RELIGION, CULTURE AND MENTAL HEALTH IN SOMALI REFUGEES IN CHRISTCHURCH, NEW ZEALAND

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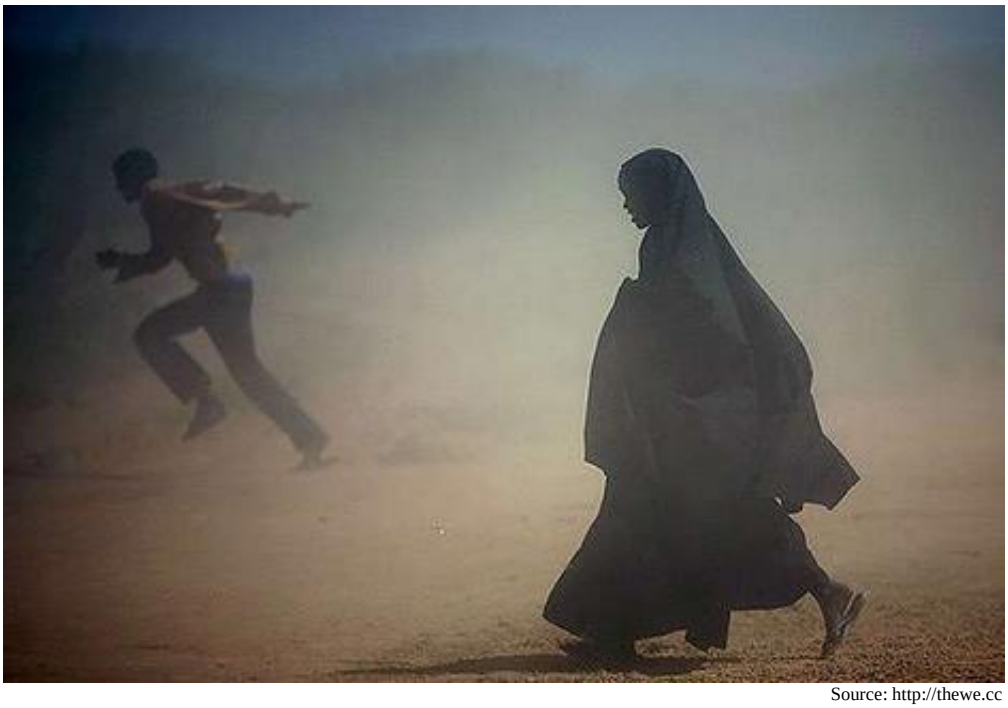

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A dissertation submitted for the degree of
MASTERS OF PUBLIC HEALTH
at the University of Otago, New Zealand

November 2011

بسم الله الرحمن الرحيم

(In the name of Allah, the Most Beneficent and the Most Merciful)

Dedicated to the Somali
refugee community in
Christchurch, New Zealand

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ACKNOWLEDGEMENTS

Firstly, I would like to thank my supervisor, Dr. Lee Thompson for her help, advice and constant encouragement during the project. I would also like to thank Dr. Matthew Croucher for his guidance and assistance during the project.

My special thanks to all the participants who welcomed me into their lives and generously gave their time to help me. I also take this opportunity to thank the advisory group of Somali community members, especially Ahmed Tani, Mahmudh Osman and Hassan Haji. I extend this thank you to other members of the Somali community in Christchurch for providing the opportunity to work with the community. It certainly has been a privilege and the start of a journey.

I would also like to thank my friends and family for their constant support and encouragement, which was much needed during this stressful period, spanning the two major earthquakes in Christchurch. Most of all, to my wife, Naju, thank you for your unfailing support, encouragement and love.

ABSTRACT

There is existing international literature which shows a general trend of higher rates of mental health problems in refugees. However, there is significant inconsistency in these findings which is related to multiple methodological issues. This includes significant differences in cultural perspectives of mental health in refugee populations compared to predominant Western perspectives. The Somali refugee population has increased steadily in New Zealand over the last two decades. However, there is a significant lack of research about the mental health of Somali refugees in New Zealand, particularly in Christchurch. This qualitative study aims to explore perspectives of mental health in Somali refugees in Christchurch using a community based participatory research. The specific research objectives include explorations of descriptions of mental health problems, experiences of mental health problems and health services and recommendations of community members regarding health services and the mental health of the community. This information was gathered through in-depth interviews with the use of purposive sampling. An inductive thematic analysis was used to analyse the transcripts of the interviews. The results revealed an overarching theme of the central role of religion and culture in shaping perspectives of mental health problems in the Somali refugee community in Christchurch. The results also showed that pluralistic explanations for mental health problems were prominent, resulting in individuals seeking multiple approaches to dealing with these problems. Spiritual and religious explanations and approaches to treatment such as spirit possession and prayers with Quranic readings were common. Biomedical explanations and mainstream treatment approaches appear to be less accepted, but more prevalent in younger populations. Stigma related to mental health problems was identified as a significant barrier in dealing with mental health problems. This appears to be related to a categorical view of mental health problems with stereotypes of unpredictability, dangerousness and incurability. Other identified barriers included lack of awareness about mental health problems, lack of trust in health professionals and language difficulties. More importantly, the participants identified religion and spirituality as well as family and community supports as factors contributing to resilience.

CHAPTER 1: INTRODUCTION AND BACKGROUND

Introduction

Mental health in refugees is of significance due to the refugee experiences of forced migration, likelihood of exposure to traumatic events and resettlement in unfamiliar circumstances. The quantitative literature has shown generally increased prevalence rates of mental health problems, despite much inconsistency (Fazel, Wheeler & Danesh, 2005). This inconsistency is related to various methodological problems which also include different cultural perspectives of mental health problems in refugee communities and the predominant Western concepts of mental health. Qualitative studies have been used to explore these cultural differences in perspectives of mental health in different refugee communities. There is also an increasing recognition about lack of refugees' own perspectives in previous studies, resulting in an increasing use of participatory methodology in refugee research.

New Zealand has a long tradition of accepting refugees from different parts of the world. The higher rates of mental health problems combined with the poor utilisation of services and the lack of adequate studies in New Zealand have led to the identification of research into mental health in refugees as a national priority within mental health research (Te Pou, 2008). The Somali refugee population was selected for the study as they represented a significant proportion of the New Zealand refugee community (RefNZ, 2010). There is a significant lack of studies regarding mental health of the Somali refugee population in New Zealand. More specifically, no studies have been carried out in Christchurch, where the Somali population, the social setting and the mental health services are likely to be different from some other parts of New Zealand.

Research Objectives and public health significance

This qualitative study aims to explore perspectives of mental health held by Somali refugees in Christchurch using a community based participatory approach as the guiding methodology. It was felt that collaborative research to explore mental health perspectives of Somali refugees in Christchurch would be an important step in addressing mental health issues in this community. The specific objectives of this research were formulated in collaboration with the community and these include exploration of the following aspects.

1. Descriptions of mental health problems in the Somali refugee community in Christchurch.

2. Experiences of mental health problems and health services of community members in this community.

3. Recommendations of community members regarding health services and the mental health of this community.

This research is likely to contribute to our knowledge about the mental health of Somali refugees in Christchurch and be of public health significance. It is likely that Somali perspectives on mental health and illness have implications on help-seeking behaviour and the provision of culture-specific clinical interventions as well as guiding primary prevention programmes and mental health promotion efforts. The knowledge about Somali experiences with services, barriers in accessing services and recommendations from community may have a possible role in making relevant changes to service provision in addressing mental health needs of the Somali refugee community.

Before discussing the literature about the mental health of Somali refugees, it may be pertinent to explore some background issues relating to refugees in New Zealand, as well as about Somalia as a country of origin.

Background about refugees in New Zealand

Over the last century, the many wars and armed conflicts throughout the world have resulted in increased numbers of refugees worldwide. The United Nations Refugee Convention, 1951 defines a 'refugee' as;

> *"any person who, owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable, or owing to such fear, is unwilling to avail himself/herself of the protection of that country" (UNHCR, 1996, page 16).*

One of the key provisions of the Convention is the obligation of states that are party to it, not to expel or return a refugee to a state where he or she would face persecution (UNHCR, 1996). As a signatory to the United Nations Refugee Convention, 1951, New Zealand has had a long history of welcoming refugees from around the world. Refugees can come to New Zealand through the United Nations High Commissioner for Refugees (UNHCR) quota programme, as asylum-seekers, or through family reunification programmes (Ministry of Health, 2001).

Following the ongoing civil unrest in Somalia which started in 1991, refugees from Somalia have been arriving in New Zealand (Ministry of Health, 2001). Since then, there has been a steady growth of the Somali refugee population in New Zealand. Over the last two decades, the number of refugees entering New Zealand as UNHCR quota refugees from Somalia has only been surpassed by refugees from Iraq (RefNZ, 2010). It is generally accepted that the city of Hamilton has the largest Somali refugee population in New Zealand, but obtaining accurate information about the Somali population living in New Zealand cities is fraught with difficulties (Ryan, 2007). Some studies have estimated the Somali refugee population living in New Zealand to be about four thousand, with most of them having arrived as quota refugees or as part of family reunification (Guerin, Guerin, Diriye & Yates, 2004). There are no accurate figures on the size of the Somali refugee population living in Christchurch, but unofficial figures estimate this to be around three hundred (H. Haji, personal communication, 1st November, 2011).

Background about Somalia

Somalia is located in the most eastern part of Africa in what is called the Horn of Africa (see figure 1). The population of Somalia is estimated to be between six to seven million, although there is no established census data (Griffiths, 2003). Somalia has one of the most homogeneous populations in Africa with 98% of the people described as Somalis (Bhui et al., 2006).

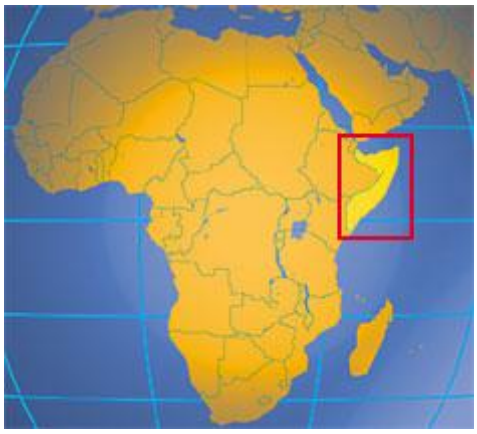

Figure 1: Map of Somalia in Africa

In the colonial era, various European powers including the Italians, English and French established dominance over divisions of Somalia (Abdullahi, 2001). After Somalia gained independence in 1960, a repressive military regime came into power in 1969 and ruled for 21 years (Griffiths, 2003). There was increasing resistance from clan-based armed factions during these years which culminated in the overthrow of the military regime in 1991 (Abdullahi, 2001). Somalia was left without any central government when the clan based factions were unable to form a government of national unity and the country plunged into ongoing civil war (Griffiths, 2003). Since 1991, Somalis have fled the country in significant numbers to neighbouring countries and all over the world (Elmi, 1999).

The Somalis are traditionally nomadic people and a clan-family system forms the basis of Somali society (Elmi, 1999). Somalis often live in extended family groups, with males typically assuming the role of head of the family while maintaining responsibility for the financial wellbeing of the group (Abdullahi, 2001). Although the care of children is primarily the responsibility of the women, in practise everyone contributes (Elmi, 1999). In terms of language, Somalis follow an oral tradition with a

written language only introduced in 1972 (Guerin, Abdi & Guerin, 2003). The language consists of various dialects of Somali, but 'Common Somali' is understood by most Somalis (Bhui et al., 2006).

The large majority of Somalis are Muslims and Islam plays a very important role in the culture and way of life of Somalis (Elmi, 1999). Somalis and Muslims generally believe that Islam is a comprehensive way of life and that religion cannot be separated from social and political life, because religion informs every action a person takes (Pridmore & Pasha, 2004). Muslims believe in the *Quran,* which is believed to be a divine revelation from their God or Allah to his last prophet, Prophet Mohamed *(peace be upon him).* Muslims also generally believe in spirits or *jinn* as a parallel form of created beings (Elmi, 1999). Muslims also believe in the concept of Divine Will and Predestination which involves the belief that everything is predetermined by Allah, without necessarily compromising free will of individuals (Taib, 2000). A more detailed exploration of the complex philosophical and theological ideas regarding pre-determinism and free will is beyond the scope of this dissertation and can be found in the above reference.

