given all this..Prozac or whatever..Valium..yeh, it happens. The other thing is, about the feeling..one must know that the culture that these people have..how would they express their feelings...in Somali culture, expressing your feelings..whether it's even happiness,	Viewing Western GPs as unhelpful: giving psychiatric drugs Criticising GPs: feeling unheard Distinguishing between cultures: Somali not expressing emotions / inhibited

love, other emotions..it's really inhibited...let alone when it's mental illness..you know. If someone is deeply in love with someone, they would never never put it out.	
R: Why do you think that is?	
P1: I, I think it's happened there, and for centuries..someone is an artist through songs or maybe he or she would recite this and say it, but if sitting here and saying 'you know I feel deep inside..' it would be a shock for some people and they'd say 'wow..how dare you say this'..and you know will you expect them people who have got from that kind of culture and say 'you know what..I'm feeling a bit low and depressed and..I have got some bufus..' They wouldn't come and say..honestly..so if someone is expecting to get that out of their mouth..	<p>Linking inhibition to traditional roots</p> <p>Comparing west and Somali culture: Somali people showing shock at emotional expression</p> <p>Comparing west and Somali culture: West should accept Somali inhibition</p>
R: It's not going to happen?	
P1: No	
R: Do you think then....what's your view then when someone goes to a Dr and they talk about physical pains..	
P1: That is physical pain. If they have mental health..I don't think they would go to a hospital and explain this and say "I've got some Jinn in my head..something is going on in my head and I'm getting crazy.." I don't think there's..I don't know..when a Somali young man or woman is taken to a hospital in a psychiatric unit..that time is the time they are already screwed up...I took to hospital two, two people who are related to me..a friend and a relative...one to erm Royal Free, another to UCL..and that time they were completely gone you know	<p>Stating barriers to help- seeking: unlikely to access MH help</p> <p>Linking Jinn to MH</p> <p>Labelling: crazy</p> <p>Seeing hospitalisation as existing point of help-seeking</p>
R: Mmm	
P1:...and one wanted to commit suicide, the other one refused to wash, to eat, to do anything..locked himself in his bedroom...so that is the minute we would know that these people have got mental illness...but before that it's early stage, or whatever stage it is, I don't think we can know...and I wish there would be some way we could find out about these people before they reach this stage.	<p>Noticing only extreme signs / symptoms</p> <p>Depression as unrecognisable: showing difficulty of noticing depression</p>
R: In the group you talked about how you think one way of doing it would	

be to have more people like Ahmed, who are training..	
P1: Yeh	
R:..and they can teach the community..do you think that's the way?	
P1: Yeh I think that would be great..not only that, erm...yes we need some professionals who are in the profession who would come out and talk to the people..and some brochures, booklets, leaflets in Somali, explaining this..giving the terminology for this..all these different mental health gradation names...let us try to translate this into Somali and there must be anxious for some Somali translators who are professional I believe..why don't they try and find out all these wordings for..similar words..Somali words..there must be some..we don't know now..maybe they can even invent now, because when we go to 'waali' and 'bufus'or whatever they are saying, it has to have some kind of grades..and when we went to the community or professionals, and explained this to them, and give them some kind of workshops..and people understand this, then..you know..maybe is this illness in the developed world only? Is this illness only in the developing world..is it starting now? Do we know this?	<p>Changing beliefs: need for literature in community</p> <p>Wanting to learn western terms</p> <p>Showing difficulty in language translation</p> <p>Showing extremes in Somali language</p> <p>Questioning whether depression exists only in West</p>
R: Mmm..and also is it an illness?	
P1: You know you said that in the Somali families and relatives...if someone..let me say I know that sometimes they don't express their feelings..sometimes I would say..and we use this word 'murug', which is 'murug'...I would go and tell 'I am a bit murug..I have this'..and then they would ask me 'what's wrong?'...that murug is not something that just came out of the blue...it has some connections with external events..whether 'oh my daughter has failed exams..and I am having this murug because of that or I've got this murug because my dad is in a village, and there's wars going on..'...Yes that kind of feeling here, and it is always connected to a physical thing..external, physical thing. But er..is depression like that? Is depression something which is just people are thinking 'oh....I am low because life is worthless to me or I don't see myself having a good time or erm I don't see why I'm here..' you know, is that depression? How is it different from our murug. Because our murug..I can see it has got some erm...	<p>Comparing languages: Linking 'murug' as similar</p> <p>Murug always related to circumstances / solvable problems</p> <p>Comparing languages: Comparing 'murug' and depression</p> <p>Trying to fit depression into existing language</p> <p>Questioning what depression is</p>
R: connection?	
P1:...and medicine as well..you know 'I have murug because I am in debt'...and someone would say 'ok, I pay half of it, the other half you gonna pay this way'..and the murug is gone. 'I have murug because she left	Comparing languages: murug as solvable

