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The author, whose name appears on the title page of this work, has obtained, for the research described in this work, either:

a. human research ethics approval from the Simon Fraser University Office of Research Ethics

or

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Abstract

**Background:** The refugee experience has been associated with increased rates of psychosocial challenges. At the same time, evidence suggests that those who resettle in Western countries underutilize Western mental health services. The reluctance of refugees to use mental health services has been attributed to barriers to accessing services such as language, complexity of the health system, and differing explanatory models of illness. The same is true for Somali refugees in Western countries. Studies suggest that Somali refugees prefer spiritual healing for psychosocial illness and that some return to East Africa for healing. However, little is known about the mental health of the Somali community in Canada and the services they utilize for psychosocial problems.

**Objectives:** In conducting original ethnographic study, I aimed to understand the psychosocial challenges faced by Somali Canadians, their health seeking behaviors, and their access and barriers to psychosocial services in Canada. Because some have sought psychosocial services at international destinations, I conducted fieldwork in Kenya to provide new evidence on the little-known transnational spiritual healing systems popular among diasporic Somalis.

**Methods:** Ethnographic fieldwork and in-depth interviews were utilized. Thirty-seven in-depth interviews of about an hour each were undertaken in Canada and Kenya. Fieldwork focused on visiting spiritual and cultural healing centers in Nairobi for three to four hours each.

**Results:** The findings show that some families struggle with childhood autism and youth substance use, while others deal with psychosocial and spiritual distress such schizophrenia, depression, and Jinn. The preferred treatment approaches ranged from holistic biomedical treatments combined with spiritual healing to only cultural and spiritual healing.

**Discussion:** This study reveals important findings regarding psychosocial and substance use problems among Somali Canadians. I discuss psychosocial illnesses, challenges with accessing
Canadian healthcare services, the role of spiritual healers, and seeking culturally appropriate services in East Africa. I further discuss substance use problems among Somali Canadian youth, the lack of culturally appropriate services in Canada, and the emergence of transnational cultural recovery programs in Kenya. I also highlight challenges associated with transnational rehabilitation programs.

*Keywords*: Somali Canadians, translational health practices, ethnography, psychosocial illness, Jinn, *dhagan celis*. 
Dedication

To my mother, Rahma Abdi, who enrolled me in primary school so that I would never need an interpreter for English and Swahili (Kenya’s official languages). To my father, Sheikh Abdullahi Ibrahim who embodied the value of education and hard work. To my dear uncle Eng. Dr. Alikheir, thank you for uplifting me and all family members through education.
Acknowledgements

This dissertation would have not been possible without the help, support, and guidance of so many people. Let me take this opportunity to express my deepest gratitude to all those who made this journey a success!

I would like to pay tribute to my supervisory committee member, the late Dr. Elliot Goldner who passed on November 27, 2016. His support, kindness, thoughtful critique, and knowledge sharing will be missed, but his work is not in vain.

I would like to express my deepest appreciation to my senior supervisor, Professor Marina Morrow. I have learned so much from you and am incredibly lucky to be mentored and taught by you. I cannot thank you enough. I am so very grateful to my committee members, Professor Lorraine Halinka Malcoe and Professor David Ndetei, for your teaching, coaching encouragement and support throughout. In addition, I thank the faculty and my fellow students at the faculty of health sciences for their support throughout this process. Thank you to colleagues and fellows at the Center for the Study of Gender, Social Inequities, and Mental Health.

Special thanks go to the research participants, family members and my community—the Somali Canadians in Metro Vancouver and Kenya. This research is for you.

I am fortunate to come from an incredible family. Heartfelt thanks to my siblings in North America and Kenya. Finally, my dear wife and friend, Rahma Maalim and our lovely children Hodhan, Fatuma Udgoon & Shaqlan. Your love and support are why this PhD come through.

Shukran
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<tr>
<td>APA</td>
<td>American Psychiatric Association</td>
</tr>
<tr>
<td>ASD</td>
<td>Autistic Spectrum Disorder</td>
</tr>
<tr>
<td>BCMA</td>
<td>British Columbia Muslim Association</td>
</tr>
<tr>
<td>DSM</td>
<td>Diagnostic and Statistical Manual of Mental Disorders</td>
</tr>
<tr>
<td>LMIC</td>
<td>Lower and Middle-Income Countries</td>
</tr>
<tr>
<td>MHA</td>
<td>Mental Health Act</td>
</tr>
<tr>
<td>NACADA</td>
<td>National Campaign Against Drug Abuse</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post-Traumatic Stress Disorder</td>
</tr>
<tr>
<td>RCMP</td>
<td>Royal Canadian Mounted Police</td>
</tr>
<tr>
<td>UNHCR</td>
<td>United High Commission for Refugees</td>
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<td>WHO</td>
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Chapter 1: Introduction

Somalia has been without an effective national government since the collapse of the military regime of General Mohamud Ziyad Barre in 1991, when armed rebels joined forces and drove the military leader and his government out of power and out of the country. After toppling the military junta, the armed rebels failed to agree on how to form a unified government. The disagreement led to inter-militia conflict that took on a clan dimension, in which militias fought each other along their tribal or clan identity, expanding inter-clan or inter-tribal conflict. This violent inter-clan conflict has claimed thousands of lives, uprooted communities from their homes, and displaced millions internally and externally (Barnes & Hassan, 2007; Elmi, 2010; Issa-Salwe, 1996; Kapteijns, 2013).

