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Article

Cultural translation of refugee trauma: Cultural idioms of distress among Somali refugees in displacement

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Abstract

Westernized approaches to mental health care often place limited emphasis on refugees' own experiences and cultural explanations of symptoms and distress. In order to effectively assess community mental health needs and develop interventions grounded in local needs, mental health programs need to be informed by an understanding of cultural features of mental health, including cultural idioms of distress (CIDs). The current study aims to explore CIDs among Somali refugees displaced in Kenya to understand mental health needs in cultural context and serve the community in a culturally responsive and sensitive manner. This research was conducted as a two-phase qualitative study. First, key informant interviews with Somali mental health stakeholders generated a list of 7 common Somali CIDs: *buufis*, *buqsanaan*, *welwel*, *murug*, *qaracan*, *jinn*, and *waali*. Typologies of each CID were further explored through four focus group interviews with Somali community members. The findings from a template analysis revealed Somali lay beliefs on how trauma and daily stressors are experienced and discussed in the form of CIDs and how each term is utilized and understood in attributing symptoms to associated causes. This study highlights the need to incorporate colloquial terms in mental health assessment and to adopt a culturally relevant framework to encourage wider utilization of services and religious/spiritual support systems.

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Background

Decades of war and chaos in Somalia have led to the forced migration of over 1.1 million Somali refugees to neighboring countries (United Nations High Commissioner for Refugees [UNHCR], 2016). Cumulative trauma and prolonged displacement have affected every corner of life, generating profound challenges for Somali communities. Common issues include persistent impacts of war trauma (Mollica et al., 2001), torture (Jaranson et al., 2004), postresettlement stress and acculturative challenges (Ellis, McDonald, Lincoln, & Cabral, 2008; Pernice & Brook, 1996), substance abuse (Sowey, 2005), gender-based violence (Crisp, Morris, & Refstie, 2012; Pittaway & Bartolomei, 2001), and social discrimination in the host community (Ellis, Miller, Baldwin, & Abdi, 2011). Due to tremendous trauma and adversity, rates of common mental disorders among Somalis are consistently high regardless of setting, though numbers may vary across samples and measures. Previous studies have reported PTSD prevalence rates among Somalis ranging from 14% to 37% (J. T. de Jong et al., 2001). In refugee camp settings, some studies found a 48% prevalence of PTSD in Uganda (Onyut et al., 2009) and a 38% prevalence of depression in Ethiopia (Feyera, Mihretie, Bedaso, Gedle, & Kumera, 2015). In a study in Somalia, a third of women reported significant PTSD symptoms (K. de Jong et al., 2011). In an inner city community clinic in Minnesota, almost 60% of Somali women had comorbid depression and PTSD, while 80% of males and 32% of females under 30 presented with psychotic disorders (Kroll, Yusuf, & Fujiwara, 2011). Such mental disorders are often exacerbated by the use of substances, including khat (Bhui et al., 2006; Ellis et al., 2008; Odenwald et al., 2007).

Despite such compelling mental health needs, Somali refugees in Kenya have limited access to mental health services and psychosocial support, especially resources that are culturally relevant. Deficient infrastructure in low-resource settings tends to hinder the capacity and availability of mental health providers and thus result in unmet community needs and ineffective advocacy (Razzouk et al., 2010). In addition, various cultural barriers, such as different perceptions of mental health experiences and preferences for treatment options, pose additional challenges to the provision of relevant mental health interventions for refugee populations (Crumlish & O'Rourke, 2010). Problems often arise in utilizing Western diagnostic criteria, which may lead to ineffective and inadequate diagnosis and treatment (Fazel, Wheeler, & Danesh, 2005).

Westernized approaches to mental health often place limited emphasis on refugees' own experiences and cultural explanations of symptoms and distress (Carroll, 2004). Refugee mental health research has explained the rates of PTSD among

refugees as primarily the result of exposure to war and other traumatic experiences associated with refugee situations (Kienzler, 2008). Although conceptually and practically relevant to assessment of trauma impacts, the concept of PTSD has been overly dominant in refugee mental health literature. J. T. V. M. De Jong and van Ommeren (2002) criticized excessive attention to PTSD in many postconflict interventions, emphasizing the importance of culturally informed epidemiology. Alienating experiences in mental health care may lead refugees to decline treatment due to distrust of healthcare providers, shame, and fear of being stigmatized (Weatherhead & Daiches, 2010). Studies have shown that in many settings, refugees often seek help from well-respected traditional healers in times of distress, while they may perceive medical services as less accessible (Saeed, Gater, Hussain, & Mubbashar, 2000). A lack of understanding of the conceptualization of mental health in non-Western cultures may impede the acceptance and effectiveness of mental health programs for refugees.

In an effort to address such concerns, the DSM-5 elaborates cultural impacts on mental disorders in more complex and multifaceted manners, replacing the term culture-bound syndrome (CBS) with cultural concept of distress (CCD) that distinguishes three types of cultural features of mental health experiences: cultural syndromes, cultural idioms of distress, and cultural explanations or perceived causes (American Psychiatric Association [APA], 2013). As per the DSM-5, CCDs provide a potential useful framework to engage with local community members and develop appropriate assessment and intervention tools tailored to specific cultural groups by enhancing our understanding of how mental health is perceived, discussed, and managed in the cultural context of refugee communities.

