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Abstract

Perceived social support has been correlated with refugees' positive mental health outcomes; yet, little is known about the perceived sources of support after secondary migration to new-destination rural towns. Somali refugee men (n _ 49) residing in a rural Midwest United States community were recruited using respondent-driven sampling to complete a self-administered structured survey in English or Somali using audio computer-assisted self-interview software. Questions assessed perceived

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sources of support, psychological distress, and happiness. Somali participants reported low utilization of both informal (30.4%) and formal (24.4%) supports when sad, stressed, or worried. Two thirds of participants reported low levels of distress and 98% reported being happy or very happy. This exploratory research contributes to understandings of Somali men's perceived support in a postsecondary migration setting. We discuss implications for social support interventions and culturally tailored assessment, diagnoses, and treatment to enhance Somalis' support and psychological well-being.

Keywords*:* refugees, social support, determinants of health, help seeking, United States

The United States is a major destination country for Somali refugees (Huisman, 2011; Kapteijns & Arman, 2008). Third-country resettlement, the permanent relocation of refugees from an asylum country to a new country, is considered the last durable solution by the international humanitarian community and is reserved for cases in which voluntary repatriation and local integration are not possible (United Nations Refugee Agency, 2019). Refugees selected for the United States resettlement program do not have a choice in where they will live (Mott, 2010); resettlement has typically occurred in urban areas in which local refugee resettlement agencies arrange short-term housing as well as monetary, employment, and medical assistance (Marks, 2014; United States Department of Health and Human Services, Administration for Children and Families, Office of Refugee Resettlement, 2015). Although refugees traditionally arrived in large United States cities, there has been a greater focus in the past three decades to resettle refugees in smaller cities and suburban towns (Bose, 2018). New formal resettlement patterns have been coupled with secondary migration of refugees to rural destinations. Little is known about the health, well-being, and perceived social support of refugees residing in rural United States towns, despite the fact this is an increasing phenomenon (Gilhooly & Lee, 2017).

Perceived social support refers to the cognitive appraisal of connection to other individuals (Streeter & Franklin, 1992) and has been associated with improved mental health status (Kawachi & Berkman, 2001; Lakey & Orehek, 2011). Perceived support has been conceptually linked to mental health in two primary ways: (a) by buffering or moderating against the adverse effects of stress, and (b) by providing individuals a sense of meaningful social roles in tandem with access to health-promoting forms of support (Almeida, Molnar, Kawachi,

& Subramanian, 2009; Cohen & Wills, 1985; Lakey & Orehek, 2011). Social support has been conceptualized as multidimensional with at least four functions of support (i.e., instrumental, emotional, informational, and companionship; Cohen & Wills, 1985), although effects of support on mental health often emphasize emotional support (e.g., Tonsing, Zimet, & Tse, 2012). Emotional support is frequently divided into familial and friend support, though multiple other relationship types may provide support in both informal (e.g., elder or religious leader) and formal (e.g., mental health professional) roles. For refugees and immigrants, postmigration settlement is a major life event (Puyat, 2013) and is often characterized by disruption of social support through contraction of social networks, loss of social roles, language barriers, discrimination, limited economic assets, and reduced access to culturally meaningful resources (Goodkind, 2006; Goodkind et al., 2014; Puyat, 2013).

Social networks in new receiving communities play a key role in refugees' well-being (Stewart et al., 2008). Family separation and disrupted family dynamics have been associated with refugees' psychological distress (Schweitzer, Greenslade, & Kagee, 2007), whereas perceived support from family and ethnic community has generally been associated with better psychosocial and mental health (Abraham, Lien, & Hanssen, 2018; Beiser, 1999; Marmot et al., 1975; Schweitzer, Melville, Steel, & Lacherez, 2006; Silveira & Allebeck, 2001; Simich, Beiser, & Mawani, 2003; Tippens, 2020). There is mixed evidence pertaining to whether support from members of the new country's host community enhances African refugees' subjective well-being and mental health. Schweitzer et al. (2007) found that support from one's wider community did not affect emotional and mental health while Muhwezi and Sam (2004) identified support from the host community as a buffer against postmigration stressors. We attempt to contribute to the gap in knowledge pertaining to refugees' health and wellbeing in secondary migration contexts by examining relationships between Somali men's perceived support and mental health.