Since 1991, the ongoing inter-clan conflict has evolved and attracted different actors, such as the U.S. intervention in 1994 in which thousands of Somali civilians died after a Somali militia shot down a U.S. military plane. This tragic incident led to the blockbuster Hollywood movie, Black Hawk Down (Dalby, 2008). After September 11, 2001, the United States extended its “war on terror” to Somalia by engaging military campaigns against the Islamic Courts Union, which ruled much of Somalia briefly in 2006 and 2007. In early 2007, with the support of the United States, the Ethiopian government declared war against Somalia; its army invaded and toppled the Islamic Courts Union. This invasion led to more violence as other armed militias averse to the Ethiopian and American intervention were born, especially Al-Shabaab and Hizbul Islam (Barnes & Hassan, 2007; Elmi, 2010; Kapteijns, 2013).

Nevertheless, the conflicts and crisis in Somalia have existed for much longer than the current crisis. They date back to colonial times when European powers (Britain, France, and Italy) violently partitioned, occupied, and colonized the Somali-inhabited East Africa region\(^1\) into

\(^1\) Somali inhabited region before European colonization
five countries: British Somaliland (now, semi-autonomous Somaliland and part of the Republic of Somalia), French Somaliland (present day Djibouti), Italian Somaliland (now, Republic of Somalia), British Northern Frontier Districts (now North-Eastern region of Kenya), and Ogadenia (now, 5th federal region of Ethiopia).

Figure 1: Somali inhabited region before colonization (source-http://www.mapcruzin.com)
From colonial times to the present day, wars, invasions and occupations across the region have been ongoing. The Independent Republic of Somalia’s attempts to unify the different regions politically and militarily were repeatedly met with strong and coordinated territorial defense actions by Ethiopia and Kenya. These nations (Kenya and Ethiopia) were, in turn, backed by the former USSR, United States, and Britain for strategic geopolitical reasons (Issa-Salwe, 1996).

As a result, the Somali people have endured many ills during the last century. These include colonization, wars, a famine that killed a quarter of a million people in 2011-2012, and
another devastating round of drought in 2017. The longstanding instability has brought untold suffering, massive loss of lives, gross human rights violations, psychological traumas, and significant internal and external displacements that continue to the present day.

Over the years and as a result of the wars and civil conflicts, Somalis were and continue to be displaced from their home countries. For example, about one million Somalis were displaced during the Somalia-Ethiopia war of 1977, while the recent breakdown of the nation-state government in 1991 has led to another exodus of over a million to neighboring countries and beyond (Elmi, 2010). Kenya alone holds more than half a million Somali refugees in the Dadaab and Kakuma refugee camps, the former being the largest refugee camp in the world. Meanwhile, similar numbers remain internally displaced within Somalia (UNHCR, 2012).

The effects and after-effects of this intractable state of war have been discussed almost exclusively in the contexts of security, piracy, terrorism, and famine (see Berns-McGown, 1999; Elmi, 2010; Issa-Salwe, 1996; Kapteijns, 2013). However, few studies have been conducted in Somalia on the mental health effects of these wars. A notable study was a situational analysis by the World Health Organization (WHO), which estimated that one in every three Somalis suffers from some kind of mental illness, putting Somalia at one of the highest rates in the world (2010). The WHO study states that the rates of mental illness among Somalis in Somalia is higher than other low-income countries due to the prevailing conflict and associated problems, such as poverty, famine, and inter community violence (WHO, 2009; 2010).

Although studies on mental health in Somalia are limited, existing studies of Somali refugees in Western countries reveal similar findings with respect to mental health problems associated with effects of war, displacement, and the refugee experiences (see Carroll, 2004; Ellis, MacDonald, Lincoln, & Cabral, 2008; Jaramson, et al, 2004; Warfa et al, 2006;).

Globally, existing literature supports a general trend of higher rates of mental health problems in refugees (Fazel, Wheeler & Danesh, 2005; Fazel, Reed, Panter-Brick & Stain,
Studies done among Cambodian, Bosnian and Vietnamese refugees consistently indicates the positive correlation between effects of war and psychological problems (see Hollifield et al, 2002; Steele et al, 2005; Steel et al, 2009). Overall, these studies report a higher occurrence of post-traumatic stress disorder (PTSD), anxiety, and depression among individuals exposed to violence, displacement, torture, and other effects of war and natural calamities.

Despite higher prevalence among refugees, studies show that new immigrants and refugees in Canada and other Western countries underutilize Western mental health services (Hansson, Tuck, Lurie, & McKenzie, 2010). The discordance between higher rates of mental illness and lower uptake of biomedical mental health services among the refugee populations in Western countries have been attributed to differences in explanatory models about mental health in refugee populations compared to the predominant Western biomedical framework for understanding mental health issues. In addition to the differing explanatory models, refugees and immigrants from the Global South often face difficulties in navigating complex Western health care systems due to language barriers, racism, and discrimination by service providers (Hansson, Tuck, Lurie & McKenzie, 2010). As such, refugees and new immigrants turn to their cultural and community healing approaches to deal with psychosocial problems (Hansson, Tuck, Lurie & McKenzie, 2010; Kirmayer, Gudzer & Rousseau, 2014; McKenzie & Bhui, 2007).

Studies in Europe suggest that Somali refugees who settle in Western countries opt for traditional/spiritual treatment (Gahan & Arkkho, 2010; Guerin, Guerin, Diriye & Yates, 2004; Molsa, Hjelde & Tiilikainen, 2010), including returning to East Africa or the Middle East for further spiritual healing (Tiilikainen, 2011; Wedel, 2011). Tiilikainen (2011) describes transnational healing and rehabilitation approaches for mental health and substance use among diasporic Somalis. Diaspora or diasporic Somalis is a term to describe Somalis who settle in high income countries or regions such as Western Europe, the United States, Canada and the Gulf countries in the Middle East (see Al-Sharmani, 2007).
The Somali community in Canada has increased steadily over the last two to three decades after the collapse of the nation-state of Somalia in 1991 (Omar, 2013). Despite the increase in Somali immigrants to Canada as refugees, little research exists about their mental health and how they use mental health services. An earlier pilot study I conducted in British Columbia (Ibrahim & Alkusayer, 2016) is among the few studies conducted in Canada (see Elmi, 1999; Kediye, Valeo & Berman, 2009; Jordan, Matheson, & Anisman, 2009). These few studies all point to a community struggling with substantial psychosocial challenges.