Outline of dissertation

Having discussed some of the background issues pertinent to this dissertation, an outline of this dissertation will be presented. The next chapter explores the existing literature about mental health of refugees generally with a focus on the mental health of Somali refugees. Chapter three explores in detail the methodological aspects related to the study, while chapters four and five presents the main themes emerging from the study in relation to the available literature. Finally, chapter six discusses the implications of these findings before concluding with recommendations.

CHAPTER 2: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

This chapter explores some of the current available literature on the mental health of Somali refugees. The first part discusses the prevalence of mental health problems in refugees generally, while exploring inconsistencies in the findings. This is followed by a more detailed analysis of the literature about the mental health of Somali refugees. Some of the theoretical concepts which are relevant to this discussion of the literature such as stigma and resilience are also presented. This chapter concludes with a discussion about the limitations of the current literature.

A literature search was conducted using the databases PsychINFO, Medline and Web of Knowledge, using the keywords "refugee" or "Somali" or "Somalia" with "mental health", "mental health problems", "mental illness", "psychiatry" and other similar terms. The literature search was restricted to articles in English for pragmatic reasons. The literature search also included literature obtained using internet search engines as well as the use of New Zealand university databases. Many of the research articles from the reference list were also pursued.

PREVALENCE OF MENTAL HEALTH PROBLEMS IN REFUGEES

There is an existing body of research about mental health in refugees which has documented high rates of prevalence of mental health problems in refugee communities (Steel et al., 2009). One robust systematic review and meta-analysis by Fazel et al. (2005) reported that in the larger studies, 9% were diagnosed with post-traumatic stress disorder (PTSD) and 5% with major depression, with significant heterogeneity evident within the studies. There is little reliable data on the prevalence estimates of mental health problems in refugee communities in New Zealand (Te Pou, 2008).

Although there is a general trend for a higher risk of mental illness in refugee communities, research has produced widely varying figures (Hollifield et al., 2002). Such wide variation raises joint concerns of selective citation of low estimates contributing to a neglect of refugee mental health, and conversely, selective citation of

higher estimates contributing to stigmatisation and inappropriate assumptions about the degree of disability associated with such psychiatric morbidity (Fazel et al., 2005).

The wide variation of prevalence figures of mental illness in refugee populations may be related to the diversity of refugee experiences, which relates to differences in language, culture, pre-settlement experiences in country of origin and settlement experiences in various host countries (Steel et al., 2009). Many studies have explored various pre-migratory, migratory and post-migratory factors related to mental health in refugee communities. These include various types of traumatic experiences, immigration status, language proficiency in country of resettlement, social networks, family disruption, perceived discrimination, levels of acculturation and socio-demographic background (Abbot 1997; Te Pou, 2008).

Another reason for the wide variation of prevalence figures for mental illness in refugee communities may be related to methodological factors, including the inconsistent and inappropriate choice of measurement tools, procedures, sampling and analytic techniques (Davidson, Murray & Schweitzer, 2008). There may also be other methodological difficulties such as language and cultural barriers in conducting research with refugee populations (Hollifield et al., 2002).

Perhaps most importantly, it is likely that these variations are also related to deeper conceptual issues relating to Western conceptualisations and cultural assumptions about the nature of mental health and illness being applied to refugee communities. The traditional Western biomedical model tends to ignore the role of social and cultural factors affecting mental health. However, research with refugee groups suggests that their perspectives on mental health are not necessarily shaped by psychobiological conceptualizations as in the Western traditions which tends to separate mind from body, and self from society (Summerfield, 1999; Simich, Maiter, Moorlag & Ochocka, 2009). Researchers have paid less attention to how collective cultural experiences and larger social systems shape perspectives of mental health. It is likely that such differences in perspectives of mental health in refugee populations may have contributed to the variation in prevalence figures.

MENTAL HEALTH IN SOMALI REFUGEES

Having discussed issues about mental health of refugees generally, the literature about the mental health of Somali refugees will be reviewed next. It is worthy of note that there is an increasing body of literature about the mental health of Somali refugees. Most of this research comes from countries such as the United Kingdom, the United States, Canada and Netherlands. There has been only minimal research about Somali refugees in New Zealand (Guerin et al., 2003; Guerin et al., 2004; Ryan, 2007). This is not unexpected as there is only limited research about the mental health of refugees in New Zealand generally (Te Pou, 2008).

It is also worth noting that there were no comprehensive reviews of literature published on the topic of mental health of Somali refugees. However, there is significant quantitative as well as qualitative literature available about the mental health of Somali refugees. As expected, the focus of these different types of research is somewhat different, often revealing divergent findings. This literature review will include a general review of both types of studies.

The relevant quantitative literature regarding the prevalence of mental health problems in Somali refugee community will be discussed first, followed by a discussion of the factors which appear to be linked to mental health in Somali refugee communities in these quantitative studies. Utilisation of mainstream services by Somali refugee communities for mental health problems will be explored while analysing some of the barriers which may contribute to this. Some of the qualitative literature exploring Somali perspectives of mental health including Somali descriptors of psychological distress, causative explanations and treatments will then be discussed. This will be followed by a discussion about aspects related to the stigma of mental health problems in Somali refugee communities and issues related to resilience, before finishing off with a summary of the major findings of the literature review.

Prevalence of mental health problems

As with other refugee populations, quantitative research on the prevalence of mental health problems in Somali refugee populations appears to be inconsistent with significant differences in sampling and psychometric tools used. Some studies report low rates of Western-defined mental health problems in Somali refugee populations (Silveira & Ebrahim, 1998; Halcón et al., 2004). However, most studies reported higher rates of mental health problems including PTSD, anxiety and depression (Bhui et al., 2003; Bhui et al., 2006; Gerritsen et al., 2006a). Bhui et al. (2006) found that over a third of Somalis (36.4%) had a mental disorder with 33.8% having anxiety or depression while 14% had PTSD. This British study attempted to comprehensively adapt the psychometric assessment tool to this specific cross-cultural context. Some cross-sectional studies have also suggested comparatively lower rates of mental disorder in Somali refugees and asylum seekers compared to their Iranian and Afghan counterparts (Gerritsen et al., 2006a).

Many quantitative studies have also attempted to investigate various factors that affect the mental health of Somali refugee populations using regression models. The role of traumatic experiences and their association with mental health problems are frequently highlighted in studies (Bhui et al., 2003; Halcón et al., 2004; Ellis, MacDonald, Lincoln & Cabral, 2008; Gerritsen et al., 2006a). Studies have linked limited family and community support to poor mental health (Gerritsen et al., 2006a; Silveira & Ebrahim, 1998; Ellis et al., 2008; Silveira & Allebeck, 2001). Furthermore, certain demographic factors such as female gender, being older and shorter duration of resettlement also may be related to mental health problems (Ellis et al., 2008; Gerritsen et al., 2006a). It is also worth noting that the use of *Khat*, a substance with amphetamine-like properties has also been associated with mental health problems in some quantitative studies (Bhui et al., 2003; Bhui et al., 2006). *Khat* is a leafy plant originating in East Africa used traditionally in Somalia for its stimulant effects and is consumed by chewing its leaves (Elmi, 1999).

Service utilisation in Somali refugees

Despite the prevalence of mental health problems amongst refugees, many studies appear to show an underutilisation of mental health services by refugees (Kinzie, 2006). This underutilisation of health services for mental health problems is also a common theme in both the qualitative and quantitative literature exploring the mental health of the Somali refugee population in different countries (Bhui et al., 2003; McCrone et al., 2003; Gerritsen et al., 2006b; Palmer, 2006).

Gerritsen et al., (2006b) reported fewer contacts of Somali refugees and asylum seekers with their general practitioners as well as mental health services compared to their Iranian and Afghan counterparts. McCrone et al., (2005) described that Somali refugees living in London had relatively high levels of need but a low level of service use. Many of the quantitative studies asserted that services should adapt to the mental health needs of the Somali population which were typically high (Bhui et al., 2003; McCrone et al., 2005; Bhui et al., 2006).

There has been some research exploring some of the barriers to accessing services for mental health problems, mainly in the qualitative literature. Language barriers have been one of the more consistent findings in the literature (Elmi, 1999; Guerin et al., 2003; Guerin et al., 2004; Palmer, 2006). Structural barriers such as cost and transport issues have also been identified in some studies (Guerin et al., 2003). Some studies have also described bureaucratic processes and the associated formality with using services as a barrier (Elmi, 1999; Guerin et al., 2004). Elmi (1999) also highlights the lack of awareness of mental health problems and available services as a potential barrier. Other studies have also suggested that the stigma attached to mental illness, lack of awareness of Somali culture by health professionals and mistrust of services as significant barriers (Ryan, 2007; Guerin et al., 2004; Palmer, 2006). However, one of the overarching themes in the literature is related to the cultural differences in the Somali perspectives of the causes and treatments of mental health problems which act as a major barrier in accessing mainstream services for mental health problems (Elmi, 1998; Guerin et al., 2004; Palmer, 2006; Ryan, 2007).

Somali descriptions of mental health problems

The importance of exploring perspectives of mental health in the Somali cultural context is becoming evident. There is relevant qualitative literature which explores Somali concepts of mental health and illness, its causal attributions and treatments. A useful place to start will be an exploration of the literature around Somali expressions of psychological distress and there are a few qualitative studies which have explored this.

Walli is a commonly described term in the qualitative studies as an expression of psychological distress in Somali culture and is often translated as being "mad" or "crazy" (Carroll, 2004; Guerin et al., 2004; Ryan, 2007). However, this may not always be the most appropriate translation and *walli* can also imply being not "normal" and the term can be used in diverse situations as in conversational use, akin to the word "crazy" (Guerin et al., 2004). Descriptions of *walli* include shouting, aggression, violence, talking incessantly, mutism, walking without purpose and other socially inappropriate behaviours (Carroll, 2004; Guerin et al., 2004; Ryan, 2007). Some researchers have made comparisons of *walli* to western concepts of psychosis associated with more severe mental illness (Carroll, 2004; Ryan, 2007).

The other main descriptive term described by Somalis is *jinn* possession to imply possession by spiritual entities which are believed to cause psychological symptoms. Others have also referred to *zar* possession which refers to more traditional pre-Islamic term used for spirits (Whittaker et al., 2005). Some researchers have described wide ranging symptoms which can be attributed to *jinn* possession by Somalis, including milder symptoms akin to depression, anxiety and psychosomatic symptoms (Ryan, 2007). However, most descriptions of *jinn* possession are described as being very similar to *walli* (Carroll, 2004; Guerin et al., 2004; Ryan, 2007). Ryan (2007) describes that although it is difficult to disentangle the differences between these two states, the major difference between *walli* and *jinn* possession may be in relation to its aetiological explanation and treatment response as discussed later.

Qualitative research in Somali refugee communities has also discussed other descriptive terms used as expressions of psychological distress. However, there appears to be some inconsistency in the use of some of these terms. *Murug* appears to refer to sadness and some researchers have compared this to depression (Carroll, 2004; Zarowsky, 2004). However, others have also described this as being more similar to symptoms of PTSD (Ryan, 2007). *Welwel* has been used to describe more normal worry (Ryan, 2007; Zarowsky, 2004). Other terms such as *wareer, boofis, niyadjab* and *qalbijab* are also used in studies to refer to a range of symptoms suggestive of anxiety and depression. It appears that most of these Somali terms are used to refer to psychological responses to life events rather than being necessarily pathological.

Somali beliefs about mental health problems

Somali perspectives of the aetiology and treatment of mental health problems are based on their beliefs about health and disease which include a mixture of traditional and religious beliefs. There is no conceptual framework that includes a spectrum of health and disease among Somalis. Studies have described that Somalis view mental health as dichotomous and mental illness as only encompassing the more severe and often untreatable cases (Guerin et al., 2004). This has significant implications in terms of diagnosis and treatment of health problems as well as stigma around mental health problems.

In terms of aetiology, the concept of *jinn* possession appears to be the most common explanation for mental health problems among the Somali community. This appears to be a consistent finding in most of the qualitative research (Carroll, 2004; Guerin et al., 2004; Whittaker et al., 2005; Ryan, 2007). However, there appears to be little information about why people may be afflicted with *jinn*. There are suggestions that *jinn* possession may be mediated by curses and witchcraft (Elmi, 1999; Ryan, 2007).

