

Mental Health Problems and Healing among Somalis in Sweden*

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I. Introduction

Refugees are particularly at risk of mental health problems and they often have special needs that must be met if integration into the new country is to succeed.¹ However, there is a lack of research that focuses on the refugees' own perceptions and ideas about mental health.² One of the largest refugee populations worldwide is the Somalis. It is estimated that more than a million have fled their country because of the civil war.³ Many Somalis in the diaspora experience anxiety, marginalization, and mental health problems. At the same time, few make use of biomedical health services when suffering. Moreover, there exists a certain mistrust of the biomedical health sector.⁴ In addition, many Somalis turn to non-Western healing practices when suffering from episodes of ill health.⁵ Somalis in the diaspora have depression and anxiety related to war, the loss of family members, and afflicting spirits known as *jinni* or *jinn*.⁶

This essay examines ideas and experiences of mental health problems among Somali refugees in Sweden. It explores these issues from an anthropological perspective by emphasizing people's own words about illness, healing, and well-being. In so doing, the article adds to the knowledge about how Somalis in the diaspora conceptualize and respond to mental illness.

II. Somali-Swedes and Medical Health Care Services

About 30,000 Somalis reside in Sweden today.⁷ Many suffer from health problems. The probability of becoming hospitalized is high among Somalis, both compared to native Swedes and to other immigrants.⁸ Many also feel discriminated against, stigmatized, and unwanted in Swedish society; a situation that tends to lead to isolation and segregation. At the same time, the role of religion as a source of comfort has become more important.⁹

A. Swedish Medical Health Care Personnel and their Encounters with Somali Patients

When interviewing Swedish biomedical health care personnel about their encounters with Somali patients, it was generally agreed that Somalis seldom sought help for mental health problems and that medical doctors hardly ever recommended or referred patients to psychiatrists or psychologists or prescribed antidepressants. A physician said that, "many Somali patients suffer from depression but few will admit it and very few consult a health care unit [for mental health problems]. If I tell someone that he has a psychological problem, he will deny it." Another physician claimed that Somali patients generally made a sharp distinction between body and soul, and that "the soul is very rarely discussed." He also felt that he was expected to present a diagnosis almost without asking the patient anything: "If I ask a patient what he thinks about his problem, I will appear very strange. A doctor is supposed to know the problem."

Somalis often expressed psychological problems as "headaches, chest pain, and forgetfulness," according to McGraw Schuchman and McDonald.¹⁰ Medical personnel in Sweden claimed that Somali patients often had diffuse pain in the whole body or in a certain body part, such as the head or the back. This could move around and after some time cause pain in another part of the body. In many cases, according to the biomedical practitioners, the physical symptoms could be related to stress and feelings of worry. A physician explained that, "Many women are single and they have between three and eight children. This often causes a lot of stress." The physicians and nurses reported that Somali patients often exaggerated their symptoms in order to get the physician's attention, but also that they were very stoic and seldom showed any signs of pain in their faces when they were examined. This, in turn, often made it difficult to give a diagnosis. On the whole,

Somali patients were considered to be “difficult to deal with” and sometimes hard to understand.

B. Somali-Swedes’ Experiences with Biomedicine and Biomedical Personnel

Many Somali-Swedes have experienced prejudice, discrimination, and even racism in Swedish society.¹¹ Prejudicial treatment was also common when meeting with physicians and nurses. Several people recounted that there was little understanding for Somali forms of healing in hospitals, such as reading the Qur’an. On occasion, the reading was interrupted because visiting time was over, which, in turn, could complicate and delay the healing process. A woman in her thirties retold a story about a very sick young Somali girl in a Swedish hospital. The physicians had first opposed the Qur’an reading but later gave in when they could do no more for the girl. In the narrative, the girl became well after an imam had read the Qur’an and the physicians were very surprised.

