Centre for Appearance Research

The experiences of young Somali adults with visible facial differences

Presentation by
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14.07.2023
VTCT Foundation Showcase

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Evidence to date

- Beauty is prescribed by social standards, which can vary with time, place, culture and faith (Swami and Tovée, 2007)
- Health is intersectional - impact of multiple identity markers, including ethnicity (Johnson *et al*., 2016)
- Homogenous samples (White, Western; Johnson *et al*., 2009)
- Methodological limitations – outcome measures, language barriers, challenges to recruitment (Naqvi and Saul, 2012)

How do non-WW groups view and experience visible differences?

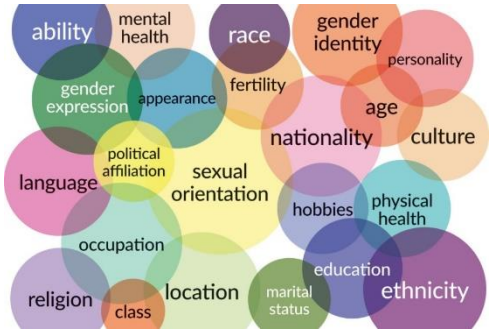
Diverse visible difference research (UK)

UK visible difference research

- South Asian perceptions of visible differences (Hughes *et al.*, 2009)
- South Asian perceptions and experiences of CL/P (Reekie, 2011)
- Bangladeshi woman perceptions and experiences of neurofibromatosis (Rozario, 2007)
- South Asian women perceptions and experiences of vitiligo (Thompson *et al.*, 2010)
- Chinese women perceptions and experiences of skin conditions Lam and Thompson (2021)
- South Asian women perceptions and experiences of breast cancer (Patel-Kerai *et al*., 2017; Patel-Kerai *et al*., 2015; Patel, 2014)

Stigma/lack of social acceptance, cultural beliefs about causes of conditions, reduced social support/opportunities, treatment dissatisfaction, negative self-image

Directions for research – the UK Somali diaspora



- 'BAME' can be problematic and unhelpful – may not resonate with communities, or neglect important differences between groups (Khunti *et al.*, 2020)
- Somalis constitute one of the largest diasporas in the world, estimated at over 1.2 million
- UK has one of the biggest and most established community of Somali migrants in Europe
- Somalis are reported to experience some of the worst outcomes in health (including health literacy), and broader SES (unemployment, poverty, economic inactivity)
- UK Somalis may be particularly at risk of discrimination as they are not only migrants, but also Muslim and Black (Warfa *et al*., 2012)

What are the experiences of UK Somalis with visible facial differences?

Method

- Qualitative, RTA (underexplored, outcome measures may not be appropriate)
- Semi-structured interviews (remote)
- Interpreters (previously identified as a barrier to minority group engagement in appearance research (Naqvi and Saul, 2012)) & translated participant-facing documents (e.g., research advert)
- Public Involvement with community representatives (3 from the Somali community and 1 from the visible difference community) + evaluation
- Creative recruitment strategy: social media (Reddit), community outreach (Somali and visible difference), personal referrals, media appeals:

❑ BBC Radio Bristol's breakfast show

❑ BBC news article (Nura Aabe)

