Perceptions of Mental Health in the Somali Community in King County, WA: A Community- Based Participatory Research Project

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Abstract

Perceptions of Mental Health in the Somali Community in King County, WA: a Community-Based Participatory Research (CBPR) Study

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Seattle's metropolitan area is home to the third-largest Somali community in the United States(Census Bureau, n.d.). Many refugees experience mental health repercussions as a result of fleeing war, famine, other violence in their home countries, as well as stresses associated with resettlement including language barriers, culture shock, unemployment, and adapting to western societies. The challenges facing Somali immigrants and refugees throughout King County are complex and contribute to significant unmet mental health needs. Using a Community-Based Participatory Research approach, this study explores the Somali community's perceptions of mental health and access to mental health services in King County, WA. We conducted key informant interviews and focus groups made up of mental health providers, religious leaders, and Somali community members (new arrivals, men, women, and young adults [age 18-25]. This study finds a significant gap between the Somali community's and the western biomedical sphere's mental health perceptions and approaches to treatments. The Somali community commonly utilizes traditional and religious practices and perceives western services as lacking culturally appropriate services that address their mental health needs. To address this gap, the authors recommend the development of cultural humility in western services, including mental health services adapted for the Somali population; collaborations with and mental health awareness among local Imams and community members; and the creation of community workshops aimed at destigmatizing mental health.

INTRODUCTION AND BACKGROUND

There are 65.6 million people who are forcibly displaced around the world, 22.5 millions of whom are refugees(UNHCR - The UN Refugee Agency, 2017). Most refugees are displaced due to adverse and traumatic events such as war, persecution, violence, and natural disasters. Forced displacement has been increasing since the mid-1990s; according to the United Nations High Commissioner for Refugees 1 in 113 people globally are forcibly displaced. Three countries account for half of the world's refugees: Syria at 4.9 million, Afghanistan at 2.7 million, and Somalia at 1.1 million(United Nations High Commissioner for Refugees, 2016).

Kimayer, et al explains the refugee migration patterns in three phases: pre-migration, migration, and post-migration resettlement. Each of these phases presents multiple factors that can affect the mental well-being of refugees. During pre-migration, many people experience trauma and a loss of social support and security(Kirmayer et al., 2011). In migration refugees may live in harsh conditions, be exposed to violence, and experience uncertainty of their future. Lastly, in post migration many feel a loss of social status, unemployment, difficult acculturation, and discrimination(Kirmayer et al., 2011; Miller & Rasmussen, 2017).

Previous studies have found that refugees are at high risk of developing mental health conditions due to the cumulative trauma they experience, and additional stressors and adversity faced in host countries(Cardozo, Talley, Burton, & Crawford, 2004; Fazel, Wheeler, & Danesh, 2005; Kirmayer et al., 2011; Miller & Rasmussen, 2017; Onyut et al., 2009). Common mental health diagnoses among refugee populations include post-traumatic stress disorder (PTSD), major depression, and anxiety(Miller & Rasmussen, 2017). A systematic review of refugees resettled in western countries found that refugees are ten times more likely to have PTSD compared to the general population. The study suggested that one in ten refugees in western countries have PTSD, one in twenty have major depression, and one in twenty-five have generalized anxiety disorder(Kirmayer et al., 2011). Furthermore, these diagnoses can have long-lasting impacts on individuals. For example, a study conducted among Cambodian refugees showed that 62% of participants suffered from PTSD and 51% suffered from depression two decades after the initial trauma(Marshall, Schell, Elliott, Berthold, & Chun, 2005).

The first Somalis arrived in the United States in the 1960s as immigrants seeking employment and educational opportunities. The second wave of Somalis arrived in the United States in the 1990s as refugees fleeing a civil war. Since the civil war, over 1 million have been forcibly displaced internationally and another million are internally displaced. Many of these refugees resettled in Minnesota, Columbus, Seattle, and San Diego. Today, these cities still have the highest numbers of Somali immigrants(King-ries, 2014).

Much like other refugee groups, many Somalis experience hardships during their migration process such as exposure to torture, loss of loved ones, and hunger(Bhui et al., 2003). These hardships have long term impacts on Somali refugees' lives and mental health. According to the World Health Organization, 1 in 3 Somalis living in Somalia have experienced mental health illnesses(UNHCR - The UN Refugee Agency, 2016). Other studies have suggested that Somalis experience PTSD at rates ranging from 33%- 80%(Bhui et al., 2003; Kroll, Yusuf, & Fujiwara, 2011; McCrone et al., 2005; Onyut et al., 2009). A 2010 study among Somali refugees living in

Minnesota estimated a prevalence of mental health conditions at 80% in Somali men and 60% in Somali women(Kroll et al., 2011).