Importantly, our study highlighted the significance of psychosocial challenges faced by individuals and families from conflict countries such as Somalia, Afghanistan and Iraq (Ibrahim & Alkusayer, 2016). The psychosocial challenges were discussed in the context of trauma, depression, youth substance use, and family conflict within the Muslim community in Metro Vancouver. Furthermore, this qualitative study based on interviews of imams across mosques in Metro Vancouver, revealed the important role spiritual healers play in supporting the Muslim community in British Columbia.

**Self-statement**

I am a mental health clinician with many years of experience in clinical practice in East Africa, the United States, and Canada. During my clinical work in the United States and Canada, I have come across several individuals and their family members who have, within the course of their struggles with psychosocial challenges, including substance use, decided to seek help from the health care systems and spiritual/traditional resources available in their local communities. At times, they have even decided to seek further treatment across the Atlantic, traveling back to East Africa. Due to my position as a community member and mental health

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2 I use the term psychosocial challenges to describe psychological, psychiatric or mental illness, or mental health issues. Psychosocial issues/challenges/illness is interchangeably used with mental illness.
clinician trained as a registered nurse with mental health specialization and social work at a masters level, I have been consulted by family members in respect to their struggle with psychosocial and substance use issues. In fact, as a member of the Somali Community in Metro Vancouver, I have been asked to contribute money to purchase a flight for a Somali Canadian man who returned to Northern Somalia for psychosocial healing.

I situate myself in this research as a Kenyan Canadian of Somali ethnicity. I come from the North-Eastern region of Kenya (formerly Northern Frontier Districts in colonial British ruled Kenya), which shares a long border with Somalia and region five of Ethiopia (formerly Ogaden Somali region). These three bordering regions are entirely inhabited by ethnic Somalis.

My family history reflects the struggles and triumphs of many Somali communities across the East African region, a history that has been shaped and reshaped by colonial and postcolonial experiences. As a native born of the northern part of Kenya bordering Ethiopia, the colonial demarcation has impacted the lives of my community, as the international border cut through my community’s traditional land, thus dividing their grazing and farming land (see Lowenstein blog3). The demarcation and carving up of the Somali inhabited land into different countries such as Kenya, Ethiopia, Somalia and Djibouti led to numerous irredentism conflicts in the region in the early 1960s and 1970s when Kenya, Djibouti and Somalia attained self-rule from Britain, France and Italy, respectively (Elmi, 2010). The international demarcation introduced new barriers in accessing community land and resources, and eventually for some, the loss of their ancestral land. As a Kenyan Somali, I have lived and experienced the effect of the arbitrary demarcation of our ancestral land by the British and Italian colonial governments, a

demarcation that has been a source of conflict, displacement, and trauma for decades (Ibrahim & Morrow, 2015; Lowenstein, 2010).

As a nurse, I had the opportunity to work in Northern Kenya, a region inhabited by Kenyan Somalis. I also had the privilege to work as a reproductive health nurse at Dadaab refugee camp and as a nursing lecturer in Mogadishu, Somalia. While I was in Somalia, teaching nursing school in late 2006 and early 2007, most of the south and central part of Somalia was under the regime of the Islamic Courts Union. The Islamic Courts Union was an Islamic-based militia, which stabilized most of the country after defeating tribal warlords who were accused of arbitrary killings, abductions, and human rights violations after the overthrow of the military junta of Mohamud Ziyad Barre (Elmi, 2010). My tenure as a nurse educator at the Hermann Gmeiner Nursing School operated by the SOS Children's Villages International, a non-profit organization, ended abruptly when the Ethiopian army – with full support of the U.S. Government – invaded Somalia in early 2007 and toppled the nascent regime of the Islamic Courts Union as part of the U.S. expansion of the “war on terror” (Barnes & Hassan, 2007; Elmi, 2010).

While teaching at the nursing college in Mogadishu, Somalia, I came across several Somali individuals from Canada, the United States, and Western Europe. They received treatment at a run-down mental health facility in downtown Mogadishu. The fact that Somali individuals from stable, safe, and wealthy nations were seeking treatment from a troubled country from which many had fled from was both intriguing and puzzling to me. Somalia is still mired in conflict and politically unstable. Through further inquiry, it has become apparent that some of those in the psychiatric facility in Mogadishu had been deported by Western\textsuperscript{4} countries due to drug use and criminal offences. They also suffered from mental health and substance

\textsuperscript{4} The terms, Western nations and Western countries, are used throughout this thesis in reference to countries in Western Europe and North America (United States and Canada), where hundreds of thousands of Somalis have resettled and continue to settle since the civil war in 1991.
use problems, while others were brought back involuntarily by family members for similar issues having to do with drugs, crime, and mental illness.

As a nurse educator at SOS Hermann Gmeiner Nursing School in 2007, I realized that mental health was not part of the courses offered for the three-year diploma community health nursing program. Thus, I developed and taught the first mental health nursing course during my short tenure at the college. Teaching both the theory, but more importantly, the clinical practice at the only psychiatric facility in Mogadishu led to my encounters with patients from Western countries treated at this facility.