Cultural idioms of distress (CIDs)

The term *cultural idiom of distress* (CID) refers to culture-specific expressions, symbols of emotional suffering, or culturally acceptable ways for individuals to communicate distress within specific contexts (Dein & Illaiee, 2013; J. T. de Jong & Reis, 2010; Kleinman, 1991). Research investigating CIDs has revealed how lay people describe symptoms and distress to others in their community in ways that enable communal understanding and acceptance through shared meaning (J. T. de Jong & Reis, 2010; Karasz, 2005; Nichter, 1981). In southern Guinea Bissau, for example, the idiom of distress *kiyang-yang* has been used by the community to describe postwar-related symptoms and trauma (J. T. de Jong & Reis, 2010). Another study through a CID lens revealed how the same notion of mental disorder, such as depression, can be differently experienced and discussed across cultures, as when Anglo-Australians focus on individual and phenomenological experiences, while East Africans highlight structural inequalities and social dislocation (Kokanovic, Dowrick, Butler, Herrman, & Gunn, 2008). Although cultural syndromes and cultural explanations are communicated through culturally specific terms, phrases, or modes of discourse, CIDs are not necessarily linked to specific symptoms, syndromes, or causal explanations (APA, 2013). Rather, such

vernacular terms as ''nerves'' and ''depression,'' and common bodily idioms of distress may ''convey a wide range of discomfort, including everyday experiences, subclinical conditions, or suffering due to social circumstances rather than mental disorders'' (APA, 2013, p. 14).

Several studies on Somali CIDs have been conducted in resettlement countries and Somalia. Carroll (2004) explored three key mental health expressions obtained from Somali refugees resettled in the US: *murug* (sadness or suffering); *waali* (craziness due to trauma); and *gini* (craziness due to spirit possession). Ryan (2008) also noted *walli* and *jinni* as the key idioms of distress along with *qalbijab* (broken mind), *boofis* (*buufis*; restlessness and excessive rumination or longing for resettlement), and *murug* (sadness and depression) among Somalis in New Zealand. Betancourt, Frounfelker, Mishra, Hussein, and Falzarano (2015) explored mental health terms and descriptors among Somali Bantus in the Maay Maay language, which included: *aasiwaalidin* (conduct problems), *wel wel* (worry), *dherif* (anger), and *takoor* (persistent sadness). Mölsä, Hjelde, and Tiilikainen (2010) investigated various mental health concepts, including those related to spiritual possessions and severe mental illness (e.g., *jinn*, *saar*, *khafif*, *qalbijab*, *maseeyr*, *waali*, etc.), using two focus group interviews with Somali seniors and two individual interviews with Islamic healers in Finland. *Buufis* as psychological distress has been well documented in several studies (Bhui et al., 2006; Byrskog, Olsson, Essén, & Allvin, 2014; Horst, 2006; Jinnah, 2017; Mölsä et al., 2010). Various phrases and descriptors to describe mental status or abnormal behaviors were explored and discussed in the context of Somalia (Reggi, 2014, cited in Cavallera et al., 2016).

Despite the significant strides in describing key Somali CIDs, few studies have examined the spectrum of Somali expressions of mental distress in response to refugee trauma. Also, most studies on Somali CIDs have been conducted in the context of Western resettlement countries and few have examined refugee displacement in urban African settings specifically. Though some expressions and conceptions may persist, CIDs are subject to change during acculturation to the host community (Mölsä et al., 2010). To provide more comprehensive assessment and treatment options relevant to Somalis in displacement, it is important to investigate refugees' constructs and expressions of mental illness that are specific to local understanding and practices that may not map onto existing Western diagnostic criteria. The current study aimed to explore a range of CIDs among Somali refugees in urban Kenya, in order to help care providers improve mental health communication and better serve this vulnerable population in a culturally responsive and sensitive manner.

Methods

The study was conducted in Eastleigh, a suburb of Nairobi, Kenya, which hosts over 100,000 Somali refugees and immigrants and is known as the largest Somali community outside Somalia (Moret, Baglioni, & Efionayi-Mäder, 2005). This was a qualitative study with two phases: (a) key informant interviews with Somali mental health stakeholders, and (b) focus group interviews with local community

members. This design allowed the researchers to identify major CIDs commonly used to express distress and mental disorders in the Somali refugee context and to explore their usage by Somali community members.

Key informant interviews

The first author conducted key informant interviews to generate a list of common Somali CIDs in the context of refugee displacement in Eastleigh. With assistance from the Somali community leaders and local partners, this study employed a purposive sampling strategy to recruit information-rich participants who could provide culturally valid perspectives on the mental health experiences of Somali refugees. A total of 15 Somali stakeholders participated in the key informant interviews: two psychiatrists (one male and one female); a primary care doctor (female); five pharmacists (four males and one female); two traditional healers (two males); and five paraprofessional counselors at a local clinic (one male and four females). All informants were Somali-born, except for three female counselors who were born and raised in Kenya as Somali refugees. To obtain a range of views, the researcher recruited participants with different educational and professional backgrounds. Preliminary data analysis and data collection were performed concurrently with the interviews in order to ensure data saturation as well as to allow triangulation of information sources (Bernard, 2012). To identify the common CIDs, probe questions on common mental stressors and expressions of mental distress were used. All participants were fluent in both Somali and English and all interviews were conducted in English as preferred by participants.

Participants reported multiple Somali idioms and concepts to describe the mental health outcomes of common refugee adversities, such as war, forced migration, multiple losses including family and community, gender-based violence, chronic poverty, discrimination, an uncertain future, insecurity, and fear of detainment and deportation. Various idioms and vernacular terms were reported to describe Somali trauma responses, some of which, however, were not unanimously agreed-upon among interviewees, or were replaceable with more comprehensive and common terms. *Dhimir*, for example, is a formal term that designates mental illness or psychiatry in general, but since some informants were not familiar with the term, it was not included in the final list. Instead, *waali*, the most popular term, which has almost the same meaning as *dhimir*, was retained. When multiple concepts were available to express similar kinds of emotional distress, participants were asked to indicate the most widely utilized and representative term. For example, multiple terms were reported to express emotional distress associated with family loss and severe deprivation, but *murug* was agreed-upon as the most common and broad term to express mental state of afflicted persons and was chosen over *tacsi*, *qalbijb*, or *baroortii*, all of which are related to sense of loss, grief, and mourning. A set of terms referring to spirit possession, *saar/zar*, *mingis*, and *wadaado*, were initially recognized during key informant interviews. These involved similar symptom expressions and forms of suffering to *jinn(i)*, even though the root of the beliefs varied. However,

these terms were not recognized by some participants, especially those who were young or left Somalia at a young age. Due to insufficient and divergent responses by participants, they were not included. Such discrepancies were due to variations in education, regional background, age, and generation of participants (Carroll, 2004; Dein, Alexander, & Napier, 2008).

