Migration, Gender Roles, and Mental Illness: The Case of Somali Immigrants in Norway

Abstract

This article explores why Somali immigrant women in Norway have a lower utilization rate of mental-health services compared to Somali men. Based on qualitative research, it argues that the maintenance of traditional gender ideals shapes barriers and opportunities for mental-health utilization. Discussing health beliefs and responses in relation to gender roles and integration, the study identifies different illness implications for Somali men and women. Whereas Somali women's symbolic association with family accentuates perceived stigma, contributing to collective and individual concealments, higher utilization of mental-health services among Somali men is associated with social exposure. The findings suggest that research and outreach measures related to mental health require attention to immigrant women.

Introduction

Across cultural contexts, notions of masculinity and femininity have a decisive influence on people's health beliefs and behaviors (e.g., Courtenay 2000). However, when people migrate and resettle in societies different from their own, pertinent questions arise regarding both the negotiation and enactment of gender ideals and the gendered dimensions of health and health-care utilization (Llacer et al. 2007). This article examines how gender, conceptualized as negotiable cultural frameworks that situationally organize relational thoughts and practices between men and women, shapes the ways that Somali immigrants in Norway think about mental illness and its associated responses.

The Norwegian welfare state builds on the ideal of equitable redistribution through a universal scheme of tax-financed health and social services (Kildal and Kuhnle 2005; Kvist et al. 2012). Within it, every inhabitant is entitled to a wide array of health and care services based on need, irrespective of tax contribution. Yet there are great variations within and between immigrant groups in terms of how they utilize different services in Norway (Diaz et al. 2014;Næss and Vabø 2014; Straiton, Reneflot, and Diaz 2014). Within this landscape, Somali women distinguish themselves by having a significantly lower utilization rate of specialized mental-health services, compared to both Somali men and ethnically Norwegian women (Elstad, Finnvold, and Texmon 2015). More specifically, whereas the utilization rate among ethnic Norwegians between 20 and 69 years of age was 8.0 percent among women and 6.5 percent for men between 2008 and 2011, for Somalis the gendered pattern was reversed, with a mere 4.5 percent for women and 6.9 percent for men (Elstad, Finnvold, and Texmon 2015:58). Although comparable national statistics are scarce, the fact that Somali women utilize other specialist health services at a similar rate as native Norwegian women indicates that mental illness might be set apart from other health problems (Elstad, Finnvold, and Texmon 2015). In this regard, the disproportionate rates of mental-health utilization between Somali men and women raise critical questions about within-group mental-health disparities and potential gender differences in service access. The aim here is to provide an explanation for the outlined statistical pattern through qualitative exploration of the underlying determinants.

On the surface, disproportionate rates of mental-health service utilization between Somali men and women suggests the hypothesis that Somali women tend to have fewer or less significant mental health problems, compared to their male counterparts, upon resettlement in Norway. However, this presumption appears questionable, considering the incremental association between war and trauma experiences and mental disorders (Steel et al. 2009). In this regard, it is notable that female gender is a particular risk factor for the development and

exacerbation of post-traumatic stress disorders (PTSD) in adult civilian survivors of war trauma and torture (Johnson and Thompson 2008). Somali women, for example, were subjected to violence, loss, and fear during the Somali Civil War (1991-present), in the predominantly Somali refugee camps in Dadaab, Kenya, and as migrants to Europe (Bokore 2013; Gardner and El Bushra 2004; Horst 2006; Kagwanja 2000; Rivelli 2010). In fact, studies among Somali refugees in both Africa and the United States suggest that Somali women have experienced violence and trauma to the same extent as Somali men (Jaranson et al. 2004; Onyut et al. 2009; Cavallera et al. 2016). A prerequisite for the present exploration is therefore that Somali women in theory, because of their war, migration, and resettlement experiences, are equally susceptible to mental illness as are Somali men.

Moreover, although pre-migration trauma experiences can elevate the risk of mental disorders in refugees (Bhui et al. 2003), it is important to note that conditions and events in their resettlement destinations can also have a decisive influence on immigrants' mental health (Hynie 2018; Miller and Rasmussen 2010). Studies among different immigrant groups – Turkish immigrants in Denmark (Mirdal 2006) and Mexican farm-workers in the United States (Finch, Frank, and Vega 2004) - suggest that acculturation and integration stressors have sustained negative impacts on immigrants' mental well-being after resettlement. Conversely, successful social integration, which implies alleviation of stressors such as language barriers and loneliness, might have positive implications for immigrants' mental well-being (Chen et al. 2017). However, while social integration has been found to improve immigrants' mental well-being in general, dominant notions about gender roles might produce different challenges and opportunities for men's and women's socio-cultural adaptation and social participation (Dalgard and Thapa 2007). Hence, the gendered disproportionality in Somalis' mental-health service utilization in Norway must be examined in light of local social practices and processes of adaptation and integration.

Immigrants' healthcare-seeking practices are often complex processes shaped by the interplay of cultural and structural conditions (Rogler and Cortes 1993). In the case of Somalis in Norway, their pursuit of mental-health services is impacted by their previous lives in different socio-cultural and socio-economic settings and the migration/resettlement experience itself, both of which influence their health status and perceptions of formalized healthcare. While the cultural and acculturative sides of "mental illness" conceptualizations and responses among Somali immigrants have been subject to much scholarly research in countries like Finland, the United States, and Sweden (e.g., Johnsdotter et al. 2011; Pavlish et al. 2010; Svenberg, Skott, and Lepp 2011; Wedel 2012), specific attention to gender has been limited. Given the decisive influence that gender roles and social networks can have on immigrants' perspectives on health issues and attitudes about utilizing health and care services (Næss and Moen 2015), however, the subject merits further critical attention.