Background

Somali im/migration to the United States has been described as occurring in two distinct waves (Kapteijns & Arman, 2008). Just 9 years

after Somalia's independence, the Supreme Revolutionary Council, led by Mohamed Siad Barre, deposed the president and prime minister in 1969 (Adam, 1992). After this 1969 military coup, many Somalis migrated to the United States for work or study; as Siad Barre's dictatorial rule spread in the 1980s, the Somali diaspora expanded across the country, comprised primarily of students, asylum seekers, and refugees with the economic capability to move abroad (Kapteijns & Arman, 2008). The second wave of Somali immigration occurred following the collapse of the Siad Barre regime in 1991 (Kapteijns & Arman, 2008; Walls, 2009). Despite multiple peace negotiations and attempts to install a national government, sectarian violence left Somalia without a permanent central government between 1991 and 2012 (Abdi, 2007; BBC, 2018; Human Rights Watch, 2011). In the years following Siad Barre's ejection from power, Somalia became characterized by both an increase in militarism and the advent of warlordism (Adam, 1992); more than 300,000 civilians died as a result of violence and famine during this time and another two million persons were displaced (Hammond, 2014; Internal Displacement Monitoring Centre, 2006).

Somalis were designated a priority group for United States resettlement in the early 2000s and represented the majority of African refugee arrivals for a number of years (Huisman, 2011). In fact, between 2000 and 2018 nearly 104,000 Somalis were resettled in the United States (Refugee Processing Center, n.d.). This second wave of Somalis had spent a significant time displaced in camps and cities in Ethiopia, Kenya, and Yemen between fleeing Somalia and being resettled in the United States (Kapteijns & Arman, 2008). Somalis from this group have been resettled in 45 states across the United States, largely concentrated in metropolitan areas but with high rates of secondary migration, including to new destination rural towns in the Midwest (Centers for Disease Control and Prevention, 2018; Huisman, 2011; Kapteijns & Arman, 2008).

Few studies have been conducted on the mental health of African immigrant and refugee groups (Pavlish, Noor, & Brandt, 2010), and research with Somalis has primarily focused on trauma and posttraumatic stress disorder (PTSD; Lincoln, Lazarevic, White, & Ellis, 2016). Predisplacement factors that affect Somalis' mental health include exposure to civil war and sectarian violence, torture, famine, and family loss and separation (Abdi, 2007; Carroll, 2004; Jaranson et al., 2004; Shannon, Wieling, McCleary, & Becher, 2015). Somalis have reported

higher trauma exposure compared to other refugee groups, which has been associated with physical and psychological symptoms, including PTSD, depression, and anxiety (Bentley, Thoburn, Stewart, & Boynton, 2012; Bhui et al., 2003; Gerritsen et al., 2006; Halcón et al., 2004; Jaranson et al., 2004; Matheson, Jorden, & Anisman, 2008). Transit factors associated with poor mental health include protracted stays in refugee camps, sexual violence, and lack of basic necessities, such as food and housing (Abdi, 2007; Perera et al., 2013). Finally, postmigration stressors reported by Somali refugees living in the United States include housing problems, employment difficulties, and adjustment difficulties (Perera et al., 2013). Kleist (2010) found that Somali refugees resettled in Denmark described men's postmigration difficulties as being worse due to the transfer of male authority to 'the welfare state.' (Abdi, 2014, p. 460) conceptualizes this as an extension of a "male breadwinner-female homemaker binary" that accompanied increased religiosity in Somalia since the conflict and clashed with Somali refugees' reality of reliance on public assistance in the United States. Indeed, shifting gender roles have been identified as undermining Somali men's self-perceptions of masculinity and diminishing their self-esteem and dignity in postmigration settings (Warfa et al., 2012).

