LAUREA

Somali immigrants' perceptions of mental health

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2010 Otaniemi

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Bachelor's Thesis
November, 2010

Laurea University of Applied Sciences **Abstract**
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The purpose of this Bachelor's thesis was to explore Somali immigrants' perceptions of mental health. The aim was to find out how Somali immigrants viewed mental health, mental disorders and how they would help a person with a mental disorder. The study belongs to the Empowering Work research and development path in Laurea University of Applied Sciences, and the working life partner of the study was Espoo Mental Health Association (Espoon mielenterveysyhdistys ry). Qualitative research methods were used to conduct the study. Semi-structured interviews were carried out to gather the data, consisting of two individual and three group interviews. Altogether twenty-five Somali immigrants were interviewed. Content analysis was used to analyse the data. The findings showed that for example good health, peaceful environment, social support, and ability to practice one's own culture and religion contributed to positive mental health. The two last ones were also considered important when asking about sources of help. Religion was seen important when maintaining health and wellbeing, and when healing illnesses. The informants thought the immigration process in itself was a threat for both physical and mental wellbeing. Furthermore, difficulties faced in Finland or lacking something in life, for example friends or family, were commonly seen as risk factors. Due to their Islamic beliefs, the informants thought that severe disorders, where hearing voices is a symptom, were often caused by the Devil or bad spirits. Overall, the informants' perceptions of mental health and sources of help were similar to those typical in western thinking. However, their perceptions of mental disorders were more related to their culture and religion.

Key words: mental health, mental health disorders, Somali immigrants in Finland

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Tämän opinnäytetyön tarkoituksena oli tutkia somalialaisten maahanmuuttajien käsityksiä mielenterveydestä. Tavoitteena oli selvittää, kuinka somalialaiset maahanmuuttajat näkivät mielenterveyden, mielenterveyden häiriöt ja kuinka he auttaisivat henkilöä, jolla on mielenterveyden häiriö. Tutkimus kuuluu Voimaannuttavan Työn Tutkimus- ja Kehittämislinjaan Laurea-ammattikorkeakoulussa, ja tutkimuksen työelämän kumppanina oli Espoon mielenterveysyhdistys ry. Laadullisia menetelmiä käytettiin tutkimuksen tekemisessä. Puolistrukturoituja haastatteluja tehtiin tiedon keräämiseksi, ja ne käsittivät kaksi yksilö- ja kolme ryhmähaastattelua. Yhteensä 25 somalialaista maahanmuuttajaa osallistui tähän tutkimukseen. Sisällönanalyysiä käytettiin tiedon analysoimiseksi. Tutkimuksen tuloksista kävi ilmi, että esimerkiksi hyvä terveys, rauhallinen ympäristö, sosiaalinen tuki ja se, että pystyy harjoittamaan omaa uskontoa ja kulttuuria vaikuttivat osaltaan positiiviseen mielenterveyteen. Kahta viimeistä pidettiin myös tärkeinä, kun kysyttiin avun lähteistä. Uskonto nähtiin tärkeänä terveyden ja hyvinvoinnin ylläpitämisessä sekä sairauksia parannettaessa. Haastateltavat olivat sitä mieltä, että maahanmuuttoprosessi itsessään oli uhka sekä fyysiselle että henkiselle hyvinvoinnille. Lisäksi Suomessa kohdatut vaikeudet tai jonkin, esimerkiksi ystävien tai perheen, puuttuminen elämästä nähtiin yleisesti riskitekijöinä. Islamin uskomustensa takia haastateltavat ajattelivat, että vakavat häiriöt, joissa sairastunut kuulee ääniä, olivat usein paholaisen tai pahojen henkien aiheuttamia. Kaiken kaikkiaan haastateltavien käsitykset mielenterveydestä ja avun lähteistä olivat samankaltaisia kuin tyypillisessä länsimaisessa ajattelussa. Kuitenkin heidän näkemyksensä mielenterveyden häiriöistä liittyivät enemmän heidän uskontoonsa ja kulttuuriinsa.

Asiasanat: mielenterveys, mielenterveyden häiriö, somalialaiset maahanmuuttajat Suomessa

CONTENTS

1 INTRODUCTION

There are currently almost 156 000 immigrants, i.e. foreign nationals, in Finland (Tilastokeskus 2010a) and the numbers are increasing yearly (Tilastokeskus 2010b). As the numbers of immigrants increase, there has also been an increase in discussion on immigration and immigrants in the Finnish media. However, immigrants' mental health and its problems have not been discussed or studied that sufficiently, although there would be a lot to study. Immigration has a potentially negative impact on mental health (Simich 2009), thus learning about immigrants and mental health is crucial. According to Simich (2009), immigration poses threats to one's mental health and wellbeing, as the process can be very stressful. In a new country one has to learn a new language, a new social system and new cultural rules. And these are just some of the stress factors. Becoming a part of society is a long process, according to Simich, and this poses even more threats for one's mental health. Some immigrants are also refugees, which adds to the risks of mental health problems. According to Ramsay, Gorst-Unsworth and Turner (in Bhui 2002, 150) refugees are at a higher risk for mental disorders than others.

Somalis are one of the largest immigrant groups in Finland (Tilastokeskus 2010b). According to Tilastokeskus (2009b), there are currently almost 11.000 Somalis living in Finland. Somali immigrants, like other people, may have problems with mental health, but they do not seek help as easily as native Finns do (Tiilikainen 2003, 218). Due to war and other difficulties in their home country, Somalis are at risk of suffering from post-traumatic stress disorder and depression. Apart from traumatic experiences, they may not receive enough support once in Finland, which can add to the risks of mental health problems. According to Tiilikainen (2003, 218), Somali families in Finland seem to mainly seek help once the situation is already severe. A person might be psychotic, dangerous to others, or then none of the traditional Somali treatments - such as reading the Koran, the holy book in Islam, or using a spiritual healer - has worked. In Somalia they would have more family to help, but as in Finland there is less, the situation might become severe before the families will seek professional help. For these reasons, it is important to find out more about how Somalis view mental health and how they act when there are problems. That information would be useful for both professionals and non-professionals, so that immigrants could be helped to integrate into society and mental health problems could be prevented or treated at an early stage. Therefore the research questions guiding the study are:

a) What are Somali immigrants' perceptions of mental health?
b) Where do Somali immigrants look for help in a case of a mental health problem?

We have chosen this thesis topic, because it is relevant to our field of study which is social services with the specialisation in mental health and multicultural work. In addition, as we are likely to work with immigrant clients in the future this may add to our multicultural competence. The working life partner in this study was EMY ry (Espoon Mielenterveysyhdistys ry, i.e. Espoo Mental Health Association). EMY ry is an organisation that aims at raising awareness about mental health problems and does preventive work as well as rehabilitative work (EMY 2009b). An employee of EMY ry has conducted a survey to find out whether there is a need to broaden their services for immigrants. The survey examines views of people who work with immigrants. The findings show that immigrants suffer from similar mental health disorders as native Finns. Moreover, immigrants are often left alone with mental health disorders and are therefore at a greater risk of becoming marginalised. (Julkunen 2008). Thus EMY ry has tried to involve immigrants in their activities, but not many immigrants have attended. Due to this fact, EMY ry suggested a thesis topic in order to find out more about immigrants' views on mental health and their need for support.

Overall, the findings of this thesis show that informants' religion and culture had an impact on defining mental health disorders. Furthermore, the ability to practice one's own religion and culture was a crucial factor in maintaining health. Apart from that, factors in maintaining mental health were similar to those in other cultures. Mental health problems seemed to be a sensitive discussion topic for the informants. According to the informants, most of the problems were caused by difficulties they had faced either in Somalia, during the immigration process or generally when living in Finland. It seems that some Somali immigrants are in need of support when adapting into Finland. In other words, they lack information and social networks which then causes illnesses and other problems. The informants seemed interested in participating in various activities in order to stay healthy and be happy in Finland. However, lack of information about the activities as well as language and communication issues make participation often difficult.

2 BACKGROUND OF THE THESIS

2.1 The R&D project and working life partner

The thesis belongs to the R&D (research and development) project "Työn rajalla". This project concentrates on people who are not in regular paid work, such as the unemployed, people on disability pensions, people whose pay is supported by the municipality, and artists. The goal of the project is to empower these people, which means for example increasing their own control over their lives and improving their self-esteem. Organisations involved in the project, EMY ry and Askel for instance, have something in common: their clients are

outside the official labour market or the meaning of work has become an issue in their lives. Specific client groups the organisations have are for example the mentally ill in rehabilitation, substance abusers in rehabilitation, and immigrants.

EMY ry is one of the organisations in Työn rajalla –project and the working life partner in this thesis. EMY ry is short for Espoon Mielenterveysyhdistys ry (Espoo Mental Health Association) and the association was founded in 1985 (EMY 2009a). Its main objectives are to unite and activate people with mental health problems who live in Espoo and the surrounding communities. Furthermore, EMY ry aims at raising awareness about mental health problems and does preventive work, for example publishes studies related to people with mental health issues, and arranges rehabilitative activities. These can be done by EMY's paid staff or EMY's members. EMY ry belongs to Mielenterveyden Keskusliitto (Finnish Central Association for Mental Health) which is an umbrella association for mental health in Finland (Mielenterveyden keskusliitto 2009). The main funding for EMY comes from the Finnish Slot Machine Association RAY and the City of Espoo. In addition, the parishes of Espoo and other co-operation partners provide some funding. Emy also has an employment project called Audentes, that is funded by TE-keskus/Ely (the Centres for Economic Development, Transport and the Environment) (Riikka Koola 2010). (EMY 2009b). There are also several other co-operation partners.

EMY ry has seven units around Espoo (EMY 2009b). To mention some, there are two cafés located in Jorvi Psychiatric Hospital and Aurora Rehabilitation Home, an office in Tapiola for guidance and information, and for most of the activities there are the open member houses Lilla Karyll in Espoo Centre and Meriemy in Kivenlahti. According to Koola (2010) EMY has currently approximately 330 members (statistics from December 2009). They can participate in rehabilitative activities, camps, trips and meetings. Peer support is significant and there are, for example, discussion and activity groups led by persons with mental health problems. In Kivenlahti and Espoo Centre members can participate in household chores and cooking in the mornings and in group activities in the afternoons. However, participation is not compulsory in any activity. The principle is to increase the members' own decision-making and to find their resources. EMY ry does not offer therapy or treatment. Everyone is welcome as diagnoses or referrals are not asked.

2.2 Background of the thesis

This study seeks to find out how Somali immigrants view mental health, its problems and where they look for help in a case of a mental disorder. The point of studying these issues is to produce information that will help EMY ry consider immigrants' needs, when thinking about including them into the activities EMY ry provides. Apart from that, the study aims at offering relevant information to others working with immigrants, as previous studies show that

immigrants do suffer from similar mental health problems as other people, and immigration itself causes a potential risk to mental health (Simich 2009; Tiilikainen 2003, 218). The study concentrates on Somali immigrants' views, as studying more than one immigrant group would be too wide a topic for a Bachelor's thesis. Even though the informants only consist of Somalis, they still represent immigrants and their views can be added to or compared with general information on immigrants and mental health.

To narrow down the topic, it was agreed with EMY ry that we would choose one of the largest immigrant groups in Espoo as the target group. According to Tilastokeskus (2008), these groups are Russians, Estonians and Somalis, when categorized by mother tongue. It is more accurate to look at language groups instead of nationalities because there are, for example, 4919 native Somalis living in Finland, but 10647 people who speak Somali as their first language (Tilastokeskus 2009a, 2009b). From the three largest immigrant groups we chose to concentrate on Somalis, as they were a group we knew least about and therefore had a greater possibility to enhance our multicultural skills and become familiar with this large immigrant group.

As most Somalis are Muslims (Tiilikainen 2003, 35) it also provided a chance to deepen our knowledge about Islam. This is important as we will most likely have Muslim clients in the future when working in the social service sector. It is estimated that there are about 32000-48000 Muslims living in Finland. This estimation is based on information provided by Martikainen (2008, 71). According to Martikainen, only 4800 Muslims have registered to religious communities, and this number is about 10-15% of all Muslims living in Finland (Väestörekisterikeskus in Martikainen 2008, 71). When comparing the amount of Muslims in Finland to all the immigrants in Finland, 121739 (both statistics from year 2006), we find that 26-39% of immigrants in Finland are Muslim (Tilastokeskus 2009a; Martikainen 2008, 71). It is a high percentage, which means it is very likely for us to have Muslim clients if we work with immigrants.