In exploring the association between gender roles and mental illness conceptions and responses among Somali immigrants in Norway, this article recognizes that Somalis often face multiple pressures to renegotiate their identity and gender roles in diaspora (Hopkins 2010; Kleist 2010). On the one hand, Somali immigrants face cultural and transnational pressures to maintain religious practices and modes of social organization associated with their home country. On the other hand, there are host-society demands for cultural adaptation and work participation. For this analysis, we can imagine the identities of Somalis in Norway "as 'framed' by two axes or vectors, simultaneously operational: the vector of similarity and contiguity; and the vector of difference and rupture" (Hall 1990:226). Accordingly, a consideration of how Somalis negotiate and settle tensions between competing traditions and sources of influence is integral to the present inquiry.

By drawing attention to the association between migration, gender roles, and mental illness, this article aims to contribute a more nuanced perspective on the social dynamics behind

immigrants' mental-illness conceptualizations and responses. Insights regarding gender's role in shaping the social sides of mental illness can help shed light on gendered barriers to mental-health services, hidden health needs, and potential areas of intervention. Based on in-depth interviews with Somalis in Oslo, this article argues that whereas the enactment of Somali notions of gender complementarity is associated with conditions permitting the social exposure and targeting of Somali men's mental illness, Somali women's responsibilities and symbolic position within the family contribute to both collective and self-initiated strategies of symptom concealment.

Before presenting the analysis and its methodological basis, I first provide an outline of the Somali, predominately Islamic, conception of mental illness and a description of Somali resettlement experiences in Norway. These sections frame the topic and set the scene for the presentation of findings on the following four themes: differences in Somali men's and women's public visibility and targeting by mental-health outreach initiatives, Somali women's symbolic status and mental-illness responses, the implications of institutional mistrust for mental-health contacts, and gendered non-disclosure of mental-health problems. To conclude, the article highlights the importance of examining immigrants' healthcare integration in light of extra-medical concerns and influences.

Mental Illness in Somalia and in Diaspora

The Somali Civil War, which in 1991 erupted into a full-scale, clan-based conflict in the power vacuum that followed the toppling of Siyad Barre's dictatorship by a coalition of opposition groups, not only displaced and dispersed more than two million Somalis but left deep imprints in the population's mental health (Cavallera et al. 2016). A 2010 analysis of the mental-health situation in Somalia showed that more than one third of the population suffered from mental disorders (Rivelli 2010). Relatedly, a growing body of research across disciplines and country

contexts has shown that mental illness is a prevalent health problem among Somalis in diaspora across Africa, Asia, Europe, North America, and Oceania (e.g., Kroll, Yusuf, and Fujiwara 2011; Mölsä, Hjelde, and Tiilikainen 2010; Whittaker et al. 2005).

Somalis in diaspora rely on traditional forms of medicine and healing, upheld through transnational connections to Somalia, while at the same time adapting to new health-care cultures (Tiilikainen and Koehn 2011). Although mental illness is an exception in this regard, it is notable that unorthodox beliefs, such as possession by malevolent *zar* spirits as explanations for women's mental illness (Lewis 1998), have been largely abandoned or redefined among Somalis in diaspora for practical reasons, as they have in Somalia because of recent Islamization (Tiilikainen 2010). At the same time, belief in *jinn*, or spirit possession as a principal cause of "mental illness," has remained strong among men and women across both Somalia and the diaspora (Abdullahi 2001; Mölsä, Hjelde, and Tiilikainen 2010; Tiilikainen 2011). The symptoms associated with *jinn* are sometimes synonymous with what western medicine defines as depression, stress-related disorders, and psychosis (Al-Issa 2000). However, an important distinction can be made between possession, which is seen as temporary and resolvable, and *waali,* or "craziness," which is the Somali term for chronic loss of self-control (Carrol 2004). It is when a person's behavior appearspathological, rather than normal, that *jinn*-possession is ruled out. Hence, considering that the initial responses to suspected *jinn*-possession are the same toward Somali men and women, it is in relation to behavior that falls outside the normative framework of interpretation that we might decipher whether and how gender roles shape barriers and opportunities for utilizing mental-health services.

Broadly speaking, the Somali system of health and healing consists of two main branches of treatments and rationales: (1) viewing and treating illness and injury as naturally caused and (2) viewing and treating illness, and mental illness in particular, as caused by the spirit world (Helander 1995). According to the Qur'an, the spirit world is unquestionable; thus,

most Muslims acknowledge the existence of *jinn*, shapeshifting creatures or spirits created by scorching fire that occupy a parallel world to that of humans (Qur'an 15:26-27). They can be male or female, appear in different forms, and be provoked to enter and tamper with human subjects. As is the case with humans, some *jinn* are good, and others are evil. The evil ones, related to the *Shaytaan* (the devil), are associated with illness. While illnesses or possession by *jinn* can occur as punishment for presumed wrongdoings (Rothenberg 2004), humans can also call upon *jinns* by way of *sihr* (black magic) to inflict harm upon others.

A more common explanation for illness and other forms of misfortune, such as failed marriages, miscarriages, or loss of wealth, however, is *al'ayn* (the evil eye), when envious or ill-intended persons wish harm upon others (Utz 2013). Because the source of mental illness is often understood by Somalis to be external to the body and because a number of potential stigmas exist, Somalis are frequently careful of how they ask about others' health and what they tell about their own (Helander 1995). A particular characteristic of Somali illness labels and associated remedies is thus that they are often initially assigned "by the household and not by healers or experts," with persons within and beyond the extended family gradually consulted if conditions worsen (Helander 1995:83). From this perspective, we can presume that trusting relationships and familial circumstances have a decisive influence on Somali immigrants' information sharing, help-seeking behavior, and health-related interactions (Næss 2019). Therefore, in efforts to understand the social determinants behind the disproportionate rates of mental-health utilization between Somali men and women in Norway, the ways that Somalis enact traditional family ideals in diaspora is a topic that requires research attention.