In addition to Somalis' shifting postmigration social and familial roles, Ellis et al. (2010) stated that Somali immigrants and refugees residing in the United States are in, at minimum, "triple jeopardy" of discrimination due to being refugees, racialized as Black, and predominantly Muslim. Experiences of xenophobia, racism, and Islamophobia seem to place Somalis at increased risk for poor mental health outcomes.

Context of the Present Study

The presented exploratory, hypothesis-generating study is part of an ongoing effort by the Minority Health Disparities Initiative (MHDI) at the University of Nebraska to address the health of rural communities residing in the state. The specific town has a population of approximately 10,000 and is classified as a nonmetro, micropolitan area by the United States Department of Agriculture (2019). The opening of a meatpacking plant in 1990 attracted immigrants and refugees; the town has experienced a demographic inversion such that

immigrant residents now comprise the majority of residents. In addition to an increase in the numbers of Latinx immigrants over the past two decades, high rates of secondary migration exist among Somali refugees who were initially resettled in different locations and moved for employment in the meatpacking industry. The meatpacking industry depends heavily on an immigrant labor force, which frequently drives migration. Traditionally, Latinx workers occupied these positions (Broadway, 2007) yet increasing numbers of refugees from Africa, including Somalis, have diversified the labor force in recent years across the United States (Huisman, 2011; Mott, 2010; Shandy & Fennelly, 2006). The exact number of Somalis living in the presented town is unknown but has been estimated to be approximately 1,500. Since the town is not a federally designated refugee resettlement location, there are no resettlement agencies to support newcomers; however, a Somali community center provides assistance to refugees who have moved to the town. Although there have not been any reports of hate crimes against members of the town's Somali population, the city council denied the Islamic Center's application to expand its location fewer than 5 years ago. The American Civil Liberties Union intervened, warning of religious discrimination, and a permit was eventually granted by the council.

The MHDI as been engaged in community-based participatory research with community leaders, health professionals, and service providers in the town. Community partners approached the MHDI to conduct a health needs and assets survey, as accurate data did not previously exist given the demographic shift. This study provides descriptive statistics on social support and mental health as well as an examination of the relationship between social support and mental health among Somali refugee men residing in a rural Midwestern town.

Method

Participants and Procedures

Participants were recruited using respondent-driven sampling (RDS), a type of chain-referral recruitment that relies on respondents to recruit subsequent participants within their social networks using a limited number of "coupons" that, when exchanged, provide the

referring participants with additional compensation (Gile & Handcock, 2010; Heckathorn, 2002). RDS has been used with hard-to-reach immigrant and refugee populations in health research (Keygnaert et al., 2014; Montealegre, Risser, Selwyn, McCurdy, & Sabin, 2013; Rhodes et al., 2012). Each individual who completed an interview was provided with up to three coupons, which they could give to others who were eligible for this study. Participants were given $20 for completing the survey and an additional $10 for each coupon that resulted in a completed interview. Recruitment was restricted to those who were 19 or older (the age of majority in the state where data were collected) and who lived in the town. Participants completed a self-administered survey in English or Somali using audio computer-assisted self-interview. For this study, only participants who identified as Somali and who were born outside of the United States were included. The sample included 53 Somali refugees. The majority of Somali refugees were men (92.5%). Because there were only three Somali women and one participant who did not answer the gender question, we elected to focus analyses on Somali men (n = 49; Mage = 41.21; SD = 14.84). This study was approved by the Human Research Protection Program at the University of Nebraska-Lincoln. All procedures were performed in accordance with the ethical standards of the 1964 Helsinki Declaration and its later amendments. Informed consent was obtained from all individual participants included in the study.