In 2009, I read the story widely reported by the Canadian media (see Diebel, 2009) about an autistic Somali Canadian man stuck in immigration limbo in Kenya after been denied entry back into Canada. The story of this twenty-five-year-old autistic\(^5\) man from Ottawa described the struggle faced by a single mother who could not find appropriate psychosocial interventions in Canada for her son; she decided to take him back to East Africa with the hope of finding a better outcome (Diebel, 2009). The story came to light when the young man was arrested at the Kenyan airport under suspicion of passport fraud, as the photo on his passport did not resemble him at the time of travel. The Canadian government revoked his passport without diligent verification. The young man languished in the dreaded Kenyan prison cells for almost three years. Only after significant coverage by the Canadian press and opposition politicians, the conservative government finally issued him a new passport and allowed him to return to his home in Ottawa.

The media, opposition parties, and civil rights groups accused the government of inadequate support for distressed Canadians in foreign countries. Some even accused the government of discrimination towards Canadian Muslims (see Bakht, 2008), claiming the government denied services to Muslims or even colluded with foreign governments in their

detention and mistreatment (Diebel, 2009). The recent high profile\textsuperscript{6} out-of-court financial payments and apologies for Omar Khadr\textsuperscript{7} and the three other Canadians of Muslim faith tortured in foreign countries attest to such claims. The media coverage of this autistic Somali Canadian framed the story from the angle of the Canadian government’s disregard of its duty to serve Canadians facing problems in international settings. Nevertheless, the issue of autism and the challenges this family faced in finding appropriate help in Canada did not attract much attention. Unfortunately, this is the reality for many Somali Canadian, as my research findings show.

My initial observations in Mogadishu, my clinical and community experience, and the issue of the twenty-five-year-old autistic man compelled me to undertake this research as the focus of my doctoral study to find out more about the psychosocial issues affecting Somali Canadians and how they cope with those challenges.

**Purpose of Study**

I conducted original ethnographic research to understand the psychosocial challenges faced by Somali Canadians, their health seeking behaviors, and their access and barriers to mental health services in Canada. Because some Somalis have sought mental health services and supports at international destinations, I also conducted interviews and fieldwork in Nairobi to provide new evidence on the little-known transnational spiritual and healing systems popular among diasporic Somalis. Specifically, my thesis research examines: (a) the psychosocial issues affecting Somali individuals and their families; (b) how people cope with those challenges at the individual, family and community level; (c) the appropriate resources available or the lack of them in their local community in Canada; (d) the psychosocial and spiritual healing services

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\textsuperscript{6} Canadian men tortured in Syria (http://www.cbc.ca/news/politics/torture-syria-31-million-1.4372689)

\textsuperscript{7} Omar Khadr gets apology (https://www.thestar.com/news/canada/2017/07/03/khadr-to-get-apology-compensation-over-10m-as-lawsuit-settled.html)
available in East Africa and the reasons Canadian Somalis travel for such services; and (e) the challenges associated with transnational health and healing practices.

Regarding spiritual and transnational healing practices, I investigated the existence of such services in Canada and Kenya, but I did not address the effectiveness of such interventions or services. To examine the psychosocial needs and challenges of Somali Canadians, I interviewed health practitioners, spiritual healers, individuals with lived experiences and their family members. I analyzed narratives and embodiment of distress, how psychosocial distress is perceived, and how such perspectives influence how people seek help and choose services. At the beginning of my doctoral studies, I undertook an ethnographic pilot study to explore the role of spiritual healers or imams in addressing the psychosocial needs of the Muslim community in Metro Vancouver. This pilot study was published in a referred journal and forms part of my thesis research (Ibrahim & Alkusayer, 2016).

Layout of the Thesis

The thesis comprises six chapters organized as a three-paper thesis manuscript. The first chapter covers the overall introduction, my self-statement, study objectives and rationale, and a literature review of Somali mental health issues.

Chapter Two analyzes the theoretical frameworks used to study mental health research in the context of refugees, Africans, and Muslims. The conceptual and theoretical frameworks discussed are: colonial/transcultural psychiatry, refugee mental health and transnational mental health. This discussion features a critical focus on the historical background of biomedical psychiatry in the context of colonialism. This chapter forms the first of the three papers of the

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8 Lived experience(s)—in the mental health context the term “lived experience” is used to describe individuals experiencing or having experienced mental illness, psychological distress or psychosocial illness. It can also refer to those with substance use problems.
thesis and is based on my recently published critical review of colonial and biomedical psychiatry.⁹

To give a brief description of the three frameworks, transcultural psychiatry in its contemporary form understands psychosocial or mental health issues of non-Western cultures by acknowledging the diversity of explanatory models of psychosocial illness among different ethnic and cultural groups. The second framework, refugee mental health, focuses on trauma-related psychological conditions such as post-traumatic stress disorder and related conditions.

The third framework, the transnational framework, focuses on the movement of people, services, and ideas in physical and virtual spaces where psychosocial and spiritual services are sought after and provided in different geographical and technological spaces. These new transnational healing practices appear to be ahead of the research curve and remain largely unknown to researchers and scholars. Nevertheless, they flourish in many communities and parts of Africa. Western-based Somalis constitute one of several African communities that have re-established or invented unique ways of addressing psychosocial and spiritual challenges as part of the diaspora experience (see Dilger, Kane & Langwick, 2012; Tiilikainen & Koehn, 2011) Although the transnational framework is used in understanding transnational health practices, I make clear the intersection and interrelation among all three frameworks and how they inform each other.

Chapter Three covers the research methodology and tools. I utilized a qualitative methodological approach to understand the psychosocial challenges of Somali Canadians. I conducted ethnographic interviews and fieldwork in Canada and Kenya. I obtained, transcribed,

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and analyzed in-depth one-to-one semi-structured interviews and fieldwork notes. In this chapter, I also provide details of the study population, sampling method, descriptions of field study sites, and ethics approval from relevant authorities in Canada and Kenya.