The final list of CIDs determined through key informant interviews included: *buufis*, *buqsanaan*, *welwel*, *murug*, *qaracan*, *jinn*, and *waali*. This set of CIDs reflected shared beliefs and experiences of cultural groups influenced by the contextual conditions, such as the community's interaction with different cultural groups, reservation of traditional (i.e., Somali/African) or religious (i.e., Islamic) practices and customs, phases of migration, and socioeconomic conditions. As the largest Somali community outside Somalia, Eastleigh has attracted Somalis from various backgrounds, ranging from asylum seekers and camp-registered refugees, to Somali immigrants having settled before the Somali Civil War, to Somali diasporas or repatriates from Western countries (Campbell, 2006; Lindley, 2007). Protracted refugee situations in Kenya also enforced a unique assimilation process for Somali refugees (Purkey, 2013), which might allow the development of unique sets of conceptions as well as linguistic choices that embrace experiences of both displacement and settlement.

Focus group interviews

The study adopted and modified the Explanatory Model Interview Catalogue (EMIC; Weiss, 1997) in order to develop an interview guide and explore typologies of each CID. The EMIC, based on Kleinman's (1991) explanatory model approach, consists of several domains of inquiry, including distress patterns, perceived causes, help-seeking and treatment, and general beliefs on illness (Weiss, 1997). The current study focused on the first two domains, symptoms and causes, using EMIC questions as a guide to elicit cultural narratives of common mental disorders and emotional distress. The original EMIC questions examine subjective interpretation of general illness by the person with such an illness. To better understand socially constructed and culturally validated narratives, this study aimed to obtain socially constructed ideas of CIDs shared by community members, rather than the first-hand experiences and beliefs of persons with the respective mental health issues (Gergen, 2009). Therefore, this study employed a focus group interview (FGI) method, in which each question inquired about common distress idioms and explanations shared by community members. Questions about common symptoms, perceived causes, and contexts of use of CID in the community allowed respondents to exchange and validate ideas about cultural practices and beliefs through open discussion (Natasia & Rakow, 2009). Multiple follow-up questions were used for clarification and validation of answers (Shenton, 2004).

Four focus group interviews were conducted with eight women (age range 19 to 32 years; $M = 24.75$, $SD = 3.95$); eight males (age 18 to 38 years; $M = 26.83$, $SD = 7.11$; two unknown); 11 madrassa teachers (age 21 to 56 years; $M = 33.20$, $SD = 11.37$; one unknown); and four mental health outpatient clients (age 19 to 28 years; $M = 24.66$,

$SD = 4.093$, one unknown) at a local clinic in Eastleigh. Each focus group was conducted by the first author with the assistance of an experienced, bilingual Somali interpreter who is also a psychosocial counselor in the community. Each focus group started with a brief psychoeducational talk to normalize mental health experiences and emphasize the context of questions as being related to how the Somali community generally perceive or experience distress. All focus groups were audio-recorded after agreement, and translated by the interpreter.

Data analysis

All the FGI data were transcribed verbatim in English for analysis, followed by a vetting process in which the transcripts were cross-checked with the interpreter and a bilingual local counselor to ensure accuracy of translation. This study adopted a template analysis method, a form of thematic analysis that provides a scheme and a priori themes to organize data into clusters aligned with the research questions (King, 2004). The common symptoms and causes of each CID were arrayed in a template structured by a few conceptual categories, which had emerged from preliminary analysis of the data. For symptoms, the authors sorted the responses to each CID in four categories: (a) physical or somatic; (b) psychological, both emotional and cognitive; (c) social, behavioral, or interpersonal; and (d) religious/spiritual. The responses on perceived etiology were organized into one of three categories: daily stressors, trauma, and other mental health issues. Two authors conducted consensual coding, whereby each performed analysis independently and reached agreement on each categorical response through a reconciliation meeting. Then, preliminary findings in the form of templates were shared with a clinical counselor in Eastleigh for external audit to avoid misinterpretation of the data by researchers and to increase trustworthiness of the findings (Krefiting, 1991). Across four groups, there were minor discrepancies mainly due to incomplete or partial reports of causes or symptoms. The external audit suggested that some discrepancies between groups might be related to reports based on common versus possible symptoms and direct/proximal versus root causes, as well as cultural and gender differences. This process allowed the authors to determine the final findings that are based on common symptoms and direct/proximal causes. This two-step triangulation in data coding and analysis helped enhance the credibility of the data, while allowing reconciliation of subjectivities between researchers and respondents (Mays & Pope, 1995).

Results

The template analysis facilitated extracting Somali conceptualization of mental health with a set of symptomatology and etiology grouped into each CID as per the modified EMIC questions. Commonly recognized symptoms of each CID revealed a spectrum of severity in emotional and mental distress (see Table 1), while etiology responses described contextual factors that shape mental health experiences and provide clues concerning the believed trigger of the CIDs (see Table 2).