There seems to be little emphasis on the role of trauma in the aetiology of mental health problems among Somali refugees in the qualitative studies. While Carrol (2004) attributes *walli* to severe trauma, this appears to be the exception. Most of the studies reveal that most Somali refugees did not seem to feel that this was a major

contributor to mental health problems (Guerin et al., 2004; Whittaker et al. 2005; Ryan, 2007). However, post-migration factors such as housing, finances and social support were identified as significant issues contributing to mental health problems in many studies (Guerin et al., 2004; Palmer, 2006; Ryan, 2007). Some studies also highlighted the issue of having family members back in Somalia as a contributory factor to poor mental health (Guerin et al., 2004; Ryan, 2007).

Biological explanations for mental health problems appeared not to be the norm among Somali refugees. Most studies show that Western concepts such as 'stress' and 'depression' are relatively new concepts to Somalis and unheard of back in Somalia (Elmi, 1999; Guerin et al., 2004; Ryan, 2007). However, some studies suggest that the concepts of *jinn* possession are questioned more and replaced with biological explanations, especially among the younger population (Whittaker et al., 2005).

With regard to substance use, this appears to be generally a non-issue apart from the traditional *Khat* use. Some qualitative studies have described the use of *Khat* as contributing to mental health problems (Elmi, 1999; Ryan 2009). These findings in the qualitative literature appear to be consistent with some of the findings in the quantitative literature. However, some New Zealand studies have reported that this has been a minimal issue in New Zealand due to lack of availability (Guerin et al., 2004).

In terms of addressing mental health problems, Somalis use a variety of approaches which are different to Western treatment approaches to mental health problems. One of the key approaches to dealing with mental health problems in the Somali community includes Quranic readings and prayers (Elmi, 1999; Ryan 2009). This appears to be not necessarily restricted to mental health problems, but also to some physical problems (Guerin et al., 2004). It is described that an *Imam* or a knowledgeable person in the community will usually read special verses of the *Quran*, usually in the presence of family members or supportive community members, held over sessions which can sometimes last for a few days (Guerin et al., 2004). At times, these sessions can also involve more ritualised ceremonies to treat *jinn* possession, akin to exorcism (Elmi, 1999). It has been described that one of the

main differences between *jinn* possession and *walli* is that individuals with *jinn* possession recover after these sessions, whereas there is little response in the latter group (Ryan, 2007). It is worth noting that historically, pre-Islamic traditional rituals such as *mingis, zar*, *borane* and *hayat* were also used to drive out spirits by means of dances, songs, perfumes and fumigations (Elmi, 1999). Other traditional complementary treatment approaches such as the administration of herbs, massage, wearing amulets and fumigations have also been historically common (Elmi, 1991; Guerin et al., 2004).

It is of little surprise that Western treatment approaches with medications and psychological treatments appears to be less well accepted by Somali communities. Some have described how these differences lead to reluctance in taking medications for mental health problems contributing to non-adherence (Elmi, 1999). It also appears that there may be even greater reluctance to engage in psychological treatments. Psychological treatments such as one to one professional counselling appear to be an alien concept to most Somalis (Palmer, 2006). As such, poor levels of engagement in individual psychological treatments for mental health problems have been well described (Guerin et al., 2004). However, traditionally, family and relationship problems have been approached with a type of family or community counselling, involving family members or religious leaders (Elmi, 1999).

Stigma and mental health problems in Somali communities

There is significant general literature about stigma and mental health problems and a detailed discussion of this issue is beyond the scope of this dissertation. The term stigma originates from ancient Greece, denoting a physical brand or marking which is applied to social outcasts to indicate their devalued status (Goffman, 1963). Stigma involves stereotypes that characterize members of devalued groups in blanket terms creating a rift between "us and them" (Hinshaw & Stier, 2008). It is also closely related to prejudice, the negative perceptions and opinions that often emerge toward such individuals and discrimination, the denial of rights and opportunities of those who are degraded. Corrigan, Markowitz and Watson (2004) have conceptualised the effects of stigma on individuals with mental health problems on different levels which include public stigma, self-stigma, and label avoidance. Public stigma is described as

the phenomenon of large social groups endorsing stereotypes and subsequently acting against a stigmatized group and self-stigma is the loss of self-esteem and self-efficacy that occurs when people internalize public stigma (Corrigan & Watson, 2002). Label avoidance is described as people not accessing services in order to avoid the negative impact of a stigmatizing label (Corrigan et al., 2004). Over the course of history, mental health problems have been associated with significant stigma leading to much prejudice and discrimination against individuals with mental health problems (Hayward and Bright, 1997).

Similar to many other cultures, stigma related to mental health problems appears to be a significant issue among Somali communities. Although many studies have mentioned this, there has been little detailed exploration of this issue. Stigma appears to stem from Somali views about mental illness being related to only the more severe and untreatable forms of mental health problems (Guerin et al., 2004). Somalis generally believe that people with mental health problems are incurable and never recover fully. This is evidenced by an old Somali proverb which can be translated as "we can say about a mentally ill person he may be all right for now, but we can't say he is cured" (WHO, 2010). Stigma associated with mental health problems understandably leads to poor acceptance and denial of such problems and often can be a barrier to utilising services (Elmi, 1999). Despite the associated stigma, most families generally continue to be involved in the care of their family members and form an important part of the support structure for people with mental health problems (Ryan, 2007). However, studies have commented on stigma surrounding mental health problems impacting on wider issues such as employment and marriage prospects (Guerin et al., 2004). It has also been described that stigma associated with *walli* may be more than *jinn* possession which suggests that spirit possession as an explanation for an individual's suffering may be more acceptable in the Somali community (Ryan, 2007).

Resilience and mental health in the Somali communities

There is increasing emphasis given to resilience and mental health in recent years (Friedli, 2009). Although there are numerous definitions of resilience, resilience generally refers to an individual's ability to cope with stress and catastrophe (Ryan,

2007). The factors which are believed to enhance the likelihood that someone will be resilient in the face of considerable adversity are often referred to as 'protective factors' in quantitative studies. The study of resilience and the factors that contribute to resilience are particularly relevant to the area of refugee research. Refugees are arguably the maximum example of the human capacity to survive despite the greatest of losses and assaults on human identity and dignity. As such, a paradigmatic shift with a focus on resilience in refugee research has been convincingly advocated by some researchers (Muecke, 1992, Watters, 2001). Some of the studies exploring resilience in Somali refugee communities are explored further.

In the quantitative studies exploring mental health of refugees in Somali communities, some of the studies commented on possible protective factors which were associated with lower rates of mental health problems. Halcón (2004) described fluency in English, emigrating at an earlier age and having family members in the same host country as such factors. Completing formal education and stable employment has also been associated with fewer mental health problems (Bhui et al., 2006). Other studies have also highlighted that maintaining religious practices and adequate social support may also be protective against mental health problems (Silveira & Allebeck, 2001).

There have been only a few studies discussing resilience and mental health problems among Somali refugees in the qualitative literature. Some early ethnographic studies commented on Somali refugees' resilience as being related to the ability to navigate one's way through distinctly different cultures (Rousseau et al., 1998). There has been a significant focus on the role of religion as a major factor in the resilience of Somali refugees (McMichael 2002; Guerin et. al., 2004; Whittaker et al., 2005; Ryan, 2007). Islam is seen as a critical factor in the psychological wellbeing of Somalis, which provides a source of guidance in how to react, understand, and cope with loss and stress (Ryan, 2007). Furthermore, Quranic verses, prayers, and other religious rituals were considered to be protective against spirit possession (Whittaker et al., 2005). One of the other main factors contributing to resilience has been cited as family and community support (Whittaker et al., 2005; Ryan, 2007). One of the contemporary challenges facing Somali refugee communities in Western countries is the changing family and community dynamics which affect the level of support afforded to individuals in dealing with their problems (Guerin et. al., 2004).

SUMMARY AND LIMITATIONS OF STUDIES

It is evident that there is significant research focussing on the mental health of Somali refugees. A review of the quantitative studies showed that there is little consistent information available about the prevalence of mental health problems in Somali refugee communities. However, these studies reveal important information about risk factors and protective factors related to mental health problems in these communities. One of the more consistent themes in the studies is the significant under-utilisation of mainstream mental health services by Somali refugee communities for mental health problems and many studies have explored potential barriers contributing to this under-utilisation. Differences in cultural conceptions of mental health problems appear to contribute to this underutilisation of mainstream mental health services.

A review of the qualitative studies provided a useful understanding of these conceptual differences in Somali communities. It was evident that Somalis used distinct terms such as *walli* and *jinn* to conceptualise psychological distress which do not necessarily have respective Western counterparts. Somali conceptualisations of mental health problems appear to be deeply rooted in their traditional beliefs and religion. *Jinn* possession provides a common explanation for the cause of mental health problems. The qualitative studies proved to be divergent from the quantitative studies as there was little focus on trauma as a cause of mental health problems. However, it was common in both types of studies for factors such as limited family and community support, accommodation and employment problems to be associated with high levels of mental health problems. Traditional treatments such as Quranic reading, exorcism rituals and other complementary treatments like herbal remedies and massage are frequently used first. There is little focus given to psychobiological explanations. Hence, medications and individual psychological treatments appeared to be of less relevance in the treatment of mental health problems. Stigma around mental health appears to be a significant issue which has been mentioned in many studies. There has also been an increasing focus on resilience in Somali refugee communities and many studies have shown that religion, family and community support are important in promoting resilience in Somali refugee communities.

Despite the increasing literature on the mental health of Somali refugees, there are significant methodological limitations in the reviewed studies. Some of these limitations reflect broader methodological issues such as the use of Western diagnostic constructs. However, others are more related to specific issues with methods such as sampling and analysis of data. The criticisms of quantitative and qualitative studies are somewhat different and they are described separately.

The main criticism of the quantitative studies is with the psychometric tools used to evaluate mental health problems in Somali refugee communities. The vast majority of the reviewed studies used a range of different psychometric tools which have had little previous use in this setting, without adequate standardisation procedures for use in this cross-cultural context (Hollifield et al, 2002). It is also worth noting that there was only one study which attempted to culturally adapt the assessment tool to the Somali context (Bhui et al., 2006). However, this still raises the broader issue of these psychometric tools being based on Western diagnostic constructs of mental health. It is clear from the findings of the qualitative studies that Somali perspectives of mental health problems are constructed within culture-specific belief systems which have unique conceptions of nosology, causality, and treatment. Hence, the use of these psychometric tools, based on Western constructs is arguably overly reductionist and contributes to the inconsistency in the findings related to the mental health of refugees in the quantitative literature. Another limitation observed in the quantitative studies is the lack of adequate sampling procedures which has also been identified as generally a complex issue in a hard to access population such as Somali refugees (Spring et al., 2003).

There were also significant limitations with the qualitative studies reviewed. A significant proportion of the reviewed qualitative studies appeared to lack clarity with regard to methodological aspects such as sampling procedures, details of method and analytic processes. Many studies provided little information about the demographic details of people interviewed and purposive sampling procedures used (Rousseau, 1998; Elmi, 1999; Guerin et al., 2004; Zarowsky, 2004). It is worthy of note that most qualitative studies did not describe the processes undertaken to ensure methodological rigour. There were only a few studies which explicitly described audio-taping of interviews (Silveira & Allebeck, 2001; Whittaker et al., 2005; Ryan, 2007). Many

studies were also not clear about whether translation to English was necessary. Many of the qualitative studies used different terms to talk about mental health problems such as "madness", "mental illness", "mental health problems" and "mental health" and often interchangeably. As there is evidence that these may imply significantly different meanings in Somali communities, this is likely to impact on the information obtained (Ryan, 2007).

As discussed before, there has only been minimal research about the mental health of Somali refugees done in New Zealand. It is important to note that there may be significant differences in the host country which may impact on the generalisability and transferability of research findings in other countries. Furthermore, the majority of research in New Zealand has been carried out in Hamilton, which has the largest number of Somalis in New Zealand (Guerin et al., 2003; Guerin et al., 2004; Ryan, 2007). It is possible that there are significant differences in Christchurch, especially in terms of the available services and the organisation of the community. Some of the qualitative studies have also been carried out on restricted groups of Somali refugees such as women, elderly and adolescents which may further impact the transferability of results (Rousseau, 1998; Silveira & Allebeck, 2001; Whittaker et al., 2005; Ryan, 2007).