Measures

Sociodemographic characteristics. Participants were asked their age, sex, household income (1 = $0 to $1,200, 2 = $1,201 to $1,750, 3 = $1,751 to $2,150, 4 = $2,151 to $3,100, 5 = $3,101 to $4,500, 6 = $4,501 to $5,500, and 7 = $5,501 or more), number of years residing in the current location (1 = 10 years or longer, 2 = 6–9 years, 3 = 3–5 years, 4 = 1–2 years, and 5 = less than one year; this variable was recoded so that higher scores represent more years in the current location), and average months spent in current location annually (1 = 12 months/the entire year, 2 = about 9 months/most of the year, 3 = about 6 months/about half of the year, and 4 = About 3 months/not much of the year; this variable was recoded so that higher scores represent more months per year spent in current location).

Sources of perceived emotional support. Participants were asked, "The last time you were feeling sad, stressed or worried, did you turn to any of the following people for support or advice?": elder family/clan member, family/clan member about your own age, friend, doctor, healer (defined here as health worker outside of the formal health or biomedical systems, e.g., spiritual healer), community health worker, mental health professional, religious leader, community leader. Participants were asked to answer yes (coded 1) or no (coded 0) for each person. A measure of informal support was created by considering the following individuals: elder family/clan member, family/clan member about your own age, and friend. Specifically, a binary index of informal support was created by categorizing those individuals who reported at least one informal supportive person the last time they felt sad, stressed or worried as yes and those who reported no informal supportive people the last time they felt sad, stressed or worried as no. A measure of formal support was created by considering the following individuals: doctor, healer, community health worker, mental health professional, religious leader, and community leader. Specifically, a binary index of formal support was created by categorizing those individuals who reported at least one formal supportive person the last time they felt sad, stressed, or worried as yes and those who reported no formal supportive people the last time they felt sad, stressed, or worried as no.

Distress. Distress was measured using the six-item Kessler Psychological Distress Scale (K6), a six-item measure of distress (Kessler et al., 2003). The K6 was designed to assess global distress with an emphasis on symptoms of depression and anxiety and has been used in multiple large national and international studies as a screening measure for internalizing mental health difficulties (e.g., the National Health Interview Survey or World Health Organization Mental Health Surveys). The measure has been translated into 21 languages. The Somali version used in this study was translated by a female Somali community health worker (CHW) and checked by a second female Somali CHW; both collected data from Somali participants.

Participants rated how frequently they experienced each symptom during the previous 30 days ranging from 1 (*All of the time*) to 5 (*None of the time*). Each item was recoded so that 0 represented *None of the time* and 4 represented *All of the time*. Example items were "During the past 30 days, how often did you feel worthless?" and "During the

past 30 days, how often did you feel nervous?" The K6 is scored by summing scores from each item with higher scores represent higher levels of distress. Internal consistency in this sample was high (α = .74). Findings from prior work indicate the scores of 13 or above discriminate cases of serious mental illness from noncases (Kessler et al., 2003). Research also suggests that scores between 5 and 12 reflect moderate levels of psychological distress (Prochaska, Sung, Max, Shi, & Ong, 2012).

Happiness. Happiness was measured with one item: "How would you rate your happiness?" Participants were asked to rate the item on a 5-point Likert scale ranging from 1 (*Very happy*) to 5 (*Not at all happy*). This item was reversed coded such that higher values represented higher levels of happiness. There is some evidence that suggests a single item measure of happiness is related in expected directions to several established measures of emotional well-being, which supports its validity (Abdel-Khalek, 2006; Moldovan, 2017; Rego, Machado, Leal, & Cunha, 2009). Previous research supports the use of self-reported happiness with Somali refugees (e.g., Pratt et al., 2017). Additionally, there is evidence from qualitative research with Somalis that being together with families/friends brings happiness (McMichael & Ahmed, 2003) and that "loss of happiness" and "inability to feel happiness" are major causes of distress among Somali refugees (Schuchman & McDonald, 2008).