Buufis

Similar to anxiety in terms of symptoms, *buufis* is related to obsession with certain desires, particularly those related to resettlement that may be spurred by harsh living conditions that move individuals towards resettlement in an affluent foreign country. Paranoia is described as being on the more severe end of the *buufis* spectrum, while most described *buufis* as encompassing unsettledness or tenseness. Originally derived from a Somali word meaning "to withhold breath," *buufis* used to refer to a rather serious condition in Somalia that might emerge as a result of chewing too much khat (i.e., a local stimulant herb) or repercussions of civil war and clan conflicts tearing apart former social networks. The current usage of *buufis*, however, is usually limited to the context of resettlement or diaspora:

> When a person would like to go somewhere else, he normally talks about it, normally talks about going there. But Somalis here don't have the means [to go], so they abnormally repeat talking about that [foreign] country. Some people, they believe that it [*buufis*] is a disease because you can see the person just stressing himself. Even sometimes he hates the country where he lives, the place where he is and even hates his parents or relatives and the people who he lives with, so there are so many kinds of symptoms.

Participants described the cause of *buufis* as lack of resources and opportunities for education, work, and a decent life, all of which was directly and collectively affected by Somali war and displacement. Despite its dysfunctional effects, *buufis* was perceived as a normal status or condition due to its high prevalence and apparent external causes widely spread in the Somali community.

> There are some people, they [who] want to go to America. Somebody have relatives, they [who] are living in America. And they are wanting to go to America. They can't find a road to go to America. They want to get a visa, but they are not getting that visa. They become mad, but it's not mad.

Although the symptomatology of *buufis* significantly impedes and disrupts social functioning, those with *buufis* are perceived as neither normal nor abnormal. As many participants corroborated, "you see, they are saying everybody in Eastleigh has *buufis*." Even the participants of focus groups openly revealed that they have *buufis*. In spite of its negative impacts, particularly on social relationships and daily functioning, strong denial and avoidance of reality was understood in the context of pervasive clan conflicts and Somali diaspora. Being on the spectrum between normality and abnormality, *buufis* may develop into a more abnormal and pathological state as locals believe that "young people having *buufis* who continuously think about it [resettlement] may damage somewhere around head." The recognized treatment for *buufis* symptoms was being resettled in a third country and

Table 1. Common symptoms associated with Somali cultural idioms of distress (CIDs).

	Buufis	Buqsanaan	Welwel	Murug	Qaracan	Jinn	Waali
Equivalent diagnosis							
Similar Western diagnosis	NA (Desire for resettlement)	Acute anxiety, internal "noise"	Anxiety, adjustment disorder, panic disorder	Depression	PTSD	NA (spirit possession)	Psychosis, schizophrenia, dementia
Physical							
Back pain			✓	✓	✓	✓	
Chest pain		✓	✓	✓	✓	✓	
Headache or dizziness		✓	✓	✓	✓	✓	
Stomachache		✓	✓	✓	✓	✓	
Liver pain						✓	
Fever						✓	
Sweating			✓			✓	
Shaking			✓		✓	✓	
Muscle pain/tension			✓		✓	✓	
Fatigue			✓	✓		✓	
Feeling sick (unknown part or all over the body)			✓	✓	✓	✓	
Feeling numb (in limbs)					✓	✓	
Fainting					✓	✓	
Unusual strength						✓	
Weight loss		✓		✓	✓	✓	
Insomnia	✓	✓		✓	✓	✓	

(continued)

Table 1. Continued

	Buufis	Buqsanaan	Welwel	Murug	Qaracan	Jinn	Waali
Psychological (cognitive, emotional, and mental)							
Anger	✓	✓			✓	✓	
Helplessness	✓	✓		✓	✓		
Frustration	✓	✓			✓		
Negative affect	✓	✓			✓		
Sadness				✓	✓		
Crying			✓	✓	✓		
Anxiousness	✓		✓		✓		
Feelings of uneasiness	✓	✓	✓				
Lack of concentration	✓	✓		✓	✓		
Constant worrying			✓	✓			
Excessive or obsessive thoughts	✓	✓	✓		✓		
Hopelessness	✓	✓		✓	✓		
Hallucination or delusion							✓
Suicidal ideation		✓	✓	✓	✓		
Neglect of self				✓	✓		✓
Lack of self-efficacy	✓						
Social/interpersonal and externalized symptoms							
Isolation		✓		✓	✓	✓	
Suspicion of others			✓				
Fear of others			✓				

(continued)

Table 1. Continued

	Buufis	Buqsanaan	Welwel	Murug	Qaracan	Jinn	Waali
Lack of interest in relationships				✓	✓		✓
Change in behavior		✓			✓	✓	
Bizarre behavior						✓	✓
Talking to oneself					✓		✓
Outburst of anger					✓	✓	✓
Violent or aggressive towards others					✓	✓	✓
Not obeying social norms							✓
Poor hygiene							✓
Religious/spiritual							
Neglect of religious duties (refuse to pray or go to mosque)				✓	✓		
More reliance on religion (in the hope for something)	✓					✓	
Extremist thought					✓		
No spiritual connection							✓

Table 2. Perceived causes associated with Somali cultural idioms of distress (CIDs).

	Buufis	Buqsanaan	Welwel	Murug	Qaracan	Jinn	Waali
Daily stressors							
Lack of livelihood	✓						
Lack of education	✓						
Lack of opportunity	✓						
Poverty	✓	✓					
Resettlement-related	✓	✓					
Family problems		✓					
Relational problems		✓				✓	
Physical health problems			✓				
Distressing event*		✓	✓	✓			
Unfulfilled desires	✓	✓	✓				
Trauma-related stressors or war-related trauma							
Abuse		✓					✓
War	✓				✓		
Gender-based violence					✓		
Loss of a loved one				✓	✓		
Trauma in general			✓		✓		✓
Injustice (human rights violation)	✓			✓			
Other mental health issues							
Anxiety		✓	✓				✓
Jinn				✓			✓
Sadness (depression)							✓
Developmental disorder							✓
Psychological distress		✓	✓				
Genetic factors							✓
Substance abuse						✓	
Curses						✓	
Not obeying religious rituals						✓	
Walking on dirty roads						✓	
Unknown cause							✓

Note. *Distressing events include: loss of job, divorce, moving, injury or sickness, etc.

therefore having work and education opportunities, which was not feasible for most community members.