One of the other general criticisms of the studies is the lack of inclusion of refugee perspectives in these studies. Some authors have criticised that Western psychiatric categories have been ascribed to refugee populations in ways which pay scant attention to the social, political and economic factors that play a pivotal role in refugees' experience (Summerfield, 1999). Rather than portraying refugees as ''passive victims'' suffering mental health problems, more recent paradigms have advocated the use of holistic approaches that take account of refugees' own experiences and needs (Watters, 2001). This has paved the way for more participatory approaches to researching mental health in refugees.

Despite the limitations of the available quantitative and qualitative research, they provide valuable insights into the mental health in Somali refugee communities, providing a useful platform to set the scene for this study. The next chapter describes the details of the methodology pertaining to this study.

CHAPTER 3: METHODOLOGY

This chapter describes the methodology and methods used in this collaborative study undertaken to explore mental health perspectives of Somali refugees in Christchurch. It initially explores the reasons for the choice of qualitative research paradigm used in this study. This is followed by a description of the details of the methods used. The important ethical aspects pertaining to this study are explored then, followed by a discussion of aspects related to ensuring methodological rigour. The chapter concludes with a discussion of the analytic method to allow for better flow.

METHODOLOGICAL APPROACH

It was felt that a qualitative research approach would be most suited to explore perspectives on mental health in the Somali refugee population in Christchurch. As is evident from the literature review, the concepts of mental health of Somali refugees are based on culture-specific belief systems and the use of Western based quantitative instruments can be overly reductionist and unreliable. A qualitative approach has the advantage of allowing a detailed exploration of these complex concepts (Creswell, 2009). The lack of previous research in this area also necessitates an exploratory approach and qualitative approaches are better suited for this purpose (Mays & Pope, 2000).

Community based participatory research (CBPR) principles was chosen as the guiding research methodology. The ontological assumptions of CBPR are rooted in reality being produced historically through social, political, economic, cultural and gender factors (Guba & Lincoln, 1994). As such, this research acknowledges multiple realities. CBPR involves dialogue and interaction between the researchers and the community to arrive at the results, which are acknowledged as being value mediated and used to effect social change (Wallerstein & Duran, 2003). The key to CBPR is a collaborative approach with the community as partners in all phases of the research process. CBPR recognises the community as a unit of identity with a focus on building strengths and resources in the community through a cyclical and iterative process (Israel, Schulz, Parker, & Becker, 1998).

There are many reasons why CBPR was chosen for this research. CBPR principles are especially suited for researching marginalised populations such as refugees. The refugee context is shaped historically through political, social, cultural and economic factors which create significant power imbalances between researchers and these communities. Furthermore, perspectives of mental health are dominated by Western concepts and other cultural perspectives are given less relevance. CBPR also has the advantage of maximising engagement with community participants which arguably increases the credibility and relevance of the findings to the community (Wallerstein & Duran, 2003).

Despite the idealistic conceptualisations of CBPR, there are significant practical limitations of the application of these principles. There can be problems with optimal identification of who represents the community given the heterogeneous nature of some communities (Israel et al., 1998). Furthermore, CBPR can also often be slow, time consuming with potential conflicts arising due to different agendas between the different stakeholders involved (Israel et al., 1998).

In terms of the methodological approach, there were also aspects of ethnography embedded in the attempts to understand the perspectives of mental health from a different cultural point of view. However, it was important that these views were obtained in collaboration with the community and this approach has been coined as community based ethnographic participatory research by some researchers (McQuiston, Parrado, Olmos-Muniz, & Martinez, 2005).

Research relationships

The research relationship is of crucial importance in CBPR. Although I am not a refugee or a Somali, I had established relationships with the Somali refugee community in Christchurch over the seven years I have lived in Christchurch. I have had previous contacts with the Somali community through the mosque and other community gatherings, due to my Islamic background. I discussed my interest in carrying out research with the Somali refugee community. This included involvement in community meetings as well as discussions with prominent elders and general members of the community.

It was decided to form an advisory group of five Somali community members in consultation with my supervisor and members of the community. Such advisory groups have a useful function in cross-cultural research and are often used in CBPR (Ellis, Kia-Keating, Yusuf, Lincoln & Nur, 2007; Liamputtong, 2008). This advisory group performed an important collaborative function in the initial planning stages and subsequent progress of the research. It was important to ensure that members of this advisory group had gender balance and different community roles.

The research topic of mental health had not strictly originated from the community and reflects my professional background. However, there was significant interest from the community about undertaking research on mental health as many perceived this to be a significant problem in the community. The broad aim of the research was agreed to be a focus on improving the mental health of the Somali refugee community. After discussions within the advisory group, the three specific objectives of the research were formulated. This included exploration of the descriptions of mental health problems in the community, experiences of mental health problems and health services and recommendations of community members regarding health services and the mental health of the community.

DETAILS OF METHOD

Data collection

There were discussions with the community advisors about the details of the method which would be most suitable for this research. We discussed the use of semi-structured in-depth interviews which may be most suited for facilitating detailed exploration of the perspectives of mental health in a sensitive manner. We also explored the use of small focus group discussions, which may allow for participation of larger numbers with more diverse views. However, there were significant concerns expressed about the level of participation in a group setting, due to the potentially stigmatising nature of discussions about mental health in the Somali community. Because of this and the exploratory nature of the study it was agreed that semi-structured interviews would be best suited for this study.

With regard to the content of the semi-structured interviews, there were discussions with the advisory group and it was decided to focus on the specific research objectives. We also agreed that discussions around experiences of mental health problems and contacts with health services would be generally focussed on community experiences rather than individual first hand accounts as this may facilitate better participation. It was also discussed at length whether to use the word "mental illness" or "mental health problems" in the interviews. It was agreed that "mental health problems" were preferable in an effort to capture the diverse concepts while sounding perhaps less stigmatising. A guide for the semi-structured interview is attached as Appendix B.

Sample selection

Purposive sampling was used to select the participants for this research in consultation with the community advisory group. It was important to ensure a range of perspectives were covered within the Somali refugee community in Christchurch, including both male and female perspectives. Some of the participants were also members of the advisory group as well. It was felt the use of the community advisory group for participant selection may limit the possible gate-keeping effect from using one individual.

The main issue with participant selection was the language barrier as I could not speak Somali and most of the Somali refugee community, especially the older generation, had limited fluency in the English language. Most of the advisory members felt that it was important not to limit the participants to those who had a reasonable command of English and were willing to be involved in data collection and translation procedures to assist with the study. However, in discussion with the academic supervisor, it was decided that participants be restricted to those with a reasonable command of English. This was mainly due to pragmatic constraints of a dissertation which did not allow for funding and time to complete translations.

The potential participants were initially approached by one of the advisory community members about the study. An introductory meeting was then arranged with this advisory member, the potential participant and the researcher, if the potential

participants were willing. This introductory meeting served to provide information about the research and obtain verbal consent. The information sheet about the study (attached as Appendix A) was also discussed during this meeting. A further meeting was arranged with the participant for the interview, if they gave verbal consent for this. The participants were encouraged to consider the option of having a support person of their choice present during the interview. It is worth noting that most of the female participants opted to have a support person during the interview. The duration of the interview was about an hour on average.

Description of the sample

A total of eleven potential participants were initially approached by the advisory members and seven of these potential participants agreed to proceed to arrange an introductory meeting. Most of the potential participants who opted out at this initial stage cited poor English as their reason. All the potential participants who had the introductory meetings agreed to participate in the study and an interview was subsequently arranged. The demographic details of all the participants will be summarised descriptively due to concerns around possible confidentiality issues as the Somali refugee community in Christchurch is relatively small and individuals are easily identifiable. The names of the participants used in the quotations have also been changed and their ages omitted to protect confidentiality.

A total of seven participants were interviewed for the study. Gender balance was reflected well among the participants with four males and three females. The age range of the participants was between 26 and 56 years. Apart from the two youngest participants, the other five participants were married and had children. All the participants had been living in New Zealand for more than 10 years and this ranged from 10 to 17 years. The refugees had sought their refugee status into the country through different programs such as the family reunification programme, quota refugee programme and the women at risk programme. In terms of employment status, it is worthy of note that six participants were in stable employment, with one participant being unemployed. It can be argued that this is not reflective of the general refugee Somali community of Christchurch. However, the most likely reason for this is due to the selection criteria requiring fluency of English language.

ETHICAL CONSIDERATIONS

The CBPR methodology employed in this research has been convincingly argued as the most ethical approach to research with refugees, in terms of ethical issues such as informed consent, risks and benefits for the community (Ellis et al., 2007).

The issue of informed consent can be difficult due to the significant power imbalance between the researcher and the participants. It was important that the process of informed consent was gradual with emphasis on the ability to opt out at any stage of the research without any adverse consequences for the individual, family or the community. It was felt strongly that verbal consent was more appropriate than written consent with the Somali refugee community, due to their strong oral tradition and unfamiliarity with written language. This was presented to the Ethics Committee for consideration and was subsequently approved for this study. The ethics application for this research was approved by the Upper South A Regional Ethics Committee - URA/10/09/066.

It was also important that there were significant benefits to the community as a result of the research. Refugees are often wary of researchers and results of the research can sometimes lead to further stigmatisation of the refugee community without any meaningful benefits to that community (Mohamed & Loewenthal, 2009). The collaborative process of CBPR ensures that the research is relevant and beneficial to the refugee community. It is also important to disseminate the results of research adequately and appropriately to reap the full benefits of the research.

Another important ethical concept was that of respecting the confidentiality of the participants. This was of utmost importance given the close-knit nature of the small refugee community in Christchurch and the collaborative process used in analysis. The transcripts and recorded interviews were available only to the researcher and supervisor and not to the members of the advisory committee. Potential information which could identify the participants was removed. The themes emerging from the research were also discussed from a community perspective rather than an individual perspective to minimise identification.

METHODOLOGICAL RIGOUR

It was important that steps were taken to ensure methodological rigor to maintain credibility of the research. The interview was audio-taped and then transcribed verbatim for purposes of auditability. There were also reflective notes written after each interview, which complemented these transcripts during the analysis stage. There was significant discussion and frequent interactions with the supervisor during the analysis stage. The analysis was also discussed with all the advisory members, while ensuring de-identification of participants. This was to ensure that their perspectives were obtained collaboratively which forms an important part of CBPR (Wallerstein and Duran, 2003).

The seven participants were carefully considered in collaboration with the advisors to ensure a range of views from the community were represented. Admittedly this was difficult due to the small number of participants involved. The number of participants also in this study is below the number usually required in qualitative studies to achieve saturation (Guest, Bunce & Johnson, 2006). However, it is of note that there were minimal new themes emerging even after the seventh interview, which suggests that a significant level of saturation was approached.

Reflexivity

Reflexivity is an important issue in qualitative research and it is important to be reflective about the influence of the researcher's own background (Kuper, Lingard, & Levinson, 2008). Having grown up in the Maldives, my cultural roots and Islam have always been an important part of my life. My experiences having lived away from my own country for most of my adult years (seven years in Australia and seven years in New Zealand) for purposes of training had forced me to adjust to a foreign environment in different ways. Although my professional training is in Western medicine and Western psychiatry, I have always had an interest in cultural aspects of mental health. My religious background, lived experiences and my professional training is likely to impact and influence my involvement in this research. It was always important to be mindful about this to ensure that interviews and analyses reflected the views of the participants. These issues were discussed frequently and explicitly during supervision.

Limitations and Strengths

In terms of the limitations of the study, the main limitation was the restriction of participants to those who were fluent in English. It can be argued that this may adversely select participants which are not reflective of the Somali refugee community in Christchurch. However, effects of this were minimised with careful selection of participants. Another limitation includes difficulties in reaching the ideals of CBPR fully in this study. The research topic did not originate from the community which is the ideal in CBPR. It was also difficult to obtain the input of advisory members fully during the analysis, mainly due to restrictions of time with significant interruptions due to the earthquakes in Christchurch.

However, the major strength of this study remains the use of CBPR as a guiding methodology. This allowed for increased cultural sensitivity with mutual respect between the community and the researchers. This also allowed for better engagement with the community which is likely to result in increased credibility of the findings. In terms of the context of this research, the previously established relationships with the Somali community by the primary researcher and the relatively longer duration of this dissertation project (18 months) also allowed time for the research relationship to establish and mature during the project. The choice of in-depth interviews as a method was also a strength as it paved the way for sensitive analysis of complex concepts which was necessary for this exploratory study.