me...'	
R: So what do you think? From what you know about depression...?	
P1: I am honestly confused when I look at it...is murug the same? Because when you say a Somali person is depressed, and I ask him 'are you depressed'..even if that person is repressed in the Western terminology..he or she would tell me something which is external, physical that has got some kind of treatment...	Comparing languages: showing confusion about definition of depression Comparing languages: questioning whether depression as having an external cause
R: So do you feel that it's rare that someone who might say they're depressed..do you feel it's rare that they might say that without there being any reason? Would there always be a reason?	
P1: Of course, yes. And that reason is not a reason which is abstract..it is tangible, it is something which you can solve. And that is the nearest to anything related with depression...past that and it's madness.	Questioning definition: low mood in Somalia always connected to external tangible reasons Labelling: low mood without reason is madness
R: Ok..	
P1: And that's more. It's someone who's not one's self and er I don't know...is it that madness is something to do with the biochemical balance in one brain and that's it...and depression is or murug is something which is physical and he's got this and once it is solved it is gone, but that balance is stable there and has got nothing to do with it. Do we know that?	
R: If someone was labelled as depressed, how is the rest of the community going to feel about that person?	
P1: Yeh, they will say that 'this person is mad'. And there's a saying...I don't know the exact wording but the meaning is 'if someone becomes mad, insane and after that becomes better..it is not always the same'..	Showing community stigma: - labelling as madness - Viewing madness as incurable
R: Ok..so they are never quite the same?	
P1: The same. That saying is there and you see even sometimes, it's really rude in front of people..	
R: So knowing that, even if we train more people like Ahmed...	
P1:..how can we eradicate this stigma? Is that what you're saying?	
R: Yeh	
P1: I think it will be there, but after time, if this illness is there in the community and they see people who've got this, and they've got better, back to the community..productive and normal..	
R: mmm	

P1: I think they will accept it	
R: Ok..but it would take time	
P1: Yeh..because I can see now..and you can see in this community now..Somalis who were in their camps and who had this bufus..by the time they came here, they joined their families...they are ok.	Linking separation from family / community as cause
R: Do you see bufus and depression as very similar?	
P1: I think it's kind of madness, but in Somali it's got this...I told you this word has just come into Somalia in the 1990s and it was just when they were in these refugee camps and were sort of frustrated, angry erm traumatised..all this..what they have seen..the loneliness in the refugee camps..their families are somewhere else...and then they had this mental illness..so that's what they call bufus..and the person who's got bufus...their er behaviour is something similar to someone whose mad	<p>Likening bufus to madness</p> <p>Defining bufus: Linking civil war experiences to creation of 'bufus'</p> <p>Defining bufus: Likening bufus to madness</p>
R: Ok	
P1:...not washing..talking to himself er being very isolated from the community..and er kind of this glazing eyes looking..you know and all this. So after reading Koran on them and erm people trying to be very kind, you know they wash him, read the Koran on him..and then maybe he or she has got a chance to come to Europe and join their families..that thing kind of disappears..	<p>Identifying signs of madness</p> <p>Showing Koran as healing</p> <p>Reuniting with family as healing</p>
R: So maybe it's something about being around people..	
P1: Yeh	
R:...that's helpful	
P1: Yeh..so it could be that...I don't know..(sighs)..because the community is now here in Western Europe, and this illness is reality here..it is existing, and people who have got depression who were given medication have got better..can we just ignore this and say 'no this community do not have this and let's not go into the western world's kind of illness..you have to come up with your own terminology which can define and explain what the mental issue terminologies we have, and the people must be familiar with this...we should know this..otherwise I think er the illness will be within the community and there will be many sufferers...	<p>Seeing depression as existing only in West</p> <p>Comparing languages: seeing lack of language as barrier</p>
P1: The issue is..before this person reach the stage where it's complete madness..how would they figure out..how can you get that out from a Somali young man..that he is going onto complete madness...how would	<p>Not recognising depression</p> <p>Questioning concept of depression</p>