Results

Descriptive statistics for study variables are presented in **Table 1**. As shown, the average age was 41.21 years (*SD* = 14.84). The majority of individuals reported a monthly income between $1,201 and $1,750. A large percentage of individuals (42.9%) reported living in their current location for 10 years or longer; nearly one in five participants (18.4%) reported living in their current location for less than 1 year. Most individuals (65.3%) reported residing in their current location for the entire year. With regard to perceived support, the percentages that reflect whether individuals turned to different supportive others the last time they felt sad, stressed, or worried ranged from 11.1% (mental health professional) to 28.3% (family/clan member about your age). Consistent

Table 1. Descriptive Statistics for Study Variables

Study variables	*M or %*	*SD*
Sociodemographic characteristics		
Age	41.21	14.84
Monthly income		
$0 to $1,200	22.4%	
$1,201 to $1,750	69.4%	
$1,751 to $2,150	2.0%	
$2,151 to $3,100	6.1%	
$3,101 to $4,500	0.0%	
$4,501 to $5,500	0.0%	
$5,501 or more	0.0%	
Years in current location		
Less than one year	18.4%	
1–2 years	8.2%	
3–5 years	18.4%	
6–9 years	12.2%	
10 years or longer	42.9%	
Time spent in current location yearly		
About 3 month/not much of the year	2.0%	
About 6 months/about half of the year	14.3%	
About 9 months/most of the year	18.4%	
12 months/the entire year	65.3%	
Social supports		
Informal support[a]		
Elder family/clan member	20.8%	
Family/clan member about your own age	28.3%	
Friend	18.2%	
At least 1 informal support	30.4%	
Formal support[a]		
Doctor	19.6%	
Healer	17.8%	
Community worker	11.4%	
Mental health professional	11.1%	
Religious leader	15.6%	
Community leader	15.9%	
At least 1 formal support	24.4%	
Mental health		
Distress: Categorical		
Low	66.7%	
Moderate	22.9%	
Severe	10.4%	
Distress: Continuous	4.13	5.02
Happiness: Categorical		
Not at all happy	0.00%	
A little happy	0.00%	
Somewhat happy	2.1%	
Happy	54.2%	
Very happy	43.8%	
Happiness: Continuous	4.42	0.54

Note. *N*s ranged from 44 to 49.
a. Percentages are percent of sample that responded *Yes* to each support system.

with these findings, only 30.4% of individuals reported turning to at least one informal support the last time they felt sad, stressed, or worried. Moreover, only 24.4% of individuals reported turning to at least one formal support the last time they felt sad, stressed, or worried. These findings suggest that Somali men tended to use relatively few formal or informal supports that last time they felt sad, stressed, or worried.

With regard to mental health, findings indicated that 66.7% of participants exhibited low levels of distress (scores of 4 or less on the K6), 22.9% exhibited moderate levels of distress (scores between 5 and 12 on the K6), and 10.4% exhibited severe levels of distress (scores of 13 or above on the K6). In terms of happiness, most participants (98%) reported being "happy" or "very happy" (M = 4.42, SD = 0.54). The relations of perceived support to sociodemographic characteristics and mental health are reported in **Table 2**. Independent samples t tests were conducted for continuous variables (age and distress) and Mann–Whitney U tests were conducted for ordinal variables (income, years in current location, time spent in current location yearly, and happiness). As shown, there were trends (differences were marginally significant) in which individuals who reported turning to at least one formal support person tended to live longer in their current location and spend more time during the year in their current location than those who reported no formal supports. No differences were found for age or income variables between those who reported at least one formal support compared to those who did not report any formal supports. No differences were found on any sociodemographic variables between those who reported at least one informal support compared to those who did not report any informal supports.

Findings further revealed that individuals who reported at least one informal support had significantly higher levels of distress compared to those who did not report any informal supports. Similarly, individuals who reported at least one formal support had significantly higher levels of distress compared to those who did not report any formal supports. No differences were found between those who reported at least one informal support and those who did not report any informal supports on the measure of happiness. Similarly, no differences were found between those who reported at least one formal support and those who did not report any formal supports on the measure of happiness.