DATA ANALYSIS

The data gathering interview was digitally recorded and transcribed verbatim for analysis. An inductive thematic analysis was used to analyse the transcripts of the interviews. An inductive approach identifies themes that are strongly linked to the data themselves without trying to fit this into the researcher's analytic preconceptions (Braun & Clarke, 2006). The transcript was analysed systematically multiple times in a step by step fashion initially with the generation of sub-themes. These sub-themes were then reviewed with a view to defining and naming the recurrent overarching broader cohesive themes (Braun & Clarke, 2006). It is also worth noting that the inductive thematic analysis was modified to a certain extent by the participatory process to reflect the areas that were felt to be important to the community.

There were discussions with the individual participants during the analysis stage to clarify issues which arose from their respective interviews. There was collaboration with the advisory members during the analysis stage to arrive at the final results. However, this was at times practically difficult due to time constraints as well as unfamiliarity with the research process by some of the community advisory members. During the analysis, it was also interesting to note that participants would talk distinctly about their own individual views and community views.

The analysis reveals two distinct themes with an overarching theme of the central role of religion and culture in shaping Somali perspectives of mental health. The first theme explores how culture and religion affects conceptualisation and explanations of mental health problems in the Somali refugee community in Christchurch. The next theme explores different ways in which culture and religion influence how Somalis deal and cope with mental health problems. These themes are presented in the following chapters.

CHAPTER 4: CONCEPTUALISING AND EXPLAINING MENTAL HEALTH PROBLEMS

It was clear from the analysis that culture and religion shaped how Somalis conceptualise and explain mental health problems in the Somali refugee community in Christchurch. This chapter initially explores how Somali cultural and religious beliefs affect their concepts of mental health and mental health problems. This is followed by a discussion of how these beliefs influence their explanations of mental health problems.

CONCEPTUALISING MENTAL HEALTH PROBLEMS

It was evident from the results that the participants consistently commented on the importance of religion and culture in their lives. Islam was described as playing a vital role in their daily lives with a dominant influence on their world-views. Given this, it is of little surprise that Somali culture and religion play a significant role in shaping their perspectives of mental health. This pivotal role of religion and culture has also been consistently described in previous research exploring mental health in Somali refugee communities (Guerin et al., 2004; Palmer, 2006; Elmi, 1998; Ryan, 2007). One of the participants aptly summarised this as follows.

> *"Religion is very important to us. As you can see Somalis are practicing Muslims and we believe that this is best for us. I think this is very important for our well being and our life…Everything is connected to religion. Somalis are very religious people…I think this is very important for their mental health…"*
>
> ***Hawwa*** ♀

Among the Somali refugee community in Christchurch, people who were doing well in terms of mental health were generally described as those having no mental health problems. However, a few of the participants were able to elaborate on this further and relate this to the individual's functioning. This was framed in terms of being able to fulfil the role obligations of being a good Muslim and a responsible member of the family and society. Previous research has also commented on this identification of spiritual health and social interconnectedness with mental health in Somali refugee communities (Simich et al., 2009). This concept of mental health being related to

optimal spiritual, social and family functioning is illustrated eloquently by one of the participants as follows.

> *"Our perception of the mentally capable person is a person who can provide for his own family and a person who respects his culture and religion, meaning that he is a good Muslim person… who is good to his fellow Muslim brothers and sisters and to the community. And also… if possible that he has some sort of a good education background, at least he become a good father"*
>
> ***Ali*** ♂

It is not surprising then, that people with mental health problems were described as people who were not able to fulfil these role obligations expected by the society. Participants described further that people with mental health problems had behaviours such as not sleeping, shouting, talking excessively, not making sense, walking or running aimlessly and responding to imaginary voices. One of the consistent features of mental health problems described by the participants was the unpredictability with the potential for violence towards others and themselves. Some of the participants also went on to describe how people with mental health problems were often tied up and isolated back in Somalia because of these concerns. Some of the descriptions of behaviours related to mental health problems by the participants are exemplified below.

> *"Always with mental health* [problems]*… they are shouting, they are running, they are hurting themselves, they are hitting others…"*
>
> ***Amina*** ♀

> *"Some of them they can't sleep. They will walk day and night. Some of them they will fight. They can be violent. Some of them they will laugh day and night. Some of them they will talk to people who you cannot see..."*
>
> ***Aisha*** ♀

These descriptions are very consistent with the features described by previous qualitative research exploring mental health in Somali refugee communities (Carroll, 2004; Guerin et al., 2004; Ryan, 2007). Furthermore, previous research also suggests that Somali communities had categorical descriptions of mental health problems. This dichotomy was also evident in this research and participants generally described people as either having or not having mental health problems. There was little discussion of a continuum of mental health problems, ranging in severity. However, two participants described that some people can present with features such as social withdrawal, uncommunicativeness and inability to look after themselves and suggested that such people may possibly progress to more florid presentations described earlier. This suggests that perhaps some members of the community may have less dichotomised views of mental health problems as illustrated below.

> *"Well, the one thing which may somehow be at the lower level* [of mental health problems] *is, there are certain times when the individual will not even talk, they just keep quiet, no communication at all…and people think that they have lost the ability to communicate… so this is one way…"*
>
> ***Abdi*** ♂

It is also of significance that participants consistently described how Somalis believed that people with mental health problems never recover fully and that such problems are seen by Somalis as incurable. Furthermore, some participants described that even though some of the more florid symptoms improve, the person never recovers fully to reach their pre-morbid levels as illustrated by the quote below.

> *"Somali people, they say that the person who becomes one time crazy, he not come again 100 percent… Even if he became good, he is not like before…he is not 100% okay… meaning they say person who become crazy, he is never complete…even if he gets better…"*
>
> ***Ahmed*** ♂

Such beliefs have also been consistently described by previous researchers (Guerin et al., 2004; Elmi, 1998; Ryan, 2007). The implications of these beliefs are very significant and will be discussed further later.

In terms of Somali words used to describe people with mental health problems, all the participants described the word *walli* and explained it as meaning literally 'crazy'. This appears to refer to the more florid presentations of mental health problems described above. This is also consistent with descriptions of this term *walli* given in previous qualitative studies (Carroll, 2004; Guerin et al., 2004; Ryan, 2007). However, Guerin et al., (2004) commented that this term *walli* can be used in diverse situations such as conversational use. This is similar to the findings of this study as some of the participants described how *walli* was also used in colloquial expressions, akin to the use of the word 'crazy' as described below.

> *"Walli… means that the person is not going the right way… you don't have to be really crazy, but doing wrong things… but you can use it more commonly when speaking…"*
>
> ***Ahmed*** ♂

The other word also frequently associated with mental health problems was *jinn*, which refers to 'spirits' and also used synonymously with 'spirit possession'. However, this research also suggested *jinn* appeared to refer to a more causative explanation of mental health problems rather than the state itself. This view was supported by some researchers such as Ryan (2009). Other words, such as *murug* and *demur* also were mentioned by one participant to refer to mental health problems, but were not consistently described.

It is evident that the conceptualisation of mental health problems in the Somali community is rooted in their cultural and religious beliefs. Somali culture and religion are central to their lives and mental health problems are described by the inability to function in performing their respective religious, family and social obligations. Somalis generally describe mental health problems categorically, often depicting the severe end of mental health problems. It is also generally believed such problems are incurable. Having discussed how Somali culture and religion shape their conceptualisation of mental health problems, how these beliefs influence their explanations for mental health problems will be explored next.

EXPLAINING MENTAL HEALTH PROBLEMS

It was clear from the analysis that culture and religion play an important role in influencing explanations of mental health problems among the Somali community in Christchurch. It was interesting to note how most of the participants described multiple factors and were pluralistic in their causative explanations of mental health problems. These include spiritual and religious explanations, ongoing settlement difficulties and to a lesser extent biomedical explanations.

In terms of religious and spiritual explanations, the general theme of people being predestined for life events was evident consistently in all the participants. This belief in Divine Will and Predestination was described as one of the cornerstones of the Muslim faith. As part of this belief, health problems as well as other life problems were explained as trials of life and occurring through the will of Allah. Some participants also explicitly explained mental health problems as part of the Divine Will and Predestination. This is exemplified eloquently by Hawwa as follows.

> *I believe it* [mental health problems] *is written by Divine Will into their lives, like medical problems and other problems in our lives. We Muslims believe in divine will and predestination and I think in some way its part of fate.*
>
> ***Hawwa*** ♀

Although it is likely that these beliefs facilitate better acceptance of health problems in Somalis, one should be cautious in assuming that this implies a fatalistic view about health problems including mental health problems. These concepts of Divine Will and Predestination have not been explored in detail in previous research exploring mental health of Somali refugees. Elmi (1999) discusses illness and healing as occurring only by the will of God and how suffering from health problems is not necessarily seen negatively, but also an opportunity for forgiveness for one's sins. It is hardly surprising that these Somali beliefs about health problems and healing have implications for how they deal with health problems, including mental health problems, as discussed further in the next chapter.

The most common spiritual explanation for mental health problems described by the participants was attributed to being afflicted with *jinn* as described below.

> *"Mental health problems are always linked to something called jinn. So anyone with mental health problems is thought to be somehow attacked by jinn…."*
>
> ***Abdi*** ♂

Jinn were described as spiritual entities which can enter human bodies causing mental health problems. Many participants talked about how this spiritual explanation was more common in the older population and back in Somalia. Some also suggested that the younger Somalis placed little emphasis on spiritual explanations such as *jinn.* However, it was also evident that while some of the younger participants placed less emphasis on this explanation, they seemed careful not to refute this. This belief in *jinn* possession causing mental health problems is consistent with previous research (Elmi, 1999; Carroll, 2004; Guerin et al., 2004; Ryan, 2007). Some of these previous studies also commented on how these beliefs were more common among the older Somali refugees (Guerin et al., 2004; Ryan, 2007).

Most of the participants described features of *walli* being attributed to *jinn* possession. However, others explained that *jinn* afflictions were not limited to such florid mental health problems, but could also cause other mental health problems as well as physical problems. Ryan (2009) also describes *jinn* affliction causing minor forms of mental health problems as well as psychosomatic difficulties. It was also difficult to elucidate from the participants, what exactly causes a person to be possessed by *jinn* in the first place. Discussion of this also appears to be lacking in previous studies. One participant suggested that this could be due to wrong actions or not saying the appropriate prayers. Despite this, he was clear that *jinn* possession can happen to people who have strong faith as well. Another participant, Hawwa also suggested that it can be mediated through *sihr* or 'black magic' as described below.

> *I believe people can become unwell* [with mental health problems] *because of 'sihr' or black magic..... I believe it is not something prohibited. However, I think some people still do practise and this can cause mental health problems.*
>
> ***Hawwa*** ♀

Many participants described adjustment and resettlement challenges in New Zealand as having contributed to mental health problems. All the participants described significant challenges during the initial settlement period. These included difficulties adjusting to their new life, in terms of food, weather, culture, religion, minimal family supports, and perhaps most importantly language barriers. All the participants described a major change in their lifestyle. Hamza described his language difficulties as follows.

> *"The first one year was too much for me… I was thinking why I am here and I wanted to go back…The world is going upside down… you can't communicate with people… people trying to be friendly with you, but you can't, because you don't understand what they're saying…. I went to school and they are trying to explain to me something… they just open their mouths, but I don't know what it is… It was really hard… To be honest it was one of the hardest things I have ever done…"*
>
> ***Hamza*** ♂

Many participants described how these initial settlement difficulties became ongoing stressors which contributed towards mental health problems. Such stressors described include language barriers, poor employment opportunities, financial problems, accommodation difficulties and social isolation. These concerns are exemplified by the following quotation.

> *"I believe a lot of the problems from the community are because people don't have jobs. Some people don't have enough education to get a job. The language is a problem. Some people they need the families. There are many community problems. I think it is mostly social problems. Their life is so difficult here."*
>
> ***Aisha*** ♀

This is consistent with previous studies where adjustment challenges and post-migration stressors such as employment, housing, finances, social support have been identified as significant issues contributing to mental health problems in many studies, both in the quantitative and qualitative literature (Gerritsen et al., 2006; Silveira & Ebrahim, 1998; Ellis et. al, 2008; Silveira & Allebeck, 2001; Guerin et al., 2004; Palmer, 2006).