The traditional solution to mental disorders, whether symptoms are presumed to be caused by the evil eye, black magic, or direct possession, is performing *Ruqyah*, or exorcism, by reciting the Qur'an, saying prayers (*du'aa*), and consulting religious expertise (Mölsä, Hjelde, and Tiilikainen 2010). Somalis commonly refer to persons recognized for their religious

competency as *sheikh* or *wadaad*, the former term indicating superior Islamic competency (Lewis 1998:59). Exorcists can thus be Imams (Islamic leaders) or persons recognized for their abilities as "traditional" healers. According to Tiilikaninen (2011), there are an increasing number of professional healers and clinics in Somalia, and *jinn* is one of the most common diagnoses, especially for mental disorders. It is also notable that *jinn* often remains the most common explanation for mental problems in the diaspora, as found among elderly Somalis in Finland (Kuittinen et al. 2017). Somali religious healers in the diaspora operate through a familiar cultural framework, as can be seen in the fact that some Somalis pursue reputed experts locally or travel to other countries to consult them (Svenberg, Skott, and Lepp 2011; Wedel 2012). The maintenance of these practices and perspectives has implications for how Somali immigrants understand and relate to biomedical concepts of mental illness.

Perseverance of imported perspectives on and treatments for mental illness among Somali immigrants has been linked to the association between presumed craziness or biomedical diagnosis and ideas of stigma and permanence (Mölsä et al. 2010; Whittaker et al. 2005). In line with a study on dementia perceptions among Norwegian-Pakistanis (Næss and Moen 2015), this link suggests that skepticism toward biomedical diagnosis relates to its unclear purpose and potential social implications, such as shaming the family. Because the Somali language has few words corresponding directly to biomedical concepts, a diagnosis in a context like Sweden can be perceived to affirm that one is mentally ill or "crazy" (Wedel 2012). This point is also exemplified in a study among Somalis in the US state of Minnesota, where a wife's depression was identified as potentially disgraceful to her husband and his position as household head (Pavlish, Noor, and Brandt 2010). As this finding suggests, interpretations and responses to mental-illness symptoms in diaspora might intertwine with symbolic ideas about Somali gender roles to produce different implications for men and women. To contextualize the question of whether the enactment of traditional gender roles can explain the disproportionate

rates of mental-health utilization between Somali men and women in Norway, I now provide a brief account of the Somali resettlement experience.

Somali Resettlement in an Individualized Society

Since the mid-2000s, Norway's Somali population has more than doubled to a current 42,802 persons, about half of whom have status as refugees, making them Norway's largest non-western immigrant and refugee group (Statistics Norway 2019). This rapid population growth is attributable to high birth rates, family reunification, and a continuing stream of asylum-seekers and creates a highly diverse population in terms of residency duration, migration experiences, education, and acquired familiarity with a Norwegian cultural and institutional context. Recognizing this diversity is central to the present exploration of how gendered social dynamics shape immigrants' mental-illness conceptualizations and responses.

Norwegian integration policy combines the principles of what Nancy Fraser (1995) has called "a politics of redistribution" and "a politics of recognition." This mix implies that immigrants who obtain residency in Norway have unequivocal social rights, including access to public healthcare, alongside the freedom to maintain cultural and religious practices (Brochmann and Hagelund 2012). Ideally, integration in this context implies a situation where immigrant status is not decisive of life opportunities and social participation (Alba and Nee 2009). However, in practice, while social inclusion and non-discrimination lie at the core of Norwegian integration policy, many Somalis in Norway do not experience a sense of belonging and feel excluded from mainstream society (Open Society Foundations 2013). Continued immigration and high unemployment rates over time (Statistics Norway 2018a) have not only cast Somalis as scapegoats in Norwegian immigration and integration debates but also nourished the mass media's construction of Somalis as a problematic group associated with a culture of violence, masculine domination, *khat* consumption, and female circumcision

(Engebrigtsen and Fuglerud 2009). It is also notable in this respect that Norwegian public employees often perceive Somalis as a difficult group to work with because of their proud and demanding attitude, combined with a presumed unwillingness to adapt, whereas Somalis often report humiliation in these encounters (e.g., Fangen 2006). From immigrants' perspective, negative portrayals by the host society, combined with experiences of exclusion, might exacerbate forms of "bounded solidarity" and inward-looking social orientations (Portes and Sensenbrenner 1993), including a preoccupation with maintaining transnational bonds (Carling, Erdal, and Horst 2012).

Although many Somali refugees who came to Norway and other western countries in the late 1980s and early 1990s were among the better off and better educated (Gundel 2002:264), the process of adaptation and integration has not been easyfor more recent arrivals (Fangen 2008). One reason for this is that most recent Somali asylum-seekers have come from southern Somalia (Norwegian Directorate of Immigration 2016), where the rise of the Islamist group Al-Shabaab, droughts, famines, and continued fighting have restricted everyday life more than in Somaliland (northern Somalia) over the last decade (Moyi 2012). Somali immigrants therefore tend to arrive with limited or no familiarity with functioning public or state institutions (Engebrigtsen and Farstad 2004). An associated integrational hindrance is that educational and linguistic requirements for employment in Norway have increased over the past decades while the demand for unskilled labor has decreased(Norwegian Ministry of Education 2016). The fact that 6 out of 10 Somali women and 2 out of 10 Somali men haveno formal education upon arrival in Norway underscores why many experience an educational lag that restricts employment opportunities (Vrålstad and Wiggen 2017). Relatedly, adaptive challenges among Somalis are evident in the employment rates of 48.2 and 28.7 percent for men and women, respectively, the lowest of all immigrant groups in Norway (Statistics Norway 2018a). While low job participation among Somalis could be attributed to limited education and perhaps to

discrimination (Midtbøen and Rogstad 2012), the gendered difference in employment is exacerbated by the fact that Somali couples often have many children and a desire to uphold a traditional Somali family system (Engebrigtsen 2007; Fangen 2006; Fuglerud and Engebrigtsen 2006).