A Somali woman in her early thirties gave her view of the problems that Somali people encountered:

There are a lot of prejudices against Somalis. People have heard that Somalis are difficult, complicated and strange. If I am mentally ill and behave completely crazy, they will say it’s a ‘Somali thing’ or a ‘Somali woman.’

I went with a friend to the Health Unit. She suspected that she had sinusitis. She had been sick for several days and had a lot of pain. The physician asked her how many children she had. She said eight. Then he said, ‘You are not sick, you are worn out, that’s why you feel like this.’ She had to leave without treatment. I have heard several mothers saying that they never reveal how many children they have so that the doctor won’t think they are sick because of their children. They are told to do gymnastics, drink water, meet people and that they have too many children. Swedes see children as a problem. We see children as resource, richness and an obligation.

III. Somali Concepts of Mental Ill-Health

Mental illness is generally denied and stigmatized by Somalis.¹² Hospitalization because of mental illness is also highly stigmatized in Somali culture.¹³ It is usually not until someone becomes severely ill and, for

example, is struck by a psychosis and cannot take care of himself/herself that psychiatric or biomedical health care is considered. Interviewees commonly expressed a fear that there would be rumors about madness or spirit possession if it became known that one sought help for depression or other mental health problems from biomedical health care services. It was also considered improper to recommend that someone seek psychiatric care or psychological help as this could easily cause feelings of shame, frighten the person, and affirm that he/she actually had become "crazy." Moreover, to take antidepressants also "confirmed" a state of madness. A middle-aged man said that he did not expect the psychologist to understand him or his culture. In fact, he expressed fear that the psychologist's questions "could make it worse." He also expressed worry about possible side effects of antidepressants and fear that psychiatric treatment could lead to being locked up in a mental institution for years.

Overall, Somali-Swedes seldom contact psychologists.¹⁴ Many are inclined to avoid psychological treatment as psychologists tend to be associated with mental illness.¹⁵ When talking to an academically educated Somali woman in her thirties about why so few people sought psychological help for their mental health problems, she said:

The problem is that we Somalis don't believe in psychologists. That is especially true when one, for example, hears voices [which is a sign of possession by spirits, or *jinn*]. Many suffer from post-traumatic stress disorder. They go around with neurotic symptoms for years and nothing happens. Then they get a psychosis.

She added that it should be possible for physicians to refer Somali patients to someone who had psychological knowledge but who did not openly carry the "epithet" psychologist. In this way, patients with mental health problems would get a collocutor and could discuss their problems without being viewed as "mad" by others or by themselves.

A man in his early forties reported that some Somali men were depressed because they lived alone and felt lonely, and that this had to do with gender relations in Sweden: "If you are a real Muslim, you should not live alone. You have to get married to avoid problems. The problem is that here in Sweden the women have a higher status and importance. They sometimes kick out the men."

The Somali language contains several words for describing various stages and forms of mental ill-health. "*Welwel*" was described by the

Somali-Swedes as a form of general stress, worry, or depression, to some extent caused by the Swedish winter weather. The term "*murug*" also refers to feelings of severe stress and anxiety, frequently due to worry about unemployment or family problems or constantly thinking of relatives in war-torn Somalia. A woman in her thirties explained: "You could have problems in your marriage and no one to talk to because you don't trust anyone or you could hear bad news from your hometown where you have family. Then you sit and think about that constantly, until you are completely overwhelmed and obsessed by worry."

Another concept is "*buufis*," which indicates severe depression or near insanity. The malady may strike Somalis in Sweden but it mainly affects men in Somalia and in refugee camps in neighboring countries, commonly those who have strived to migrate to the West for a long period of time.¹⁶ A 25-year-old woman explained: "You have this longing which is never realized and you become like crazy. People could tell you how nice it is in Sweden and you want to go there, but you don't make it."