One of the other consistent features identified by participants was their concern for other family members. Participants described significant disruption to the family structure with loss of family members and dispersion of family members due to the ongoing civil war in Somalia. Many of the surviving family members were still living in Somalia or other neighbouring African countries in refugee camps, whereas a lot of other family members had fled as refugees to other distant countries. Some participants suggested that loss of family members and concern for them were likely to contribute towards mental health problems. Aisha described this as below.

> *"The war affected us really because when you can't go back to your country and visit for you family and relatives, it is hard. Home is home and we would like to go back and visit, but because of the safety, we can't go back"*
>
> ***Aisha*** ♀

This is again consistent with previous research which has identified concern for family members back in Somalia as a contributory factor to poor mental health in Somali refugees (Guerin et al., 2004; Palmer, 2006; Ryan, 2007). Furthermore, disruption of family structure can lead to breakdown of the social support network which can lead to social isolation. Lack of social supports has been consistently shown by previous studies as contributing to mental health problems, both in studies within the general refugee community as well as studies within the Somali refugee community (Te Pou, 2008; Gerritsen et al., 2006; Silveira & Allebeck, 2001; Guerin et al., 2004; Palmer, 2006).

It was interesting to note that none of the participants discussed previous traumatic experiences as contributing to mental health problems. Only one participant mentioned trauma and stated that 'this was not part of the Somali dictionary'. This may be consistent with some of the previous qualitative studies which described trauma as not being a major contributing factor to mental health problems (Guerin et al., 2004; Whittaker et al. 2005; Ryan, 2007). However, it should also be emphasised that traumatic experiences were also not directly asked about and explored during the interviews in this study.

Many participants also described that they believed that some mental health problems may be related to illness. This was described generally by the younger participants. However, all the participants consistently described that mental health problems were generally not ascribed to illness back in Somalia. Furthermore, participants also described that 'stress' and 'depression' were unheard of in Somalia and how these terms were only introduced after they came to New Zealand. This was also described in previous studies which described Western concepts such as 'stress' and 'depression' as relatively new concepts to Somali refugees (Elmi, 1999; Guerin et al., 2004; Ryan, 2007). However, many participants in this study went on to describe how there was increased awareness of these concepts in the Somali community as exemplified by the quote below.

> *"Well, I think our community's understanding have somehow increased… now got a greater understanding of stress, depression because of the association with the doctors and system…. these concepts are very different and were never used before in the Somali culture"*
>
> ***Abdi*** ♂

Most of the participants also commented about the detrimental effects of substance use contributing to mental health problems. However, all of the participants were in agreement that drugs were not a major issue in the Somali community in Christchurch. This appears to be consistent with finding of the study by Guerin et al., (2004) which described substance use as a minimal issue in New Zealand.

The results of this study show that Somali culture and religion play a major role in conceptualising and explaining mental health problems. Somali refugees in Christchurch appeared to attribute multiple causes to mental health problems, including spiritual explanations such as Divine Will and Predestination and *jinn* possession as well as other factors such as lack of social support, concern for family members, unemployment, financial and accommodation difficulties. There also appears to be increasing attribution of mental health problems to more Western concepts such as stress and depression, especially among the younger population.

CHAPTER 5: COPING AND DEALING WITH MENTAL HEALTH PROBLEMS

It is evident from the previous chapter that culture and religion play a pivotal role in influencing concepts and explanations of mental health problems in the Somali refugee community in Christchurch. Given this, it is hardly surprising that this is reflected in the ways in which Somalis deal and cope with mental health problems. This chapter initially explores how mental health problems are dealt with in the Somali community in Christchurch. This is followed by an exploration of the barriers and strengths in addressing mental health problems in this community.

DEALING WITH MENTAL HEALTH PROBLEMS

The results of this study showed that there were different approaches to dealing with mental health problems in this community. Cultural and religious approaches to dealing with mental health problems are common in the Somali refugee community in Christchurch. Family involvement and community support was seen as paramount. Participants also described their views and experiences of mainstream approaches to dealing with mental health problems in New Zealand.

Firstly, participants consistently talked about the importance of readings from the *Quran,* and praying to *Allah* to seek relief from mental health problems. This was generally described as the first step in managing mental health problems in the Somali community. Many participants explained further that the ultimate source of all healing is from *Allah* and that healing can happen only through Divine Will as typified below.

> *"Somalis totally have faith in God, which is Allah, and say like whatever it is, Allah is the one who can treat…."*
>
> ***Ali*** ♂

Participants described that Somalis believed that the *Quran* is the divine word of *Allah* which provided a source of divine guidance and healing. Somalis believed that *Quran* was a source of healing and some participants described it being like 'a medication' and a 'pain-killer'. This is also consistent with previous studies where Quranic readings and prayers were identified as one of the key approaches to dealing

with mental health problems (Elmi, 1999; Guerin et al., 2004; Ryan, 2007). Some of these studies also commented on how prayers and reading *Quran* was not necessarily restricted to dealing with mental health problems, but also to some physical problems (Guerin et al., 2004). Participants in this study described that readings from the *Quran* and praying to *Allah* was not just for mental health problems, but also for physical health problems and other life problems as a means of divine guidance and assistance. This is exemplified by the following quote.

> *"We read the Quran and do prayers for all our problems. This is the same for physical and mental problems, and not just that even for other big decisions in life such as marrying someone… for most problems, first we read Quran and we pray to the God and ask the help of God to guide us."*
>
> ***Hawwa*** ♀

The participants described a ritualistic process for these Quranic readings when used to manage mental health problems. Family members and respected elders would gather at the afflicted person's house to read the *Quran* collectively, often over multiple sessions. It was described that this would often help free the person from the *jinn* possession. These ritualistic Quranic readings to treat mental health problems have also been described by previous studies (Guerin et al., 2004; Ryan, 2007). Such ritualistic Quranic readings were described as being common in the Somali community in Christchurch and not just back home in Somalia.

Many of the participants also described a more elaborate ceremony of specialised Quranic readings by *sheikhs,* or people of religious knowledge, when the more simple Quranic reading rituals were felt not to be working. It was described that only some *sheikhs* possessed this special knowledge and how they would read certain parts of the *Quran* to drive the *jinn* away from the afflicted person. This appeared to be similar to exorcism ceremonies in other religions and these ceremonies have been described in previous studies (Elmi, 1999; Guerin et al., 2004; Ryan, 2007). The participants agreed that there were no people who possessed this type of knowledge in the Somali community in Christchurch. One participant described how some families in the past have taken family members back to Somalia for such *jinn* exorcism ceremonies. The following quote by Amina paints a vivid description of such an exorcism ceremony.

"They do some kind of treatment… They bring the person and they put something on the fire and they read some verses of the Quran... some have different voices and they say a group of demons has gone into this person. Part of the treatment is reading the Quran, sometimes this fire and sometimes they spit and shout "Go away, Go away"…and this time spirits come physically, speaking in many voices. The spirits will be asked to leave the person…Sometime one of the voices will say 'I will leave'… that is how they treat… sometimes the person becomes conscious after that and say 'I am fine and I am here…' and will be better…"

Amina ♀

Some of the participants also commented on another type of cultural exorcism ceremony involving bringing other spirits to help the person who may be afflicted with the *jinn*. These ceremonies appeared to have their roots in African cultural traditions, rather than in Islam. These ceremonies were described as involving groups of people with dancing, music, singing and feasting. This ceremony is led by a traditional healer who is able to control spirits and would often involve the use of herbs, incense and perfumes. They were described as being distinctly different to the Islamic religious exorcism ceremonies by the participants. One such ritual is called *mingis* and the following quote by the same participant is presented here as it included the best description.

"We call mingis, it's like people have spirit coming to them. We have specialised person who has control of that. They are groups of people who go together. They have drums and they have singing… They have fun… and also they are treating from one person to another. They have like socialise, drums… they are playing like that music, very beautiful song…and one person will come… and they will ask "Who came" to the field and they call the name of the spirit… and spirit says ' I come from Baghdad', 'I come from Malaysia'…"

Amina ♀

Some of the previous studies have also commented on these traditional ceremonies (Elmi, 1999; Ryan, 2007). Participants in this study described these ceremonies as being very costly and uncommon these days. These were described as being more common in Somalia before Islam became more popular over the recent decades.

Furthermore, many of the participants described that they did not believe that such ceremonies should be practised as they believed they were against Islam.

> *"I think it was popular before people had learnt Quran. Islamic teaching was not very popular in Somalia before… but then since 1980s there has been a lot of NGOs from the Middle East who came to Somalia and spread Islam, the Arabic language and then people start talk about the use of mingis being prohibited because it's about associating things with Allah… So it has been discouraged and it doesn't enjoy that level of publicity anymore"*
>
> ***Abdi*** ♂

It was also evident from the analysis that the participants consistently described how families were always involved in the care of the family members who have mental health problems. The family members usually were involved in managing and co-ordinating the care for their loved ones. Participants also described how the extended family is usually involved and how they would step in if there was no immediate family. The families may also at times involve other community members, neighbours and other community elders. The importance of family and community support for people with mental health problems has also been discussed in previous research (Elmi, 1999; Guerin et al., 2004). This appears to be related to the collectivist culture of the Somali community which has its roots in religious beliefs as illustrated below.

> *"In our culture, neighbours are also families. We are Muslim and we believe that your neighbour is your brother or sister and there is a responsibility for your neighbour according to our religion. Neighbour's children are like your children and neighbours are very important in our culture"*
>
> ***Aisha*** ♀

Most of the participants described that Somalis would see little role for mainstream treatment for mental health problems. They agreed that Somalis would generally be reluctant to seek their general practitioner or specialist mental health services for mental health problems. Some participants explained that Somalis generally believed that conventional medicine was ineffective in treating mental health problems in their community. Many of the participants also described how they had heard other

Somalis say that medications did not help mental health problems and that this made their condition worse.

> *"Some people…they believe that if you are crazy, New Zealand system of health, they will give some medicine that you'll be always crazy… some of the people they believe that… I don't know whether that is true or not…"*
>
> ***Ahmed*** ♂

Most of the previous studies also were consistent with these findings that Somalis were reluctant to seek mainstream health services for mental health problems and considered medications as being not effective (Elmi, 1999; Guerin et al., 2004). Furthermore, many participants also did not generally believe in one to one psychological treatment from health professionals. This has also been commented on in previous research (Palmer, 2006; Mohamed, 2009).

However, some of the younger participants suggested they may consider seeing the doctor initially and described that similar views were common among the younger generation of Somalis in Christchurch as quoted below.

> *"I have to go to someone… people with knowledge… I have to go to the hospital, I have to see the doctor …. I don't think the younger people believe that* [jinn possession] *so much and would go to the doctor…"*
>
> ***Hamza*** ♂

It was interesting to note that even for participants who described that mainstream mental health services and medications were of some benefit, they were clear that spiritual treatments were equally important. Such beliefs were explained by suggestions that doctors and medications acted as a means of healing through the Divine Will of God. These explanations are typified by the quotes that follow.

> *"Yeah, yeah… because even the doctor…doctor don't know 100% what this man... but if I read Quran and pray Allah, Allah help this person, Allah help the doctor, make good decision… this is what we believe…"*
>
> ***Ahmed*** ♂

"First of all, that there is the general assumption or belief that the treatment would not work well without the Will of Allah. Everything depends on the Will of Allah. So if Allah uses the medicine as a source of treatment it will work well… otherwise it won't help, because this is fundamental principle of belief. If it is Allah's Will the medication will work and if it's not Allah's Will the medication is not going to work… which is why people resort to using the Quran first and foremost… and even if we go through normal medical procedures, they still will rely the Quran, because they believe that the right moment or the right time has not yet come and it has not yet been prescribed by Allah…so they don't give up hope in Quran…"

Abdi ♂

Some participants also elaborated and explained that Somali religious beliefs encouraged people to seek assistance for mental health problems from other means such as doctors and medications and did not restrict people to only reading *Quran* and prayers. One participant expressed this as follows.

"It is something fundamental to adhere to your culture and religion. In my understanding, our religion does not rely only just reading the Quran… but also God allows prescription… for medication and medical opinion."

Ali ♂

This may also explain how some Somalis are able to seek assistance from mainstream mental health services while also engaging in traditional treatments. These insights may also provide an important opening to encourage Somalis to seek assistance from mainstream health services for mental health problems which is consistent with their cultural beliefs and religion. There is little discussion of these concepts in previous studies.

It is evident that there were different ways of dealing with mental health problems in the Somali refugee community in Christchurch. Having discussed these different approaches to dealing with mental health problems, the next part explores barriers and strengths in addressing mental health problems in the Somali refugee community in Christchurch.