Although migration is often associated with newfound opportunities and pressures to renegotiate gender roles (e.g., Jolly and Reeves 2005), the enactment of traditional gender ideals as a source of identity and ontological security in diaspora both reflects and amplifies Somalis' adaptation difficulties (Engebrigtsen 2007; Hopkins 2010). Within the Somali system of gender complementarity, which is becoming of less concern to second-generation Somalis (Fangen 2008), men and women often have relatively separate social networks, with women responsible for the domestic sphere and men responsible for earning income and outward authority (Lewis 2002). Despite challenges experienced by many Somali men in fulfilling the breadwinner role in Norway, the provision of public welfare support has enabled Somali couples to have many children and Somali women to remain the locus of identity production and cultural perseverance through childrearing (Engebrigtsen 2007). Yet, welfare support, particularly to mothers, can also have an unsettling effect on gender relations in that it works to "empower" women by elevating their financial status and limiting their reliance on men (Kleist 2010). While this empowerment has the advantage of facilitating the termination of troubled marriages for both Somali men and women, it also works to increase Somali women's vulnerability and workloads as they usually maintain custody of children upon divorce (Engebrigtsen 2007). Hence, because Somali men and women often have different roles and separate social networks and spacesand because Somalis in diaspora are often principally concerned with their appearance and status in the eyes of fellow Somalis (Kleist 2010), we can presume a gendered dimension to the barriers and opportunities experienced by Somali men and women for utilizing mental-health services.

Methods

This article is based on in-depth interviews with Somalis in Oslo and its environs throughout 2015 and early 2016. At the outset, three key informants representing organizations interested in immigrant health facilitated my entry into the different clan-compartments of Oslo's Somali community. Although beyond the focus of this article, clan affinity is a defining aspect of Somalis' familial and social lives in Somalia (e.g., Lewis 1994) and diaspora (e.g., Næss 2018). According to informants, who themselves represented different clans, for many Somalis in Oslo clan-affinity is decisive of the choice of which café to visit, which mosque to attend, and which Somali immigrant organizations to join. Hence, conscious of this community's compartmentalization, the three key informants expedited links to other actors within their networks, allowing further snowball sampling of persons known or presumed to have insights or experiences regarding Somalis'health situation. Reflecting the centrality of oral communication and face-to-face interaction within Somali culture, having a shared reference point in previous interviewees seemed to motivate participation and information sharing.

In total, 38 persons (20 men and 18 women) between the ages of 20 and 64 participated in the study. In-depth individual interviews of 1 to 2 hours were conducted with 26 participants, including 2 high-ranking mosque representatives, 8 persons representing Somali immigrant organizations, 9 healthcare professionals (psychiatrists, psychiatric social workers, and nurses), and 7 lay persons. The 12 remaining persons participated in focus groups. The sample included persons who had seen instances of mental illness in their families, who had worked with or encountered mentally ill persons regularly, and who possessed only indirect knowledge of mental illness. Two considerations dictated my decision to recruit this diverse set of participants. On the one hand, because mental illness is a sensitive topic, arranging interviews with Somalis known to have mental-health problems was both practically and ethically restricted. Whereas Somali participants working with psychiatry were concerned that a potential

diagnosis, language difficulties, and mistrust could obstruct informed consent and sound data, other participants were reluctant to convey contact information for fear it would reveal persons in vulnerable situations. On the other hand, to capture the potential nuances in attitudes and perspectives within Oslo's Somali community, it was necessary to account for factors like age, residency duration, language, and education among interviewees.

To supplement individual interviews, with the assistance of the leaders of two immigrant organizations, I arranged two focus groups, involving 4 and 8 participants, respectively. I moderated these discussions to attain further insights into conflicting perceptions of, experiences with, and attitudes toward Norwegian health-care and mental-health services. The focus groups and individual interviews took place in a variety of settings, including hospitals, cafés, informants' homes, mosques, and organizations' headquarters. I conducted all data gathering in Norwegian. Recruitment primarily of Somalis with command of the Norwegian language was informed both by the aim to interview persons with experience and insight regarding the convergence between Somali and Norwegian health-care cultures and by considerations voiced by the three initial informants regarding trust, terminology, system familiarity, and inclusion of both men and women.

While recruiting primarily Somalis familiar with two health-care cultures eased communication, reflexivity was still necessary regarding my social position as an ethnically Norwegian, male researcher during research planning, data collection, and analysis (e.g., Berger 2015). The question of positionality was clearest when some interviewees, upon my introducing the research topic, positioned me as an "outsider." One measure that helped establish a sense of trust in these situations was my demonstrated awareness of an insider's perspectives and dilemmas regarding mental illness by drawing on issues mentioned in prior interviews. Demonstrating awareness regarding stigma, rumors, and spirit possession also facilitated inquiry into the link between gender and mental illness. However, a notable disadvantage with

recruiting Somalis familiar with two health-care cultures was their inclination to discuss mental illness and Somalis' encounter with the Norwegian healthcare culture based on general cultural insights and professional experiences, rather than personal or familial illness narratives. I recorded all interviews, upon informed consent, for subsequent transcription. To account for how interview situations played out, I also jotted field notes shortly after each interview (Emerson, Fretz, and Shaw 2011).