"*Qalbijab*" or "*niyadjab*" is also a serious form of depression characterized by hopelessness, despair, and a "broken heart." This condition could occur when, for example, after many attempts someone fails to bring his/her relatives to Sweden or when one is denied a permanent residence permit by the Swedish Immigration Service. The malady is frequently related to broken dreams and expectations that are never fulfilled. The woman cited above explained: "Someone may struggle for many years to come here [to Sweden]. Once here, the person thinks that he should feel happy but he only feels more depressed. Then one loses hope; it's like the hope is broken. You've just had enough." The condition "*wareer*," on the other hand, is related to confusion and disappointment or to dizziness and high blood pressure caused by worry and stress.

These conditions are mainly treated with Qur'an readings. Milder forms of mental health problems may also be handled through conversations with a counselor within the family group.¹⁷ The maladies stand in contrast to "*waali*," a psychotic condition and a sign of pure "madness," which is considered difficult to cure and generally requires recurrent Qur'an readings, psychiatric care, hospitalization, and medication. A woman in her fifties gave her view of *waali*: "It can be temporal or permanent. A woman may temporarily forget about her own children. If it's permanent, the person lives on another planet. He

wants to be alone and could be very aggressive and tries to hit everyone and everything.”

IV. Religion and Healing

Many Muslims in the West today re-evaluate and question concepts such as cultural identity and religion.¹⁸ Among Somalis in the diaspora, this process could be described as a new form of “Islamization” in which Islamic values are becoming more important than in Somalia and people emphasize an identity based on Islam, rather than on clan or ethnicity.¹⁹ This, in turn, has brought about a sharper distinction between healing practices said to belong to Islam and practices deemed as non-Islamic, such as the veneration of saints or ceremonies where people are possessed by so-called “*mingis*” or “*saar*” spirits.²⁰ These pre-Islamic spirits, which mainly trouble women, are generally not exorcised. The afflicted instead becomes part of a cult group and the spirit becomes a companion who may take possession of the person in rituals that “emphasize dance and celebration with the spiritual world.”²¹ According to Abdullahi, *saar* possession may function “as a form of psychotherapy for stressed individuals.”²²

Saar/mingis possession is considered un-Islamic according to followers of the more strict interpretation of Islam. Consequently, the diaspora ceremonies involving spirit possession have to be practiced in secrecy and are taking on new forms as women sometimes become possessed during weddings.²³ One example of this form of possession took place in a town in southwestern Sweden during a wedding party when all the women present were dancing, singing, clapping hands, and drumming. As they shouted “come down,” a woman apparently became possessed and it was said that her “blood boiled.” The women who had been present and who recounted the event were nevertheless keen to point out that no one knew if the individual was “really possessed” and that the event was completely secular.

Most Somali-Swedes whom I interviewed frowned upon the spirit possession, although some also lamented that these cults were banned. A middle-aged man commented:

Here in Gothenburg, when it comes to the Somalis, it is the extremists who rule over everyday life. They dictate how to live. People connected to the mosques have their own, strict interpretation of Islam and they have tried to stop it [*saar/mingis*, possession cults]. They put pressure on

the clans. They said we should not worship demons. I know there are people who want to practice these rituals but they are not allowed to do so. If someone has a psychological problem and feels better when going to the *mingis* people, let the person do it. Faith is very important.

Other consequences of the Islamization process in the diaspora have been that the Sufi tradition has lost followers but also that Somali women, through their growing knowledge about Islam, have strengthened their position within the Somali diaspora communities.²⁴

A. The Qur'an

Islam is important in the diaspora when responding to all kinds of afflictions. Both physical and mental health problems are treated with Qur'an reading while family and friends give their support. The Qur'an, which may be read or placed on the body, provides common ground and guidance when responding to depression, worry, and ill-health in general.²⁵

Reading the Qur'an, preferably aloud in the Arabic language, is a common way among many Somali-Swedes to prevent illness in general and to heal people who suffer from mental and physical problems. A single woman in her thirties, who lived with some friends in a small apartment, is a case in point. Her husband had died in the war in Somalia and she had left her two children behind in Mogadishu. She recounted that if it were not for the Qur'an, she would have become crazy hearing about relatives and friends who were suffering from the war and when thinking about her children, whom she was struggling to bring to Sweden. She said that through the Qur'an she gained faith and found the strength necessary to carry on.