Despite the prevalence of mental health conditions among Somali migrant populations, there is limited mental health research and literature done on this issue, specifically on the Somali community of South King County in Washington State. Much of the literature found on this immigration experience uses traditional research approaches where researchers decide the topic, questions, and methods, then go into marginalized communities to extract the needed data, analyze, and interpret the data themselves, often without any input from the community involved. This approach tends to create tensions between researchers and community members and may affect quality of the data due to community members not feeling comfortable. We believe a research approach that addresses this problem is the Community-based Participatory Research (CBPR) model(Collins et al., 2018; Cornwall et al., 1995; Meredith Minkler, Analilia P. Garcia, Victor Rubin, & Nina Wallerstein, 2012; Wallerstein & Duran, 2010).

In this study, we use a CBPR design to perform a baseline analysis of perceptions and service availability of mental health services for the Somali community in King County, WA, which is home to the third-largest Somali community in the United States(Census Bureau, n.d.). We sought to answer questions such as: 1) What are the perceptions of mental health and mental well-being in the Somali community; 2) What are the perceived underlying causes of mental health problems in the Somali community; and 3) What are the facilitators and challenges in accessing mental health services?

METHODS

The Partnership:

This project was developed after many members from the Somali community in South King County highlighted the high prevalence of mental health conditions in the community and a lack of resources to address these concerns. These members requested the assistance of the Somali Health Board (SHB), a King County-based nonprofit organization whose mission is to improve the health outcomes of Somali immigrants and refugee communities through partnership development with health systems, health and social service providers, the Somali community, and Somali health professionals.

In collaboration with the University of Washington Department of Global Health and Health Alliance International, an international public health organization based in Seattle, SHB conducted a CBPR project exploring perceptions of mental health in the Somali Community. Our study was conducted in three phases: 1) Soliciting input for the study design from community members and steering committee; 2) Data collection (Key Informant Interviews [KII] and Focus Group Discussions [FGDs]); 3) Community round tables to verify data.

By using a CBPR approach, we wanted to focus on issues identified as priorities by the community, as well as to engage community members and researchers in an equitable partnership to utilize community knowledge, resources, and expertise the community has to offer, Figure 1 highlights what steps we have taken to incorporate CBPR approaches into this study. CBPR has eleven principles (Appendix A) which were adapted for this study(Meredith

Minkler et al., 2012; Wallerstein & Duran, 2010). A few we relied on include building on the strengths and resources within the community, creating a collaborative and equitable research partnership, fostering co-learning among all partners, disseminating findings and knowledge, and striving to address health inequalities. These principles are synergistic with the Somali Health Board and aligned with their mission to build community capacity and have community members and Somali Health Professionals at the center of healing themselves and their community. Furthermore, these principles helped build trust between community members and reach partners which combated the stigma surrounding the sensitive topic and further creating richer dialogue within the community.

Figure 1: CBPR Principles Used in This Study

<u>Steering Committee</u>

A standard participate of CBPR research is to create a steering committee. In our study, our steering committee was comprised of Somali Health Board members, health providers, and Somali community leaders. Members for this group were selected by the Somali Health Board based on their leadership roles in the King County-area community and in-depth understanding of community mental health. The purpose of this group was to mitigate the inherent power imbalance between researchers and community members by ensuring members of the community were involved in making decisions on the project. In addition, this group provided an opportunity to foster co-learning by sharing knowledge, resources, and expertise. This committee reviewed research design and provided critical feedback prior to data collection.

<u>Pilot Group and ethical review</u>

We also hosted a pilot group with 10 community members. We asked the group to look at the list of questions for the Focus Group Discussions (FGDs) and provide feedback on its cultural sensitivity and address any gaps in the interview guide. The updated guideline was included in

our IRB application with the University of Washington Institutional Review Board. This study was declared exempt by the IRB Exempt.

Study Population:

Key Informant Interviews (KII)

We conducted sixteen Key Informant Interviews. Key Informants included both Somali and non-Somali individuals. The purpose of the KII was to gather information about the Somali community's perception of mental health, causation of mental illness, and access to mental health services. Individuals were selected by Somali Health Board based on their subject expertise and experience with working with Somali community member in the Seattle Metropolitan Area (See Appendix B for list of Key Informants). The PI emailed potential participants explaining the research project (research question, study design, and goals for the future) and invited individuals to take part in the project. The PI also made follow up calls to set up meetings. A semi-structured questionnaire was used and covered topics such as participants' role in the community, their understanding of the community's perception of mental wellbeing and causes of mental health conditions, types of mental health services the community utilized, the community's perception of western services, and suggestions for how to support the health needs of the community. KIIs ranged from 60-90 minutes and generally took place at the work place of the individuals, though three interviews were conducted by phone. The PI received verbal consent from these participants to conduct the interview and audio record the sessions. The interviews were conducted in both Somali and English. In addition, the PI took field notes during all the sessions.