Data collection and analysis constituted an integrated and continuous process whereby emergent patterns and voids in the empirical material served as the basis for iterative revisions of the interview guides. In conducting new interviews, being able to draw on information that surfaced in prior ones proved fruitful for both testing statements and constructing questions that stimulated storytelling. For instance, hearing from one interviewee that he had witnessed mentally ill Somali women locked in apartments in Oslo, I had a specific example or way to probe about gender and differences in symptom interpretations and responses in subsequent interviews.

To analyze informants' stories, I applied a narrative analysis approach (Riessman 2008). By identifying thematic lines within interview data, I aimed to bring forth "meaning and reason to reported events through contextual and processual presentations" (Hammersley and Atkinson 2007:1999). During data attainment and analysis, I, thus, lent special consideration to what words and concepts participants used in their stories about mental illness, how interviewees implicated themselves in what they conveyed, and how my position as researcher informed the storytelling of men and women. This process involved reviewing notes from specific interview situations and listening for grammatical turns and shifting modes of speech in recorded interviews, for example when there was a shift in talk between a personal story and a cultural perspective. Throughout the presentation of findings, I use pseudonyms when quoting and referring to participants' stories.

Findings

Social Exposure and Targeting: Somali Men in the Limelight

This section addresses how differences in Somali men and women's visibility in spaces such as cafes, immigrant organizations, or neighborhoods might affect men and women's targeting in mental-health outreach. Participants in this study not only emphasized mental illness as a principal health concern in Norway but also tended to relate it to Somali men because of its association with unemployment, loneliness, *khat* chewing, and the idea that Somali men weremore dangerous to others than were Somali women. Moreover, participants frequently linked Somalis' perceptions about mental illness to the Somali, or Islamic, master narrative of mental illness, while also underscoring distinctions between instances of *jinn*-possession and cases of mental illness. As data accumulated, it gradually became clear that mental illness carried different social implications for Somali men and women, a fact that in turn shaped both collective and individual responses to symptoms of mental illness. Because Somali men more frequently had the freedom to socialize and spend time in public settings like cafes or in the street, their problematic mental-health behavior was more often visible to others. Because of Somali women's symbolic position within and responsibilities for the family, however, Somali women experienced both collective and individual forms of problem concealment.

A recurring notion among all interviewees was that "Somalis go to the mosque in events of mental distress." According to both Marwa (47) and Amal (44), for instance, two leaders of Somali organizations centered on women, this was because people's beliefs had a great influence on where they sought help. As Marwa explained, and as Amal had similarly mentioned in an interview, "many people therefore go to the mosque, so we see that the mosque is a social helper." Abdi-Saleh (37), however, a central figure in one of Oslo's largest mosques, believed that the mosque's role was both varied and changing. In his experience, mosque

communities had become increasingly hesitant about being associated with religious healing, following a 2013 incident at Oslo's Rabita mosque where a 21-year-old woman, allegedly undergoing an exorcism, died from heart failure. While not denying that exorcisms still took place at mosques, he stressed that many mosques had developed restrictive guidelines, including an age limit and the requirement of accompaniment by family members or other entrusted persons during treatments. This restrictiveness on part of the mosques, he felt, might increase the pursuit of Islamic solutions within the private sphere, rather than push Somalis to seek public mental-health services.

Besides individual prayer and Qur'an recitations at home, Abdi-Saleh explained that Somalis sometimes paid religious experts to come on home visits or traveled far to see them. Knowledge about these experts and their whereabouts traveled by word of mouth. From Abdi-Saleh's viewpoint, these solutions and the fact that the mosque was more an arena for advice, consultancy, and worship than a place of treatment could partially explain why suspected mental-health problems among Somalis, particularly among women, remained out of sight from both other Somali families and health-care providers. This perspective was rooted in Abdi-Saleh's experience with his mosque's partnership with a mental-health institution, where most referrals of mentally distressed persons to mental-health services concerned Somali men. However, while admitting the mosque's leadership knew little about the mental-health situation of Somali women in Norway, Abdi-Saleh emphasized that fewer contacts with Somali women did not necessarily mean that Somali women had better mental health than Somali men. Considering that both lay participants and mosque representatives identified Somali women as the typical victim of *jinn*-possession, we might deduce that gender is associated with differences in symptom interpretations and responses, but not necessarily in the distribution of mental illness.

In an interview, Ahmed (59), a psychiatric social worker engaged in what he called "bridge-building" between Somalis and Norwegian mental-health services through a major organization, said, "we have made few contacts with women, but with many men." He had become engaged in his current work following the so-called tram-murder in 2004, when a Somali man, equipped with a knife, killed one person and seriously injured four others on a tram in Oslo shortly after his discharge from an acute mental ward. This event, along with previous incidents involving Somali immigrants, not only spurred debates about Norwegian mental-health services' ability to assess and accommodate the needs of an increasingly ethno-culturally diverse citizenry but, as Ahmed's role attests, also raised concerns about Somalis' perspectives on mental illness and mental-health services in general.

When asked why his organization had reached few Somali women, Ahmed explained that their experience mostly with men was not intentional:

> Because Somali men are out in the streets or in cafes, we have been able to approach them. The women, we rarely see like this because of their families. For the women, it has to do with family honor, so families protect them; they send them back to Somalia. They protect the honor of the whole clan and family. But the men… nobody cares… They are not so protected.