Anyone may read the Qur'an, but the result is said to be better if it is read "from the heart" by someone who is close to God, Allah, such as a devout sheikh or imam. A sheikh explained that the composition of words, the structure of sentences, and the melody could affect and strengthen body and soul. He added that a healing force is liberated when the Qur'an is read and pronounced aloud. A woman in her twenties who was active in an Islamic association similarly stated:

There are seven ways to read the Qur'an with different pauses, grammar and pronunciations. Usually, those who read it have studied for many years. If you ask someone to read it, you want it to be right. The pronunciation has to be perfect. You can read it for yourself in Somali or any

other language. But if you have pain, you have to read it in Arabic. No matter how difficult it is.

When one is suffering from mental illness, the Qur'an is usually first read at home. Friends and relatives may take turns reading, while at the same time helping the afflicted with the household chores. A woman in her thirties spoke about how people who suffer from war trauma are taken care of:

It's really difficult. We read the Qur'an. We also try to talk to them and make sure they have food and clean clothes. You try to establish contact so that the person can begin to trust you and begin telling about her problems. Apart from that, there is not much to do.

If the problem is serious, a sheikh or an imam may read certain prayers (*roqia*). A group of people may also read together for the afflicted person in the mosque. A sheikh told me that he often recited the Qur'an for Somali patients at some of the hospitals in Gothenburg: "People call me to help them and I go there and read the Qur'an. First I read certain verses. If the person doesn't get well, I read verses for *jinn* and for *sixir* (sorcery). Then I try other verses." He also recommended that patients smear their body with honey and an oil called *xabad sowda* (made from seeds of the plant *Nigella sativa L.*) when listening to recitations, as this was said to hasten recovery.

Another sheikh, who frequently read the Qur'an for people with health problems, emphasized that the person being treated must have faith in the Qur'an to become healed. The sheikh not only read but also explained the messages in the Qur'an to his clients: "The person has to believe in the strength of God's words. The deeper the knowledge, the better the healing."

The Qur'an may also be read before visiting a health care unit in order to facilitate a correct medical diagnosis. Several of the Somali-Swedes interviewed said that, "the Qur'an is medicine" and explained how it was read *on* the afflicted. The reading, which in serious cases may take place for long hours several days in a row, is often combined with a short, intermittent blowing of air directed at the afflicted person or at a certain body part. A sheikh may also read Qur'an verses over a glass of water, which is then drunk by the sufferer or poured on the person's body. The healer may also blow on his right hand and place it on the ailing body part. However, for these therapies to be effective,

the afflicted must have great faith in the power of the words of the Qur'an.

Many Somali-Swedes also use the Internet for religious guidance and when inquiring about health matters. People commonly download Qur'anic recitations from websites to mp3-players and cassette recorders. For greatest effect, the verses should have been read by a devout and pious sheikh. A sheikh who was often engaged by people with health problems told me that he downloaded Qur'anic recitations from YouTube, which he recommended that people listen to, preferably at high volume, when they suffer from illness and other problems.

B. *Jinn*

When people suffer from mental health problems, they are occasionally said to be possessed by a spirit known as *jinn* ("*jinn*" is plural and "*jinni*" is singular). A thirty-year-old woman explained: "It mainly affects women and often those who are mentally weak, vulnerable and exposed to something. It may be that they are depressed and have problems." People who lack relatives are said to be especially vulnerable.²⁶ If someone wants to be alone, isolates himself/herself, is quiet, irritable, or speaks incoherently, possession by *jinn* may be suspected.