All in all, the study is relevant and needed on a larger scale, as Somalis are one of the largest immigrant groups in Finland (Tilastokeskus 2010b) and not many studies have been made about how they view mental health (for more information on previous studies, see section 4). It adds to our professional growth and, at the same time, others working in similar professions can deepen their knowledge and skills as well. Furthermore, it is a study that EMY ry has requested based on a need they had encountered. Through this study we have a possibility to find out what particular Somali immigrants in Espoo and Helsinki think about maintaining mental health and supporting those who have mental health problems.

3 MENTAL HEALTH AND ITS PROBLEMS

3.1 Mental health across cultures

According to Nordling and Toivio (2009, 84), mental health is a multi-faceted concept and therefore difficult to define. Mental health is affected by a number of factors including genotype, early interaction, life experiences, social relationships and stressfulness of the current life situation. In addition, Nordling and Toivio point out that mental health cannot be measured as it is not an absolute concept, and it varies in the same way as physical health. It is impossible to scientifically define what perfect mental health or the lack of it is. Therefore every individual must define the state of his mental health by himself. However, this may not be possible in the cases of certain psychiatric illnesses when an individual's sense of illness is missing. (Nordling & Toivio, 2009, 84).

Fernando (1991, 76) states that western psychiatry pushes people to think too much about mental illness when they should think about mental health. Despite that, professionals in the field have an idea of what mental health is or should be. Kakar (in Fernando 1991, 76) defines mental health as the situation where one is psychologically functioning, able to manage and direct their own personal as well as social life, is at peace with the way s/he is able to express their own spirituality and ethnicity, and finally, does not have symptoms causing stagnation or inoperativeness.

Fernando (1991) as well as Nordling and Toivio (2009, 85) and Schubert (2007, 75) discuss mental health and mental illness in relation to cultural norms of health, illness and normality. All of these writers seem to agree that culture plays a major role in defining what is normal and what is abnormal. Nordling and Toivio (2009, 85) point out that what is regarded as normal in one culture might be regarded as abnormal in another. Law is the strongest cultural norm in this sense as it states how to act in the case of abnormal behaviour. According to Schubert (2007, 75 & 77-80), normality is mostly assessed through the behaviour and subjective experiences of an individual. However, each culture creates its own definitions and borders for normal and abnormal behaviour. For this reason, normality is assessed through the behaviour of an individual in relation to others. External factors are also considered including an individual's appearance, clothing, cleanness, smell, body language and verbal expression. Moreover, responses to normal and abnormal behaviour vary across cultures. Fernando (1991, 75-76) adds that the above-mentioned cultural norms may be distorted which is shown as racism, for example.

In addition, most views on mental health across cultures include a person's sense of wellbeing and belonging to a group or society. The group or society is defined depending on a person's

identity and worldview. It can be a nuclear family or an extended family, a community, a nation, an ethnic group or the system of ancestors and gods, for example. Therefore spiritual beliefs, ethical values and identity are related to mental health as a whole. Also the current social and political concept has to be considered. (Fernando 1991, 76-77). Another commonality across cultures is that the concepts of health and illness are interrelated. Also madness is recognised in one way or another in every known culture. (Fernando 1991, 78-80).

3.2 Mental health disorders

Before looking at the most common mental disorders in Finland, it is worth discussing what the term mental disorder actually means in Western countries. Without doing so, it might be more difficult to study the perceptions of Somali immigrants living in Finland. According to Fernando (1991, 75), the border between mental health and mental disorder is unclear and therefore it is widely discussed in Western psychiatry. Nordling and Toivio (2009, 84-85) and Schubert (2007, 75-76) link mental health and its disorders to the question of normality and abnormality. In addition, mental disorders can be regarded as subjective experiences of loss, most often meaning the loss of control over one's life. (Schubert 2007, 75-76).

The current American Diagnostic Manual (American Psychiatric Association 2000, XXXI) suggests that mental disorder or, in other words, abnormal behaviour includes a number of characteristics. Firstly, it causes present distress or impairment in one or more important areas of functioning for an individual. Secondly, it increases an individual's risk of death, pain, disability or an important loss of freedom. Thirdly, it is linked to behavioural, psychological or biological dysfunction. Perhaps most notably, it must not only be an expected reaction to a particular event, such as the death of a loved one. (American Psychiatric Association 2000, XXXI). Over the last few years it has become easier to speak about mental disorders. Nevertheless, mental disorders or mental health problems are characterised by labelling, fear, shame, guilt and lack of knowledge. For these reasons, seeking help is often put off. All this can become an emotional burden for the person suffering from the mental health problem and for his or her social environment. (Nordling & Toivio 2009, 85).

As this study looks into mental health problems, some disorders had to be chosen as a basis of the western view. For the purposes of narrowing down the study, five most common mental disorders were chosen. It may have been more interesting to study views on less common disorders but for the purposes of narrowing the study focus and to maximise the usefulness of the findings for EMY ry, the five most common mental disorders were chosen. According to a study done by Pirkola and Sohlman in 2002, at least a fourth of Finns suffer from symptoms that impair their psychological functioning and cause mental distress. The most common

disorders that cause such symptoms are anxiety disorders, clinical depression and disorders related to substance abuse. It seems that these disorders are as common in Finland as in other Western European countries. (Pirkola & Sohlman 2005, 5-6). This information is supported by newer statistics concerning the use of services in Finnish psychiatric hospitals. Five most common diagnoses among patients are schizophrenia, psychoses, bipolar disorder, clinical depression, and anxiety disorders. (Stakes 2008, 11-12 & 108-109). We regard these statistics as reliable sources and a basis for choosing the mental disorders, since they are rather new and nation-wide.

3.2.1 Anxiety disorders

According to Davison, Johnson, Kring and Neale (2007, 122) anxiety and fear are essential in order for a human being able to survive. Anxiety is defined as apprehension over an anticipated problem i.e. a future threat. By contrast, fear is a reaction to an immediate threat. (Davison et al 2007, 122). In the case of an anxiety disorder, anxiety and/or fear have turned from occasional and acceptable reactions into conditions that disrupt the whole life of an individual (Nordling & Toivio 2009, 95). According to Davison et al (2007, 122-123) each anxiety disorder is defined by a different set of symptoms, but high levels of anxiety and/or fear are essential in all of them. In addition, anxiety or fear must interfere with an individual's functioning or cause psychological distress to be diagnosed. The most common anxiety disorders are Specific Phobia, Social Phobia, Panic Disorder, Generalised Anxiety Disorder (GAD), Post-traumatic Stress Disorder (PTSD) and Acute Stress Disorder.

Specific Phobia means an excessive fear of specific objects or situations that is not related to any real danger. Social Phobia therefore means fear of unfamiliar people or social scrutiny. This phobia is particularly common in Finland. Panic disorder includes recurrent panic attacks and anxiety over them. It is often accompanied by Agoraphobia which means fear of being in places where panic attacks may occur. Generalised Anxiety Disorder (GAD) is diagnosed when anxiety is long-term (for at least six months) and extends to most or all areas of everyday life. Acute Stress Disorder is the aftermath of a traumatic event. A person re-experiences the event, avoids stimuli associated with it and suffers from increased distress. Post-Traumatic Stress Disorder is similar but is long-term, whereas Acute Stress Reaction occurs less than four weeks after the traumatic event. (Davison, Johnson, Kring & Neale 2007, 123; Nordling & Toivio 2009, 95-100).

To end this section, a few words about statistics and choosing the anxiety disorder. Even though there are a number of different anxiety disorders, they have many common symptoms. They are also presented as a cluster in statistics and classification systems. For

these reasons, we did not choose just one anxiety disorder for the study, but used symptoms that many of them share.

3.2.2 Depression and Bipolar Disorder

The concept of depression is used in various connections in everyday life, and also its clinical description is multi-faceted. In everyday language, depression means “feeling low”. The feeling usually passes relatively fast. In fact, depression in this sense is a normal reaction to disappointments or set-backs in life. (Nordling & Toivio 2009, 104).

Clinical depression is different mainly because it is a long-term condition. To be diagnosed with depression, an individual needs to have suffered from its symptoms for at least two weeks. However, depression can last from two weeks up to several years. The main symptoms include sad mood or loss of pleasure. They are accompanied with several psychological and physical symptoms such as sleeping problems, changes in appetite and weight, loss of energy, psycho-motor retardation or agitation, difficulty concentrating, thinking or making decisions, feelings of worthlessness and recurrent thoughts of death or suicide. Clinical depression is divided into mild, moderate, severe and psychotic episodes depending on the symptoms and their impact on functional capacity. Clinical depression is the most common reason for people going on early retirement in Finland. (Davison et al. 2007, 230-231; Nordling & Toivio 2009, 104-105).

Bipolar disorder was formerly known as manic-depressive disorder because it includes mood swings from mania to depression (Nordling & Toivio 2009, 127). According to Davison et al. (2007, 233), mania means distinctly elevated or irritable mood. A person with mania typically has, for example, increase in goal-directed and pleasurable activities, unusual talkativeness, decreased need of sleep, flights of ideas and grandiose beliefs of oneself. This leads to reckless behaviour (e.g. spending, driving, substance abuse) and difficulties in social relationships. Mania is often preceded by a hypomanic episode in which the symptoms are milder and last only for a few days. (Davison et al. 2007, 233; Nordling & Toivio 2009, 128-129).

A depressive episode of bipolar disorder is similar to clinical depression. A person with bipolar disorder may also experience mixed episodes, but most of the time episodes are either purely manic or purely depressive. Mood swings may occur rapidly, even within a few days. Often depressive episodes are longer than manic ones, especially when a person gets older. (Davison et al. 2007, 233; Nordling & Toivio 2009, 129).

3.2.3 Schizophrenia and Psychoses

According to Nordling and Toivio (2009, 119), psychoses are the most serious mental disorders. Furthermore, they are different from each other in terms of symptoms and factors that have caused them. Psychoses can occur as such or they can be symptoms of diagnosed mental disorders such as schizophrenia, bipolar disorder and psychotic depression. Also alcohol is known to induce psychoses. (Nordling & Toivio 2009, 119).

Psychoses are characterised by a limited or significantly decreased sense of reality. An individual may not always know what is true or untrue. For example, he can hear voices but cannot be sure whether he or someone else makes them. Also other perceptions can be distorted or an individual may suffer from hallucinations. A person who is in a psychosis often regards life as chaotic, frightening and unpredictable. Therefore his speech or behaviour may not make any sense to other people. Getting treatment at an early stage may be difficult because a person who is in a psychosis does not have a sense of illness. (Nordling & Toivio 2009, 119).

As mentioned earlier, psychoses may occur in connection with schizophrenia. The diagnosis of schizophrenia has existed for over a century. It is the most researched serious mental disorder but still we are far from understanding it. Before the first psychosis, most people with schizophrenia go through a period of other symptoms including obsessions, mood swings, cognitive and behavioural changes, illogicalities in thinking and speech, emotional withdrawal and loss of pleasure. The symptoms can last up to five years before the first psychoses occurs. These symptoms, in addition to psychotic experiences, belong to the main symptoms of schizophrenia. Also lack of emotional expressiveness or, in contrast, inappropriate expressiveness are common when suffering from schizophrenia. (Davison et al. 2007, 350; Nordling & Toivio 2009, 122).

Schizophrenia is divided into sub-types according to its symptoms, their onset and prognosis. Globally, symptoms seem to be quite similar. However, patients in developing countries have a more acute onset and a more favourable cause. Schizophrenia may sometimes begin in childhood but usually the onset is in late adolescence or early adulthood. (Davison et al. 2007, 350 & 356; Nordling & Toivio 2009, 120-122). The symptoms do not only have an impact on patients' lives but also on the lives of friends and family. This also applies to other mental disorders. All too often this leads to marginalisation, loss of friends and social isolation. Depression and substance abuse are particularly common among people with schizophrenia. About half of them try to commit suicide during the course of their illness. (Davison et al. 2007, 350; Nordling & Toivio 2009, 124-125).