one find out? Err...what are the symptoms..how would we know that this person, surely after a month he will have some kind of nervous breakdown...	Seeing depression as onset of madness
R: Mmm	
P1: I don't know...and yes when they have a nervous breakdown they will have support from the community...people will come. try and help him, his relatives his family member, his friends would come and help him..we don't know when does this start and what are the symptoms? I think maybe the professionals will find out that and tell us...if it is other illness..cancer and all this...they say 'if you see these symptoms..this is what you have to do...' but can the mental health professionals put together some symptoms and say 'if you see these symptoms in yourself, pls seek help'	Showing collectivist help in community Not recognising depression Lacking awareness of western model (symptoms)
R:Mmm. Well thank you so much for your time...you have been so helpful and it has been a pleasure talking with you..(ENDING).	

5.2 Example: initial codes to focused codes

INITIAL CODES	FOCUSED CODES
<ul style="list-style-type: none"> • Seeing being alone is shameful • Linking isolation to rumination • Linking being isolated from community as a cause • Depending on community to prevent / stop isolation • Being alone is not social norm • Integrating in community is protective factor / healing • Lacking experience of seeing people alone • Seeing being alone is not collectivist 	<p>Community as protection</p>
<ul style="list-style-type: none"> • Seeing Western lifestyle as stressor • Feeling scattered / separated community • Criticising individualistic culture • Seeing ind. Culture as increasing stress / frustration (o) • Identifying isolation with individualistic culture • Linking individualistic culture to difficulties in reaching out • Linking individualistic culture to difficulties in reaching out • Viewing western culture as stricter • Comparing collectivist and individualistic lifestyle • Viewing UK as more isolating • Comparing west and Somali culture: • Seeing west as selfish • Reuniting with family as healing • Linking separation from family / community as cause • Comparing west and Somali culture: Blaming Western culture for isolation • Linking separation from family / isolation to problems (drawing on experience of young man in uk) • Comparing west and Somali culture: seeing west as materialistic 	<p>Comparing cultures - blaming Individualistic / western culture</p>

<ul style="list-style-type: none"> • Comparing west and Somali culture: Describing negative influence of West on women • Comparing West and Somali culture: west as more isolating • Seeing western culture as isolative • Linking diversion from culture to isolation • Seeing diversion from culture as big problem • Viewing harmful behaviour as a cause of MI 	

5.3 Memo examples

5.3.1 Memo in relation to category 'losing community: losing strength'.

Community as power / protection

Participants have talked consistently about the role of the community with regard to the wellbeing of the individual. There appears to be consistent emphasis on the collectivist nature of the community, especially with regard to the close-knit element and a sense of consistent support by extended family and those in the local community. Many talked about the benefits of this in providing support to the individual and the family – especially pre-migration with regard to child-rearing and providing extra support around the home.

Participants spoke of the collectivist involvement in helping those who were seen to withdraw. Reaching out to the individual was portrayed as common. Being aware of an individual's absence from the community seemed to trigger a need to discover the reasons behind this, and participants spoke of reaching out to the individual. However, it was acknowledged that individuals may commonly avoid disclosing their difficulties to others – in line with the nature of enduring difficulties, and perhaps a fear of disclosing problems to the community. Despite this, participants spoke of reaching out to the family or those close to the individual, in order to explore the origins of the individual's difficulties; with the aim of assisting.