BARRIERS AND STRENGTHS

It is clear that culture and religion play an important role in how mental health problems are dealt with in the Somali refugee community in Christchurch. The analysis also revealed that the participants identified significant barriers which are related to culture and religion in dealing with such problems in this community. These barriers are first discussed in this chapter. The analysis also revealed that the participants identified significant factors which were related to culture and religion as being protective against mental health problems and related to resilience.

It was evident from the participants' accounts that there were multiple barriers to dealing with mental health problems in the Somali community in Christchurch. The main barriers identified by the participants include stigma related to mental health problems, lack of awareness of mental health problems, mistrust in mainstream services, poor awareness of Somali culture and religion in health professionals and language barriers. These barriers will be explored further, along with various suggestions put forward by the participants to address some of these barriers.

Stigma surrounding mental health problems was consistently identified as a barrier in accepting and dealing with mental health problems in this community. Many participants described a sense of 'shame' for the person and families if they had mental health problems. It was also explained that this stigma may be related to the Somali belief that mental health problems were incurable and people never recovering fully. Some participants also made reference to this stigma as being related to the propensity of people with mental health problems to be violent and unpredictable. The following participant explains stigma surrounding mental health problems as below.

> *"Stigma is that people will start somehow look down upon those people* [with mental health problems] *without much dealings with the rest of the community. Somehow people will give up hope with the belief that once people are afflicted with a mental health problem will ever recover… this is same for most of the community including close family… and its more like shame…"*
>
> ***Abdi*** ♂

Many participants also commented on how families often would try and hide the fact that a family member has mental health problems from the rest of the community due to this sense of 'shame'. Stigma of mental health problems was described as contributing to significant social consequences such as unemployment, poor marriage prospects and loss of social status. One of the participants described this as below.

> *"The families always try to hide as much as they can too. The family always feel shame. For example, if their daughter has got mental illness, it is not easy to find husband …person is not complete if they have mental problem…"*
>
> ***Amina*** ♀

It is also perhaps worthy of note that none of the participants admitted to having mental health problems of their own or within their family, but described people with mental health problems within the community. One could speculate that this may be related to stigma, although this may not necessarily be the case.

Stigma surrounding mental health problems in the Somali community has been identified as a significant issue in previous qualitative studies. Stigma has also been identified as a significant barrier to utilising services, leading to denial and poor acceptance of mental health problems (Elmi, 1999). The findings of this study are consistent with other studies which suggest that stigma is related to the belief that people with mental health problems are incurable and never recover fully (Guerin et al., 2004; Ryan, 2007). Furthermore, this study also suggests that stigma may also be related to the beliefs that people with mental health problems are often violent and unpredictable.

Participants consistently identified the lack of awareness of biomedical understanding of mental health problems in the Somali community as a significant barrier in dealing with these problems. Furthermore, it was also generally agreed by the participants that most Somalis had a poor understanding of mainstream treatments and services available in the community to deal with mental health problems. This lack of awareness about biomedical constructs of mental health problems and the services available in the community have also been previously identified as a significant barrier in previous studies (Guerin et al., 2004; Palmer, 2006; Elmi, 1999).

Given this, it was not surprising that all the participants referred to the importance of increasing awareness of mental health problems in the Somali community. Many participants also talked about the importance of awareness of treatments and services available in the community for dealing with mental health problems. They talked about how increased awareness of mental health problems as treatable illnesses may help decrease the stigma surrounding mental health problem which may enable better acceptance of treatment. This is also discussed as being important in the literature related to mental illness and stigma (Hinshaw & Stier, 2008; Byrne, 2010). One of the participants, Hamza, described this as below.

> *"I think it's the knowledge* [about mental health problems]*....it is the key, if you don't know if this thing is a door or wall, it is no good. You have to know what it is, you have to know the knowledge, you have to know about mental health"*
>
> ***Hamza*** ♂

The process of involving the community and organising such awareness programmes were also outlined by some participants. Most of the participants described that it was important to approach the elders of the Somali community first and involve them in any such process.

> *"I think the best way would be to involve the community leaders and use them to spread the message to the community. The Somali community usually does get together pretty regularly and they do look up to their community leaders."*
>
> ***Hawwa*** ♀

Some of the participants also identified the issues of mistrust of mainstream health and social services by Somalis as a significant barrier in accessing mainstream treatment and services. This is consistent with some of the previous studies which also identified issues of mistrust of services as a significant barrier (Ryan, 2007; Guerin et al., 2004). One of the younger participants described this as below.

"Somalis don't trust any foreign doctors…or 'outsiders'… they are outside from our culture … I believe that surely they can help us. But many cannot see that… they can never see that doctors can help us, especially … New Zealanders. Maybe doctors with a similar culture… that is if he is a Muslim… he or she Muslims or if he came from our region… but other than that they cannot trust any doctors…"

Ali ♂

Some of the participants discussed the importance of establishing better relationships with health professionals and services with the Somali community in Christchurch to address these issues of mistrust and increasing the awareness. Participants also consistently highlighted the need to increase awareness among health professionals about Somali beliefs and culture. One participant commented about how something as simple as learning a few Somali words or phrases can go a long way towards building trust and improving the relationship with health professionals.

"If there is a local doctor from New Zealand, and they start to for example get to know the Somali culture and get to know their language… say a few phrases of the Somali language to them… they take it really deep into their hearts and you pretty much… instead of walking a 100 miles you are already half way through… just by saying a few words in their own language."

Ali ♂

Some of the participants also emphasised that increasing awareness of Somali religion and culture was especially important for general practitioners as they were the first port of call, with most Somali families usually attending the same general practice. Other participants also talked about the importance of being culturally sensitive when patients are admitted in hospitals and facilitate appropriate cultural interventions such as the opportunity to pray and read the *Quran.* It may also be important for health professionals to be proactive about this as most Somalis do not feel that they can ask for this as demonstrated by the quote below.

"When people are admitted to places like Hillmorton hospital [psychiatric hospital] *their parents would want to come and read the Quran while they are there. Some would want to bring the person to mosque on Friday, so that at least they can perform the prayers… but then the health professionals really don't understand that… therefore they don't even provide a room which is conducive to perform this kind of blessings… Such practices haven't been declined, but it has been not offered and it has not been requested because they feel it is not even their right and that it is not appropriate, they feel it is not acceptable…"*

Abdi, 49♂

Language barriers were described as a significant barrier in dealing with mental health problems. This has also been consistently highlighted in other studies (Guerin et al., 2003; Guerin et al., 2004; Palmer, 2006; Elmi, 1999). Many Somali refugees, especially the older generation were described as having poor fluency of English. Participants talked about the use of formal interpreters and family members as interpreters to overcome this. However, some participants commented that Somali interpreters in Christchurch were inadequate in numbers and often had poor knowledge of medical jargon. It was also identified by one participant that there were not enough female interpreters which may be a potential barrier for women with mental health problems. Participants commented on the need to train better interpreters with increased awareness of mental health problems and terms. Some of the current concerns about interpreters are well summarised in the quote below.

"The interpreters probably don't have the jargon of the medical terms for mental health, whereby they can convey the message the doctors are giving the patients… and on top of that, there could be women who will not want to expose their problem to interpreters who are usually male…There are few [women], *but mostly men".*

Hawwa ♀

While language barriers may be a significant barrier in dealing with mental health problems, this has wider implications of unemployment and financial difficulties which are likely to contribute to mental health problems in the first place. Hence, it is important to address these language barriers with the provision of language classes to

the Somali refugee community, especially during the initial phase of resettlement. This has been discussed as being an important part of resettlement services in the refugee literature (Te Pou, 2008).

Participants also talked about the importance of involving and training local Somalis to address the language and cultural barriers. They also highlighted that this could be important for increasing awareness of mental health problems in the Somali community. This is also important to foster better relationships between community and services, while empowering the community. The use of specific cultural workers to address these language and cultural barriers is prominent with other minority cultures such as Maori and Pacific workers in New Zealand as described by one of the participants below.

> *"Some of the local people* [Somalis] *need to be trained, because these people know the culture and language already. In Maori, they have their own, in Pacific, they have their own people. Our people, they need something like that for their own."*
>
> ***Amina*** ♀

Apart from talking about barriers in dealing with mental health problems, participants also talked about strengths in dealing with their mental health problems. These factors were also described as being as protective against mental health problems and are related to resilience. Participants consistently talked about the role of religion as an important coping tool in life and identified this as being protective against mental health problems. This is consistent with the previous studies exploring resilience in Somali refugees (Guerin et. al., 2004; Whittaker et al., 2005; Ryan, 2007). The role of Islam as an important factor in resilience is highlighted by the following quotes.

> *"The only thing I was going to add was that… sometimes faith can be a very useful tool or as a coping mechanism because when go through problems of either trauma or other hardships, if they have got a strong faith, then they are likely to survive, they believe that there is a test from Allah and it's a test upon them and therefore they have to accept it. It is like a trial…"*
>
> ***Abdi*** ♂

"Most of Somali lives revolve around religion and I think Somalis would often look to religion to solve their problems. They also accept a lot of their problems as part of their fate. It is also an important part of our strength to accept things."

Hawwa ♀

One of the other factors participants talked about as being protective against mental health problems was being connected to family and the community. These strong links to family and community reflected the importance given to collectivist values in Somali culture and religion. This is also consistent with previous studies which have highlighted community and family support as important factors which contributed to resilience in the Somali community (Whittaker et al., 2005; Ryan, 2007). One of the participants described the following about the sense of the community spirit in the Somali community in Christchurch.

"Somalis in Christchurch are generally a very close-knit community and see each other regularly. We support each other and share happiness and sadness together. Most of us know each other well.

Abdi ♂

Despite the collectivist nature, many participants also reflected on the tribal conflicts in their community back in Somalia and how this was a source of ongoing tension. Most participants reported that such tribal conflicts were not a major issue in the Somali refugee community in Christchurch, especially among the younger generation. One participant summarised her view about tribal differences as follows.

"In Somalia, we have are a divided community because of the tribes and war. But now we are one community. And I think this is very important for us to be together to deal with problems…we have tribes here, but we try and not to emphasise that. We try and not to acknowledge the tribes as we are out of the country and there not so many of us here. It is good to work together and help each other. But everyone of course knows where he or she comes from…"

Aisha ♀

This chapter has discussed different ways of dealing and coping with mental health problems in the Somali community in Christchurch. There are multiple approaches dealing with mental health problems in this community, including spiritual treatments such as prayers, reading the *Quran* and specialised exorcism type ceremonies as well as more conventional treatments such as medications. Most Somalis, especially the older generation were generally reluctant to consider mainstream treatments such as medications to deal with mental health problems. However, this appeared to be changing and the younger population was described as more willing to accept mainstream health services. There were also multiple barriers in dealing with mental health problems described by the participants, which include stigma, lack of awareness about mental health problems, lack of trust in health professionals and language difficulties. Most importantly, participants also identified religion and family and community supports as significant factors contributing to resilience against mental health problems. Having presented the results of this study, the next chapter will explore a general discussion and conclusion of issues arising from the results.

CHAPTER 6: DISCUSSION AND CONCLUSION

This final chapter of the dissertation initially presents a discussion of some of the conceptual issues from the themes presented in the earlier chapters. This is followed by presenting the recommendations of the study. A discussion about further dissemination of the results and scope for future studies is presented before the final concluding remarks.

OVERALL DISCUSSION

There were significant conceptual issues which were evident from results of the study. Concepts related to mental health problems in the Somali refugee community are closely related to spirituality and religion and this will be discussed briefly. This is followed by a brief exploration of stigma related to mental health problems and increasing awareness of mental health problems in this community. Finally, a brief discussion about the importance of addressing and focussing on resilience is presented. These discussions are brief due to the pragmatic constraints of a dissertation, in terms of time and word limits.