4 SOMALIS' VIEWS ON HEALTH ISSUES AND HEALING

4.1 Previous research

In this section the thesis concentrates on previous studies on how Somalis view health, mental health and their methods of healing illnesses. Marja Tiilikainen has researched Somali women living in Finland. According to her research (2003), Somalis have very different ways of seeing illness than western people do. Her examples mainly consist of physical illness, not mental, but they give us an idea of how Somalis living in Finland think. Mulki Mölsä, on the other hand, has researched ageing Somalis and has some information on how they view mental health disorders (2009).

Both researchers' findings are presented in this section giving a foundation for what Somalis think of health and mental health. It is just as important to look at Mölsä's research as it is to look at Tiilikainen's. Even though Tiilikainen has little information on mental health, her research is valuable to this thesis as Somalis might talk of other illnesses when actually talking about something that we perceive as a mental health disorder (Mölsä 2009). For example, someone might talk about back pain, when, according to western thinking, they would really be talking about a mental health disorder, like depression (Mölsä 2009; Tiilikainen 2003, 198-206). For this reason it is important to study the illnesses that Somalis recognize and have. It was also thought beforehand that knowing the names Somalis use for illnesses could be useful in interview situations, if they would mention any in their own language. We were expecting this as it was already seen in both Tiilikainen's (2003) and Mölsä's (2009) research.

Marja Tiilikainen only researched Somali women, thus her results only tell us how Somali women perceive health issues. As Mölsä researched both genders and does not mention if information is from females or males, we can only refer to Somalis when using her findings. This may make it seem like no males have been researched even though it is not true. However, we do not know the female-male ratio in Mölsä's research. Sometimes Mölsä's and Tiilikainen's research seemed to have slightly contradicting results, which can perhaps be explained by the gender factors. Mölsä also researched ageing Somalis, i.e. people over 50 years of age. These older Somalis may have different views compared to younger generations. It could also be due to sample sizes, which we have no information on.

Apart from Mölsä's and Tiilikainen's research, there will be a few references to a smaller research conducted by Anniina Jokinen and Marjaana Virtanen in 2005. They did four theme interviews and one group interview on the topic "Somali immigrants and Finnish health services – how do they meet". The study was done for a university course. Because of the

nature of that research, it being much smaller than the other two and done by students, we will only be using it to support what Mölsä or Tiilikainen have found out, not as a major reference.

4.2 Health issues

According to Somalis the cold air in Finland causes problems such as bronchitis and sinusitis, along with various muscle, stomach, and back aches. The coldness and darkness cause people to become tired and have a lack of energy, which Somali mothers find difficult to deal with. This is an issue that was not present in Somalia, and some mothers may feel incompetent in handling these new problems. Pain is a definite sign of something that is wrong. Somalis may sometimes talk about pain when they are talking about their fatigue. Fatigue may be more difficult to admit. (Tiilikainen 2003, 198-203). In Tiilikainen's own conclusions she notes that Somali women often seem tired, but in the Somali culture an ideal woman is "capable, entrepreneurial and strong" (Abdalla in Tiilikainen 2003, 203). It is a weakness to show one's emotions to the husband or his family, and speaking about fatigue earns a label of being lazy. It is easier to say they have some kind of an ache, and then have a nap to cure that ache. (Tiilikainen 2003, 203).

Somali women feel alone when they are mothers. In Somalia they had help from their own mothers and women who were not mothers yet. In Finland young females are not interested in helping and many do not have their own mothers in Finland to support them. Fatigue is strongly connected to being a mother, but also to being in Finland. In Somalia the mothers were not tired. One reason to this is that in Finland women are expected to take part in some activities or study Finnish. (Tiilikainen 2003, 203-204). Fatigue is a way to mask other issues even among Finnish mothers. Marja-Liisa Honkasalo (in Tiilikainen 2003, 205) found out that Finnish women found it easier to speak about fatigue than depression or insecurities and fears. According to Tiilikainen (2003, 206) if Somali women speak about not being able to sleep, it is often a sign of depression and stress.

In Tiilikainen's research there was little mention about a Somali illness called the "Evil Eye" (see section 4.3) or any illnesses that have to do with sorcery or witch craft (Tiilikainen 2003, 207). On the other hand Mölsä (2009) found that Somalis do get Evil Eye in Finland, but fails to mention any so called spiritual reasons to getting sick. In reasons why people become mentally ill she mentions "Zar" and "Jinn" (see 4.3). Other reasons to mental disorders Mölsä found in her research are chewing khat, drinking alcohol, unhealthy or non-fresh food, jealousy (polygamy), forced marriages, having unsafe sex, if you do not exercise, poverty, environmental disasters, civil war, losing a loved one, impotence, infertility, and loneliness. As for new causes, i.e. what Somalis have noticed in Finland, are unemployment and

neighbours who verbally abuse. Tiilikainen (2003, 200 & 202) also mentions the affects of war, people who have said mean things and lack of fresh food causing illness. Tiilikainen's research mainly suggests that these cause illnesses such as heart disease or pains, whereas Mölsä's list was purely for what causes mental disorders.

4.3 Illnesses described by Somalis

"Evil Eye", also known as "ILL", "inkaar" or "habaar" (Mölsä 2009; Tiilikainen 2003, 207) caused illness in Somalia, but some Somalis are unsure whether it causes problems in Finland. According to Tiilikainen Evil Eye is a way parents can curse their children if they have been bad or neglected their duties towards their parents. The curse causes various illnesses, disablement and bad luck or disasters in life. (Tiilikainen 2003, 207). Mölsä lists some diseases that are seen as caused by Evil Eye: rash, stomach ache, fainting, children vomiting, sting of a nettle, lactose intolerance and allergies. Mölsä also talks about inkaar as a word that means one needs to respect their parents, and if parents are disappointed in the child's behavior or words the child gets inkaar.

Spirits are believed to cause illness in the Somali culture. One of the best known spirits is "Jinn" (Mölsä 2009). Jinn is something that causes illness, but it also helps to, for example, diagnose urine or blood samples in Somalia. Jinn can enter someone and cause illness, and one can catch it from another. According to Tiilikainen (2003, 208) Jinn always states if s/he is the cause of the illness. For example one woman had symptoms that matched Jinn, but it was caused by cursing or sorcery, as Jinn did not come up. When treating Jinn the whole family gets treated. If Jinn is the cause of an illness, the person is often violent, throwing and breaking items, screaming, crying and talking non-stop, talking to themselves, hearing voices and may have other mental health issues (Tiilikainen 2003, 215-216 & 238). If a woman has Jinn, she is able to smoke cigarettes, drink alcohol, and do other things women are normally not allowed to do. The explanation is that it is Jinn who is making her do it. (Mölsä 2009). Jinn can also be used as a common name for a spirit, if it is unclear what is in the person (Tiilikainen 2003, 236). Other spirits are for example "Saar" spirits like "Mingis", "boorane", "ruuxaan" and "sharax" (Tiilikainen 2003, 241 & 245 & 247).

"Qalbijab", also known as "albi-fua" and "Niyad-nab", is something similar to our depression, but has some differences to it. For example Qalbijab is something Somalis would not book a therapist time for, it is healed by trying to go forward and with support of others. If women speak of depression in Finnish, they usually mean Qalbijab. (Tiilikainen 2003, 212-214). The word means broken heart or broken mind, but it can also be seen as disappointment, depressive feelings or frustration (Mölsä 2009, Tiilikainen 2003, 212). A person suffering from Qalbijab requires a lot of support, as it can develop into "madness", which is far more

difficult to heal. Support can be for example re-marrying, or someone taking one's children away for a while to let the mother recover. What causes Qalbijab is having to give up plans or dreams, losing a loved one, memories of war and flee, and being a refugee. There are also reasons related to having to live in Finland: not knowing the new culture, unemployment, poverty, living without your family, loneliness, lack of Finnish friends and a worry about relatives living in Africa. (Tiilikainen 2003, 212-214).

"Welwel" is a form of anxiety and similar to Qalbijab, even though more severe. In Qalbijab a person knows what is wrong and it can pass. If someone has welwel, there is something wrong all the time and the person constantly worries or is fearful of something. Qalbijab and welwel can both lead to "waalli" if the person does not receive support, and waalli is often impossible to cure. Waalli is madness, where the soul and body diverge. Waalli is known as psychosis in the western countries. (Mölsä 2009; Tiilikainen 2003, 208 & 215). Buufis reminds psychosis, but it is more like a severe depression symptom and anxiety (Mölsä 2009). The word was developed when people began to move out of Somalia. Another word connected to worry and nervousness is "Walaac" (Tiilikainen 2003, 208). It can also mean speech that is out of control, and the person suffering from it might only able to think about one thing all the time.

4.4 Somalis' ways of healing illnesses

Somalis have their own ways to deal with health issues. According to Tiilikainen (2003, 220) Somalis use the Finnish health care system especially for physical problems. Some mental health and psychosomatic issues are dealt with religious professionals and healers. This happens especially if the illness is caused by a spirit (for example Jinn), witch craft or sorcery. If they cannot find a proper healer in Finland, the ill person can be taken all the way to Somalia for healing (Tiilikainen 2003, 231). Somalis also use friends' advice in curing illness (Tiilikainen 2003, 220).

Reading the Koran helps with many health problems (Tiilikainen 2003, 224). The Koran can be listened to from a cassette, or it can de "read". Reading often means remembering parts of the Koran. Some might recite parts of the Koran into their hand, and then stroke the ill person with that hand. This is done to concentrate the Koran's healing effect to a certain place or even the whole body. In cases of total madness, where the person cannot be helped, they can still be calmed by reading the Koran (Tiilikainen 2003, 216-217). However, some of the Somalis believe "what Koran cannot heal, a doctor cannot heal" (Tiilikainen 2003, 225). However, they still state that the Koran is not medicine, and if a doctor prescribes medicine it should be taken. Tiilikainen researched women only, but Jokinen et al found out similar views in their research. According to Jokinen et al (2005, 43) many Somalis use the Koran as

an extra way to heal themselves, but some of the more religious ones believe it to be the most important healing method. Nowadays apart from listening to the Koran from a cassette or reading it aloud, it can also be listened to from the internet as an mp3 (Mölsä 2009).

Holy water, "tahliil", is also used in Finland. According to Tiilikainen (2003, 228) it is not used as commonly in Finland as in Somalia. According to Mölsä (2009) holy water can be used to treat anything, and it is used by drinking it or washing yourself with it. The ill person's friend can go to the mosque and get the tahliil prepared for the ill (Tiilikainen 2003, 228). Apart from holy water, the spiritual world and rituals are a very common way to heal people among Somalis. According to Tiilikainen (2003, 236) in Finland they are not used as much as in Somalia, and some Somalis even doubt they exist. Some common ways of removing spirits or keeping them happy within the person, are specific rituals done by a "Calaqad". Calaqad is a person who is a master, has achieved "the maximum" and can now heal others (Mölsä 2009). Jinns are often seen as bad spirits, whereas Saars will be fine as long as you keep them happy, for example with certain dances and incenses (Tiilikainen 2003, 236).

Sharax and mingis are two rituals used for healing a person when they have a spirit bothering them. According to Tiilikainen (2003, 241) Sharax is used first and mingis in two years time, but often people want to use parts from mingis already in the first one. Mingis and Sharax are also spirits, but rituals designed for them can be used for Jinn and Saar too. Both rituals can consist of dancing, listening to music, burning incense, aromatherapy and group therapy (Mölsä 2009). According to Mölsä there are five ceremonies but in Finland it is only possible to do two, as there are not enough people who know how to do them. Thus they can promise Jinn to treat the illness better in one to two years, when they reach ceremony number two. Later on they can travel abroad to find a person who can do the last ceremonies. It takes about seven days of dancing to get rid or Saar-Mingis, and the finer decorations and perfume, the better the spirit calms down (Mölsä 2009).

5 CONDUCTING THE STUDY

5.1 Research questions and methods

This study was based on qualitative research methods. Semi-structured interviews were used as a data gathering method and inductive content analysis as a data analysis method. Our aim was to explore the informants' thoughts, opinions and experiences, all of which cannot be categorised beforehand. For these reasons, qualitative methods were more suitable for this study than quantitative ones. These methods were used to find answers for the research questions, which were

a) What are Somali immigrants' perceptions of mental health?
b) Where do Somali immigrants look for help in a case of a mental health problem?