Table 2. Relations of Perceived Informal and Formal Support to Sociodemographic Characteristics and Mental Health

	Informal support			*Formal support*		
Study variables	*Yes*	*No*	*t/M-W U*	*Yes*	*No*	*t/M-W U*
Sociodemographic characteristics						
Age	45.38 (15.14)	40.16 (15.12)	−1.05	45.64 (14.83)	40.50 (15.09)	−0.98
Income[a]	24.50	23.06	210.00	23.91	22.71	177.00
Years in current location[b]	27.32	21.83	170.50	28.86	21.10	122.50†
Time spent in current location yearly[c]	26.36	22.25	184.00	28.77	21.13	123.50†
Mental health						
Distress	7.08 (5.99)	2.66 (3.80)	−2.47*	7.64 (6.07)	3.12 (4.34)	−2.70*
Happiness	19.77	24.31	166.00	22.82	23.06	185.00

Note. *N*s ranged from 44 to 46. The Yes category for both Informal support and Formal support includes individuals who reported at least one supportive person the last time they felt sad, stressed or worried. The No category for both Informal support and Formal support includes individuals who reported no supportive people the last time they felt sad, stressed or worried. Values under Yes and No columns represent *M*s (*SD*s) for continuous variables (age and distress) and mean ranks for ordinal variables (income, years in current location, time spent in current location yearly, and happiness). Mean ranks were obtained by conducting Mann-Whitney *U* (M-W *U*) tests. *t*s reported for continuous variables and M-W *U*s reported for ordinal variables.

a. Income was coded as follows: 1 = $0 to $1,200, 2 = $1,201 to $1,750, 3 = $1,751 to $2,150, 4 = $2,151 to $3,100, 5 = $3,101 to $4,500, 6 = $4,501 to $5,500, and 7 = $5,501 or more.

b. Number of years residing in current location was coded as follows: 1 = less than one year, 2 = 1–2 years, 3 = 3–5 years, 4 = 6–9 years, and 5 = 10 years or longer.

c. Average months spent in current location annually was coded as follows: 1 = about 3 months/not much of the year, 2 = about 6 months/about half of the year, 3 = about 9 months/most of the year, and 4 = 12 months/the entire year.

† $p < .10$; * $p < .05$.

Discussion

Our study examined perceived sources of emotional support and mental health of Somali refugees in a rural Midwest United States town. The presented town is not a designated refugee resettlement site and therefore does not have typical resettlement support mechanisms and agencies in place. As such, this study contributes to the presently scant literature on refugees in a postsecondary migration setting, specifically pertaining to Somalis' perceived formal and informal supports. Additionally, most research with Somali refugees in the United States focuses on women and youth; the analytic sample presented in this article consists entirely of adult men, providing new insight into this refugee group.

We were surprised that participants generally reported low levels of distress and high levels of happiness. In a longitudinal study assessing Somali and Oromo refugees' premigration, transit, and postmigration stressors and mental health in the United States, Perera et al. (2013) found that Somali adults struggled to adapt to life in the United States. Difficulties participants reported included harsh Minnesota winter weather, language acquisition, unsanitary and unsafe housing conditions, unemployment and underemployment, and cultural differences (Perera et al., 2013). Adaptation difficulties have generally been associated with anxiety, depression, and PTSD among immigrant and refugee groups (Lincoln et al., 2016; Perera et al., 2013; Pumariega, Rothe, & Pumariega, 2005). Additionally, Somalis have been shown to face discrimination in high-income resettlement countries, which has been associated with greater endorsement of depression and PTSD symptoms (Ellis et al., 2010; Mölsä, Kuittinen, Tiilikainen, Honkasalo, & Punamäki, 2017). Inability to show feelings of happiness has been reported as a common occurrence among Somali refugees in postmigration settings, which is connected to psychological distress (Schuchman & McDonald, 2008).