These spirits are said to live in an invisible parallel world although they may take the shape of humans and animals and occasionally fall in love with human beings. *Jinn* are commonly associated with darkness and filthy places. If a child gets a headache and begins to tremble after passing through a dark place, possession by *jinn* could be a possible cause. Possession may also occur if, for example, a child has thrown a stone that hit a *jinni*, which then entered the child. A man in his early forties told me about a friend who had thrown a hand-grenade into a rubbish heap during the war in Somalia and "killed ten *jinn*." After the event, he woke up at night screaming and was said to be "speaking with another voice" as he was attacked and possessed by several *jinn*.

To protect oneself against *jinn*, one must practice ablution before prayer and pray five times a day to Mecca. It is also important to take care and guard oneself when stepping into places considered unclean, such as the toilet or the garbage room, by entering with the left foot and leaving with the right. A sheikh explained: "If you have done something bad, or if you don't practice Islam, the *jinni* will attack you. The *jinni* will then say, 'If he becomes a real Muslim, I will leave him.'"

A *jinni* may also manifest itself as physical illness with pain in the person's heart, legs, back, head, or some other body part, and may show its presence by causing strange and exceptional body movements or by making the person temporarily cross-eyed. In these and other forms of *jinn* possession, biomedical treatment is considered inefficacious. Instead, repeated readings of the Qur'an are required. A woman in her forties said: "If the person goes to the hospital, they won't find anything and nothing can be seen on the x-ray. If it's because of *jinn*, no medication will help. Then it's only Qur'an reading [that helps]."

A sheikh who has specialized in exorcising and expelling *jinn* may also be consulted and read certain verses from the Qur'an. If the person is possessed by a *jinni*, it will let its presence be known by saying "no, no" or "turn off," as it cannot endure hearing the sheikh reciting the verses. The *jinni*, which is said to be "burned" and weakened by the recitation, may at first refuse to speak and may try to take over the situation. It may scream and cry and try to mislead the sheikh by giving incorrect information, or by telling lies about its identity, or by saying that the Qur'an should be destroyed. Frequently, the *jinni* is said to speak with various dialects or foreign languages with male and female voices. This confrontation is critical but also dangerous; if the sheikh is not strong enough to control the situation and dominate the spirit, it could "take over" and the afflicted person could become worse. Eventually, if everything turns out well, the *jinni* will reveal its real identity and why it has possessed the person. This may take days, however, or in difficult cases, weeks or even months of repeated recitations. Finally, the spirit is told to leave the person by his/her little toe or little finger.

A larger group of people may also read Qur'anic verses for the afflicted in the mosque. A man in his thirties told me about a young woman who was screaming all the time. She was taken to a mosque where an imam and a group of men repeatedly read the Qur'an. According to the narrator, the woman became better after some time. In a similar case, a woman in her twenties who lived in northeastern Gothenburg had been having severe pain in her body for some time. She was taken to a medical doctor by two female friends. One of them related that, during the medical examination, the sufferer "had something inside her body that moved and went over to the back." She also twisted her arms in ways that "really wasn't possible." As the physician tried to hold her still, she became cross-eyed, according to the accompanying friend. She added that, "the physician could not find anything wrong with her."

Subsequently, she went to a mosque where ten men and an imam sat around her and read the Qur'an. According to the friend who earlier had accompanied her to the physician, the woman began to tremble and the *jinni* began to speak and tried to cause confusion by saying, "I'm a Muslim, I'm a Christian, I'm a believer, I'm not a believer..." It was also said to have spoken languages such as English, Arabic, and an Ethiopian language, none of which the woman was said to have mastered. In addition, it spoke Somali dialects that were unknown to her and mimicked the dialects of the persons who tried to talk to it. Finally, it began to talk about everything that had happened and that the *jinni* "came from a man who once wanted her." After the event, she became better and her pain diminished. However, she had to regularly repeat the sessions at the mosque in order to become completely well.