Focus Group Discussions (FGDs)

The second portion of the data collection included 9 FGDs with 5 to 13 participants at each session. In order to elicit broad community perspectives, focus group discussions were conducted among several categories of respondents including mental health providers, religious leaders, and Somali community members (1 new arrival group, 1 religious leaders group, 1 session with mental health providers, 2 men groups, 2 women groups, and 2 young adults groups [age 18-25]. Due to cultural gender concerns, we decided to separate men and women in the older groups. This decision was made because traditional Somali culture can be patrilineal, and male dominated(Shepard,2008). There were two youth sessions which included individuals ranging from 18-25 years old. These sessions were conducted with youth due to generational differences and language barriers between young adults and older adults. There was one new arrivals group which included individuals who have lived in the United States for less than five years to find out the perception of individuals who have recently relocated to South King County compared to those who have lived there for a decade or two. There was one session with religious leaders. The Somali community is a strong faith-based community and Imams often council members of the community, so we wanted to include the religious leaders in the research process. There was also one session with mental health providers to give another perspective of available mental health service.

FGD participants were recruited from referrals by local organizations serving the Somali community, snowball sampling, and from community events. For more details see Appendix C. Sessions were held at Somali Health Board offices, Somali Family Safety Task Force, and Buena Casa Apartments in Kent, WA. Focus group discussions lasted from 90 to 120 minutes. Most

focus groups were conducted by a Somali-speaking facilitator and were conducted in Somali; however, the youth group and the mental health provider FGDs were conducted primarily in English. During the sessions members of the research team took detailed field notes documenting the conversations.

Two FGD guides were used to facilitate the discussions, one for Somali community participants and the other for mental health care providers. The interview guide for Somali community participants asked questions regarding their definition of mental health, types of mental health services available, challenges/barriers individuals with mental health issues face, their perception on psychotropic medicine, and suggestions for how to strengthen current mental health services. The mental health care provider FGD guide included questions regarding mental health challenges refugees and immigrants in King County face, types of services available, how Somali community members access these services, their experiences with serving the Somali community, and suggestions for how to strengthen current mental health services.

Community Round Table

CBPR principles emphasizes the importance of bring the data back to the community. We conducted community round table to discuss data findings in an accessible manner, collect input from the community on data accuracy, and create an opportunity to commit to addressing the community's mental health concerns.

During this session, the Primary Investigator presented a high-level overview of the data findings in Somali. Following this overview, six community members facilitated discussions with community members to explore issues of data accuracy and recommendations for addressing community mental health needs. At the end of the meeting the community members had the opportunity to join the SHB Community Mental Health Task Force. The Mental Health Task Force will translate research findings to develop community led interventions to address mental health concerns. This event was the final step in our data collection.

Participants who took part in the individual interview and focus group sessions provided written consent. The Primary Investigator (PI) explained the consent document and process orally in Somali for those who did not speak or read English. In addition, the PI collected verbal consent for the audio recording of the sessions. Participants who took part in the FGD, KII, and community round tables were provided a $25 gift card as a small compensation for their time. Gift card amount was determined by the Steering Committee.

Data Analysis

KIIs, FGDs, and community round tables were all audio recorded and a member of the research team took detailed field notes. The field notes were then transferred to an online qualitative data analysis software, ATLAS.ti. Two members from the research team who took part in the data collection process went through the audio recordings and read the field notes to develop an initial codebook with thematic codes. One of these members was the PI, a Somali native. The other was a Caucasian research assistance whom has experience with Somali community. They then coded the documents independently and then met regularly to clarify definitions and refine the codebook.

RESULTS

Knowledge and Practices about Mental Health

Knowledge

Many of the participants described mental wellbeing in three distinct levels of mental health: *Caafimaad* (Well), *Waalli* (crazy), and *Wallida Khafiifka ah* (”soft crazy”). These categories were described by all FGDs and KIIs with the exception of mental health professionals and younger participants, who talked about mental health as a spectrum rather than as distinct categories. All the groups expressed challenges explaining mental health wellbeing and conditions due to a lack of specific terminology in the Somali language.

***Caafimaad* (Well):**

Those who are perceived as “well “are seen as functioning, which was described as taking care of themselves and family and able to maintain relationships with others. Those who are well were also described as not showing any mental health symptoms, such as a change in attitude or mood, acting outside one’s character, not sleeping, paranoia, violence towards others, and memory loss. A respondent explained caa*fimaad* as,

> *“We don’t have a fixed understanding of what mental wellbeing looks like. However, those considered healthy work, take care of their families, and engage society. In Somali, we say “*Qof dadku nabad ku qabaan*” meaning society is not bothered by this person. As soon as a person starts fighting or yelling at their neighbors or other members of society they are considered sick”* (Key Informant)

***Waalli* (Crazy)**

Participants described *waalli* as the complete opposite of ca*afimaad,* those who are no longer functioning and present obvious mental health symptoms. These individuals were labeled as people who “lost their mind” or were “disconnected from reality.” A participant explained *waalli* as,

> *“This out of bounds area known as* waalli *(crazy) is identified when a person is no longer able to function in social norms. For example, if a person has decided to no longer wear clothes. Another example says hello to a person and they scream instead of greeting the person back and…. this is their typical response”* (Key Informant)