Previous research on African refugee integration in rural Minnesota provides a possible explanation for high self-reported mental health in our sample. Shandy and Fennelly (2006) found that even though Somali participants admitted challenges, they described stable wages, affordable housing, a peaceful community, and other quality of life indicators. Similarly, a study with ethnic Karen refugees from Burma (Myanmar) in Georgia revealed satisfaction with social networks, higher employment, affordable housing, and community among rural-residing Karen compared to urban counterparts (Gilhooly & Lee, 2017). It is possible that quality of life factors explain high self-reported mental health among Somalis who migrated from an initial urban resettlement site; however, the study design makes this impossible to conclude. Similarly, high levels of happiness may be explained by religiosity and religious coping strategies, which have been established as improving psychosocial and mental health among African refugees, including Somalis (Adedoyin et al., 2016; Kroo & Nagy, 2011; Silveira & Allebeck, 2001). Another explanation may relate to Somali participants' sense of belonging and embeddedness in the community; more than 40% of participants reported living in the town for more than a decade, and 65% stated they reside in the town for the

entire year (i.e., not migrating seasonally). Additionally, the presence of a Somali community center may help newcomers overcome adjustment difficulties reported by Somalis in other studies (e.g., Ellis et al., 2010; Perera et al., 2013).

It is also important to consider Somalis' conceptualization of mental health. Guerin, Guerin, Diiriye, and Yates (2004) found that symptoms of depression (e.g., headaches, frequent crying, insomnia) were accepted as a normal part of life among many Somalis. Further, Nichter (1981) argued for the need to view ethnopsychiatric phenomena through what he termed "idioms of distress," ways of expressing distress that are imbued with cultural and contextual significance. Somali idioms of distress reveal distinct etiologies of emotional and psychological health problems (Im, Ferguson, & Hunter, 2017; Mölsä, Hjelde, & Tiilikainen, 2010; Ryan, 2008). For example, although idioms such as *buufis* (fixation on certain desires; Horst, 2006; Jinnah, 2017) and *busqanaan* (emotional distress characterized by physical and interpersonal/externalizing symptoms) share symptoms with anxiety disorders, context-specific explanations for these problems include lack of resources and opportunities as well as exposure to a variety of daily stressors (Im et al., 2017). *Buufis*—literally meaning "to blow" or "to inflate" in Somali—has been used by Somalis since arriving in Kenyan refugee camps in the 1990s to refer to an intense desire to be resettled abroad (Horst, 2006; Jinnah, 2017). Researchers later used *buufis* to describe a form of mental illness that occurred among Somalis who were not accepted for third-country resettlement (Jinnah, 2017). Contextualized in this manner, *buufis* provided a socioculturally acceptable way for Somalis to express distress related to limbo and extreme disappointment as shaped by external factors. It is possible, therefore, that internalizing indicators used in the psychological distress measure did not accurately assess mental health in this population.

Somali participants also reported low levels of both formal and informal supports. Previous literature on Somalis' social support in high-income countries highlights dissatisfaction with lack of family and ethnic group support in resettlement in tandem with nostalgia for the informal peer support that existed in Somalia (McMichael & Manderson, 2004; Mölsä et al., 2010; Silveira & Allebeck, 2001; Stewart et al., 2008). Stewart et al. (2008) also found that Somali newcomers in Canada first relied on other Somalis; however, after exhausting these

networks, they were more likely to seek support from formal agencies and institutions. This is also notable, as Somali men have been shown to distrust formal public assistance institutions in resettlement contexts as reliance on welfare challenges Somali male authority (Abdi, 2014; Kleist, 2010). Results indicated that Somali men who had one supportive other compared to those who reported no supportive others had higher levels of distress. This was true for both informal and formal supports and appears to contradict hypotheses that social support may exert its effects through positive social relationships that enhance subjective well-being (e.g., Sarason, Sarason, & Gurung, 1997). One possibility is that individuals experiencing more symptoms of anxiety and depression utilized supports more frequently, meaning that individuals feeling distress utilized their support systems. There is additional need for longitudinal research to see if seeking support leads to reductions in distress over time. Conversely, it could mean that individuals in perceived support networks were not meeting the needs of participants, leading to increased distress. Additional exploration of quality and functionality of social support is an important area for future research with Somali refugees as some participants may have rich and highly supportive friendship networks without any familial networks whereas others may have more diverse but lower quality support across multiple different sources (see Wittenberg-Lyles, Washington, Demiris, Oliver, & Shaunfield, 2014).