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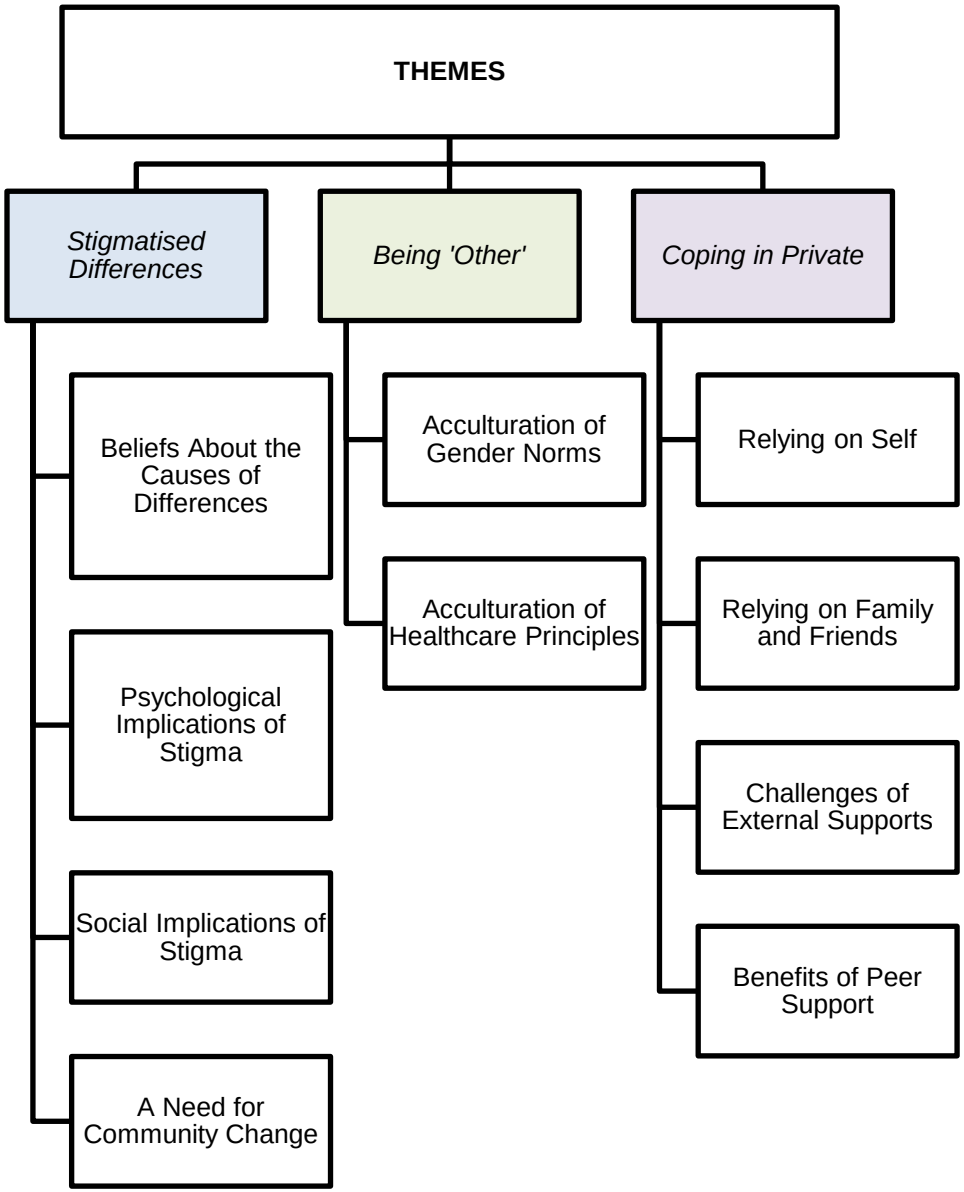
Participants

- 8
- 19-28 years (m = 23.5)
- Visible differences included congenital conditions *(n* = 2), skin conditions (*n* = 2), and acquired facial scarring (*n* = 4)
- All participants were born in Somalia and had immigrated to the UK when they were between 5 and 14 years of age (m = 7.6)
- University (*n* = 4), college (*n* = 3), secondary school *(n* = 1)
- Single (*n* = 6), in a relationship (*n* = 1), married (*n* = 1)
- Unemployed (*n* = 5), employed (*n* = 2), homemaker (*n* = 1)



"They could hate you for no good reason. They could go ahead and say it's a curse. They could discriminate you"

"Skins are very different.

Your skin is not like my skin"

"I've just been surviving on my own"

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Theme 1

Stigmatised Differences

- Beliefs About Causes
- Psychological Implications of Stigma
- Social Implications of Stigma
- Need for Community Change

Theme 3

Coping in Private

- Self
- Family and Friends
- Challenges of External Supports
- Benefits of Peer Support

Theme 2

Being 'Other'

- Acculturation of Gender Norm
- Acculturation of Healthcare Principles

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(Some) Limitations

- Covid-19, remote
- Accessibility and inclusivity – older, no-tech, ESL (no uptake of interpreters)… possibly those with greatest need?
- My position
- ❑ Taboo topic – are participants more or less willing to share with an outsider?
- ❑ My ethnicity (not Somali), my age, my gender, my role (trainee health psychologist) – how did this influence the study, and how participants spoke with me (particularly about these issues)?

Take-aways for the AC

- Possible barriers to engagement:

Previous negative healthcare experiences & reduced health engagement, stigma about conditions (and other health-related beliefs), stigma about psychosocial support, social isolation

Language barriers

Logistical barriers

- Possible motivations for engagement (research):

Altruism and a desire to help others, personal interest, enjoyment, curiosity, and the therapeutic benefits of sharing (Gill *et al.*, 2013)

- Seeing 'peers'

Staff, images used online and in promotional materials

Take-aways for the AC

- Culturally sensitive services

Consider various religious calendars in service-delivery, adapt services to specific cultural needs where possible (e.g., importance of religion in wellbeing, role of the family in care, preference for oral communication)

Specific support for different communities?

- Community outreach

Effective recruitment strategies point to importance of pre-established community relationships

- Avoid deficit approach
- Avoid as possible ‘BAME’

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Thank you

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