C. Sorcery and the Evil Eye

Among Somali-Swedes, there also exists a belief that *jinn* can be sent to a person through acts of sorcery (*sixir*). All interviewees assured me that this was extremely uncommon in Sweden. Despite this, there was a certain fear of sorcery. A woman in her twenties explained: "If you pay a visit to someone who doesn't like you, you may think that they are trying to poison me. Or if you pass your aunt's house, who doesn't like you and you don't like her, and catch a cold, you may think that she gave you the cold." In addition, a *jinni*, when possessing someone, is commonly said to accuse people of having cast it on the sufferer. A sheikh explained that sorcery, when it occasionally took place, was carried out by an evildoer who read the three last verses of the Qur'an backwards and used something that had belonged to the victim, such as a sweater, socks, or underwear: "It only works if you have the person's DNA; hair, sweat, or saliva."

A related notion is the Evil Eye (*isha*), which is said to occur more frequently. *Isha*, which could result in passivity and introversion, was described as a force that came into existence when someone felt jealous and wanted something that someone else had, such as a beautiful wife/husband, house, or car, or when someone, for example, said that a child was beautiful. People who were successful were said to be more exposed and they were held to be more occupied with thinking about *isha* because of other people's supposed envy and jealousy. To prevent the Evil Eye from occurring, the person who commended someone's belongings, or for example praised a beautiful child, had to pronounce

the word *Masha'allah*. This Arabic word was translated by the Somali-Swedes as "You shall have more," "It is God's work," or "May God bless you." A woman in her late twenties explained: "If I see a very beautiful girl combing her hair, I may say 'what beautiful hair, God, I also want such hair. She doesn't deserve that hair.' Then, if I forget to say *Masha'allah*, it could happen, the Evil Eye."

V. Mental Healing in a Transnational Perspective

Many stories exist among Somali-Swedes about people who suffered from mental health problems and who traveled to other countries to become well. In the case of severe problems reputedly caused by *jinn*, money may be collected from numerous family members, who often live dispersed in various countries in the diaspora, in order to pay for a trip back to Somalia or to Saudi Arabia, Kenya, or some other country in the Horn of Africa. A man in his fifties told about a friend who had to leave Sweden because of mental health problems:

This man was depressed and his relatives got together and paid so that he could go back to Somalia. When he arrived there, he became well. Here, he had been given medicines, but he could quit that when he came to Somalia. Every time he comes back to Sweden, he becomes sick. He now lives in Somalia.

Most people prefer Saudi Arabia when dealing with possession by *jinn* as this country is said to have the most skilled experts in exorcism. The story about a man and his wife, both in their late thirties, is a case in point. A few years ago, the wife suddenly became psychotic and was taken to a psychiatric ward in Gothenburg. She was admitted for five days. Her husband had recorded verses from the Qur'an, which she listened to on an mp3-player. However, she did not get much better. The husband felt that the psychiatrists could not understand what was wrong with her and that nothing could be done. Some time later, he brought her to a sheikh in Saudi Arabia who read verses from the Qur'an through a loudspeaker. The husband told me that during the exorcism his wife screamed, "we won't come back, we won't come back." He added that after a while "she slept very well and became well. If it [the possession] does not return within three years, she is completely well. She was possessed by *jinn*."

Somalis in Sweden are also occasionally visited by people who are experts in the exorcism of *jinn*. During fieldwork, I was told about a highly skilled Somali-Norwegian sheikh who “knew how to communicate with *jinn*” and who regularly came to Sweden. A woman in her twenties explained: “*Jinn* are afraid of him. When they [the possessed] hear that he is on his way, they calm down. Earlier they may have been aggressive and not wanting to listen.”

VI. Conclusion

This research has brought to light a certain mistrust and lack of understanding between Swedish health care personnel and Somali-Swedes concerning the origin and treatment of mental health problems. Many Somalis believed that the medical personnel often dismissed physical pain as psychological or social “stress,” which, in turn, made their symptoms seem less valid. They felt that their complaints often were not taken seriously. Physicians and nurses were also said to overemphasize and misuse certain cultural traits, such as when “madness” was said to be “a Somali thing,” while at the same time lacking an understanding of non-biomedical forms of healing, such as Qur’anic reading.