***Waallida Khafiifka* (“Soft Crazy”)**

The final category shared by the general population was labeled as *Waalida Khafiifka* (soft crazy). *Waallida Khafiifka* was characterized as a step before the person becomes crazy. These individuals show early symptoms of mental illnesses but are currently still functioning in society. One participant stated,

> *“We as a community don’t see things in a binary way…the metaphor ‘*Qofkii Jimcada waallan raba Khamiista ayaa laga gartaa’ *(those who are going to go crazy on Friday, we see the crazy in them on Thursday) meaning we can tell when someone is going to turn crazy.”* (Somali Man)

Early symptoms used to identify these people include talking to themselves, memory loss, and acting out of one's normal character. Another respondent referred to this state as,

> *"They have the* 'waallida khafiifka ah' *(soft crazy). The illnesses is nearby for them… they start talking to themselves and are absent from reality."* (Religious Leader)

Limited Mental Health Language

Participants also noted a lack of specific terms in the Somali language to describe mental wellbeing and mental health conditions. An example of this includes the way another participant describes postpartum depression.

> *"In Somali they say* 'Umusha ayaa shaydaan ku maray' *meaning a devil went inside the pregnant women to refer to extreme postpartum depression that is mixed with a psychosis."* (Key Informant)

Participants also mentioned describing physical symptoms that might occur at the same time as a mental health issue. One respondent said,

> "*Due to lack of definitions for mental health conditions, it is the symptoms that are discussed rather than the conditions themselves."* (Mental Health Provider)

Attitudes about Mental Health

Respondents shared that mental health is considered a taboo topic and perceived as a *"tragedy, something that is not wanted, and shameful"* (Somali Woman). These attitudes have been perceived by the mental health provider community as well, as one participant expressed,

> *"Somalis' perspective and standpoint of mental health is still negative; people don't see it as something that could be cured or shared. Every family feels ashamed…. and sees those with illnesses as a lost cause*" (Health Provider)

Another participant explained,

> *"We have a lot of terms to describe those with illness '*wuu waalanyahay', 'qulub buu qubaa', 'wuu isla hadlaa', 'dharkuu dihgtay*' all of which are demeaning and hurtful. Especially those with more severe illness are extremely mistreated and dehumanized".* (Key Informant)

However, health professionals and young participants shared a more complex understanding of mental health describing various stages and using western terminology to describe the stages (DSM-5). The group described mental health conditions faced by people who don't show symptoms and are functioning, including conditions such as anxiety and depression. A younger participant shared,

> *"With the older generation they haven't really been taught like the different kinds of mental illnesses, so I figured it'd be hard for them to identify if a person has depression*

or if you have anxiety and stuff like that...They wouldn't look at the person and see the signs and make the connections." (Younger Somali Community Member)

Causes of Mental Health Conditions:

Some participants (including men, women, religious leaders, and new arrivals) identified five main causes of mental health challenges: *Jinn* or *Jinni* (spiritual possession); *Sixir* (black magic); *il* (evil eye); weak *Iimaan* (piety); and trauma and challenges in host country. Mental health professionals, younger community members, and key informants generally did not associate mental health conditions with these causes; rather they cited biology, genetics, exposure to trauma, cumulative stress, and drug usage.

***Jinn* (Spiritual Possession)**

Jinn, which is a belief that is present in Somalia and came with some participants through the migration process, was described as a spiritual possession that has the capability of causing mental illness. It was described by one participant as,

> *"Spiritual creators similar to humans that are invisible to the human eye but follow and possess people…They live in bathrooms, toilets, and garbage areas… one should protect themselves from* Jinn *by making a* dua *[prayer]".* (Religious Leader)

Another participant further explains *Jinn* as,

> "*The difference between* Jinn *and other causes of mental health is the Jinn is something that is inside you and will speak over the person...I remember when I was younger I saw people who had another person speaking over them. This was the* Jinni*, the* Jinn *would say their name is, where they followed this person, and what they want from this person."* (Key Informant)

***Sixir* (Black Magic)**

Respondents described *sixir* as an intentional curse individual cast on others causes people to have mental health conditions. A participant stated,

> *"*Sixir*, is a man made. For example, there was this beautiful girl...and one day she become sick… Later, we found out that a man who become in love with her did witch craft to curse her. Or let's say there is a person who you don't like. If you're an evil person you will go to a* sixirloow*(person who specializes in* sixir*) and ask them to curse the neighbor for you."* (Key Informant)

***Il* (Evil Eye)**

While *sixir* was described as an intentional curse, *il* is often cast subconsciously, often as a result of internalized jealousy. One respondent explained *il* as,

> "Il *(evil eye) is close to* sixir *but people cast this illness without going to a* sixirloow. *If this person admires what you have and instead of say mashallah they look at this thing with envy and will cast* ill*…For example if a guy loves a woman and is always thinking*

about her then his admiring can cause mental health problems …many times if you're not careful you can make people sick without your knowledge." (Key Informant)