Buqsanaan

Buqsanaan means "loud noise" and refers to a state of "jammed mind" in Somali, as it is considered to cause internal noise in the mind. Rather than a mental illness, it is more accurately described as an emotional state or condition that a person can experience for a period of time while distressed. One participant described this experience as "like your mind whereby you are thinking everything that is a negative thing." It is generally thought of as an emotional and cognitive reaction to sudden and severe stressors or crises, such as financial crisis, relational problems, or concerns related to relocation. In addition to daily stressors, one traumatic event, abuse, was identified as a cause of *buqsanaan*. Psychological stress and other mental health symptoms, such as *buufis*, were also noted as a potential cause. The short-term course of *buqsanaan* and the Western diagnosis of acute anxiety and panic attack sounded alike, as a participant described:

> Having *buqsaanan* is like we see somebody is talking to himself a lot. Because we are living in foreign country where we come to seek peace or to supply our family but still we are not feeling belonging, we have *buqsaanan* of thinking about going to another country, like Western countries.

Symptoms of *buqsanaan* were characterized by both various physical symptoms and interpersonal/externalized symptoms, such as isolation and a change in behaviors. Perceived prevalence of *buqaanan* in the Somali community was believed to be high: between 60% and 95%. Given the nature of *buqsanaan* (i.e., arousing by intense feeling), it is generally considered curable by the removal of the source of problems. Study participants indicated that traditional healing methods, formal counseling, job opportunities, mindfulness exercises, and increased socializing can reduce *buqsanaan*. A participant described the need to advocate for intervention in cases of *buqsanaan* to assist community members, stating, "Because if you just avoid him or her [with *buqsanaan*] maybe he will get so much stress more than he had. So maybe he can just kill or harm himself or do something that is not good."

Welwel

Welwel is characterized as constant worries and anxious cognitions and behaviors. Similar to and yet distinct from *buqsanaan*, *welwel* is seen as a more stable form of anxiety disorder. As participants commonly noted,

> We can describe *welwel* as [being] anxious. You know when you are just anxious about something it's very bad. You want to get something but you are afraid to lose it, so

> you try hard to concentrate on it. You want to get the thing and actually you are just worrying about it because you don't want to lose it. Being so anxious.

Welwel is believed to be chronic, similar to *buufis*. It can be cured by solving the problematic issue, or be mitigated by simple emotional coping such as Qur'an recitation, prayer, and personal reflection. Participants, however, emphasized the need for intervention when symptoms of *welwel* are present to prevent an individual from decompensating into a more severe form of mental disorders, such as *waali*. Common symptoms of *welwel* were described by participants as both physical and psychological. Physical symptoms include back pain, chest pain, headache or dizziness, stomachache, sweating, shaking, muscle pain and tension, fatigue, and feeling sick in unknown part or the entire body. Weight loss and insomnia can be experienced, but this is not always the case. Psychological symptoms consist of being anxious, feeling uneasy, worrying constantly, being suspicious of others, fearing others, and crying. Many of the symptoms reflect the Western concept of anxiety disorder or panic attack. The perceived causes are similar to those for *buufis* and *buqsanaan*, including daily stressors such as physical health problems, distressing events, and unfulfilled desires. *Buufis*, *buqsanaan*, and *welwel* are all closely associated and yet distinct, and all are highly prevalent in the Somali community in displacement due to heightened daily stressors in addition to the cumulative burdens from war and community trauma.

Murug

Murug is commonly compared to the Western concept of depression, encompassing common themes that are associated with depression symptomatology. There are a few idioms to refer to sorrow or grief in Somali, including *cabijab* and *tacsi*, but *murug* is known to be the most common and strongest word to express mental health concerns related to deep sorrow. It is typically believed that when *murug* is left untreated, or further stress is experienced by someone with *murug*, this can develop into more severe mental health problems, such as *qaracan* or *waali*.

> *Murug* is a kind of sadness. You know sadness can cause so many things and things can cause more sadness. For example, you want to go somewhere and you did not succeed, so that things can make you so sad. For example, you lost part of your family and you can be sad. For example, when you have done some work but you did not get foods, you can also be sad. So there are always some problems.

Focus group participants did not fully agree whether *murug* is curable or not, but the commonly reported treatment modalities were religious coping, such as prayer and Qur'an recital. This is also related to the main causes of *murug*, which is often associated with certain losses, including means of living and loved ones. As one participant described, *murug* is "sadness over something that is out of your control, such as death of a family member or injustice." Symptoms of *murug* were described

as coming from all four symptom categories, with physical symptoms being the hallmark features of the disorder. Religious and spiritual responses were also involved in *murug*, such as a neglect of religious duties, including refusing to go to mosque or partake in daily prayers. *Murug* was also described as a state where the afflicted person is having trouble feeling emotions or in a state between constant worry and emotional numbness.

Qaracan

Qaracan, meaning ''shock'' or ''trauma'' in Somali, was noted by Somali mental health professionals to be a severe mental state that is comparable to the Western diagnosis of PTSD. This comparison is readily identifiable in the reported symptoms and causes of *qaracan*. Participants described the symptoms of *qaracan* as associated with all four categories of symptoms. Some participants linked *qaraan* to symptoms related to panic attack.

> If you feel *qaraan*, maybe you feel like you will come to die. And, at that time, you want to leave that place and you want to go to some place to relax because that is the feeling a lot people is around so you can go to a place to become alone and relax.

Qaracan was also described as being present in religious or spiritual outcomes such as neglect of religious duties, which is aligned with lowered social functioning and self-neglect. Also, developing extremist thoughts was peculiar to *quaracan*. The causes of *qaracan* were strongly associated with exposure to traumatic events, such as loss of loved ones, war, community violence, and other forms of severe trauma. Participants noted that *qaracan* is caused when ''something unexpected happened to you'' and its symptoms are often exacerbated ''because people are not in their own country. They are in a foreign country, so stress is higher,'' which highlights the multifaceted nature of cultural understandings of trauma and its sequelae.