From both Ahmed's and Abdi-Saleh's viewpoint, the lack of social restrictions regarding Somali men's presence in public spaces and, thus, their displays of unconventional behaviors and resulting visibility had contributed to men rather than women being targeted in existing outreach initiatives. At the same time, while asserting that the outreach to primarily Somali men was not intentional, they also admitted that both spotting and establishing contact with unacquainted Somali women were difficult. According to Ahmed and Abdi-Saleh, reaching Somali women with potential health needs was especially problematic because of the combination of closed family networks, the relatively separate social networks of Somali men

and women, and the stigma associated with mental-health problems. From their narratives, women's domestic roles and responsibilities not only restricted their visibility in public but also elevated the presumed social risks of displaying symptoms, admitting illness, or seeking help. From this perspective, disclosure of Somali women's mental illness, particularly to Somali acquaintances or persons beyond the immediate family, might put into question their fulfillment of feminine ideals, which in turn could reflect poorly on Somali men's positions as household heads. Relatedly, both Ahmed and Abdi-Saleh hinted that mental illness in Somali men and women could trigger different responses. The missing women in both Ahmed and Abdi-Saleh's narratives therefore spurred the question, "where were the women?"

Somali Men's Problem with Women's Mental Illness

This section discusses Somali men's and familial responses toward mental illness in Somali women. If a person becomes *waali,* which translates to "crazy," Somali tradition says that he/she will never get well (Mölsä, Hjelde, and Tiilikainen 2010). Descriptions of the ways that people in this state are treated in Somalia echo this attitude. For instance, the practice of "chaining" persons whose behavior is unpredictable, aggressive, or self-destructive is widespread in Somalia, including in the country's mental-health facilities (Johnsdotter et al. 2011; Rivelli 2010; Tiilikainen 2011). While used to contain individuals in the face of unavailable medications and treatments, the practice can be a "permanent trauma" in itself, as communities sometimes regard mentally ill persons as eternally dangerous and unpredictable (Rivelli 2010:23), with sometimes-fatal consequences for such individuals. Despite the availability of psychiatric treatments in Norway, similar practices are sometimes re-enacted in diaspora.

Arif (64), who is a psychiatrist, explained in an interview at his home that he had witnessed such containment practices in Somali homes in Norway:

> Also in Oslo, that there are people contained inside apartments. This is mostly women. Some of them have mental retardations or psychological disorders, and some have become psychotic at a young age. Their families keep them hidden. When they manage to, they will return them to Somalia, but as long as they do not have a place to send them, they keep them locked up at home. If you can pay, send a hundred dollars per month, then you can get an aunt or someone to watch over them in Somalia, but depending on their behavior, they will often stay chained. This is because, in Norway, it is more stigmatizing to take women for treatment than a man.

When asked about the reason for this containment practice, several interviewees pointed to the connection between Somali women's symbolic status and the family's honor, as well as to vague references to the potential danger posed by mentally ill Somali men. Because forced containment violates Norwegian law, all interviewees, except participants who had seen the practice in Norway or Somalia, clearly disassociated themselves from it as they spoke. Although both Somali men and women were subject to containment, the underlying attitude among men and women interviewees was that women's bodies became subject to collective, especially men's, social control upon displaying unconventional behavior, whereas men's bodies typically did not.

According to a number of interviewees, maintenance of containment practices in diaspora was symptomatic of imported health beliefs and a limited familiarity with and trust in psychiatric services. In an interview with Mido (43) for instance, the leader of a Somali organization, he stated that "mental illness is untraditional, so we do not talk about it." According to him, an implication of this attitude was that mental illness, in cases where possession was unlikely, often remained seen as stigmatizing, untreatable, and something to conceal. Sometimes, only the immediate family knew about mental problems. In this regard, while transnational connections and local bonding capital can be advantageous for adaptation

and belonging upon resettlement, there can also be a backside to strong transnational network relations in diaspora (Ryan et al. 2008). Mido explained that strong network relations not only limited contacts, familiarity, and trust toward Norwegian mental-health services but also encouraged alternatives to professional help and potential stigma. Besides local containment and spiritual healing, one such alternative, as mentioned by Arif, was to return severely ill persons to Somalia in the hope of improvement.

Several interviewees brought up the utilization of transnational ties to Somalia as a way to return persons with mental problems. Hala, for instance, who worked at a nursing home, was familiar with one case where "a husband sent his wife and children back to Somalia where her family could take care of them." This return, she explained, was driven by the husband's wish to relieve himself of both childrearing responsibilities and stigma. Other informants had also heard about such cases, although none involving persons close to them. Hala, however, expressed doubt as to whether returning to Somalia would yield efficient help or improvement. According to her, this was because family members in Somalia were often unable to provide much care. A study on mentally ill returnees to Somaliland from Finland underscores the limited potential for appropriate help (Tiilikainen 2011). The limited potential for efficient help upon returning to Somalia was also Ahmed's contention when describing his recent travel to Hargeisa, Somaliland, accompanying a psychiatrist:

> He showed me the situation in the area that I come from. People were standing in one position facing walls, they ate little food… like dogs… they died. There are few medications available. They did this, trapped them inside a room, because if the person does something wrong, it is the family's responsibility to reimburse or settle things. Sometimes there is no family either.

Muhammad, a nurse and cofounder of a Somali organization, who had also observed the situation in Somaliland, attested to the hopelessness. In a less figurative way, he stressed, "the

family has a big responsibility, but they are often unable to provide any proper care for mentally ill family members." In other words, although relatives might attempt to provide care and involve religious experts, the result is often containment, and the idea of improvement is often faint.

Although determining the extent to which practices of containment and returns occur among Somalis in Norway is beyond this study, most interviewees were familiar with the phenomenon. The main lessons to be drawn from these examples, however, are not only that severe mental-health problems in Somali women are seen as potentially more damaging to the family than are men's but also, and more importantly, that mentally ill Somali women are particularly vulnerable to male control and to Somali men's priority of reputational preservation. The use of containment and returns is symptomatic of imported health beliefs, traditional gender roles, and limited health care integration in Norway.