Chapter Four is designed as the second paper of this three-paper thesis. It introduces the first major findings from the ethnographic data and discusses the psychosocial challenges among Somali Canadians, challenges tied to their explanatory models, refugee experiences, and post-resettlement life in Canada. The findings and discussion in Chapter Four link the three theoretical frameworks and explain why help-seeking involves transnational healing in East Africa. In addition, this chapter discusses the role of imams in providing psychosocial support for Muslim immigrants and refugees, including Somalis, in Metro Vancouver based on my earlier published pilot study that forms part of my doctoral research.

The fifth chapter forms the third paper of the thesis and introduces a new transnational substance recovery model for Somali Canadians and other Western-based Somalis. This model represents an innovative new program born of necessity after refugees encountered unfamiliar Western cultures in their adopted countries. It is specifically for Somali youth dealing with substance use and behavioral issues. Understandably, due to barriers in accessing culturally appropriate services in Canada, Somalis have created their own unique substance use rehabilitation programs in major East African cities. I undertook fieldwork in Nairobi and visited select substance use rehabilitation centers that serve large numbers of Somali diaspora clients. The findings bring forth the post-resettlement challenges Somali Canadians face, especially in raising children in a new culture different from their conservative Somali and Muslim culture. This cultural encounter threatens the expectations of Somali parents about their children, and with no satisfactory resources in their home countries (Canada or other Western countries), reinforces the transnational solution to challenging issues such as substance use. This chapter also highlights transnational challenges. Due to the lack of a continuum of care in East Africa for
diasporic youth in treatment, some fall through the cracks and become members of violent criminal gangs in the streets of Nairobi.

The sixth and final chapter of the thesis provides an overall summary and conclusion as well as recommendations for changes to research, policy, and practice. In the summary, I argue for the need for further research on Somali Canadian’s psychosocial and health needs to better understand their challenges and address their needs. I also revisit, the critical discussion on colonial psychiatry and the relevance of such discussion in the context of global mental health. In a contemporary globalized and connected world, I recommend further research from a transnational perspective among ethnic minorities.

**Literature on Somali Psychosocial Illness: An Introduction**

Ongoing war and violence cause severe psychological distress for civilian populations (Jeon, Yashioka & Mollica, 2001). Despite this, few studies of Somali mental health exist, especially in their home countries. Still, some studies; for example, the WHO (2010) estimate that one in every three Somalis suffers from some form of mental illness, thus making Somalia one of the countries with the highest rate of mental illness in low-income countries. According to the WHO study, high rates of mental illness has been attributed to intergenerational trauma, extreme poverty, and natural disasters, such as famines that occur often and with severe consequences in terms of hunger and mortality (WHO, 2010).

Many Somalis have resettled in Western countries they now call home. Studies in these countries consistently find that Somalis face psychosocial challenges because of refugee experiences (Bhui et al, 2006; Carroll, 2004; Westermeyer et al, 2010). Studies among Somali refugees in Western countries also indicate that they underutilize mainstream mental health services due to language barriers, difficulties in navigating a complex Western health system, and the fact that Somalis view mental illnesses as non-biomedical conditions best cared for
through spiritual and traditional healing approaches (see Carroll, 2004; Guerin, Guerin, Diriye & Yates, 2004; Palmer, 2006; Scuglik, Alarcon, Lapeyre, Williams & Logan, 2007).

Two studies conducted in Sweden and Finland, respectively, showed that Somalis in those countries not only prefer traditional and spiritual healing within Sweden and Finland, but that they travel to East Africa or the Middle East for further spiritual or traditional healing (Tiilikainen, 2011; Wedel, 2011). Tillikainen (2011) further investigated transnational healing in Northern Somalia (Somaliland) and found that existing traditional and spiritual healing sectors serve diasporic Somalis. However, no studies to date in the Canadian context examine Somali Canadians’ experiences with transnational healing practices. This study bridges that gap by undertaking research on transnational healing practices and spaces in Nairobi, Kenya.

As indicated, research on Somali psychosocial issues during the brief stable era of the Somali nation-state is almost non-existent. Moreover, mental health services barely existed as part of the larger government-run health care services. The only existing mental health services were a colonial era psychiatric hospital in Mogadishu, and a psychiatric unit in the northern city of Hargeisa (Scarfone, 2016). This situation is like that of other African countries, where mental health services remained unchanged from the colonial era’s institutionalized settings (see Ibrahim, 2017; Ibrahim & Morrow, 2015). In the past and until the collapse of the central government in 1991, the country lacked mental health experts; few mental health nurses and psychiatrists had been trained in foreign countries. The country did not have the capacity to train its own mental health professionals and the single medical program for the entire country lacked psychiatric professors, relying instead on the services of a visiting Italian professor of psychiatry. As a result, during its first three decades of the country’s independent existence from 1956 to 1991, mental health services were largely outside the purview of the government-run biomedical health care system.
Accordingly, the few studies and reports that address mental health in Somalia indicate that most Somalis depend on family and community support for mental health, and they rely on the services of traditional and spiritual healers for treatments (WHO, 2006; 2009; 2010). On the African continent, traditional, complementary, and spiritual healing services remain the most important services for psychosocial illness (Abdullahi, 2011; Aboo, 2011). In fact, it has been estimated that the preference for alternative and complementary approaches reaches over 80% across the continent (Mbwayo, Ndetei, Mutiso & Khasakhala, 2013). Traditional and spiritual healers are widely available, accessible, and affordable, whereas biomedically trained mental health professionals remain scarce (Abdullahi, 2011; Aboo, 2011). From an anecdotal perspective, during my seven years practicing as a community health nurse in North Eastern Kenya, I seldom saw individuals with psychosocial issues seeking mental health treatment as part of their medical care from formal biomedical health care services.