Study Limitations and Strengths

Study limitations should be noted. First, measures only examined sources of emotional support rather than quality, frequency, or types of supports within each source. Measures of mental health also consisted of a relatively brief screening measure that largely captures psychological distress, whereas more comprehensive measures of specific disorders may have yielded different results. Additional limitations resulted from the sampling strategy. Most notably, only three Somali women participated in this study. Researchers using RDS recruitment methods may wish to provide coupons to equal numbers of female and male participants to see if this increases representation in sampling. Conversely, convenience sampling may be needed to reach this subgroup. Finally, premigration, transit, and postmigration trauma and stressors were not assessed in this study, although each has been

shown to be associated with postmigration mental health status (de Arellano et al., 2018; Gudiño, Nadeem, Kataoka, & Lau, 2011; Perera et al., 2013; Perreira & Ornelas, 2013).

The study should also be considered in light of its strengths and new contributions. One such strength is the inclusion of a hard-to-reach rural refugee population in a postsecondary migration context. The assessment of sources of emotional support in these settings contributes to our understanding of how supports have been created or maintained in new destinations. Additionally, two aspects of mental health were investigated: distress and happiness. To our knowledge, this is the first study that examines self-rated happiness among refugee populations in the rural United States. Increasingly, happiness is being used conceptually to evaluate individuals' subjective well-being (Hendriks & Bartram, 2018) and has potential to inform mental and psychosocial health research with refugee groups.

Practical Implications and Conclusion

The results of this study provide evidence of heterogeneity of perceived sources of support as well as of pluralistic help-seeking behaviors among Somali refugees in a new-destination rural United States context. Importantly, this adds nuanced, contextual understanding related to perceived social support in postsecondary migration settings. We have identified two practical implications from this study. First, task shifting interventions that utilize lay health workers to address mental health have shown promise with refugee populations globally (Javadi, Feldhaus, Mancuso, & Ghaffar, 2017). Specific task shifting to enhance the quality of social support and expand access to supportive networks may improve the subjective well-being and mental health status of immigrant and refugee groups in rural settings in high-income countries. For example, Stewart et al. (2011) piloted a culturally tailored peer support intervention among Somali and Sudanese refugees in Canada. Participants and peer supporters were matched by sex and ethnicity; the intervention was comprised of biweekly support groups in tandem with individual support via telephone. Participants reported increased perceived support, decreased loneliness, and increased self-efficacy regarding navigating community resources (Stewart et al., 2011). Given appropriate community resources, a similar social support intervention may have success in

rural contexts.

Second, health providers may wish to consider Somali refugees' distinct mental health etiologies in diagnoses and treatment. It could be valuable to integrate cultural sensitivity or cross-cultural communication instruction into health professional training and continuing medical education, as culturally tailored assessment, diagnosis, and treatment has shown some promise for reducing racial and ethnic health disparities in mental health care (Kohn-Wood & Hooper, 2014). However, in a systematic review of cultural sensitivity training, Lie, Lee-Rey, Gomez, Bereknyei, and Braddock (2011) caution that existing evidence pertaining to educating health professionals is limited and not generalizable (e.g., curricula to replicate findings, not controlling for patient-provider variables.).

This study provides a starting point for mental health research that focuses on place and emplacement and that directly compares the nature of community resources, perceived support, and psychological distress among refugees residing in rural and urban settings.

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