Fear of the Child Welfare Services as a Barrier to Mental Health Utilization

Institutional trust/mistrust can have decisive implications for people's health behaviors and decisions to utilize available healthcare services (Mohseni and Lindstrom 2007; Schout, de Jong, and Zeelen 2011). In Norway, non-western children are twice as likely as that of ethnic Norwegian children to be taken by child welfare services (Staer and Bjørknes 2015), and many Somalis see this institution as problematic (Open Society Foundations 2013). A recent study shows that 86 in 1000 Somali immigrant children and 45 in 1000 children born in Norway to Somali parents were clients of childcare services, compared to 31 in 1000 non-immigrant children (Dyrhaug and Sky 2015). Regardless of the background and nature of these client relationships, many Somalis struggle to see the benefits of such contacts because stories of mistakes and invasive conduct circulate widely among Somali immigrants. In both focus groups and many individual interviews, participants brought attention to child welfare services when

asked about gender and barriers to mental-health utilization. Both Somali men and women attributed the gendering of such barriers to women's family position and to fear of involvement by child welfare services.

Adil (24), a student interviewed following the Friday prayer (salãt al-jum'ah) at a large mosque, for example, explained, "Somalis call each other and meet all the time. In a very short time, Somalis all across Norway will have heard rumors or stories about critical situations involving Somalis." This information, although potentially distorted in the flow of exchange, is particularly impactful, considering Somali culture's oral foundation and lack of trust in state institutions (Lewis 2002). A central observation here was that both Somali men and women attributed great risk to utilizing mental-health services, not simply because of social stigma and community exclusion, but also because of a perceived link between contact with mental-health services and targeting by child welfare services.

According to Marwa and Amal, "many Norwegian-Somali women think that if I explain my situation to a psychologist or a doctor, they will take my child" – a point raised in other interviews as well. As Hira (31), who worked as a nurse, shared, there were even Somalis who moved between municipalities to protect their families from child welfare services. Mohammed (28), who was also a nurse, held that a central reason for this skepticism was that "child welfare services do not recognize that controlled forms of violence is something that all Somali children experience during their upbringing." While in stark contrast to Norwegian non-tolerance of corporal punishment and disciplining of children (Stang 2011), in interviews, the negative view of child welfare services was associated with the low threshold for action and correspondingly high risk of mistakes.

Both Somali men and women of different ages expressed concerns about the trustworthiness and intentions of child-welfare services. Mido exemplified this risk, saying that "child welfare services sometimes make judgements about the situation of children simply

based on the standard of the apartments where families live." From Mido's viewpoint, the fact that Somalis were in economically disadvantaged positions not only increased the presumed risk of misjudgments but also obfuscated recognition of child welfare services' mission to ensure the well-being of children and families. Involvements by child welfare services in generaltypically occur based on reports by police, schools, kindergartens, parents, medical practitioners, private citizens, and to a much less extent mental-health providers (Statistics Norway 2018b). Nonetheless, Somali interviewees highlighted fear of child welfare services as reason for avoiding mental-health services in Norway.

Because most Somalis regarded family and kinship as prerequisites for stability, mental well-being, and communal recognition (Lewis 1994), the imagined familial consequences of child-welfare involvement appeared to overshadow the idea that Somali individuals and families could benefit from such contacts. Although such involvements typically affected the whole family, participants recurrently identified women as particularly vulnerable because they became the targets of blame, and self-blame, if their family was affected. Therefore, coupled with an awareness of the abovementioned repertoire of measures taken to conceal pathological behavior, Somali women themselves sometimes strove to conceal internal struggles.

Gendered Non-Disclosure: Self-Protection and Mental Health Barrier

A common source of relief for Somali women suffering mental distress was to share their problems with other women, but depending on circumstances, they might also fear disclosure and value concealment (Whittaker et al. 2005). While participants in this study acknowledged that Somali women often offer support toward other women within their social networks, with reference to mental illness, they placed particular emphasis on the issue of women who suffered in silence through the "hidden sacrifice of constant, on-going, self-giving" (Mayblin 2014:361). Several interviewees, both men and women, brought up the topic of non-disclosure and memory

suppression, suggesting that mental illness was perceived as having greater social consequences for Somali women than for Somali men. Although four interviewees suggested that Somali women were "mentally stronger" or more resilient than men when it came to mental distress, interviews also revealed that Somali women faced a different set of pressures to conceal problems and suppress memories. These pressures shaped both treatment situations and pathways to services.

According to Mariam (56), the leader of an organization concerned with Somali women and children's health, both female circumcision and exposure to torture and sexual violence were part of many Somali women'sbackground, something that impeded their mental well-being in various ways. These experiences were associated with a lingering sense of shame and stigma, making them socially dangerous to share openly. Non-disclosure of experiences and suppression of memories were therefore both forms of self-protection in Somali women's relationships with men or psychiatric consultations and intricate reasons for avoiding mental-health services altogether. Arif, an experienced psychiatrist, recalled a related patient consultation:

> I can tell you about the case of a Somali woman who had four children close after one another. When her husband came to Norway through family reunification, she got pregnant again right away. She got morning sickness but also got depressed and psychotic. She related everything to the pregnancy, although she had experienced other trauma. Even after undergoing treatment, she still would say that her conditions were purely because of her pregnancy.

From Arif's perspective, this type of trauma-denial, or self-protection, was a barrier to both mental-health contacts and treatments. The benefit of receiving professional help in this case would be to identify trauma experiences and receive help with reprocessing memories.