Silverman (2006, 43) notes that qualitative methods give the researcher an opportunity to study such areas of social reality that cannot be studied elsewhere. The focus of quantitative methods is usually on making correlations between variables. Qualitative research, instead, focuses on unstructured data gathering methods and naturally occurring data. The aim is usually to gather data about people's behaviour in everyday situations and basic social processes that affect it. Another aim is to study how a certain phenomena, for example a mental health disorder, is described or constructed by people. (Silverman 2006, 43-44). In qualitative research, as the name implies, the quality of the sample is more important than the quantity. According to Silverman (2006, 19-20 & 43), the purpose is to gain an 'authentic' understanding of informants' social realities. Thus the sample size is often much smaller than in quantitative research. Interviews with open-ended questions are believed to be the most appropriate way to reach this aim. (Silverman 2006, 19-20 & 43).

In addition, qualitative research gathers such data that cannot be defined beforehand or fitted into the researcher's questions (Silverman 2006, 43). This is also what we wanted to do. Our informants had a completely different cultural background to ours and they also had their own life histories, attitudes and beliefs. We could not know beforehand which issues they would raise or what they would not want to discuss with us. Thus we could not use a highly structured data gathering method (i.e. questionnaires). We wished to find out unexpected issues and to learn something new from our informants. We did not want to fall into the trap of believing that we knew everything beforehand.

5.2 Informants

Five interviews were conducted in this study, three of which were group interviews consisting of six to nine people, and two were individual interviews. However, one of the individual interviews consisted of two people, as the informant brought an interpreter who ended up participating as well. All together twenty-five people participated in this study. Two of them were male and the rest were female, ages varying from 18 to 56 years. A rough estimate on the average age among the informants was 30 years. Surprisingly, one of the most difficult questions in the interview was the question of age, as many seemed to be reluctant to tell their age. In all interviews we managed to find out at least who was the youngest and who was the oldest, but in one case the oldest person, aged 45, most likely presented an incorrect age. As the time was limited, we let the question go when she gave that figure, since it had already taken too long to find out.

Most of the informants had come to Finland in the 1990s. The first ones had come in 1993 and the last ones in 2008. Even so, there was not much difference in their language skills. The interviews were conducted in Finnish and in all interviews we had at least one person who could speak Finnish well, or sometimes there were a couple of people who could speak Finnish or English a little bit. The rest, who had to speak through an interpreter, seemed to have no Finnish skills. There were two informants who could speak English and partly commented in English, partly through the interpreter. The interpreter was either one of the informants, or someone who agreed to come and interpret. Whichever way the job was assigned to him or her, the interpreter always participated in the interview by his/her choice.

As EMY ry is located in Espoo, they wished the informants would be from Espoo as well. Thus the informant search took place in all multicultural centers in Espoo. In these centers we only found females, apart from one male. In order to find more male informants EMY ry asked former employees and we asked friends and their friends, who all refused to participate. One male had already agreed, but as we called to give him more information on the topic and to set a date, he immediately refused by claiming he had no time. As the time for the interview phase was becoming too long, and we still needed at least two or three more interviews, it was decided to use a former contact. Thus, the search was expanded to Helsinki, where this contact, an organization that helps immigrants, is located. The assumption was that it would be unlikely to find more male informants there, but after all the previous trouble we knew we did not have time for the efforts it would have needed, and even then it would have been uncertain to find males willing to participate. However, through the organization we arranged two interviews and one of them had a male informant. The ideal gender ratio had been half and half, in order to get versatile and more trustworthy information, but it soon had to be dismissed due to the issues described above.

The first interview took place in a multicultural center in Espoo. There informants had taken part in a Somali mothers' group. There were six women and one of them acted as an interpreter, another woman shared some comments in English. The second interview took place in another multicultural center in Espoo, consisting of the informant and an interpreter she brought along. Both took part in the study. The center had suggested looking in a local school, where this and the third informant were found. The third interview, consisting of one male participant, was held in the local library. The last two interviews we got through the organization in Helsinki. One interview was with their clients, in their space, with a student who agreed to interpret and take part. Nine women came to the interview. The other interview was slightly different. A Finnish volunteer at the organization had many activities with Somalis, and suggested to meet us at a "resident park" (in Finnish "asukaspuisto"). She had clients there and was confident some would agree to participate. From past experience with the interviews we knew that it might be difficult to agree on a place and a time, so we

prepared to do the interview on the spot. The volunteer was very helpful with asking her clients, and soon we had a group willing to take part in the interview on the spot. We had seven informants, and one of them was male. The interview was mainly held in Finnish, but one informant was eager to share her views in English as well.

Our selection criteria had been somewhat tight in order to make sure informants had sufficient knowledge and information on customs and views in Somali culture. Requirements to ensure this were that over half should have been at least 18 years old when leaving Somalia, and all informants should have been born in Somalia. The criteria were met very well. Only in two interviews there were informants who had come to Finland younger than 18 years of age. All apart from one of the informants were born in Somalia. The only informant who was born in Finland came to the interview as an interpreter, but shared some of her own views and experiences as well. The fact that two informants were either born in Finland, or had come to the country very young, did not seem to influence that much the information they were able to provide.

Most of the informants had little or no education. Some had gone through middle school in Somalia, some were studying Finnish here in Finland. One had undertaken general university studies in Somalia, some women had education in child minding, one informant was an engineer, and one was a school helper (or a classroom assistant). Our youngest informant, being born in Finland, had undertaken her schooling in Finland and just graduated from high school (in Finnish “lukio”). Over half of the informants had no education or profession. Some of them answered the education and profession question as being house-wives. This question had to be asked in case there was someone with education that could have influenced their answers, such as education in nursing, social work, medicine or psychology.

According to David and Sutton (2004, 152) the sampling method we used is called purposive or theoretical sampling. This is due to us making the decisions of what kind of people would be useful to interview for this topic, instead of for example randomly choosing them or using snowball sampling. We did consider snowball sampling too. It is, as Atkinson and Flint (in David & Sutton 2004, 152) explain, a technique where the researcher finds one person willing to participate and this person finds another one. Each informant then appoints another informant, and this is how the sample size grows. Snowball sampling is a good technique when the informants are difficult to find. We chose not to use it as it results with a biased sample and makes us dependable on others to find informants. One of us had worked with Somalis before and knew that meeting at a specific time could cause issues. This raised a concern about how would they manage and in what time frame to ask their friends to participate in the research. All in all, it was decided it is better to ask people who might work with Somalis, if we could find informants through them.

5.3 Data gathering

The semi-structured interview method was used when gathering the data for this study. As O'Leary (2004, 163) explains, a semi-structured interview is neither fully fixed nor fully free and is focused on a few themes pre-defined by the interviewer. A draft questionnaire or an interview plan is made before the interviews. However, the style of the interviews is more conversational so that the questions can be answered naturally during the flow of conversation. In addition, this interview method allows new themes and conversation topics to emerge unlike the fully structured interview would do. (O'Leary 2004, 163). These issues have also been discussed by Hirsjärvi and Hurme (2001, 47-48). They add that the topic of the planned questions is the same for all the informants but their order and wording may be changed by the interviewers. (Hirsjärvi & Hurme 2001, 47-48).

Before starting the actual data gathering process, we became familiar with the literature related to mental health and Somali immigrants. Based on the literature, we formulated the research questions and built the ethical framework. When going through the previous research on this topic, it became clear that mental health, and mental disorders in particular, is a very sensitive issue for Somali immigrants. Therefore we had to plan carefully how to approach them with the topic and make them feel comfortable speaking about it. At the same time, we had to bear the research questions in mind. In fact, the first question got changed after we had presented our thesis plan. The question was about mental health disorders instead of mental health. Unless that had been changed, finding informants might have been even more difficult than it already was, given the sensitivity of the topic. The next step was to draw up an interview plan which focused on the themes around mental health and finding help. The plan was presented in a qualitative data gathering workshop at Laurea in April 2010. There it was commented on by our thesis tutors and slightly changed by us afterwards.

The informant search and the interviews were conducted over the same period, from late April till July 2010. We did not want to search for all the informants before starting to do the interviews, because we would not know how much time was required and did not want to keep the informants waiting. For this reason, the first interview was conducted in April, the second and third in June, and the fourth and fifth in July. (See also section 5.2). In each place where the informants were searched for, we first introduced ourselves and our research topic, and then either read aloud the informed consent or gave it for an interpreter to be translated into Somali. (For the informed consent, see Appendix 2). After that, if there were people willing to participate, we agreed on the time and place of the interviews. In the cases

of two individual interviews, the informants gave out their telephone numbers and we agreed on the place and date later.

As mentioned earlier, we conducted three group and two individual interviews. O'Leary (2004, 163) notes that the one-on-one interview benefits both the researcher and the informant. The researcher has some level of control over the process and the informant has the freedom to express his or her thoughts. (O'Leary 2004, 163). Group interviews can be particularly fruitful when wanting to find out what the members of a certain group think about some actual phenomenon. (Hirsjävi and Hurme 2001, 61). During group interviews, we let the group members discuss the posed questions and case examples quite spontaneously. Overall, we were not as directive during the group interviews as we were during the individual ones. One reason for doing group interviews was the fact that most of our informants could not speak Finnish or English, yet they seemed willing to participate. We found that in groups it was easier for people to talk, and even one interpreter pointed this out. A downside was that we had little control on how many people would attend. We tried to communicate that we only needed five people per group interview, but we could not turn people back when they came, without being impolite. In the end it suited the situation well, as sometimes there were informants who had little to say.

Both of the interviewers were present during the interviews and participated equally. Before each interview, the informed consent was read aloud or interpreted and given for the informants to sign. The informants could also decide whether they wanted the interviews to be recorded or not. Consequently, three interviews were recorded using an MP3 player. In these interviews one interviewer took notes on possible non-verbal communication and the other one concentrated on asking most of the questions. In the rest of the interviews, the informants did not want the MP3 player to be on, so detailed notes were taken by both of the interviewers and one interviewer was concentrating more on the non-verbal part. The interviewer, who was asking fewer questions, also supported the other with additional questions or comments if needed. During all the interviews, tea and/or biscuits were offered by the interviewers. However, this was not told before the interviews, as the purpose was not to attract the informants' attention with free tea and biscuits.

The informants were encouraged to speak by using open-ended questions and case examples (see Appendix 1). According to Silverman (2006, 114), open-ended questions usually get more considered answers than closed-ended ones. Moreover, they allow the interviewers to explore such opinions and understandings that cannot be explored through formal questionnaires. Many researchers use qualitative open-ended interviews to explore voices of people from marginalised groups, the voices that have been ignored or suppressed in the past. (Silverman 2006, 114). In our view, Somali immigrants are an example of such a group.

When working with people who are from a different culture, we have to be very careful of our own assumptions and possible prejudices. Jandt (2004, 75) speaks about assuming similarity or difference between two cultures and how that can lead us into making false conclusions. When assuming similarity, for example in how emotions are shown, one might interpret someone showing too much emotion in a certain situation – or lacking emotion totally. Also assuming difference between one's own culture and the interviewee's can affect how the results are viewed. This can lead to a situation where the similarities of the two cultures are not seen at all. Jandt (2004, 75) suggests not to assume anything, but to ask "What are the customs?". This is why we did the interviews as openly as possible and aimed at minimising our influence on what the Somali's thought by using the case examples. Without such open questions, we could have also fallen to the trap of deciding what we wanted to find, and forming leading questions. Furthermore, the case examples were a way to make the situation easier for the interviewees. And as mental health disorders are not known among Somalis (Mölsä 2009), using terms like bipolar or schizophrenia would not help.

At times it was difficult to persuade people to participate, as the topic was very sensitive to some of the Somali informants. To lower the threshold we often suggested meeting at a place the informant was already familiar with, such as the multicultural centre they had been going to. Towards the end as time was running out, we had to interview some people in the park. The park was not the best environment to do an interview in, but if we had not accepted it, we would have had to postpone the thesis or settle with four interviews. In the park, parents were spending time with their children, and we had to find a way to interview them quickly, while they could still look after their children. In the fifth interview, which was done in the organization in Helsinki, the person who agreed to interpret was surprised by the length of the interview, as she did not have much time. The informants were told that the length would be one and a half hours.

Because the two last interviews had to be done faster, we decided to shorten the interview slightly for the two last interviews. Instead of asking "How would you help him/her" and "Where would you look for help" (see Appendix 1: Interview questions), we asked these two questions as one. This shortened the interview time just enough, so we had time to go through all the case examples, before the informants wanted to leave. All in all, the length of all interviews varied between 60 and 90 minutes. The interviews were ended by giving the informants space for questions concerning the study. The informants seemed interested in knowing more about for whom the study was done and what would be its benefits. A few of them asked if they could see the thesis report and gave out their e-mail addresses where the thesis could be sent.