The central role of religion and culture in shaping perspectives of mental health problems in the Somali refugee community in Christchurch has been repeatedly evident from the results. However, it was also evident that pluralistic explanations of mental health problems were prominent, resulting in individuals seeking multiple approaches to dealing with these problems, including traditional approaches and mainstream Western treatments. Some of the biomedical explanations and approaches were not surprisingly more popular in the younger population. Overall, it was clear that participants described a holistic concept of mental health which clearly encompasses multiple domains including religion, family, community and biomedical beliefs. Such holistic concepts of mental health with emphasis on religion and spirituality and collectivist values are common in refugee communities (Simich et al., 2009). This is also well supported in previous research exploring the mental health of Somali refugees (Elmi, 1999; Guerin et al., 2004; Whittaker et al., 2005; Palmer, 2006; Ryan, 2007). This may also suggest that more holistic models of health such as Maori health models (exemplified by *Te Whare Tapa Wha*) may be more applicable to Somali refugees (Durie, 1998). *Te Whare Tapa Wha* is a Maori health model which

depicts health as four walls of a house. The four walls represent spiritual well-being (*Te Taha Wairua*), emotional and mental well-being (*Te Taha Hinengaro*), physical well-being (*Te Taha Tinana*) and family well-being (*Te Taha Whanau*) (Durie, 1998). However, even such models may need to be adapted as the concepts of spirituality are significantly different.

Stigma related to mental health problems was identified as a significant issue in this study like many of the previous studies exploring mental health in Somali refugees (Elmi, 1999; Guerin et al., 2004; Ryan, 2007). Some of the general literature on stigma in mental health problems is also of relevance and will be discussed briefly. The results showed that there is clear evidence of stereotyping of people with mental health problems in the Somali community. Individuals with mental health problems were stereotyped as unpredictable with a propensity for violence and incurable. Such attributions to mental health problems have been well documented as contributing to stigma in previous studies (Corrigan et al., 2000). The dichotomised view of mental illness in the Somali community exacerbates the rift between "us and them", contributing to public stigma and the labelling of *walli* is seen as socially undesirable. There is also much evidence of self stigma and shame associated with mental illness in the Somali community. The significance of shame and self-stigma as an internalisation of public stigma is well described in previous studies (Corrigan & Watson, 2002; Byrne, 2010). It is not surprising that this shame and stigma extend to families and communities given the collectivist nature of their community. This was also denoted as courtesy stigma originally by Goffman (1963) and was described as the negative impact that results from association with a person who is marked by a stigma. Stigma was also identified as a significant barrier in dealing with mental health problems and this has been well described in the literature as label avoidance due to fear of possible consequences (Corrigan & Watson, 2002). There is clearly much work that needs to be done, in terms of increasing awareness of mental health problems to decrease the stigma associated with mental health problems.

As described earlier, participants talked about the importance of increasing awareness of mental health problems among the Somali refugee community in Christchurch. It is important that such health promotion efforts are approached culturally sensitively. It has been described that cultural and religious beliefs such as the belief in Divine Will

and Predestination as well as *jinn* possession are common explanations for mental health problems. As such, it is important that such explanations are not refuted. It may also be necessary to accommodate and encourage spiritual ways of dealing with mental health problems such as prayers and Quranic readings. This is crucial because as previously described most Somalis believe that the ultimate source of all healing is from *Allah*. Medications and other conventional Western treatments for mental health problems may be approached as an alternative means of dealing with mental health problems which can suffice on its own or may be done in parallel as part of dealing with the mental health problems. In terms of decreasing stigma, it will be important to increase awareness about the treatability of mental health problems and normalise mental health problems. Such awareness programmes to address stigma have been well described in previous literature (Hinshaw & Stier, 2008). Such programmes in Somali communities should also emphasise the concept of a spectrum of mental health problems as well as address the myths about dangerousness associated with mental health problems (Hayward & Bright, 1997). In terms of the process of conducting such awareness programmes, it will also be important to approach the elders of the Somali community first and involve them in such awareness programmes.

On a different note, the concept of resilience has been increasingly gaining prominence in the general mental health literature as discussed in the literature review. The concept of resilience is of special significance in refugees and some authors have convincingly argued for a paradigmatic shift in terms of the central role of resilience in refugee health and mental health (Muecke, 1991, Watters, 2001). The participants of this study identified religion and spirituality as well as family and community supports as important factors contributing to resilience in this community. These factors are consistent with the few other studies exploring the factors related to resilience in the Somali refugees (Whittaker et al., 2005; Ryan, 2007). The factors relating to resilience are not only important at an individual level in terms of their ability to cope with stressors and optimising function, but also have important implications at a public health level in terms of contributing to decreasing inequalities and empowering communities (Friedli, 2009).

RECOMMENDATIONS

Having discussed important conceptual issues, the recommendations of the study will now be presented. As discussed before, there were also significant suggestions made by the participants about ways of improving the mental health of the community as consistent with the participatory methodology. These suggestions along with findings of this study and previous literature form an important part of the recommendations of this study.

The first recommendation is to increase the awareness of mental health problems among the Somali community in Christchurch. This is likely to decrease the stigma surrounding mental health problems in the community and enable people to access treatments for mental health problems. It is also important that health promotion efforts towards increasing the awareness of mental health problems are approached culturally sensitively within a holistic framework as discussed earlier.

Secondly, it will be important to increase awareness of Somali culture and religion among health professionals to foster better relationships between health professionals and services with the Somali community in Christchurch. Participants commented on how simple steps such as learning a few Somali words or phrases can facilitate in building trust and improving the relationship with health professionals. It is also important that health professionals are aware of cultural and religious ways of dealing with mental health problems to better accommodate and facilitate this.

Thirdly, it is recommended that an adequate number of trained Somali interpreters with gender balance, be provided to address significant language barriers. Furthermore, as language barriers have significant wider implications such as unemployment, it is recommended that ongoing English language classes be provided to the Somali refugee community, especially during the initial phase of resettlement.

Fourthly, it may be important to train local Somalis from the community to act as focal points in the community to bridge the language and cultural barriers with health services. These individuals could have an important role in increasing awareness of mental health problems in the Somali community. This is also important to foster

better relationships between community and health services, while empowering the community.

Lastly, it is also recommended to focus on strengths and promote factors relating to resilience to improve the mental health of the Somali community in Christchurch. The central role of factors such as religion, family and community support in resilience has been discussed. It will be important to provide assistance to build cohesive local Somali communities with the chance to practice cultural and religious beliefs.

DISSEMINATION OF RESULTS AND FUTURE RESEARCH

Being a participatory research process, the write up of the dissertation is not the most significant end-product. Dissemination of the research forms a very important part of the participatory process. There have been ongoing discussions with the community about the different ways of disseminating the results obtained from the study. The community would also like to present the findings to the local and wider Somali community in New Zealand. It is also planned to present the findings to mental health professionals with representatives from the community. There had also been discussions about presenting the findings to the local refugee services and wider national refugee services. The community has also expressed an interest in expanding on this research and taking this further.

This research was necessarily exploratory and there is significant scope for future research. Similar methodological principles can be used to expand the research to include increased sample sizes. It will be interesting to test some of the findings of this research with bigger focus groups. It may also be important to focus on specific population groups within the Somali community such as a specific gender or age groups. It may also be worthwhile exploring the aspects of stigma further by exploring these issues in individuals with mental health problems as well as families of individuals with mental health problems. Last but not least, it would be interesting to conduct similar research in the Somali language.

CONCLUSION

Despite the exploratory nature of this research, it was able to show significant findings in terms of the central role of culture and religion in the perspectives of mental health problems in the Somali community in Christchurch. Most of the findings are consistent with previous research done in other Somali communities in New Zealand and other countries. Perhaps it has added to the existing research in terms of an increased understanding of the pluralistic explanations of mental health problems and different ways of dealing with mental health problems in the Somali community. More importantly, it has been a very positive learning experience for me, in terms of conducting qualitative research and more specifically using a community based participatory research methodology. I am hopeful that this small study has been beneficial for the Somali community in Christchurch and look forward to continue working with them.

APPENDIX A : Information Sheet for participants

Study Title: Perspectives on Mental Health of Somali Refugees in Christchurch, New Zealand

1) Researchers

This study is carried out as part of Masters of Public Health degree (University of Otago) in collaboration with the Somali refugee community in Christchurch.

Interviewer
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2) Introduction

We are carrying out a study looking at Somali views regarding mental health in the Somali refugee community in Christchurch. You are invited to take part in the study. You can make up your mind about whether to take part in the study over the next week, and you do not have to take part.

3) About the Study

- *What are the aims of the study?*

The study aims to explore the Somali views regarding mental health in the Somali refugee community in Christchurch. We are interested in exploring Somali views about what it means to be mentally healthy or mentally unwell and find out about community experiences of mental health and your experiences with health services regarding mental health. We are also interested to know about what you think about health services with regard to mental health.

- *How are the participants selected?*

The participants will be selected in consultation with some of the Somali community members.

● *What will I need to do?*

You will be interviewed by Dr. Arif Mohamed. The interview will roughly take about 1 hour and the time and place will be to your convenience and negotiated with you. Any place is appropriate as long as it is reasonably quiet, comfortable and private.

● *Am I able to have an interpreter?*

Due to practical reasons, we have limited participants to those who speak reasonable English. As such, an interpreter will not be provided. However, you can have a support person with you during the interview if you wished.

● *What about privacy and confidentiality?*

It is important to note that that the interview will be recorded. However, we will ensure your privacy and confidentiality. This information will **ONLY** be accessible to the researchers from the University and **WILL NOT** be accessible to the community.

● *Will participating in the interview cause me any problems?*

Some of the discussions during the interview may be potentially distressing. However, we will ensure that information is gathered sensitively. It may be that some of the participants need help with some of the issues discussed. We will try and guide you in the right direction to obtain the most appropriate help. You are welcome to contact Dr. Arif Mohamed or Ahmed Tani (contact numbers as given above) to discuss any concerns afterwards. If you feel that this is not appropriate and if you feel distressed, you can contact the Psychiatric Emergency Service (Contact No. 03 3640482/ 0800 930092) and this service is FREE.

● *What are the benefits?*

We hope that the information gathered will be helpful working towards improving the health of the Somali refugee community in Christchurch.

● *Will I receive any reimbursement of expenses?*

We will reimburse you $25 to cover your costs and your time.

● *What about the results?*

The results will be formally published and submitted to the university. There will be a delay of about 6 months for the final results. You are welcome to have a summary of the results if you wished to do so. We will also be discussing with the community about other helpful ways of making the results available

4) Participation

Your participation is entirely voluntary (your choice). You do not have to take part in the study and this decision will not affect your future care or treatment

You can withdraw your consent at any time you wish. You also do not have to answer all questions and you may ask to stop the interview at any time.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact an independent health and disability advocate:
Free phone: 0800 555 050, Free fax: 0800 2 SUPPORT (0800 2787 7678)
Email: advocacy@hdc.org.nz

This study has received ethical approval from the Upper South A Regional Ethics Committee, ethics reference number URA/10/09/066. Please feel free to contact the researchers or the community contact if you have any questions about this study.

APPENDIX B : Interview guide

A broad interview guideline had been formulated in collaboration with the community members. It is important to note that these questions are only a guide. The specific questions used in the interview will not be fixed and will be largely follow the course of the interview.

Introductions

- Introductions
- Check for further questions regarding information about research from first meeting (meeting organised for giving information about study and introductions)
- Check again about informed consent, reassure confidentiality (Taping begins)

Demographic information

- Age, Home and family situation
- Arrival status (Quota refugee/ family reunion/ asylum seeker)
- Years in New Zealand, Current occupation

Perceptions of mental health

- Explore perceptions of mental health (Think of someone in your community who has good mental health. What makes them mentally healthy? What does mental health mean to you?)
- Explore what might be important factors for mental health
- Explore possible similarities and differences with New Zealand views
- Perceptions of mental illness (What does it mean to have a mental illness in your community? Possible different types?)
- In your community, what causes would people attribute to mental illness?
- How are people with mental illness viewed in the community?

Experiences of mental health

- Explore experiences of mental health in the Somali community in Christchurch (Individual experiences, Experiences of family and friends as well as general community members)
- Explore experiences of mental illness in the Somali community in Christchurch (Individual experiences, Experiences of family and friends as well as general community members)
- How was mental illness dealt with in the Somali community in Christchurch? Is this similar or different to how this would have been done back in Somalia?
- Experiences of health services and mental health services in Christchurch
- Explore possible barriers to utilisation and access of health services

Recommendations regarding health services and mental health of the community

- Explore any recommendations regarding health services and mental health services in Christchurch. What can change their experiences? What will be important for the community
- Explore recommendations regarding improving understanding of Somali culture for health professionals
- Explore recommendations regarding awareness of Somali community regarding availability of health services
- Explore recommendation regarding mental health of the Somali community in general

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