Weak *Iimaam* (Faith)

Participants defined weak *Iimaan* as punishment from God resulting from lack of spiritual faith or connection. One respondent shared,

> *"Sometimes it's believed that the person didn't have* iimaan *(faith). An example of this is when someone's family member dies and the person has a mental health breakdown. It's believed that if this person had a strong* Iimaan *and believed in Allah then they wouldn't have the mental health breakdown"* (Key Informant)

Another participant further explains this concept as,

> *"You're not close to god, your spiritual [state] is lacking, you need more Quran…If you prayed hard enough, maybe, you would rid yourself of this illness".* (Somali Woman)

Trauma and challenges in host country

The last main cause participants discussed is trauma from the war in Somalia and challenges in their current host country such as unemployment, discrimination, harassment, and unaddressed basic human needs (housing, food, etc.). One participant expressed,

> *"In our community mental health is a big issue because of the circumstance we lived through...our community destroyed each other...we went through a lot of hardship at refugee camps, we went through unimaginable atrocities among ourselves and...the new land that we came into the United States was not an easy transition."* (Key Informant)

Other causes:

In contrast, the younger population, key informants, and health professionals associated mental health conditions with genetics that can run in the family, and biological and chemical imbalances. While most focus groups believed drugs such as alcohol, hookah, and marijuana have caused a mental health condition, key informants, health providers, and young adults stated drugs were a coping mechanism to deal with mental health challenges, rather than a cause.

Practices:

For the most part, respondents shared those whom are suffering from a mental health conditions ("crazy" or "near crazy") seek religious practices such as Quran reading and prayer to treat symptoms of mental illness. Secondary to these practices, community members stated seeking assistance from general practitioners for treatment. If these services did not cure the person, many expressed sending individuals back home (to Somalia or Kenya) for psychic and traditional healing. Many participants mentioned they do not seek assistance from western mental health services due to a general distrust of many western treatments. We found that youth and Somali health professionals reported that they more likely to pursue western forms of treatment alongside religious healing practices.

Religious practices

The primary location participants shared they receive their services from local mosques. One respondent shared,

> *"We are Muslim so first and foremost we must turn to the religion…people start with the faith, Quran recitation, Quran healing."* (Somali woman)

Religious leaders explain why they are the community's first response as,

> *"We are the first response for mental health treatment, we have the community trust."* (Religious Leader)

> "*There are some things doctors are not familiar with but we are (religious leaders) and that is spiritual passion and evil eye."* (Religious Leader)

The treatment provided by religious leaders was described by one respondent as,

> *"The religious leaders read Quran, make prayers, and perform a ritual to take out* Jinn *and* Sixir*…the person is put in the middle and religious leaders gather around to read Quran."* (New arrival)

Another participant added to this explanation by stating,

> *"Before they* [*religious leaders] read Quran on them [the person seeking healing] they [religious leaders] beat them up and throw holy water on them…it's believed that this treatment punishes the* jinn *and will cause them to runaway."* (Key Informant)

Secondary to religious services respondents shared turning to the general health providers to seek care for the physical symptoms of their illnesses. A respondent stated,

> *"First we try the Quran remedies, but after that doesn't work, then people seek medical treatments."* (New arrival)

Traditional Treatment

If the previous two forms of treatment didn't work, respondents stated that many Somalis might choose to go back home to either Somalia or Kenya and seek treatment from traditional healers and psychics.

Respondents explained traditional healers provide individuals with herbs such as garlic and "*Xabbad-Sawda*" (Black Seed Oil)" to bathe, drink, and/or rub their body with. They also perform a ritual called "*Mingis*" or '*Boorane*", where traditional healers sing and drum songs to the individual as a form of removing the mental health condition.

> *"You go this person and they ask you to find something specific such as unique animal or special feather and once you bring this item you join a ceremonial party with other*

people who are sick. During this party you are asked to drink specific drinks, dance to music, and by the end of this party the person is believed to be cured" (Key Informant)

Respondents explained psychics known as "*Kitaab-gaablow*",

"[Pyschics] read the person and guess what's going on with them…It's believed they might get access to the individual's written qaddar (destiny) by using 'jinn.'"
(New arrival)

Participants explained that the "*Kitaab-gaablow*" uses the information learned by the *Jinn* to predict how the person became ill. A respondent shared,

"Kitaab-gaablow is like a magician. They have a special book. The Kitaab-gaablow diagnoses people by looking into their book and provide solutions to cure yourself. They might tell you to move from your neighborhood, or they will tell you that someone cursed you because you did something wrong to them so go and apologize".
(Key Informant)

Concerns with Western Medicine

Many of the respondents stated those with mental health conditions do not use western medication due to fear it will exacerbate their issues or change the person's personality. A participant stated,

"The sick back home talk to people and themselves but here the people are quiet and alone… this happens because of medicine, back home no one gets medication."
(Somali Woman)

Another respondent stated,

"The majority of the community is scared or hate the medication. They think that the medication will make them more crazy." (Somali Woman)

Similarly, a male participant shared,

"We [Somali people] *refer to them* [western providers] *as bag fillers, instead of helping cure the illness they just give you a bag of pills."* (Somali Man)

Furthermore, they mentioned counselling or therapy services are unknown or foreign to the Somali community. However, participants shared a utilization of their own therapeutic services such as conference calls for women and coffee shop gatherings for men.