Finally, we want to point out the importance of language and communication. The use of language was particularly important in these interviews as only the interviewers' mother tongue was Finnish and yet Finnish was the language in which the interviews were conducted. O'Leary (2004, 161) emphasises that the interviewer must rely on the informants giving honest and open answers, but still the interview process is influenced by basic attributes such as gender, race and age. For instance, most of our informants were older than us, of lower educational background and of different religion and ethnic origin. For this reason, we had to be careful so that we did not make the informants feel ashamed, offended or judged. Moreover, we had to become aware that misunderstandings and misinterpretations may occur during the interview process. We tried to avoid these by giving the informants an opportunity to ask additional questions whenever they wanted to, and asking additional questions if we felt that we had not understood their answers properly.

5.4 Content analysis

After all interviews were complete, the interviews that had been taped were transcribed. Both of us transcribed them individually dividing the task equally. Before transcribing and during it we agreed upon marking important elements of speech, such as pauses and changes in the tone of voice. With the other interviews that we had only taken notes in, we combined both of our notes in order to get as complete a picture as possible. The method used then to analyse the interviews was content analysis and the coding technique was open coding. Silverman (2006, 20) notes that content analysis is, in fact, more common in quantitative research than in qualitative research, and in qualitative research it is done slightly differently. Instead of fitting the data into pre-set categories, like in quantitative research, the researcher seeks to understand how the informants categorise it and use it in concrete activities. David et al (2004, 191) define qualitative data analysis as "the attempt to identify the presence or absence of meaningful themes, common and/or diverged ideas, beliefs and practices". Both Silverman's and David et al's views are what we kept in mind while coding our data.

According to Strauss and Corbin (1990, 61) open coding is a process where data is first broken down, then examined, compared and conceptualized, and finally put into suitable categories. Conceptualizing data happens through breaking up the data into sentences, events and observations, and giving these a name (Strauss & Corbin 1990, 63). According to Strauss et al, conceptualizing is done by asking questions like "What is this? What does it represent?". In the coding process, similar events and sentences should be coded into having the same name. This reduces ambiguity of codes and the possibility of ending up with many confusing concepts. Kankkunen and Vehviläinen-Julkunen (2009, 138-139) discuss simplifying the data

into codes and give several examples on how to do it. These examples were used as models to the work we did.

Once the interviews were transcribed, both of us coded all of the interviews according to Kankkunen et al's (2009) and Strauss et al (1990) methods. Below are a few examples of the coding process. As the original expressions were in Finnish, the table stating the coding and categorizing process has our translations as the original expression. To see the translations with their original Finnish expressions, see Appendix 3.

Original expression	Simplified expression	Category	Theme
Our religion would do so that we would read the Koran to her.	Reading the Koran onto/for the person	Religion	Sources of help
Then it is read, the person is taken to the mosque and read the Koran.	Going to the mosque	Religion	Sources of help
Perhaps she does not live in her own land, missing home maybe.	Home-sickness	Difficulties experienced in Finland	Factors hindering mental health and wellbeing
When they come here they don't maybe get anything right away.. her child, son, husband.. in Finland this process takes years.	The process of reuniting a family/couple is long	Difficulties experienced in Finland	Factors hindering mental health and wellbeing
It is good to just save your own culture and religion.	Practising your own culture	Ethnicity	Factors supporting mental health
..would try to adapt as well as possible to the current culture. Although you can never, like, forget your own culture.	Adapting to the Finnish culture without forgetting his/her own	Ethnicity	Factors supporting mental health

Once all the interviews were coded, they were compared and discussed. Then the coded interviews were put together, i.e. both of our codes in interview one were joined together and the codes that were seen as best describing the initial information were left. Then the same with the other interviews was done. After all interviews had clear, descriptive codes, it was time to categorize them. Categorizing began with grouping similar items and making suggestions for category names. This method of categorizing was introduced by Strauss et al (1990, 65). According to Strauss et al (1990, 67) naming the categories is mainly up to the researcher. The names should be logically connected to what is in the category and thus quickly remind the person of the content. But apart from that, the researcher is free to

choose the name s/he wants. Strauss et al also mention that in the beginning it is not important to find the category names, as they can be changed later. This is something we found particularly helpful when moving the codes around, as names of categories were changed several times before finding a form that seemed logical enough for us.

Eventually the categories seemed to fit three themes, and within each of those themes, there were three to six categories with sub categories as well. These themes and categories represented the part of the data that we found meaningful, relevant and interesting. Meaningfulness and relevancy were evaluated based on how many times something was mentioned in all the interviews, as well as how it answered our research questions. Some codes had not been mentioned more than once, yet they were connected to the research questions or otherwise found interesting by us.

6 FINDINGS

6.1 Factors supporting wellbeing

This theme was formed from three main categories: personal matters, the surrounding world, and social matters. All of these had sub categories with concepts that had been formed based on the responses from the informants. The sub categories in personal matters are qualities, activities and ethnicity. Sub categories in the surrounding world are environment, and family and friends. The last category, social matters, consists of socializing with others, and responses to the last interview questions. The last questions were about possible interest in activities provided by organisations such as EMY ry, and about any preferences or limitations concerning the subject. These questions were slightly different from anything else asked in the interviews, but as they produced important information and the informants seemed to view them as positive factors for wellbeing, they were added to this theme.

Being healthy, being happy, having an income, being educated, and having your own time were all factors mentioned to describe a happy and healthy person. The English translations of the original questions were not accurate in the way that they already contained the words happy and healthy, but in Finnish this was possible to ask in a different way, the respondents producing these ideas themselves. Most respondents mentioned health and happiness being directly linked to a person's wellbeing, and health was mentioned in all but one interviews.

> *"Ja, kun sinä olet terve. Se on ihan hirveen tärkeä."* (Informant 1/l.1.)
>
> And, when you are healthy. It is so very important.

Activities that one can do or one does to maintain good health and wellbeing, were for example getting up early, keeping oneself clean, thinking about multiple options before making a decision, and trying to create one's dream life with what one has. Sports and exercise were mentioned in almost all interviews, the gym and swimming being the most popular. In one interview it was mentioned that Somali men in particular have lots of time for recreation and activities, as they do not look after children so much.

> *"Ajantasalla aina, pitää herätä aikaisin, syödä hyvin, siistiä pitää olla."* (Group C/Gr.C.)
>
> Being up to date, must get up early, eat well, must be clean.

The final aspect in personal matters was ethnicity. Practicing one's own religion and culture were seen as essential for one's wellbeing. Reading the Koran was mentioned as an example. Some respondents spoke about a balance between adapting to the Finnish culture without forgetting one's own.

> *"Hänellä on tärkeä että on kiinni oma uskonto ja kulttuuri, ja perhe on lähellä, pitää vain muistaa kuka sinä olet."* (I.4.)
>
> To her it's important to be attached to one's own religion and culture, and family near, just have to remember who you are.

Moving on to the next category, the surrounding world, environmental factors were seen as important contributions to one's wellbeing. Living in a positive, peaceful and safe environment was mentioned, as well as keeping your own environment (home) clean. A change of environment, i.e. travelling, was also seen as a positive contribution to one's wellbeing. Apart from this, having family and friends were often mentioned. Sometimes a definition of having a good husband or good friends was added, or having the family living nearby. The important aspect was having people one can trust, tell worries to and get support from. Sharing experiences was viewed important in maintaining wellbeing.

> *"Läheiset oikeasti.. koulutusta.. ja sitten positiivista ympäristö. ... Läheiset semmoset ihmiset jotka voit luottaa satalla sadalla prosentilla ja voit kertoo sun huolet ja voit jakaa kokemuksia ja niin pois päin."* (I.2.)
>
> Close people for real.. education.. and then positive environment. ... Close people the kind of people who you can trust a hundred percent and tell your worries and can share experiences and so on.

In the last category, social matters, there are three sub categories. First one is about socializing with others. Meeting with people and also meeting new people were mentioned by some informants as positive contributions to wellbeing. Talking was seen as important. One informant mentioned s/he calls someone else immediately, when feeling anxious. In one interview it was mentioned that if someone gets sick, they go as a group to try and cheer that person up.

> *”Hän sanoi he juttelevat keskenään. ... Et ku tulee ahdistu, hän sano että minä soitan heti kun minä tunnen pieni ahdistus tietkö.”* (Gr.B.)

> S/he said they talk with each other. ... So when anxiety comes, s/he said I call immediately when I feel small anxiety you know.

Interaction with others could happen through activities that organizations provide. The two last sub categories for social matters are thus preferences for group activities and requirements for groups. Informants listed many activities they felt suited this, such as language lessons, exercise or sports, cooking, sewing, discussion and outdoor activities. Language lessons mainly meant learning Finnish, but some were interested in learning other languages as well. For exercise swimming and gym were mentioned again as examples. However, they were only examples and did not mean they were the only ones these informants found interesting. In some interviews it was stated that anything useful would be interesting. Informants mentioned requirements for groups, if they were to attend. Most were happy to have different nationalities in the group, apart from one respondent who said it would only be good if these others were not racist.

> *“Maybe some few foreign people who are not racist, people who can show love.”* (I.3.)

Mixing males and females in the groups divided opinions. About half did not mind having both genders in the groups, but half of the women would only participate in female groups. Some females added that a male leader would be fine in other than sports groups. Some respondents also mentioned the importance of the place being near. Even travelling to another suburb within Espoo was seen as too far for these respondents, as they do not know many areas and it raises the difficulty level of attending. Others brought up the issue of having to look after children, and mentioned child minders as a requirement for being able to have hobbies or attend groups. One respondent shared views on why some Somali’s might not be interested in this kind of interaction at all. These views included some Somalis having rigid

attitudes towards others, being overly religious, and rather seeking help or support from the Koran.

> *"Paikan pitäisi olla lähellä. Vaikea käydä, jos ei tunne paikkoja. Olisi hyvä olla lähellä."* (Gr.C.)
>
> The place should be near. Difficult to go, if not familiar with the areas. Would be good if it was close.

6.2 Factors hindering mental health and wellbeing

The findings regarding this theme were formed from discussions about the case examples (see Appendix 1). All the case examples described a certain mental health disorder. In the interviews the informants often explained illnesses in their own words, but a few mental health disorders or other illnesses were mentioned. "Mental illness" itself was mentioned a few times, as well as "Buufis" (see illnesses described by Somalis, 4.3). Other illnesses mentioned were schizophrenia, a person going mad, and concentration disorder. An important aspect to the illnesses mentioned is that these suggestions were given only in the case examples of schizophrenia and psychosis. Some said that these cases had been seen in Somalia. In one group interview the informants made a point that the person (psychosis example) had not become ill because of living in Finland, family issues or their life situation, even though in other interviews such suggestions were given. Apart from these few illnesses that informants gave, the theme consisted of five categories: issues before immigration to Finland, difficulties experienced in Finland, cultural aspects, general difficulties in life, and spiritual aspects. Furthermore, difficulties in life included sub categories called a problematic lifestyle and substance misuse, and difficulties experienced in Finland a sub category of issues missing in life.

According to some informants, there were not many mental health problems or illnesses in Somalia before the civil war, but they have increased since the beginning of the war. The informants described traumatic experiences they had been through before their immigration into Finland. Being from a country with war and other trouble itself was seen as a factor that could be harmful to a person's wellbeing. In addition, some informants said the journey from Somalia to Finland was long and often very hard. It could be particularly dangerous for women as they could get raped on the way.

> *"Jotkut, ehkä nuoret naiset somalialaiset, he kulkevat pitkään, kaikki Afrikan maat. Jotkut ehkä kuolevat siellä... Ja aina tapahtuu, kun kävelee Afrikan maat, että naisia raiskataan ja... Sitten tulee tämmöisiä keissejä*

(mielenterveysongelmia).” (Gr.A.)

> Some maybe young women, Somalis, they walk a long way through all African countries. They may die there... And it always happens, when you walk through African countries that women get raped... And then we get these kinds of cases (mental health issues).