Since 1991, many Somalis have left their homeland to resettle in Western countries. Their presence has created a need for service providers and researchers in Western countries to understand their unique perspectives and traditions in order to address their needs. As such, this section attempts to provide a broad overview of the literature addressing recent mental health phenomena among Somalis.

**Psychosocial Illnesses among Somalis**

As mentioned above, Somalis experience some of the highest rates of mental illness globally (WHO, 2010). Studies conducted in Western nations show that Somalis and other refugee groups report higher rates of psychological issues, yet underutilize formal mental health services (Guerin, Guerin, Diriye & Yates, 2004; Palmer, 2006; Scuglik, Alarcon, Lapeyre, Williams & Logan, 2007; Svenberg, Skott & Lepp, 2011).

In the last two to three decades, mental health studies of Somalis have mostly been conducted in Western countries (see Carroll, 2004; Guerin, Guerin, Diriye & Yates, 2004;
Nevertheless, a few studies have been undertaken in Somalia or in the refugee camps, where most Somalis spend a considerable amount of time before relocating to countries in the Global North (Horst, 2006; Rousseau, Said, Gagne & Bibeau, 1998; WHO, 2009; WHO, 2010). In this section, I will classify the main mental health issues of Somalis into three groups, which can be discerned from the literature: (i) spiritual and psychosocial illness, (ii) psychosocial issues associated with the consequences of the war, and (iii) psychosocial issues during in-transit and post-resettlement periods.

i) Spiritual and Psychosocial Illness

In the Qur’an, health and healing is discussed in various verses as revealed here, “We reveal …from the Qur’an that which is healing and mercy for the believers” (Qur’an, 17:82). The prophet is quoted as saying that, “Allah does not send any disease [without] also send[ing] down a cure for it” (Al-Saheehyn, as quoted by Ameen, 2005). Many verses in the Qur’an and Hadith discuss health and wellness, including mental health. The use of Qur’anic and prophetic healing methods by the prophet and his followers are detailed in the scriptures (Ameen, 2005).

Somalis are nearly homogenous with respect to religion. Almost all ascribe to the Sunni denomination of Islam. Islamic healing is deeply rooted and widely practiced by Somalis (Schuchman & McDonald, 2008). The scriptures explain some of the causes of mental illness as spirit possession (Jinn), witchcraft (sihr), evil eye (al-ayn), and deviation from the prescribed path of faith practice. Treatments include exorcism (ruqya) and the recitation of verses of the Qur’an by the individual, family members, or imams and other religious or traditional healers (Ahmed & Amer, 2012; Dein, Alexander & Napier, 2008).

The belief in spiritual causality of psychosocial illness has a profound effect on the understanding of illness and help-seeking for people with such theological and cultural beliefs. In fact, in many Muslim cultures, the theological aspects remain the most important attribute of
psychosocial illness and, as such, first line treatments typically involve some form of religious and traditional healing. In Chapter Four and Five, I describe the role of imams as psychosocial counsellors in Canada (see Al-Issa, 2000; Carroll, 2004; Ibrahim & Alkusayer, 2016; Wedel, 2011). Due to the emphasis on spiritual causality in Islamic text and practice, many individuals and families seek spiritual healing and guidance from their local imams and faith healers, and in some circumstances, Somalis from Western nations travel back to East Africa for further spiritual healing (Tillikainen, 2011; Wedel, 2011).

**ii) Psychosocial Issues Associated with the Consequences of the Civil War**

Several studies show significant mental health issues associated with refugee experiences in diverse settings (Fazel, Wheeler & Danesh, 2005; Hollifield et al, 2002; Jeon, Yashioka & Mollica, 2001; Steele et al, 2005; Steel et al, 2009). The same is true for Somali refugees (see Carroll, 2004; Guerin, Guerin, Diriye & Yates, 2004; Palmer, 2006; Scuglik, Alarcon, Lapeyre, Williams & Logan, 2007; Svenberg, Skott & Lepp, 2011). These psychological experiences have been classified by Western biomedical discourse under the categories of PTSD, anxiety, and depression. Somalis also acknowledge feelings of hopelessness, despair, anxiety, and anguish as part of their symptomatology, despite not explicitly labelling such experiences and symptoms as PTSD or depression (Carroll, 2004). The after effects of trauma among Somalis have also been described in somatic terms, with emphasis on headaches and other unexplained body pains that seem untreatable with physical health remedies offered by biomedical health services. Unable to find a remedy, many Somalis “doctor-shop” and eventually travel abroad to East Africa in search of healing (Molsa, Hjelde & Tillikainen, 2010; Svenberg, Skott & Lepp, 2011). Another significant manifestation of psychological distress has been seen at family and community levels where, despite the dearth of research, evidence suggests that family dysfunction results in high levels of divorce, school dropout among Somali

The displacement of Somalis from their home countries and their experiences of living in unsuitable refugee camps have also been associated with the emergence of a unique form of psychological distress called *buufis*. This form of distress is common among Somali refugee dwellers in Kenya and at many other refugee camps (Horst, 2006; Rousseau, Said, Gagne & Bibeau, 1998). This condition emerged in the mid-1990s and is regarded as folk illness, and a mythic psychological condition, especially among young adults. Nevertheless, *buufis* is now a common psychosocial phenomenon among Somalis and has its roots in the transitory period of their refugee experiences. During this period, especially living in a refugee camp or urban settings with few opportunities for upward mobility, life feels stagnant and pathetic.

*Buufis* typically begins as a hopeful or wishful dream to be accepted for resettlement in a developed country with the hope of living a normal and fulfilling life again. In this way, it expresses the antithesis of the harsh realities in refugee camps. With limited opportunities for resettlement, however, these dreams slowly turn to despair, hopelessness, depression, and even psychosis (Horst, 2006). In many cases, *buufis* leads individuals to attempt a risky voyage. They cross the Sahara Desert to Libya, then across the Mediterranean Sea with the help of human smugglers. This dangerous route remains in use today, often leading to mass deaths by drowning in the high seas, an ignored humanitarian tragedy at the doors of Western Europe (International Organization for Migration {IOM} 2014).