Different Perspective:

In contrast to the general response, younger participants, health professionals, religious leaders, and key informants emphasized the importance of western services and shared they are more likely to utilize these services. One participant expressed,

> *"There are two schools of thoughts in the Somali community, those that have lived here for a long time/born here and the older generation/educated people. The older generation believe medication exacerbates the problem, pharmaceutical companies just want to make money and they don't understand the concept of therapy and are not open to trying it. The other group understands the need for such services and seek help."* (Key informant)

Similarly, a mental health provider shared,

> *"The ones that come in and continue to seek services are the young people. The young folks are more acculturated to this culture and have no problem sharing they have depression or anxiety".* (Mental Health Provider)

In addition, this group encouraged the community to seek a combination of religious, cultural, and western services. One participant stated,

> *"The first thing people go is- seek quranic treatment. There is no doubt that it is very beneficial, Quran is healing for all kinds of sickness. However, Allah has created sickness and its remedies...quran does not reject or contradict to seek medical treatments, rather it is encouraging this".* (Religious Leader)

Religious leaders particularly highlighted the challenges of being able to determine what services a person needs (western or religious) and the lack of mental health services at the mosque. One religious leader said,

> "*We have a hard time differentiating what illness required medical treatment or religious treatment...This is hard to do because the symptoms could present themselves in a similar manner and many times we don't know what path to take to figure out if the person needs our help or doctor's help."* (Religious Leader)

Similarly, another Imam shared,

> *"When someone is ill, they go to the mosque for help. However, at the mosque we don't have mental health offices. We can only provide religious services."* (Religious Leader)

Facilitators and Barriers to Accessing care:

Participants shared various barriers that prevent them from accessing care when faced with a mental health challenge. These barriers are faced at the individual level, the community and family level, and structural barriers.

Individual:

Internalized Stigma

Participants shared that stigma exists within various levels of the social environment and keeps individuals from seeking care due to fear of being alienated. A respondent stated,

"People don't want to ask for help because we are so prideful and mental health is seen as a weakness...we're very hush hush about everything in our culture so if someone in your family is fighting with depression, they (the individual experiencing the mental health condition and their family) *will try to hide it from the community and they won't talk about it."* (Younger Somali Community Member)

Participants expressed an additional barrier to be the perceived notion that one's problems are small compared to the challenges faced by others. A respondent shared,

"Another problem is belittling our own problems. We go to Somalia and see kids hungry in the street, people that live in huts, and we belittle our issues and say my problems are nothing and brush it off." (Younger Somali Community Member)

Masculinity:

Particularly in the older male FGD, respondents shared that there is low utilization of services due to pride, masculinity and not wanting to be vulnerable. A participant expressed,

"Most of our older men have a lot of trauma and it's very hard for them to talk about it and I understand because it's painful and they have been taught all their life not to show emotion...Men don't see help because for them it's admitting a weakness." (Key Informant)

Community/Family:

Stigma:

Due to the negative attitudes towards mental health challenges, participants shared community and family stigma as one of the many significant barriers to accessing services. One respondent shared,

"We say 'what we hear about a person during Asar *(evening), we make fun of them by* Ishah *(night)'. When we hear our neighbor is struggling, instead of helping them we call 8 people to talk about them and not one of them thinks 'let me go over there and help the sister'. This makes people hide their problem."* (Somali woman)

The younger participants expressed parental resistance as a challenge to accessing care. One participant stated,

"Parents can be a barrier. Sometimes the children recognize they have mental health issues, but the parent doesn't want to acknowledge it or take them to where they need to go for help." (Younger Somali Community Member)

Another respondent further explains this challenge as,

"They [Somali parents] *say who are you to complain? You're not dealing with anything. You didn't go through the stuff we went through. And if you're the person feeling this way, you start to feel bad for being depressed and start putting your emotions down."* (Younger Somali Community Member)

Similarly, another young person shared,

> "*Our parents saw their loved ones being torn apart and have been through a lot of things when they get here... so now with our generation- they* (parents and older community members) *are like, what! you guys aren't even going through a lot...they're like, you are only talking about, oh I have so much schoolwork. That's why you're depressed. Blah Blah Blah. Even though it's a real thing. Then they're like, well I saw somebody getting their body parts cut off. I'm still fine and I'm still living. So, you're just belittled for trying to bring up your problems.*" (Younger Somali Community Member)

Structural:
Key informants and health professionals mentioned that various mental health services are available at organizations such as Refugee Woman Alliance, NAVOS, Lutheran Community Services, Asian Counseling Referral Services and Harborview Medical Center. However, participants expressed several barriers preventing them from accessing such services.