The informants spoke broadly about the difficulties faced when living in Finland. Often some of their family members had been left in Somalia and that caused negative feelings. Moreover, home-sickness was a commonly experienced feeling. The process of re-uniting a family or a couple in Finland was found lengthy, thus causing issues with wellbeing. Other difficulties mentioned were loneliness or living alone, having not received enough support, and difficulty getting a residence permit. Experiencing racism in Finland was thought to cause problems for a person’s health and wellbeing. Particularly the racism expressed by employers, social workers and random people on the street were mentioned. The informants had to come to Finland to escape the war in Somalia. They may have expected that Finland was a country where they could live in peace, among other things, but their expectations were not met. Their education or professional degrees were not valued by employers and they faced racism because of their skin colour. That could, in their view, bring on several mental health problems. Often Somalis did not find work even if they were educated. One informant mentioned that a social worker, who shouted and showed racism, could cause depression for a Somali immigrant.

> *”On paljon ihmisiä, joka on ollut Suomessa ja kokenut paljon stressiä ja ongelmia... Somalialainen lääkäri, ollut paljon vuosia työtön Suomessa, ei koulutettu Suomessa. Kun meni takaisin Somaliaan, hän on melkein kaupungin lääkärinä. Sitten hän toimi hyvin, auttaa ihmisiä. Täällä (Suomessa) jotkut sanoi, että hän on melkein sekaisin, ei pärjää. Esimerkiks Rautatientorilla, vain kävelee edes takaisin, kun ei saa työtä Suomessa.”* (Gr.A.)

> There are a lot of people who have been in Finland and experienced a lot of stress and problems... A Somali doctor, has been many years unemployed in Finland, not educated in Finland. When he went back to Somalia, he is almost the city’s doctor. Then he does good work, helps people. Here (in Finland) some said he was nearly crazy, could not cope. For example at the railway station, he just walked back and forth, because he could not get a job in Finland.

A subject that informants kept talking about as a cause to mental health issues was something missing from the ill person's life. Not having a spouse or a partner was the most suggested cause for the illness, but also not having friends was mentioned by many. Lack of a larger extended family, and thus lack of a typical support network for the informants, was mentioned. Others were not having a good neighbour or having lost a loved one.

> *"Häneltä puuttuu niinku, se, ei vain se oma, niinku oma perhe, vaan myös se niinku vanhemmat ja ystävät ja sukulaiset, semmoset niinku, se isompi kokonaisuus, perhekokonaisuus. Joka häntä vois auttaa ja helpottaa tämmösissä.. niinku normaali, niinku arkiasioissa."* (I.1.)
>
> She is lacking like, the, not just the own like own family, but also like parents and friends and relatives, the like larger entirety, family entirety. That could help her and ease these kind of.. like normal everyday things.

There are a few cultural aspects that informants thought to hinder wellbeing in Finland. They often meant living in a place to which a person had not culturally adapted because of a different religion and habits.

> *"Ihminen lähti kotimaastaan, missä ei oo mitään parannuksia kahtakyt vuotta. Sitten tulee uuteen elämään, mikä on erilainen uskonto erilainen käytäntö... Niinni asioita hoidetaan täysin eri tavalla. Jos ei millään pääse, tuota ymmärtämään tätä yhteiskunta tänne niin kyl on sillon jonkunnäkönen mieliterveysonkelma."* (I.2.)
>
> A person left his home country where there had been no improvements for twenty years. Then he enters a new life with a different religion, different habits. Well, things are done in a different way. If he can't, well, get to understand this society, he will then have some kind of mental health problem.

Cultural adaptation was seen particularly difficult for women because of their Muslim clothing. In addition, children's coping at school was a concern for women, because school was a place where different cultures met. For men, being in a different culture could mean losing the position of being the head of the family, potentially affecting his wellbeing. The final aspect to cultural differences was that the culture and people in Finland were seen more introverted, as people would not visit each other as much as in Somalia.

> *"Ja sit on koko aika semmone niinku et on ovet auki, et kaikki tulee aina käymään. Et Suomes on tosi sellane et ollaa sulkeutuneempia, et ilmeisesti ei*

vierailla niin paljo toistensa luona. Et siel on ovet iha jatkuvasti auki.” (I.1.)

And there is a sort of, like, that doors are open, that everyone always comes to visit. In Finland people are much more introverted, and apparently people do not visit each other as much. But there doors are open non-stop.

The informants listed several difficulties in life that affected their wellbeing. These included being unemployed for a long time, being a single parent, having problems with money and having to live in a foreign country. It was mentioned that problems may accumulate, thus potentially causing the illnesses such as in the case examples. It may also be possible that a person’ had a generally problematic life style. For example, a young person would stay up late, eat badly and would not sleep enough. A problematic life style could also mean that a person had too little to do or was jammed inside the house most of the time without hobbies. Women brought about the issue that they had less free time than men did, because they had to look after the children. Sleeping problems, fatigue, fright and stress were mentioned several times during the interviews. It was said that many Somalis were stressed out in Finland.

”Somaliassa ei ollu stressiä. ... Et Suomessa ja mun mielest Euroopas just tulee stressiä aika monelle. Yleensä somalinaisilla on aika paljon siitä ku niillä on monia lapsia ja ne joutuu huolehtimaan niistä lapsista ja kaikkia muusta.” (I.2.)

In Somalia there was no stress. ... In Finland and in Europe, I think, quite many have stress. Usually Somali women have quite a lot of it ‘cause they have many children, and they have to look after the children and everything else.

One of the case examples mentioned alcohol abuse, which often raised strong opinions among informants. Over half of the informants saw alcohol abuse as a direct cause to mental health problems. Many informants noted that drinking alcohol was not a part of the Somali culture, nor was it sold in Somalia. However, some mentioned that they knew Somalis in Finland who would drink because they had problems.

”Voi olla että hänellä on alkoholiongelma. Tämä voi olla että normaali suomalaiselle, ei Somaliassa. Me uskomme että hän on rikkonut islamin usko, niin allah rankaisee häntä.” (Gr.C.)

Could be he has an alcohol problem. This might be normal for a Finnish person, not in Somalia. We believe he has broken beliefs of Islam, thus Allah is

punishing him.

In the above quote the informants mentioned Allah punishing the person, which brings us to the last category, spiritual aspects. In most of the interviews, in cases of a psychosis or schizophrenia, the informants mentioned the Devil or Satan being in the ill person's mind. In one interview the informants said the person had a Jinn inside them, and explained Jinn was a bad spirit. Informants explained that Satan, the Devil or Jinn goes inside the persons mind and shows him or her images and says the voices the person might be hearing.

> *"Ku ihmisellä tulee mieliterveydestä asiat, ni se on se saatana, joka ei hyväksy sitä ihmisen olemista. Ja se puhuu ihmisen korville. Tai se näyttä semmosii juttuja, mitä ihminen ei nää."* (I.2.)
>
> When a person gets mental health issues, it is Satan who does not accept the person's being. And it speaks to people's ears. Or it shows the kind of things that people do not see.

6.3 Sources of help

The third theme of the findings was sources of help, with five categories: Religion, social aspects, municipality and community, free time, and needs based help. The last category had a sub category called positive life changes. The categories were mainly formed from the two last questions in each case example, concerning where the informants would look for help or how they would help the ill person.

Religious practices, such as going to the mosque, turning to Allah and praying, and reading the Koran were all seen as important sources of help. Often religion was the first source to turn to, and in most situations it would be used side by side with other sources. The Koran was considered particularly important in cases where the Devil had gone inside the ill person. Many informants spoke about the calming effect of listening to the Koran, and how it is a medicine for every illness. In more severe cases of illness, informants spoke about getting an imam, i.e. a priest of Islam, to read the Koran onto or into the person. Sometimes a circle of imam's or other people would surround the ill and read the Koran onto him or her until the Devil would leave and the person was healthy. Burning sap in a small dish and taking the ill person to a treatment center in Somalia were also mentioned.

> *"Meidän uskontomme tekisi niin että lukisimme Koraania hänelle. Teemme niin että luemme itsellemme. Uskonto on aina mukana kaikessa."* (Gr.C.)

> Our religion would do so that we would read the Koran to her. We do so that we read for ourselves. Religion is always with us in everything.

Social solutions were almost as important as religion. The most popular responses in this category related to talking to someone or having a discussion with the ill person, and getting support from relatives, family and friends. Many would have helped in finding a partner or a spouse, and introducing the person to one's own friends or otherwise socializing the person. Listening to the person was also crucial. Informants said that sharing experiences with others made life easier.

> *"Ja sit... esittelis hänet niinku omille ystävilleen, et vaik ois kuinka paha jama jos siit saa kertoa jolleki ja kuulee muiden ihmisten niinku kertomuksia niinku omast elämäst ja omist vaikeuksistaan ni sit se helpottuu se oma eläminen."* (I.1.)

> And then.. would introduce the person to own friends, because no matter how bad a situation if one can tell about it to someone and listen to other's stories about their own life's and own trouble, then one's own life becomes easier.

Seeking help from a doctor was the most popular municipal resource mentioned. Talking to a psychologist or a therapist was also quite popular as well as hospital treatment. Help from a social worker was also mentioned. On the whole, doctors and psychologists were seen as people who could analyze the problem at hand and guide the person to additional help. Some informants mentioned that only few Somali's go directly to a doctor. One informant said that the psychologist or the therapist should be someone with enough information on the Somali culture and religion. This informant also made a point that she would much rather speak to a friend than to a psychologist. Sometimes informants mentioned the person needing medicine, and a few times sedatives were specified. Medicine was seen as a part of the solution, but not as the only source of help.

There were not many free time sources of help mentioned by informants, but nevertheless when they were, they seemed important. One informant mentioned gym exercise and how it purifies thoughts and ends stress. Some informants spoke about travelling as means of help. One informant said that leaving the difficult situation and going somewhere else helps.

> *"Mä oon kyl sitä mieltä, et jos meet uuden ympäristön niin se (olo/tilanne) muuttuu. ... Niinni se koskee niinku kaikkee, et jos on pahassa paikassa, ni mene pois. ...mene etelään ja tuu takasin sitte ihmisenä erilaisia ja kaikki asiat on (erilailla)."* (I.2.)

> I do think that if you go to a new environment it (feelings/the situation) changes. ..Soso it has to do with like everything, if you are at a tough spot, go away. ..go to South and come back a person different and everything is (different).

This theme had a category called needs based help. What this meant was finding out what the actual problem was and solving it, or trying to help the person in areas they needed help. For example, if the person's job was causing problems, perhaps changing the job was the solution. Or making sure the person ate properly, or helping them get rest. The sub category consisted of positive life changes, such as finding a new job, breaking the habit of alcohol abuse, help in finding something to do and help in getting the person's family to Finland. Informants also mentioned going back to Somalia as a solution, as it has healed many Somali's. The health issues in Finland might have been caused by unemployment and cultural difficulties, which were fixed in Somalia thus healing the person.

All in all, reading the Koran, going to the mosque, discussion, friends and family, and seeing the doctor were seen as the best ways of helping someone or where to seek help themselves. Many other sources of help were mentioned but these were by far the most popular. Thus we will finish this section with a quote that describes the importance of the support friends, family and relatives can offer.

> *"Somalias oli vähän erilainen maa ku tämä. Somalias ei tarvinnut niinku... äh jos jollain on ongelma niin ei tarvinnu niinku miettii ku kaikilla... kaiki ihmiset tuli yhteen käteen niinku autamaan."* (I.2.)

> Somalia was a slightly different kind of country than this. In Somalia one did not have to.. umh, if someone had a problem you did not need to think 'cause everyone.. all people came together to help.

7 DISCUSSION

7.1 Ethical considerations and trustworthiness

This section begins with ethical considerations, and trustworthiness can be found towards the end of the section. In this study ethical considerations were kept in mind throughout the study to produce equitable and credible information. Any research has the potential to create knowledge, which gives the researcher a position of power. According to O'Leary (2004, 50),

with this power come ethical responsibilities. O'Leary divides these responsibilities into two main categories: responsibilities towards knowledge production and those towards informants. Responsibilities in knowledge production consist of recognizing, understanding and balancing subjectivities, accurate reporting, developing required expertise and acting within the law. Informant responsibilities include the principle of no harm to informants, confidentiality, anonymity, informed consent, respecting the rights of informants and ensuring no harm will come to them from taking part in the study. (O'Leary 2004,50-52).