With the exception of *waali*, “madness,” Somali-Swedes seldom turn to physicians, psychiatrists, or psychologists when suffering from depression or other mental health problems because they may fear stigmatization by other Somalis and/or believe that psychological or psychiatric interventions do not have any positive effects. Some treatments were even said to be harmful or that they could “make things worse.” In particular, when possession by *jinn* was believed to be the cause, psychiatric or psychological treatments were seen as ineffective. In these cases, recitations of the Qur’an and exorcism were considered the only efficient ways of dealing with the problem. Overall, faith in the Qur’an and individual and group recitations gave many Somali-Swedes religious and secular guidance as well as a profound meaning to illness and suffering, and a way of healing both body and soul.

Somali-Swedes commonly attributed mental ill-health to the war in Somalia, social and family problems, unemployment, problems with the Swedish Immigration Service, loneliness, broken dreams, and spirit possession. To face these diverse problems, a holistic approach is needed.²⁷ This would imply teaching health care professionals about Somali views and treatments of mental health problems and their per-

ceived therapeutic benefits. It would also include educating Somali-Swedes about mental health care in general. In addition, there is a need for collocutors and cultural mediators, both religious²⁸ and secular, with knowledge about Swedish health care and Somali culture, who can build trust by acknowledging Somali cultural identity,²⁹ mediate between different explanatory models,³⁰ and give social support and help with issues like dealing with the Immigration Service and finding employment. Swedish social policies that seek to promote mental well-being among Somali-Swedes should support the forging of religious and secular social networks both within and outside the Somali group.

*Research was carried out during eleven months, from 2010-2011, in the northeastern parts of Gothenburg, Sweden. The anthropological field technique of participant observation was used. A total of 25 Somali men and women were interviewed, including three Somali sheikhs (learned persons in Islam). In addition, six biomedical health workers (two medical doctors and four nurses) and two social workers who frequently came into contact with Somali clients were interviewed. Research was funded by the Swedish Council for Working Life and Social Research (FAS) and approved by the Regional Ethical Review Board in Gothenburg.

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Notes

1. McCrone et al. 2005; Halcón et al. 2004.
2. Carroll 2004.
3. UNHCR 2007; *Human Development Report Somalia* (2001), p. 58.
4. McCrone et al. 2005; Guerin et al. 2004; Gerritsen et al. 2006; Bhui et al. 2003; Fangen 2006; Danso 2001; Palmer 2006.
5. Carroll et al. 2007; Guerin et al. 2004; Warfa 2007; Ellis et al. 2010.
6. Carroll 2004.
7. Statistiska Centralbyrån 2010.
8. Klinthäll 2007.
9. Diaz 1997; Statens Invandrarverk 1998.
10. McGraw Schuchman and McDonald (2004), p. 69.

11. Svenberg et al. 2009.
12. Svenberg et al. 2009; Scuglik et al. 2007; Ellis et al. 2010.
13. Mölsä et al. 2010.
14. Diaz 1997.
15. Finnström and Söderhamn 2006.
16. cf., Horst 2006.
17. Guerin et al. 2004; Finnström and Söderhamn 2006; Carroll et al. 2007.
18. Esposito 2002.
19. Berns McGown 1999; Tiilikainen 2003; De Voe 2002.
20. cf., Parkin 2007; cf., Abdullahi 2001.
21. Whittaker et al. 2005, p. 191; Lewis 1969; and Luling 1991.
22. Abdullahi 2001, p. 66.
23. Tiilikainen 2003.
24. Ibid.; Fangen 2006.
25. Guerin et al. 2004; McMichael 2002; Whittaker et al. 2005; Tiilikainen 2003; Halcón et al. 2004.
26. Whittaker et al. 2005.
27. McGraw Schuchman and McDonald 2004; Jorden et al. 2009; cf., Wedel 2009.
28. Ellis et al. 2010.
29. Groen 2009.
30. Kleinman 1980.

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