In Arif's consultation example, the downplaying and denial of potential mental-illness triggers indicated self-stigma. That is, by not conveying the details of her situation, the woman avoided both the consequences of a potential diagnostic label and the social dangers of an information leak. For similar reasons, as found in a study of Canadian-Somali women, "in group counselling, women often talk about sexual violence in the third person to avoid implicating themselves" (Bokore 2013:99). As this example shows, unfamiliar settings and people can accentuate pressures to disguise symptoms of trauma experiences by upholding a façade of resilience (Beauboeuf-Lafontant 2007). However, while such efforts are forms of self-protection, they are also obstacles for pursuing and accepting professional help.

Marwa and Amal, who frequently consulted Somali women experiencing postpartum depressions and other mental difficulties, found it challenging and time consuming to convince women to pursue available services. As they explained,

> We say we can come with you. We can go and have a conversation with them. You are not alone. In Norway, you have many rights. Even if you have received treatment, nobody can take your child from you. This information takes time, patience, good communication, and a shared language. It might be that Somalis who are integrated accept help, but for newcomers, it is very difficult.

There were also great differences among Somali participants in terms of integration and their ability to trust in and negotiate the Norwegian health-care apparatus. Interviewees with little or no direct familiarity with biomedicine and mental illness, for example, were often inclined to talk about it primarily with reference to the Islamic narrative. By contrast, interviewees representing the health-care system or immigrant organizations, like Marwa and Amal, recognized conflicting mental-health perspectives as a community health challenge. Perhaps most importantly, they were conscious of the need for information in Somali, patience, and trust-building in health relations.

Madinah, a 33-year-old teacher, illustrated the need for familiarization and trust with reference to her mentally ill aunt. She explained, “although we believed she was mentally disturbed, because of rumors about the system and her concern with her appearance, for years she convinced us of the dangers of seeking professional help.” From Madinah’s perspective, aware that her aunt aimed at safeguarding herself and her family from stigma, her aunt’s desire to conceal her symptoms was problematic because it strained the family internally and obfuscated professional help as a possibility. Yet, her aunt was not solely responsible for avoiding mental-health contacts. According to Madinah, her aunt’s husband had been especially adamant about waiting out the situation within the household rather than placing his wife’s health and the family’s reputation at risk. However, Madinah went on to explain that she had not given up and that she and her brother were beginning to change the husband’s views because of the stagnant situation. This example further underscores the point made by Marwa and Amal that there is a general need for information and service familiarization that can counter stigma presumptions in Somali families. Madinah’s story also hinted that the complementary division of social responsibilities between Somali men and women, particularly women’s symbolic role as carriers of family honor, works to gender perceptions of barriers and opportunities for utilizing mental-health services.

In an eight-person focus group, Ismael, an 18-year-old student, reflected on his mother’s mental health and its implications on the family. Because participants were familiar with one another, as they met regularly for social activities like music and sports, there seemed to be little reluctance about sharing information. Saying that his mother rarely spoke about her experiences from Somalia and that he therefore knew little about them, Ismael explained that he sometimes felt the consequences of her silence. In particular, he felt that his mother sometimes acted nervous and temperamental. According to Ismael, his mother, as far as he knew, had never sought any help, although he felt “she could need to talk to someone.”

Moreover, Ismael, as the oldest sibling, never confronted her with how he and his younger siblings experienced living with her, largely because they managed as a family, but also because he did not see his mother as mentally ill. Nevertheless, during the same discussion, participants voiced many of the concerns presented earlier, suggesting that risk perceptions sometimes outweighed ideas about potential benefits or health gains from consulting health professionals and investing trust in public mental-health services. Provided Somali women can fulfill communal, familial, and self-instigated expectations regarding the feminine role, the threshold can be high for tending to their own mental health in the face of potential social consequences.

Conclusion

Exploring how gender roles shape patterns of mental-healthservice utilization among Somali immigrants in Norway, the analysis presented here shows that normative gender expectations, often upheld as a source of identity and ontological security in diaspora (Kleist 2010), can moderate conceptions of mental illness to shape gendered differences in presumed barriers and opportunities for seeking and accepting mental-health services. Whereas the traditional notion of gender complementarity permits Somali men's exposure of illness symptoms in public spaces, making them potential targets of formal intervention, Somali women's responsibilities and symbolic positions as wives and mothers encourage both collective and self-initiated forms of problem concealment. The collective form of concealment, which involves containment and returns to Somalia, is thus a measure to protect individual and family reputations, whereas women's own strategies of internalization aim to safeguard themselves against both social consequences and familial actions. In this respect, this study not only calls for incorporating gender as a relational concept in studies of immigrant health and health-care adaptation but also illuminates a potential for exploring gender, adaptation, and integration through a focus on health and illness.

Although there are many Somali women who do utilize mental-health services in Norway, this study suggests that there is a general need for information about mental illness and mental-health services in the Somali language and for outreach measures or contact points that are discrete and focus on women. It is notable in this respect, as indicated in a study among elderly Somalis in Finland (Mölsä, Tiilikainen, and Punamäki 2017), that there is a preference for culturally appropriate services. Although the enactment of normative gender expectations partially explains why a mere 4.5 percent of Somali women, compared to 6.9 percent of Somali men, utilize specialist mental-health services in Norway (Elstad, Finnvold, and Texmon 2015), both outreach measures and culturally sensitive services appear contingent upon Somalis' general familiarization with the Norwegian healthcare culture. Familiarization with a new health-care culture among both men and women is particularly central to countering mistrust and negative presumptions, stigma, and associated gender disparities in barriers and opportunities for utilizing mental-health services. Hence, while culturally adapted services could contribute positively toward immigrants' cultural and institutional familiarization, this study underscores, in line with previous research (e.g., Rogler and Cortes 1993), the pertinence of addressing and understanding immigrants' healthcare integration as entwined with extra-medical processes and concerns, particularly dominant understandings and practices of gender.

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