Accurate reporting means that no misinterpretation or fabrication of results should be done (O'Leary 2004, 51). In attempt to interpret results accurately the informants were asked to clarify any parts we did not understand, and before moving onto the next question the answers were often summarised by one of the interviewers. This gave informants the chance to correct misunderstandings and add important information. We were also very careful with not plagiarising, i.e. we have given special attention to marking references in full. This is a part of acting within the law. Another part of acting within the law is reporting illegal activities that may be found during interviews (O'Leary 2004, 52). However, no illegal activities were discovered during our interviews and we did not have to consider breaking ethical principles. Developing required expertise means familiarising oneself with previous studies, the topic and commonly used methods. This has been done and relevant knowledge has been added to this report into the theoretical part and methodology.

Ethical responsibilities towards informants were achieved in the following ways. Anonymity means that no-one, even the researcher, can identify which respondent has said what (O'Leary 2004, 54). In this study anonymity was not achieved, as it would have been difficult, if not impossible, to do this study without interviewing informants face to face. However, the informants were told their rights and goals of the study before they took part, and they agreed that confidentiality was enough for them. Confidentiality refers to making sure informants cannot be identified from the results and storing data securely. We believe we have masked the identities of each informant well enough, and the data was only used by the interviewers and stored on their personal computers behind passwords. The principle of informed consent means explaining the purpose and goals of the study, research methods being used and the informant's involvement in the study (O'Leary 2004, 53). This includes explaining that taking part is voluntary, the informant has the right to discontinue at any time and no rewards are promised for taking part. A letter of informed consent was drafted according to Laurea Guidelines (see Appendix 2), and presented to the informants as explained in section 5.3 (Data gathering).

When considering the informants, O'Leary states "The interests of the researched takes precedence over any other research goals" (2004, 52). What this means is that the informants

wellbeing and traditions need to be considered before anything else. Research could not be done knowing it would harm the informants mentally or physically, or if it was going to be offensive to them. This is why we familiarised ourselves with appropriate theory beforehand and, for example, tried to avoid the use of words such as “mental health”. However, potential mental and emotional harm is difficult to predict (O’Leary 2004, 53), and no matter how many efforts are done in attempt to try and avoid it, something could still happen. We do not feel that we caused any psychological harm to the informants. The interviews were planned in a way that in the end there were a few lighter questions to lift the spirit, and we had reserved plenty of time in case the informant felt like they wanted to talk about anything related to the topic or the situation. Sometimes informants began to talk about their own difficult situation. In these cases we listened and supported them to our best knowledge.

Respecting the rights of informants is, apart from all that has been mentioned above, respecting cultural habits (O’Leary 2004, 52). The interview situation and the interview itself cannot contain anything culturally inappropriate. From previous experiences we knew that shaking hands was not a part of the Somali culture, so we only shook hands if the informant came to do it. This may seem a minor act, but representing a different culture it was difficult to judge how important it may have been to them. It is impossible to say whether we managed to find out everything we needed to know beforehand about Somali culture, but judging by how smoothly the interview situations went no big mistakes were made in this sense. Informants seemed relaxed and we always allowed room for questions and feedback in the end.

The final part of ethical considerations relates to knowledge production: Recognizing, understanding and balancing subjectivities (O’Leary 2004, 50). This is also a crucial part of validity of the study, as it is about recognising the researcher’s influence to the results (Martyn Denscombe 2003, 274-275). Both O’Leary (2004, 51) and Denscombe (2003, 274-275) mention triangulation as means to verify the authenticity of data, as well as checking researcher’s conclusions with informants. Triangulation is a way to confirm authenticity through multiple sources. What this means, for example, is not only taking note of what the informants say, but also noticing what their body language suggests when they say something. During the interviews we observed any kind of hints in body language that confirmed or was against what the informant had said. Checking our conclusions later with the informants was not possible mainly due to language issues. Most of the informants would not have been able to give their opinion on our final conclusions. Another reason was time. Most of the informants were surprised by how much time the interviews took, so we did not suggest sending the conclusions later on, as it would have required more work from them to check what we had written.

Another part in recognizing the researcher's influence to the results is reflecting on sociological constructs like gender, age, ethnicity and religion (O'Leary 2004, 43). According to O'Leary (2004, 44) gender affects what kind of trust you are able to build between the interviewees, thus affecting what kind of information they actually provide. Us being female would have helped in building trust when interviewing women, but could have posed issues when interviewing men. Somali men could have felt uncomfortable to discuss the topic with a woman. We did not get many male informants, but the ones we did get provided an equal amount of knowledge as the women we interviewed, thus we feel like gender did not have a negative impact in the interviews. Certain attributes in ethnicity, religion, age and education are seen as attributes for power and privilege and others not (O'Leary 2004, 44). According to O'Leary, our informants have many attributes for less power and privilege, such as being from a developing country, being Muslim, being a person of colour, and having secondary education or less. Whereas we had attributes from both definitions being from a developing country and white, yet still being students. Furthermore, one of us is blind. It was difficult to predict if these attributes were going to influence the interview situation, and was the influence going to be positive or negative.

After the interviews we felt like our attributes of less power and privilege had more of a positive impact than negative, lowering power relations, but is that how informants saw us? Or did they see us in a position of power and privilege? And how did this affect their answers? Furthermore, have we interpreted the informants' answers from a western perspective, or have we been able to minimise our influence on the results? Attempts were made to minimize our influence to the results, but we cannot guarantee that we were completely successful, as we are from a very different background than our informants. Despite our possible influence in the results, reliability can still be achieved through laying out all the facts about how the research was done. According to Denscombe (2003, 273-274), a key element in reliability is if someone else could repeat what has been done. Thus describing the methods being used and decisions made is crucial to maintain reliability. Another part of reliability is consistent methods (O'Leary 2004, 59-60). In our study this meant having the same questions for all informants, a similar environment for interviews, and even having same people interviewing each time. Reliability does not indicate results are the truth, it only refers to the methods and results being consistent.

Validity, on the other hand, concentrates on truth and accuracy (O'Leary 2004, 61). Apart from what has been discussed earlier, validity is about having the appropriate methods for the research and being able to justify conclusions. The decisions of appropriate methods have been justified in section 5 (Conducting the study). When discussing conclusions that have been made, we can only speak about perceptions and views these particular Somalis had on the topic. Our sample size was quite small, therefore generalisations for all Somalis cannot be

made. This study merely seeks to show what could a Somali think or do in certain situations, rather than creating all inclusive theory on the topic. This is also what brings authenticity to the study, as authenticity concentrates on the fact that conclusions are justified and credible, not on whether they are "the single valid truth" (O'Leary 2004, 61).

Trustworthiness in this study was measured through criteria O'Leary (2004, 56 & 58 & 63) mentions as key elements of credibility in research: reliability, validity, authenticity, neutrality (recognizing and reflecting upon subjectivities), and auditability (transparency in research methods and decisions). Ethical considerations were done and evaluated based on responsibilities O'Leary (2004, 50-52) mentions as being essential when doing research, supported by views of Denscombe (2003, 273-274). All in all, we believe this study has been done using appropriate measures to ensure trustworthiness and ethicality throughout the process.

7.2 Conclusions

In this section our main findings are summarised and conclusions are drawn from them. In addition, suggestions for working life development and further research topics are given. In summary, our informants' perceptions of mental health were similar to what Fernando (1991, 76) writes about western people's views of mental health. In our opinion, the informants' responses seem to be examples of the human similarity. They could be any person's responses to the question "what makes a person happy and healthy". Also, some sources of help were similar to typical western ones. However, perceptions of disorders were different, and religion had an impact on how the informants saw all three themes in the findings.

According to the informants, both the difficult experiences in Somalia and in Finland had caused a lot of problems with their health and wellbeing. They had escaped the civil war from Somalia, which had already caused issues with some informants' wellbeing, and some ended up with adaptation problems in Finland. Mostly the problems seemed to arise if they did not have possibilities to practice their own culture and habits in Finland or to integrate into society through employment, for example. According to Fernando a common view on mental health across cultures includes belonging to a group or society (1991, 76). Some informants had also experienced racism, which made integration even more difficult. They described situations where they or someone they knew had tried to fit in, but the usual response had been discrimination or racism. Moreover, some of these persons had become mad, and the final cure was to send them back to Somalia although there was still war in Somalia. The reason why Somalia had cured many, was that there they were able to get jobs and they were accepted as a part of the society.

Some of these findings relate to Mölsä's (2009) and Tiilikainen's (2003, 212-214) findings on what causes Qalbijab, the illness similar to depression. The informants did not speak about the case examples using diagnostic labels such as depression, bipolar disorder or anxiety. Rather, they tried to find the reasons behind the symptoms and mentioned often that they knew a similar case either from Somalia or from Finland. The cases of schizophrenia and psychosis were sometimes recognised, though, and called madness by some informants. Buufis, the Somali word describing a severe depression symptom (Mölsä 2009), was also mentioned in the psychosis example. Spirits, such as Jinn and Saar spirits (Mingis, boorane, ruxaan and sharax), were mentioned by Tiilikainen (2003, 241 & 245 & 247) and Mölsä (2009). They were said to cause symptoms such as violent and aggressive behaviour, screaming, hearing voices and other mental health issues (Tiilikainen 2003, 215-216 & 238). Both Tiilikainen and Mölsä found a lot of information on this topic, but in our study a spirit, Jinn, was only mentioned once. Much more common was to mention the Devil or Satan as the cause of the illness. We are unsure what this means; whether these particular Somalis were not familiar with beliefs about other spirits, or whether there are regional differences in belief systems, or some other reason we are not aware of.

Having alcohol abuse as a symptom in one of the case examples made many informants think that the illness was due to the use of alcohol. However, when asking them to imagine that the person had other symptoms before abusing alcohol, more opinions were given. Using alcohol divided opinions among the informants. Some thought that a Somali would never drink alcohol, while others said they have seen or they knew Somalis who did drink alcohol. Often it was seen that alcohol use or abuse creates problems as it is breaking the laws of Islam and Allah punishes the person for it. At first we thought it was a mistake to put alcohol abuse as a symptom, as informants were saying it is not a part of their culture, but in the end it seemed to be a very good idea. Without it, the affects of alcohol would not have been discussed, and as there are also Somalis who abuse it, it is important to know how it is viewed among them. Alcohol does sometimes go hand in hand with mental health problems and based on these interviews it happens within the Somali community as well. However, due to the fact that it is forbidden in their country and culture, it might be a very sensitive topic to discuss.

Sources of help, then, were linked to the sources of good health and mental wellbeing. Religious practices were considered important, and actually the informants would rather seek help from the Koran than by turning to medical or municipal services, or by speaking to an unknown person. According to Tiilikainen (2003, 220) Somalis use the health care system in Finland mainly for physical problems. Mental health issues, especially those concerning a bad spirit, are healed by religious professionals and healers. Evidence of this was also found in this study, as informants described religious practices that made the devil or a bad spirit escape from the ill person. However, if the problem seemed serious to the informant, they

would seek help from both the doctor and their religion. When seeking help from professionals, some of the informants would rather speak to someone who had sufficient knowledge about the Somali culture. In our view, this is an important piece of information for those working with Somali immigrants, regardless of profession.

Another important source of help was social support offered either by family, other relatives or close friends. This is supported by Tiilikainen's (2003, 212-214 & 220) findings, as some illnesses are healed through support and advice from others. Having open doors and visiting each other often in Somalia was mentioned or described in one way or another in most interviews. It seemed to be one of the largest changes in the informants' lives when they had moved from Somalia to Finland. The importance of family, relatives and friends was emphasized by many. Due to the often long processes of reuniting families and couples, people were left alone or felt alone. Loneliness was seen as something potentially causing mental health problems. The informants often did not mention support groups or other solutions the community might offer, but had found some activities to do. These activities were seen as supportive to mental health, and sometime as healing or easing in milder mental health issues. Nevertheless, the lack of relatives was seen as causing mental health problems and the best solution was to reunite the family. This raises the issue of what happens to those who have fewer family members or friends in Finland, and where do they get help from. Ideally the reception centres for refugees and integration services or social services for immigrants would guide these people to additional services to prevent them from isolation and marginalisation. However, it is not in the scope of this study to find out if that happens or how that happens.