Jinn

Jinn or *jinni* is a common concept throughout Islamic cultures referring to a spirit to which a range of mental health experiences are attributed, particularly when the cause is sudden or unknown. This CID has been found to be more frequent among women in the Somali community. As many participants noted, various unknown symptoms are ascribed to *jinn*.

> Let me say something. Actually, I can't talk about the cause of this one, but I have seen somebody who has this problem. I have seen a girl who had it. The first time I met her, she could not eat meat without getting sick. She could take something small, but she could not take more. And when she was possessed by *jinn*, it came to her and she began to eat a lot of meat.

In practice, an observed change in behavior or personality is seen as a plausible sign of being possessed by *jinn*. Participants also noted that *jinn* can cause a wide variety of physical and somatic symptoms. The most prominent initial symptomatic feature of *jinn* is fainting, which was described by both participants and Somali mental health experts as a proximal indication of *jinn*. Few psychological features were reported by participants and anger was found to be the most noticeable emotional response. At the same time, various social and externalized symptoms were associated with *jinn*, such as isolation, change in behaviors, bizarre behaviors, anger outbursts, being violent or aggressive towards others, and poor hygiene and walking on dirty roads. An increased reliance on religion in hopes of symptom reduction was also cited as a common response to *jinn*. Participants described the cause of *jinn* possession as an external, spiritually related act perpetrated against the afflicted person. Many participants indicated that *jinn* possession results from a curse placed on an individual by outside forces, including opponents. As such, the only nonspiritual cause attributed to *jinn* was relational problems. Negative spiritual or religious practice, such as disobeying religious rituals, was also recognized as both a possible cause and consequence of *jinn*. As one participant who claimed that she was possessed by *jinn* said, the only treatment for *jinn* possession is to ''believe the Qur'an, believe only the Qur'an.''

Waali

Waali is believed to be the most severe form of mental illness, and one that is highly stigmatized in the Somali community. Along with *dhimir*, *waali* is an overarching, common term that designates mental disorders in general. The state of *waali* includes psychotic features and has often been compared to the Western diagnosis of psychosis, schizophrenia, or dementia. A participant said: ''Going *waali* is when a person has reached the state where he or she is crazy. It is when people behave outrageously, like when you rip your clothes off and run around.'' Participants reported wide range of prevalence rates of *waali*, ranging from 5% to 50% of people in the community. A minor or initial stage of *waali* was considered to be curable; however, most cases were not so mild. Common treatment modalities included psychiatric institutionalization, medication, and religious or traditional healing, which involved interventions such as beating the person while reciting passages from the Qur'an or having the person with *waali* chained at home. There are few words to distinguish various mental disorders in Somali, and thus *waali* can refer to any type of severe mental disorder or disabilities, including dementia as described by one participant:

> I have at home my grandma. She cannot remember your name when you say to her. Also, she cannot remember her life even when she was young. The only moment [she remembers] is at some point her son died. Only she can remember that, and she cannot think back. To help her I take her shoes off. She takes to shouting.

Persons with *waali* were also characterized by having no spiritual connections to God. The etiology of *waali* was related to the exacerbation of less severe symptoms or disorders that were untreated and accumulated. Specific causes included both traumatic events, described as war, abuse, and general trauma, and other mental health problems or symptoms, such as severe anxiety, *jinn*, *murug*, *qaracan*, developmental disorders, and genetic factors.

Discussion

This study explored Somali lay beliefs about how refugee trauma and adversities are experienced, interpreted, and discussed in the form of cultural idioms and how each colloquial term of distress is utilized and understood in attributing symptoms to associated causes. There was a continuum of mental disorders in Somali CIDs that ranged in severity from normalized unrest and short-term anxiety to severe psychotic distress. Consistent with previous research (e.g., Horst, 2006), *buufis* tended to be normalized in terms of the Somali diaspora and was seen as prompted by the poor quality of life experienced during forced displacement without an option of repatriation to the home country. Although less grievous, anxiety-related disorders, such as *welwel* and *buqsanaan*, when untreated and accumulated could turn into more severe mental conditions, such as *waali* (Mölsä et al., 2010). Most CIDs involved a range of symptoms with varying degrees of severity. *Murung*, for example, referred to sadness ranging from everyday sadness, stress, and disappointment to psychiatric destabilization described as "craziness" (Carroll, 2004). This was similar to the more stigmatized and incapacitating *waali*, which was applied to both minor/curable and untreatable/irreversible disorders.

The study also identified different types of perceived causes and symptoms associated with each CID and articulated how mental health issues are affected by multiple refugee adversities in the refugee community. Previous studies of refugees have related mental disorders and psychological suffering to war trauma, daily stressors, or both, but there have been debates over how such factors are linked to mental health and psychological reactions (de Schryver, Vindevogel, Rasmussen, & Cramer, 2015; Li, Liddell, & Nickerson, 2016; Miller & Rasmussen, 2010; Neuner, 2010; Roberts & Browne, 2011; Silove, Ventevogel, & Rees, 2017). The symptomatology of CIDs in this study involved a triad of physical, mental, and psychosocial presentations, each of which was associated with the proximal causes of symptoms and related consequences. The findings revealed that certain symptom clusters, such as anxiety-related CIDs, were strongly associated with daily stressors, while terms for more intense distress, such as *murug* and *qaracan*, were related to uncontrollable traumas, such as the experience of war and tragic loss of family. In terms of symptom descriptors, this study also noted that internalized psychological symptoms and externalized behavioral problems are differently discussed depending on the severity of mental health issues. Both *buufis* and *waali*, representing two ends of the severity spectrum, were characterized mostly by externalized symptoms. However, *buufis*, like most other CIDs, included subjective psychological

symptoms, while *waali*, as well as *jinn*, involved few first-person descriptions of emotional symptoms, which implied othering of a person with more severe types of mental illness in the Somali community. In addition, *waali*, different from *jinn*, lacked intrapsychic symptom descriptions, both physical and psychological, which was associated with high levels of stigma. Somali lay beliefs related severe mental illness expressed as *waali* to causes that are both unsolvable (e.g., unknown source) and unsolved (e.g., cumulative mental disorders). The former cause implied few options for treatment and might aggravate stigma, whereas the latter revealed a shared understanding of the harmful effect of untreated mental disorders. This suggests that to mitigate stigma, mental health assessment and interventions should approach mental illness in the Somali community in terms of subjective experience and symptom descriptions, whether psychological or somatic, and explanations of identifiable causes.