### iii) Psychosocial Issues during In-Transit and Post-Resettlement Periods

The third category addresses psychosocial challenges associated with settlement and the post-resettlement period. Several studies (see Carroll, 2004; Ellis et al, 2008; Warfa et al, 2006) have been conducted on psychosocial issues prevalent in post-resettled Somalis in
Western countries. Overall, these studies mention trauma-related and post resettlement adjustment challenges as common issues among Somali refugees.

In general, the prevalent conditions among Somali refugees resemble those experienced by other refugee populations who face challenges adapting to new countries and cultures, and their confrontations with structural and institutional barriers to healthier integration within host communities (Kirmayer, Gudzer & Rousseau, 2014; Palmer, 2007; Pumariega, Rothe & Pumariega, 2005; Watters, Ingleblcy, 2004). In the Canadian context, studies have highlighted similar findings in regards to mental health challenges faced by Somalis as a result of their refugee experience, immigration status, race and religion (Danso, 2002; Makwarimba, et al, 2013). Others have pointed to the lack of culturally appropriate mental health services in the Canadian health care despite the significant increase in population of new immigrants and refugees from the Global South,(Simich, Maiter, Moorlag & Ochoka, 2009; Janzen, Roth, Grant; 2011)

In addition, studies reveal that Somalis, and by extension Muslims, tend to view mental health challenges through a spiritual lens and therefore prefer to access spiritual and traditional healing services rather than the mainstream biomedically focused healthcare treatments that are more available in Canada and other Western countries (Abu-Ras, Geith, & Cournos, 2008; Ahmed & Amer, 2013; Ibrahim & Alkusayer, 2016; Hansson et al, 2010)

However, in some cases, Somalis encountered the occurrence of new diseases or challenges previously unknown to them that took them by surprise. In such cases, they lacked sufficient historical and cultural knowledge to deal with them. This is the case of the rise of substance use among Somalis in North America and Western Europe.

As in most Muslim communities, most Somalis view alcohol and illicit drugs as sinful and unacceptable (Ali, 2014). As a result, those who use alcohol or illicit substances are stigmatized
and shunned (Ali, 2014). The substance use issue and the challenges of bringing up children in a Western environment is viewed by the community as a threat to the traditional family structure. Therefore, due to the lack of access to substance use services in their local communities and to try to redeem the future of the younger generation, some families engage in transnational rehabilitation practices in the form of cultural and spiritual healing for those with delinquency and/or substance use issues (Tiilikainen, 2011). The transnational cultural and spiritual healing programs are popularly known among diasporic Somalis as dhagan celis (Tiilikainen, 2011).

*Dhagan celis* is a Somali word comprised of two words: *dhagan*, meaning culture and *celis*, meaning to return or returning. *Dhagan celis* is associated with diaspora living in post-war Somalia and has gained currency in the recent years as a form of strengthening Somali and Islamic culture for Somali children born into or raised in Western countries, who seem at risk of losing their cultural identity. But *dhagan celis* also encompasses rehabilitation, either behavioral or from substance use among diasporic youth (Osman, 2012; Tillikainen, 2011).

These transnational substance use recovery programs remain largely unstudied. This thesis study provides evidence of its existence in Kenya. In Chapter Five I discuss the transnational solution to the substance use problem among Somali Canadians and other Somalis in Western countries. In addition, I also describe some of the challenges associated with *dhagan celis*.

Another psychosocial issue in the context of post resettlement challenges is childhood autism. Autism as a diagnosis was unknown to Somalis prior to their resettlement in Western countries; no known study exists either to support the existence of or lack of autism in pre-war Somalia. A study on autism among Somalis living in Sweden (Barveric-Olson, Gillberg, Ferrel, 2008) indicated that children born to Somali parents had a slightly higher prevalence of a
diagnosis of autism. Likewise, a study in the U.S. state of Minnesota reported that children born to Somali immigrants developed more severe symptoms than the general population (Hewitt et al 2013). At the same time, Minnesotan Somalis were alarmed about the large number of their children in special needs school program, a phenomenon they associate with the diagnosis of autism.

Although now widely discredited, a study published but later retracted in the *Lancet Journal* claimed a correlation between measles immunization and autism. Reportedly, the lead author (Andrew Wakefield) travelled to the state of Minnesota, a state with the highest Somali population in the United States and met personally with some Somali families as part of an anti-vaccination campaign (Lerner, 2011). Consequently, childhood vaccination among Somali children in the state of Minnesota now stands as the lowest among the general population; it has dropped from the highest rate of 98% in 2004 to about 47% in 2017 (Wolff & Madlon-Kay, 2011). In the last six years, the state of Minnesota experienced two major measles outbreaks (in 2011 and 2017). In both periods, the overwhelming majority affected were Somali American children. This fact is strongly associated with beliefs concerning the measles vaccination and autism, bolstered by the anti-vaccination campaign targeting Somali Americans in the state (Wolff & Madlon-Kay, 2014).