As EMY ry was interested in getting more immigrants to take part in their activities, the findings point out some aspects to consider. Overall, informants seemed to prefer activities to discussion groups. Undoubtedly that has to do with mental health being a sensitive issue for them to speak about. Even though most of the informants stated they were happy to attend activities with mixed nationality groups, gender posed an issue. Gender divided opinions in half, and although the sample size was small, this is a significant point. Having some groups for women only might help attract Somali women. These groups could include both Finnish and immigrant women. It seemed important that the informants could be able to share experiences with those who were in a similar situation to them. For example, groups for mothers, young women, unemployed people, people suffering from loneliness or people who are new in the area could be suitable. This supports the findings where informants stated that sharing experiences – positive and negative – supports mental health and makes life easier when it has been difficult. Taking part in such groups could also help with some of the adaptation problems informants described, as they would know Finnish people and be able to communicate with them or ask questions. However, names and themes of the groups should

be carefully thought about so that they would make participants feel comfortable about taking part. For example a group for mothers might be better than a group for mothers struggling with a mental health problem.

Many informants seemed interested in the activities arranged for immigrants and had taken part in similar activities arranged by organisations or multicultural centres. Thus a reason there are not many immigrants coming to EMY ry, could also be the advertising and marketing of the activities. As most informants mentioned doctors as a source of help, working together with the health sector could be a valuable link. If doctors would, even during regular check-ups, talk about such possibilities as the groups that EMY ry offers, perhaps knowledge within the Somali community would begin to spread. In addition, some informants spoke about going to social services for help. So, informing social work professionals about the activities could also help. Apart from marketing, it could be that services that are not directly for immigrants are difficult to recognise as services that are open for all. In other words, immigrants might not realise they also belong to such a category as "all". Most informants were taking part in various activities, but they were for immigrants only. It could be worth finding out, if immigrants perceive the activities and groups that EMY ry and others offer as something meant for Finnish people only.

Along the thesis process, a few possible topics of further research have emerged. One has been mentioned above. Perceptions of the groups and activities could be studied for example through showing leaflets about the activities and recording responses. Also other immigrant groups' perceptions of mental health and illness could be useful to study. As mentioned earlier, the informants spoke about racism and how it may trigger mental health problems. Therefore one possible research topic could be immigrants' or Somali immigrants' conceptions of racism in Finland. This could be taken further by exploring what different immigrant groups think about the relationship between mental health and the experiences of racism in Finland. Alternatively, the topic could be narrowed down to concern only racism expressed by social and health care professionals, for example.

Another research topic could be related to Somali men's perceptions of health and wellbeing, or their coping mechanisms after immigration. That study could be carried out by another immigrant or Muslim man. At least during this thesis process it was noticed that as women it was far easier for us to find female informants than male. Perhaps our ethnic background affected this as well. Studies on the immigration process, how to support immigrants during it, and how the current help system is working or not working, would also be important topics. These topics would help increase knowledge about immigrants and mental health, as well as about the effects of immigration process on individuals and what kind of help the community could offer. These topics, or some of them, have been studied in some degree,

but in our opinion not enough. Especially those immigrant groups that have not been heard should be included in research, such as Somali men, to get a fuller idea of the situation.

This study is valuable for people working with Somali immigrants, but also for those who are still studying to become Bachelors of Social Services or social workers. As the findings show, some of these informants or their friends have had difficult experiences in Finland and not much support. There is a lot that social and health care personnel could do to improve the situation, and provide that missing support. One informant spoke about a racist social worker, who had a very negative influence to her client's wellbeing. Our goal as social workers is to try to help and understand the people that are marginalised, not to turn a blind eye on the situation or make it worse. If the client does not speak about problems, we cannot assume there are no problems. We cannot force people to talk, but we can do our best to create a safe atmosphere for the person to open up. As the findings show, having knowledge about the client's culture and religion was important for some. This study, apart from sharing these Somalis' views on mental health, describes what some Somalis have been through and what they value in life. This is important information for anyone meeting a Somali client for the first time, and perhaps even for those who have worked with Somalis in the past. All in all, this study can help any professional or student to broaden their views and think about what they can do to better consider the needs of Somali immigrants.

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Interview questions Appendix 1

Taustatiedot / Background information

Sukupuoli / Gender:
Ikä / Age:
Asuinpaikka / Place of Residence:
Suomessa vuodesta / In Finland since: ----
Ammatti / Occupation:

Kysymykset / Questions

Millainen on hyvinvoiva ihminen / onnellinen ihminen? (What is a healthy and happy person like?)

Mikä saa ihmisen voimaan hyvin? (What makes a person happy and healthy?)

Esimerkkitapaus 1 / Case example 1: Habiba, 29 v.

Habiba on ollut jo monta kuukautta hyvin levoton ja huolestunut. Häntä huolestuttavat pienetkin arkipäivän asiat, mutta myös esim. oma ja perheen terveys, lasten pärjääminen koulussa ja se, osaako hän varmasti pitää huolta kodista ja laittaa ruokaa. Habiban sydän lyö usein kovaa ja rintaan sattuu.
For several months, Habiba has felt very restless and worried. She worries about even little everyday matters, but also e.g. her own health, the health of her family, her children's success at school and her own ability to do the household chores and make food. Habiba's heart often beats very fast and she also has chest pain.
(Researcher's note: Anxiety disorder, (GAD)

Mistä tässä on kyse sinun mielestäsi? (What do you think is this about?)
Miten auttaisit häntä? (How would you help him/her?)
Mistä hakisit apua, jos sinulla olisi edellä mainittuja oireita? (Where would you look for help, if you had such symptoms?)

Esimerkkitapaus 2 / Case example 2: Omar 35 v.

Omar on ollut monta viikkoa väsynyt ja ärtyisä. Väsymyksestä huolimatta hän nukkuu vain muutaman tunnin yössä. Lisäksi hän on menettänyt ruokahalunsa ja on lähes koko ajan surullinen.
Omar has felt tired and irritable for many weeks. Even though he is tired, he can only sleep a few hours a night. He has lost his appetite and feels sad most of the time.
(Researcher's note: Depression)

Mistä tässä on kyse sinun mielestäsi? (What do you think is this about?)
Miten auttaisit häntä? (How would you help him/her?)
Mistä hakisit apua, jos sinulla olisi edellä mainittuja oireita? (Where would you look for help, if you had such symptoms?)

Esimerkkitapaus 4 / Case example 3: Ibrahim 20 v.

Ibrahim on usein omissa maailmoissaan. Joskus häntä pelottaa, sillä hän näkee ja kuulee asioita, joita muut eivät näe tai kuule. Kun hän kertoo niistä kavereilleen, he eivät oikein ymmärrä. Hänen on myös vaikea keskittyä koulutöihin.

Ibrahim is often deep in his own world. Sometimes he feels scared, because he sees and hears things that others do not see or hear. When he tells about these things to his friends, they do not really understand. He also has difficulty concentrating on schoolwork.
(Researcher's note: Schizophrenia)

Mistä tässä on kyse sinun mielestäsi? (What do you think is this about?)
Miten auttaisit häntä? (How would you help him/her?)
Mistä hakisit apua, jos sinulla olisi edellä mainittuja oireita? (Where would you look for help, if you had such symptoms?)

Esimerkkitapaus 5 / Case example 4: Ismael 48 v.

Ismaelilla on joko tonella hyviä tai todella huonoja päiviä. Hyvinä päivinä hän pystyy mihin vain. Hän tekee suuria suunnitelmia omasta ja perheensä tulevaisuudesta Suomessa, käy ulkona ja käyttää palon alkoholia. Hän myös riitelee vaimonsa kanssa, joka ei ymmärrä hänen suunnitelmiaan eikä sitä, että hän käyttää paljon rahaa. Huonoina päivinä hänelle ei maistu ruoka ja hän haluaisi vain nukkua ja olla yksin.
Ismael has either really good or really bad days. On good days, he feels he can do whatever. He makes great future plans for himself and his family in Finland, goes out and drinks a lot. He also argues with his wife who does not understand his plans nor that he spends a lot of money. On bad days, he has no appetite and he would just like to sleep and be left alone.
(Researcher's note: Bipolar disorder)

Mistä tässä on kyse sinun mielestäsi? (What do you think is this about?)
Miten auttaisit häntä? (How would you help him/her?)
Mistä hakisit apua, jos sinulla olisi edellä mainittuja oireita? (Where would you look for help, if you had such symptoms?)

Esimerkkitapaus 3 / Case example 5: Nasra 39 v.

Nasran elämä on kaaosta. Hän kuulee ääniä, jotka käskevät hänä tekemään pahoja asioita naapureilleen ja joskus hänelle itselleen. On vaikea erottaa, mistä äänet tulevat. Nasraa pelottaa ja hän tuntee hajoavansa.
Nasra's life is chaotic. She hears voices that tell her to do bad things to her neighbours and sometimes to herself. It is hard for her to tell where the voices come from. Nasra is frightened and feels that her soul is falling apart.
(Researcher's note: Psychosis)

Mistä tässä on kyse sinun mielestäsi? (What do you think is this about?)
Miten auttaisit häntä? (How would you help him/her?)
Mistä hakisit apua, jos sinulla olisi edellä mainittuja oireita? (Where would you look for help, if you had such symptoms?)

Miten pidät yllä hyvinvointiasi? (How do you take care of your wellbeing?)

Monilla järjestöillä on ryhmätoimintaa hyvinvoinnin ja terveyden ylläpitämiseksi. Voisitko kuvitella osallistuvasi tällaiseen toimintaan? Miksi? (Many organisations have group activities to maintain health and wellbeing. Could you see yourself taking part in such activities? Why?)

Millaiseen toimintaan sinun olisi helpointa osallistua? (What kind of activities would you find easiest to participate in?)

Informed consent Appendix 2

SUOSTUMUS TUTKIMUKSEEN OSALLISTUMISESTA

Tutkimuksen tekijät: Nicole Gahan ja Sanna Arkko
Tutkimuksen laatu: Opinnäytetyö
Tutkimuksen nimi: Somalialaisten maahanmuuttajien käsityksiä mielenterveydestä
Tutkimustulosten julkaisu: Laurea Ammattikorkeakoulun arviointiseminaarissa suullisesti, sekä raportti kirjan muodossa. Kirja päätyy koulun kirjastoon sekä EMY ry:lle luettavaksi.

Tutkimuksessa selvitetään Suomessa asuvien somalialaisten näkemyksiä hyvinvoinnista, sekä hyvinvointiin liittyvistä ongelmista. Tutkimus pyrkii luomaan tietoa ja lisäämään ymmärrystä somalialaisten näkemyksiin näistä aiheista. Tutkimus tehdään haastattelemalla ja haastattelut nauhoitetaan (vain ääni).

Minulle on selvitetty yllä mainitun tutkimuksen tarkoitus ja tutkimuksessa käytettävät tutkimusmenetelmät. Olen tietoinen siitä, että tutkimukseen osallistuminen on vapaaehtoista.

Olen tietoinen myös siitä, että tutkimukseen osallistuminen ei aiheuta minulle minkäänlaisia kustannuksia, henkilöllisyyteni jää vain tutkijan tietoon ja minua koskeva aineisto hävitetään tutkimuksen valmistuttua.

Suostun siihen, että minua haastatellaan ja haastattelussa antamiani tietoja käytetään kyseisen tutkimuksen tarpeisiin. Voin halutessani keskeyttää tutkimukseen osallistumisen milloin tahansa ilman, että minun täytyy perustella keskeyttämistäni tai että se vaikuttaa asiakassuhteeseeni.

Päiväys

_____

Tutkittavan allekirjoitus ja nimenselvennys

_____

Translating original data Appendix 3

Original expression	**Translation of original expression**
Meidän uskontomme tekisi niin että lukisimme koraania hänelle.	Our religion would do so that we would read the Koran to her.
Sit luetaan, viedään moskeijaan ja luetaan Koraania.	Then it is read, the person is taken to the mosque and read the Koran.
Ehkä hän ei asu omilla maallan, ikävä ehkä kotia.	Perhaps she does not live in her own land, missing home maybe.
Kun he tulevat tänne he eivät ehkä saa mitään heti.. hänen lapsi, poika, mies.. Suomessa tämä prosessi kestää vuosia.	When they come here they don't maybe get anything right away.. her child, son, husband.. in Finland this process takes years.
On hyvä vain säästää omaa kulttuuria ja uskonto.	It is good to just save your own culture and religion.
..yrittäis sopeutua mahdollisimman hyvin siihen nykyiseen kulttuuriin. Vaik omaa kulttuuria ei ikinä voi niinku unohtaa.	..would try to adapt as well as possible to the current culture. Although you can never, like, forget your own culture.