Loss of community in the West following migration

There is a sense of community as strong pre-migration – those who talk about it in this way appear to be mourning the loss of this in comparison to the West. Comparisons were made between collectivist help-seeking in Somalia and here in the UK; whereby the view was that the individualistic lifestyle had an impact on restricting the norm of encouraging others to the home of an individual who may be viewed as having withdrawn. This implied the increased sense of isolation for an individual who may be seen to have withdrawn. However, persistence was still shown in the form of making decisions for an individual; such as taking responsibility for decisions for the individual's care.

The impact of the breakdown of the collectivist system was something that was referred to as participants talked about the process of migration, and being 'scattered' among countries in the Western world. Some talked about the process of feeling lost and alone on arrival. It seemed that many had

gone through the process of migration and arrived in the UK alone; away from the support of the collectivist system they had been used to.

The disintegration of the collectivist system appears to be something that is viewed as being responsible for increased isolation in the Western world. Many of the participants have talked about the influence of the Western lifestyle as both distracting those away from the collectivist culture and encouraging individualistic lifestyles. Many reported the possible reasons behind the character's presentation as being due to what they perceived to be his isolation from the community; something which appears to be unrecognisable and rare among the Somali culture.

Participants consistently associated and sometimes blamed the Western culture and lifestyle for the increased occurrence of being isolated. This was felt to be due not only to the dispersion of the community, but the influence of the Western lifestyle. Furthermore, at times it was felt that participants attributed blame to the Western lifestyle for the encouragement of living this way, and hence linked this to loneliness and further problems.

It seems that participants are therefore suggesting that such problems (demonstrated in the vignette) exist only in the West due to our individualistic culture and the breakdown of community. It seems appropriate to fit the talk of these issues together in a category that illustrates these comparisons.

5.3.2 Memo in relation to participants' talk on khat

Although the use of khat was talked commonly among the participants, it was difficult to pinpoint this as an isolated cause and appeared to be relevant only in the context of coping with the difficulties associated with migration. This has made it difficult to present it as a separate sub-category as it appears relevant only in the context of these difficulties - I had initially presented it in the context of 'coping or cause?'⁷ but this has proved difficult to position and did not seem to fit within the final category.

What appears to stand out here is khat use appears to have been spoken of mainly in regard to changes in gender roles and the increased responsibilities. In this sense it appears to be a method of coping or

⁷ (N.B. I have included this un-used category in Appendix 6.0).

escapism and thus it feels appropriate to integrate into this with talk around these changes rather than to integrate into the final category, which talks about coping and help-seeking.

5.4 Excerpt from reflective journal

Having completed the first focus group and two interviews it is already apparent that participants are perhaps responding to me in a particular way that is not felt to be true to themselves – perhaps giving me responses to what I want to hear. This is demonstrated by their use of Western words / terms such as ‘depression. It is important for me to remain aware of how factors associated with my presence – i.e. my Western culture, my gender, class and profession combined with any cultural factors that may be impacting on openness will be influencing how participants respond. This seems that it will be unavoidable / unchangeable.

In the focus group this was less present due to the presence of others – I feel this is the benefit of playing a less active role within the group – however it is clear there are processes occurring in the group that may reflect the collectivist nature of the community. For example, in focus group 1 there was a strong presence of spiritual talk, yet so far this has been less present in the interviews with Oliver and Samuel. I therefore wonder if participants may be reluctant to differ their views from others when in the presence of others. This would appear to fit with the collectivist nature of the community, and I wonder if this will persist as an observation throughout.

If these differences continue this may be something to include in my analysis – a demonstration of how data is being constructed differently in both settings (i.e. the focus groups and semi-structured interviews). My method supports the notion that knowledge can be constructed from different and repetitive sources, however it is important for me to hold on to the fact that collecting data in these different contexts appears to highlight how the process in which knowledge is constructed appears to be different.

**APPENDIX 6.0: UNUSED SUB-CATEGORY:
‘KHAT USE: A WAY OF COPING?’**

Subcategory: Khat use: A way of coping?