Lack of Appropriate Services:
Participates expressed a significant concern as lack of culturally and linguistically appropriate services. Respondents shared,

> *"When it comes to counseling, a lot of people have said that they don't go to counselors because it is usually older white people and they have no idea what I am talking about or understand my culture."* (Younger Somali Community Member)

> *"Most people are not aware of a specific mental health institute that understand the culture and religious background of our patients"* (Religious Leader)

> *"Many of the providers don't take the time understand their clients, they call me in to interpret however, most of my time is spent educating the providers themselves." (Key Informant)*

Fear of Negative Consequences
Another barrier shared by participants is fear that seeking services from western providers will result in negative consequences for them. A participant expressed,

> *"Parents that have mental problems are scared to seek mental attention because they think the system will take their children away."* (Somali Woman).

Similarly, another respondent stated,

> *"Another fear of the community is that if you go to someone, they're going to put that in your record. So, if you ever try to do something, they'll pull up that and say she was crazy or like something wrong with her."* (Younger Somali Community Member)

Lack of Central Community Hub

Respondents noted a lack of a central community hub that could provide a broad range of services was a primary barrier for accessing care. A participant stated,

> "There is nowhere for us, we need our community to support us, there is no Somali place, we need to create a place for the community with our people there to help us". (Somali Woman).

Associated Costs & Physical Distance

Other structural barriers included the associated cost of services and the physical distance of mental health facilitates from people's homes. A respondent stated individuals are *"unable to pay bills…they* (have) *no finance to go see a doctor."* (Key Informant)

DISCUSSION

As mentioned above, there is myriad of negative attitudes and stigma regarding mental conditions. These perceptions add to the existing challenges in regard to having conversations about prioritizing and addressing mental health concerns. By utilizing a CBPR approach and facilitating sessions in the Somali language, the researchers and community members were able to build trust with each other and thus helped develop a more nuanced and productive discussion.

Previous studies found that Somalis view mental health dichotomously – one is either "normal" or "crazy"(Scuglik, Alarcón, Lapeyre, Williams, & Logan, 2007). However, in this study we were able to identify a third category which participants referred to as *Wallida Khafiifka ah* ("soft crazy"). Participants defined this term as an individual who is well *("functioning in society and able to take care of themselves/others")* but showing early symptoms of mental health conditions such as memory loss or acting out of character. Youth and health professionals were also able to identify that even though an individual is "functioning well" can still experience underlying mental health conditions such as depression and anxiety. This broader understanding of mental health is important because it creates an opportunity to create early interventions and encourage members to access such interventions before one's condition becomes worse. Furthermore, this can also be an opportunity to combat the negative attitudes and stigma around mental health.

A major gap identified in this study is the tension that takes place between mental health services that exist within the biomedical sphere and the culturally appropriate methods of services needed by the Somali refugee community. The general population connects mental illness to the evil eye, black magic, spiritual possessions, and lack of piety, and remedies for these causes are largely religious and exist outside of traditional western therapy or psychotropic medicine. Respondents also shared that health care systems do not adapt to address community perceptions on mental health conditions. Furthermore, participants shared these centers lack Somali providers that can provide linguistically appropriate services. This creates an underutilization of western health services and can contribute to higher rates of untreated mental illness.

Due to these specific perceptions of mental health conditions and lack of appropriate services in the biomedical sphere, the community generally perceives mental illness as an issue that

requires treatment from religious leaders (Imams). Imams in our study encouraged the utilization of both religious and western treatment to provide a holistic approach to addressing mental health needs. The community places a great deal of trust in religious leaders and they can play significant roles in encouraging access to mental health services, so religious leaders can play a critical role in combatting the stigma surrounding mental health treatment services.

We also found a marked difference in attitudes between the older populations and the youth groups, as young people freely shared that they actively seek western care. This may be due to their education and assimilation into American culture and society, and young people could help educate the larger community about the importance of seeking mental health care.

RECOMMENDATIONS

In conducting this study, the researchers hoped to learn challenges the community faces when accessing mental health services and seek solutions to address their concerns. Below are a few strategies that can help address the mental health disparities in the community:

- To address the community's barriers to accessing biomedical services, there should be trainings for Western providers to increase cultural humility and bring awareness of the Somali community's perceptions and treatments of mental health conditions.
- To address individual and cultural barriers to accessing care there needs to be a development of community workshops that work towards destigmatizing mental health issues, increase mental health understanding, and bring an awareness of various services available. In addition, there should be workshops tailored to support the mental health needs of the younger population.
- We encourage combining traditional/religious treatments specific to the Somali community as well as biomedical treatment. To further these efforts, there is a need to develop a collaborative partnership between local Imams and mental health providers.
- In addition, there needs to be an increase in the number of Somali health professionals in mental health services. One approach to this is to reach out to younger populations and encourage them to enter the medical field.