This study also supports the important role of religion and spirituality in explaining and experiencing mental disorders, which is also associated with stigma and help-seeking (Johnsdotter, Ingvarsdotter, Ostman, & Carlbom, 2011). *Jinn* is a widely reported attribution to mental disorders in Islamic cultures, such as those in the Middle East (Bayer & Shunaigat, 2002; Obeid, Abulaban, Al-Ghatani, Al-Malki, & Al-Ghamdi, 2012), South/Southeast Asia (Haque, 2008), and many parts of Africa(Ally & Laher, 2008; Behrend & Luig, 1999). Studies of Muslim immigrants in the UK (Dein et al., 2008; Khalifa et al., 2011) and Somalis in Western countries (Svenberg, Mattsson, & Skott, 2009) have reported continued endorsement of traditional practices to treat *jinn*. Symptoms associated with *jinn* possession may be vague and nonspecific, and involve a wide range of somatic as well as psychological symptoms (Al-Habeeb, 2003; Dein et al., 2008). In this study, the symptoms of *jinn* had broad overlap with other CID symptoms (see Figure 1). Common symptoms of *jinn* in other studies range from deviant behaviors and observable behavioral change to various somatic pains and psychotic symptoms such as dissociation and hallucination (Lim, Hoek, & Blom, 2015). This wide spectrum of symptoms may reflect the fact that ascribing mental health symptoms to culturally acceptable or recognizable terms, such as *jinn*, provides individuals with a less stigmatized way to seek treatment and discuss mental health needs in the community. In fact, illness related to *jinn* has the most apparent and efficacious treatment known to the Somali community, including Qur'an recital, which may help communicate mental health issues and promote help-seeking (Dein & Illaiee, 2013; Johnsdotter et al., 2011; Weatherhead & Daiches, 2010). As previous studies have pointed out, those who are in transition in life are particularly susceptible to *jinn* possession (Ameen, 2005), while such factors as education and gender are often associated with beliefs as well as help-seeking patterns related to *jinn* (Dein et al., 2008; Lim et al., 2015). Mölsä et al. (2010) for example, noted that Somali elders strongly endorse traditional healing of *jinn*, while those who are younger, more highly educated, or of higher social status tend to be more oriented to modern or Western treatment modalities. This suggests that education as well as social context influence the extent to which *jinn* possession is accepted and used as an idiom.