The use of Khat⁸ was a topic that many participants spoke about as a potential contributor to an individual's difficulties; especially men. Initially, the use of khat was discussed as a cultural habit in the form of the recreational activity for men as it is widely recognised. However, in addition to its recreational purpose, many participants also talked about its use in the West as being a method of escape for men as a result of the increased sense of responsibilities and pressures, being culturally defined as the 'breadwinners' in the family. Khat use was therefore described a number of times as an escape from these felt pressures at home and within the family.

Although participants did not draw upon their own experiences of khat use, most reflected on seeing this process and its impact on others. As Omar begins talking about khat, he portrays it as a 'problem' in the UK, but highlights this as a way to be with others and perhaps providing a sense of feeling integrated in the community and less alone.

There is a substance misuse of Khat, which is one of the main problems of Somali men in this country. So they come together, just like your society may go to the pub or have their sort of drinking ... so this is a social interaction for men. (Oliver, L141)

Abdi also draws upon an experience of seeing a man's participation in this recreational activity as an escape from the felt pressures within the home.

... on one hand they want to cope, they want to get out of the house ... what happened is ... one man was telling me ... I said to him ... why don't you go to your house ... he said he get bored with his wife ... but his wife knows him well ... 'where are you ... provide me food'. So he run away. (Yusuf, L180-184)

Participants were commonly critical of others' use of khat, yet indicated that its use was a result of the felt increase in pressures and responsibilities in the home, as discussed by Hussein:

... they don't cook, they never used to cook, unless they come here and they are forced to cook..so what do they do ... carry on eating their khat. (Hussein, L160-161)

⁸ 'Khat' is a green-leaf shrub that is native to the Horn of Africa, and the practice of 'chewing' khat dates back thousands of years in these communities. It is widely used in the Somali community; most commonly by men, whereby groups of men will come together and chew for hours at a time.

The use of khat was blamed as causing difficulties within the family unit; as it was often discussed as a way of segregating the man from the family. In addition, it was commonly discussed as impacting on a man's ability to obtain or hold down employment; contributing to financial difficulties and hence reinforcing the changes in power-dynamics within the family unit. For example, Abdi spoke of women losing respect for their husbands and increasing demands on them.

... it gives you the buzz, but all these effects...you can't sleep, you don't have work to go to, you don't have respect at home, you can't take children to school because you're tired.. and what happens is you go very down, down down. 'you are nothing, you can't provide for your family...you can't take children to school because you're tired..'...so there are difficulties in the house when you chew khat. (Yusuf, L255-259)

Yusuf also linked the increased use of khat in the UK to unemployment and having a lack of routine while emphasising it provides only short-term relief.

When you chew khat, it's the buzz you get ... but after you finish, and you sleep, you tell yourself 'why do you do this?'.. then after you wake up it becomes like a cycle ... you don't have nothing to do tomorrow ... the thing is lack of job ... if these guys were working and at least getting outside, fresh air or friends I think they might do better. But they isolate themselves. (Yusuf, L228-232)

Many spoke about khat as being a major contributor to impacting negatively both socially and mentally . Most commonly it was described as having negative impacts on an individual's finances, their ability to sleep and to carry out day-to-day activities; linking it to isolation. Omar highlighted such social effects of khat use as resulting in a man's inability to meet the expectations of providing for the family, and portrayed this a contributor to being segregated or isolated from the community.

... this leads to a negative impact, basically, because they overuse ... then this leads to be a situation of mental illness or depression or any abnormality they have ... they don't sleep at night, they never try to go for work because they are tired in the morning, they can't ... they are tired in the morning, they can't go you know to certain jobs at the proper time ... this leads them to be finally in a position of being segregated, isolated. (Oliver, L157-160)

Summary

Khat use was therefore discussed as an activity for men, providing a way to be with others and temporarily escaping the increased sense of individual responsibility and pressure within the home associated with the Western lifestyle. However, participants commonly viewed it negatively; attributing blame to social disruption and mental instability; seeing it as preventing a man from fulfilling his culturally-defined role within the family.