The primary strength of this is study is its research approach. By doing a CBPR project, the community was able help shape the project, take part in all aspects of the research process, and have co-ownership of the research findings. Another strength of this study is the Somali Health Board's role in this project. SHB is an organization with native health professionals and are provided a great deal of trust from the Somali community in King County. In addition, the PI in this study was a Somali researcher and many of the sessions were conducted in Somali. This helped participants express themselves in their native language.

We had several limitations in this study including that many participants were recruited using snowball sampling. Since we recruited those who were interested in discussing the topic, we may have missed the perspectives of those who did not want to talk about this topic. These individuals may include those with severe mental health conditions. Furthermore, there may be a response bias in this study. This can stem from the stigma and negative attitudes that surround

this topic and this can prevent people from having open dialogue. The researchers attempted to limit this bias by asking people to not share their personal challenges and speak on the topic from a third-party perspective. Another limitation is this study focused exclusively on the Somali population in South King County and study findings may not apply to other Somali populations in surrounding areas or in other cities.

CONCLUSIONS

The Somali community, much like other refugee populations, have experienced a great deal of hardships throughout their migration process that has led to the development of various mental health conditions. The Somali community in South King County, WA recognized the high prevalence of mental health conditions and lack of resources to address these needs and reached out to the Somali Health Board for assistance. In this study, we sought to understand the community's perception of mental health and access to mental health services. Study findings suggest a gap between the services available in the biomedical sphere and the culturally specific services needed by the community. To address this gap, the authors recommend training for Western providers to increase cultural competence and humility, workshops for community members to destigmatize the topic and build mental health awareness, building partnerships between religious leaders and mental health providers to encourage a combined religious and Western treatment, and increase Somali health professional's employment in mental health services. This study can be a catalyst for the development of culturally tailored programs for the community. Future studies should explore the development of such services and evaluate their ability to address the mental health needs of the community.

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Appendix A: CBPR Principles

Principles for Community-Based Participatory Research

Effective, authentic CBPR aspires to the following qualities:

1. Recognizes community as a unit of identity.
2. Builds on strengths and resources within the community.
3. Facilitates a collaborative, equitable partnership in all phases of research, involving an empowering and power-sharing process that attends to social inequalities.
4. Fosters co-learning and capacity building among all partners.
5. Integrates and achieves a balance between knowledge generation and intervention for the mutual benefit of all partners.
6. Focuses on the local relevance of public health problems and on ecological perspectives that attend to the multiple determinants of health.
7. Involves systems development using a cyclical and iterative process.
8. Disseminates results to all partners and involves them in the wider dissemination of results.
9. Involves a long-term process and commitment to sustainability.
10. Openly addresses issues of race, ethnicity, racism, and social class, and embodies "cultural humility."
11. Works to ensure research rigor and validity but also seeks to "broaden the bandwidth of validity" with respect to research relevance.

Sources: 1-9, Israel et al., 1998 and 2005; 10-11, Minkler and Wallerstein, 2008.

(Meredith Minkler et al., 2012)

Appendix B: List of Key Informants

Organization	Title
1. Somali Health Board	Program Manager
2. Somali Health Board	Board Member
3. Somali Health Board	Community Outreach Worker/ Fund Developer
4. Swedish Medical Center	Medical Interpreter
5. City of Seattle	Community Relations Specialist & Policy Advisor for the Mayor
6. Somali Family Safety Task Force	Executive Director
7. Navos	Therapist/Case Manager
8. Skilled Nursing Facility	Nurse
9. Seattle Children Hospital	Pediatrician
10. Puget Sound Sage	Former Director
11. Abubaker Islamic Center	Imam
12. Somali Community Services	Executive Director
13. Valley Cities	Child Focused Clinician/Adult Therapist
14. Hope Central	Pediatrician
15. Youth Tutoring Center	Center Supervisor
16. King County	Project Manager

Appendix C: Focus Group Sessions

Group	Location	# of Participants	Recruitment Process
Men	Somali Health Board	23-26	Participants in this group, were recruited by a respected elder who is part of the community.
Women	Somali Family Safety Task Force (SFSTF)	24	Participants were recruited by SHB partner, SFSTF. Many of the participants are individuals whom seek services and take part in SFSTF programs.
New Arrivals	Buena Casa Apartments in Kent	14	Participants were recruited by a resident of Buena Casa Apartments in Kent. Many new arrivals are resettled in this housing complex.
Religious Leaders	Somali Health Board	11	Participants were recruited by SHB partner, Abubaker Islamic Center. Many of the respondents were current and past imams at this mosque.
Youth	Somali Family Safety Task Force & University of Washington	11	Session 1, participants were recruited by SFSTF. Session 2, participants were recruited by our PI after an event hosted by the Somali Student Association (SSA) at University Washington. Participants were all members of SSA.
Mental Health Providers	Somali Family Safety Task Force	5	Participants in this group was selected by the Somali Health Board. All participants are Somali providers. Four are mental health providers and one is a general provider.