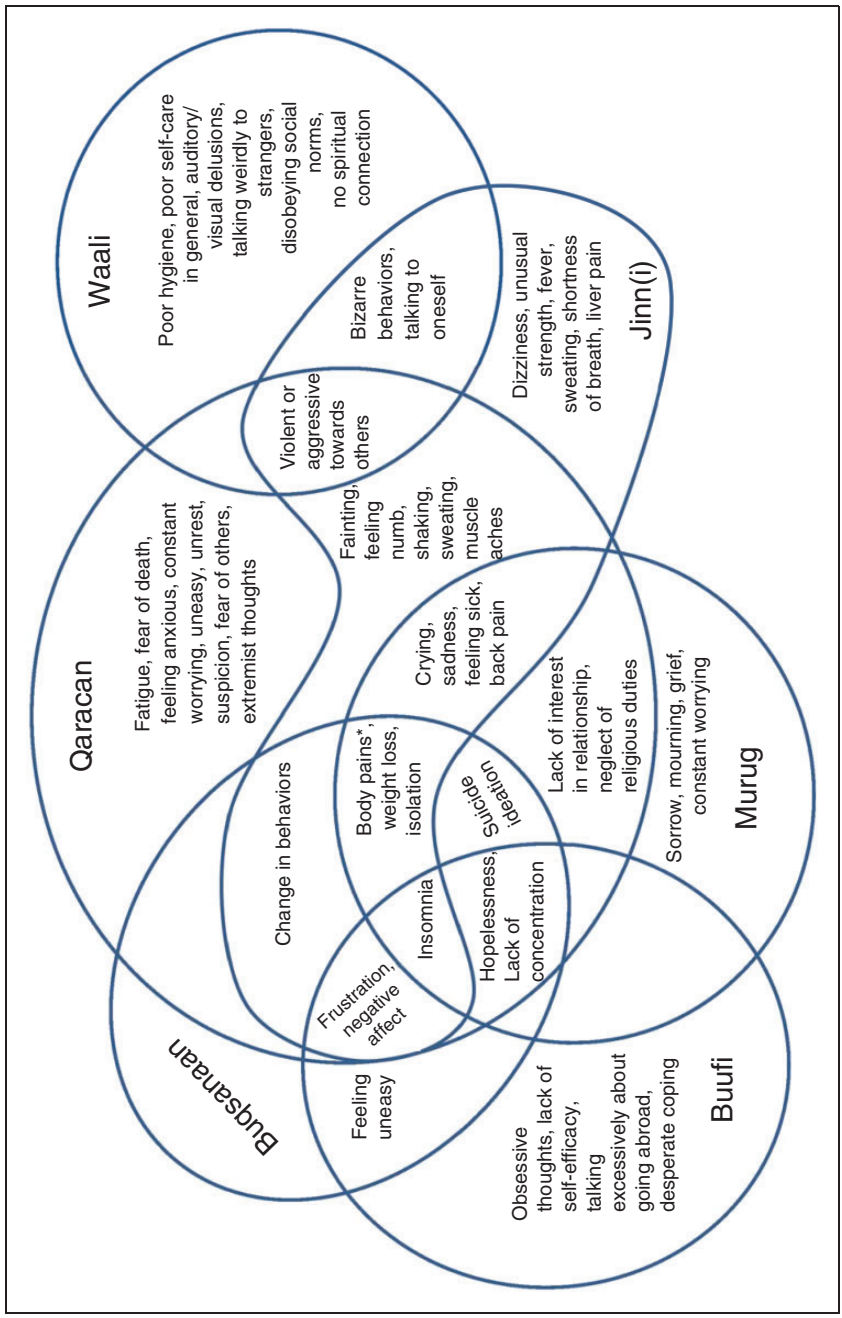

Figure 1. Venn diagram of Somali mental health symptoms as per CID.
Note. *Body pains include: chest pain, headache, stomachache, and (lower) back pain.

Research on the role of CIDs in the context of urban Somali refugee migration is limited (Carroll, 2004). As participants in this study pointed out, application of Western diagnoses may have harmful effects because individuals may be discriminated against in their community if they are suspected to be suffering from mental illness, which is automatically translated into *waali* or "craziness." In the context of Somali refugees in low-resource settings, someone "going *waali*" has few treatment options and is thus less likely to seek help than to keep silent about suffering to avoid social ostracism and discrimination. This study highlights the need for clinicians to provide mental health services informed by a solid understanding of CIDs as well as existing community stigmas and barriers that impact on the expression and communication of mental health problems. Creating diagnostic and intervention approaches that integrate an understanding of cultural contexts and colloquial terms for psychological distress is important to reduce stigmatization and promote appropriate help-seeking (Kirmayer, 1989; Nichter, 2010).

This study has some important limitations. The purposive and convenience sampling strategies used to recruit study participants may limit generalizability of the findings. Subgroup variations exist within the Somali refugee community. The participants in this study were relatively young, and generations may differ in the usage of certain CIDs. In fact, some terms (e.g., *waadado*, *shaki*, and *waalida dhaqanta*) were excluded from the analysis due to limited knowledge among some focus group participants, as well as key informants. This generational variation might also be related to differences in migration history and regional differences among Somali refugees, which should be considered in applying the findings to practice. The concepts and meanings of cultural expressions of distress may also change with migration. As Mölsä et al. (2010) have pointed out, Somali refugee communities face new sets of challenges and risk factors for mental disorders throughout the process of migration and resettlement, and such adversities require changes in understanding and coping with mental health problems. Although most cultural concepts of distress do not directly correspond to specific DSM diagnostic entities, exposure to Western society and systems may facilitate the incorporation of common mental health terminology, such as "depression," in the mental health vocabularies of refugees. Longitudinal or cohort studies are needed to explore the transformations of CID over time (Kleinman & Benson, 2006). Another limitation to be noted is the overrepresentation of female participants in this study. More females participated in this study in part due to the gender differences in cultural acceptance and willingness to recognize and discuss emotional distress. Gender significantly impacts on the perception and attitudes toward mental and somatic distress (Alemi, Weller, Montgomery, & James, 2016; Goodkind & Deacon, 2004). Further work is needed to explore gender differences in the communication of mental health problems.

While focus group interviews can be an effective method for revealing commonly shared beliefs in cultural practice and meanings (Wilkinson, 1998), responses in this

study may have been affected by variation in the composition of focus groups, which included differences in educational level, existing knowledge and awareness of mental health, previous and current exposure to Western culture and mental health knowledge, and response bias possibly undergirded by social desirability or contextual barriers (Sim, 1998). Lastly, although a rigorous vetting and triangulation process was applied to analysis, this study had to reconcile variations in some of the reports, including gaps in CID knowledge due to generational, regional, and/or gender differences. Quantification of responses might reveal a degree of agreement among participants, although sample selection bias and other issues might still remain. Mixed methods research including quantitative measures might help control for this type of response bias. It is also important to note that severity may be an important factor in understanding how CIDs can inform DSM nosology and diagnostic criteria for mental disorders, but this study did not assess severity existing within each CID.

Conclusion

This study of cultural idioms of distress among Somali refugees has several implications for work with refugee communities. To ensure effective and appropriate interventions, this study highlights the need to incorporate colloquial terms in communication between providers and individuals in expressing mental distress. Considering CIDs in engaging with refugees can promote cultural sensitivity and thus improve the quality of clinical relationships (Garrett, Dickenson, Young, Whelan, & Forero, 2008). Utilizing a culturally relevant framework may encourage discussion and help dispel stigma, leading to wider utilization of services available in the community, including religious and spiritual support systems (Loganathan & Murthy, 2011). Additionally, diversifying concepts of mental health symptomatology, beyond the framework of Western diagnostic systems, may help ensure that individuals in need of services do not fall through the cracks between pathology and superstition (Kagawa-Singer & Kassim-Lakha, 2003). Assessment of psychiatric distress, beyond conventional Western diagnosis, could help those who present with symptoms outside the "normal" diagnostic criteria be effectively identified and treated within their cultural context (Mezzich et al., 1999). Culturally grounded interventions based on local CIDs will also promote the decolonization of mental health service provision to the community and build locally driven, culturally sensitive service capacity within the community (Smith, 2012). Given the interwoven nature of mental health symptoms and consequences found in this study, a holistic approach that integrates psychosocial and spiritual support with mental, behavioral, and physical health services should be applied to this community. In conclusion, cultural contexts coupled with treatment modalities tailored to CIDs may result in an increase in help-seeking behavior and a decrease in unnecessary mental health stigma that could promote access to mental health services within the community.

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