Somali parents have nicknamed the measles, mumps, and rubella (MMR) vaccine as *aamusiso*, or literally, *the silencer* in direct Somali-English translation. Autism is typically described as the *American or Swedish disease*, depending on where the affected families live (Barveric-Olson, Gillberg, Ferrel, 2008). My study highlights similar beliefs and sentiments associated with autism and vaccinations among Somali Canadians in British Columbia; I discuss in detail in Chapter Four the experiences of Somali Canadian families in relation to autism.
Except for the studies in Sweden ((Barveric-Olson, Gillberg, Ferrel, 2008) and United States (Wolff & Madlon-Kay, 2011; Lerner, 2011), there are no specific Canadian study on the prevalence of autism among Somali Canadians. In fact the only study in the Canadian context discussed the challenges faced by Somali Canadian mothers in supporting their children with autism (Kediye, Valeo & Berman, 2009). However, despite it is rarity, autism came up as a significant issue in this study and it is for that reason that I chose to focus on as part of the study.
Chapter 2: Theoretical Frameworks

Researchers, scholars and practitioners from diverse disciplines have utilized different theoretical frameworks to understand psychosocial illness of Muslim and African refugees. These frameworks overlap in many ways. I will focus on three theoretical frameworks relevant to the study, which: i) guide the analysis of mental health services across cultures and ii) provide a framework for understanding the transnational help-seeking nature of Somalis.

In figure 3, I depict the interrelation among the three frameworks. As I will describe below, transcultural psychiatry has its roots in the biomedical framework as applied in the African context.

Figure 3: Theoretical frameworks and their interconnections

The first framework is transcultural psychiatry. The second, refugee mental health, focuses on refugee mental health in the context of post-traumatic related conditions, such as PTSD, depression, and anxiety. The third is the transnational framework, which has in recent years become associated with globalization and an increase in the transnational movement of people, business, and information. Due to the constant flow of Somalis across countries and
continents in search of safety, stability, and services, the transnational framework is ideal for this study. In the fourth and fifth chapters, I apply this framework to understand the help-seeking behaviors of Somali Canadians.

First, I will provide a critical historical analysis of biomedical psychiatry, including transcultural psychiatry, in the African context. I discuss how a critical read of this history helps us to understand the contemporary challenges of service utilization by black and ethnic minorities in Western societies. These critical perspectives on colonial psychiatry and its impact on mental health in Africa are adapted from my published peer-reviewed book chapter and forms the first of this three-paper thesis (Ibrahim, 2017).

**Colonial or Ethno-Psychiatry and its Contemporary Relevance in Mental Health Services**

The study of psychosocial issues or mental illness among African and Muslim populations from the African continent has its roots in the projects of colonialism and slavery. These studies, conducted by Western scholars and practitioners during the era of slavery and colonialism, took as their object of analysis, “the Other,” usually understood in terms of primitive and hostile natives. Ethno-psychiatry or colonial psychiatry, as it was known during the European colonization of the African continent from the late 17th century to the 20th century (McCulloch, 1995; Keller, 2007), has evolved with time and circumstance to the less oppressive discourse and practice of transcultural psychiatry. However, the move from a race-based psychiatry, grounded in eugenics, to a more inclusive and culturally nuanced understanding of psychosocial illness in the form of transcultural psychiatry has not been without problems (Kirmayer & Minas, 2000).

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10 The concept of the ‘Other’ is often used to identify a minority or less powerful group’s difference or alienation from the dominant group. It has been used to perpetuate and legitimate colonialism and slavery (see Said, 1978).
In the African and Muslim context, the classification and production of psychiatric knowledge and associated practices were not designed for the benefit of Africans and Muslims; they were rather a mechanism to label them as different, “uncivilized,” and therefore legitimately subjugated and colonized (Ibrahim, 2017; McCulloch, 1999). During the early 19th century until the 1960s when most African countries started attaining independence from European colonizers, Western biomedical psychiatry was regarded as ethno-psychiatry. It was heavily politicized and embedded within colonial policies and structures, and as a tool of colonization (Keller, 2007; Mahone & Vaughan, 2007; McCulloch, 1999). This was a period when regional ethno-psychiatric schools flourished, especially in French Muslim North Africa and British East Africa under the banners of the Algiers School of Psychiatry and the East African School of Psychiatry. During this period, psychiatrists not only identified and studied culture-specific psychopathology, but also constructed psychiatric disorders that pathologized the colonized (Mahone, 2006; McCulloch, 1995). Diagnosing patients with constructed psychiatric disorders supported a wider systemic colonial narrative that simultaneously delegitimized the oppressed and legitimized their colonization and enslavement (Ibrahim, 2017; Ibrahim & Morrow, 2015; Keller, 2007; McCulloch, 1995).

During the capture and conquest of North Africa by imperial France, the general of French Morocco, Hubert Lyautey, categorically stated that French doctors played an important role in the colonial project. For example, Lyautey stated, “In Morocco, between the medical corps and myself, there is only one spirit, one doctrine” (Amster, 2013, p. 72), which was “to help Morocco evolve towards greater justice, well-being, and liberty under the guidance of France”, further adding that doctors must be at the forefront as “agents of penetration, attraction, and pacification” (Amster, 2013, p. 72-73). Likewise, in British colonial Kenya, the interconnection between the colonial project and biomedicine was clear. The physician’s roles included that of “a clinician, a lecturer in eugenics, and an amateur agriculturalist,” among
others (Campbell, 2007:40). In fact, eugenics research blossomed within colonial psychiatry in Africa as part of understanding the African and their culture. Many researchers in the field of medicine (psychiatry) and eugenics believed that Africans were anatomically and physiologically inferior to Europeans and thus sub-normal as human beings (Campbell, 2007; Hasian, 2013; McCulloch, 1995). In North Africa, for example, French psychiatrists viewed Arab culture and their religion, Islam, as problematic from a mental health point of view (Keller, 2007).

Across North, South, and East Africa, physicians and psychiatrists were at the forefront of the colonization, oppression, and racialization of the African masses by European powers (see Heaton, 2013; Ibrahim, 2017; McCulloch, 1995). As agents of colonialism, psychiatrists used their medical authority to invent psychiatric disorders that rendered the masses “abnormal,” and were a means for psychiatrically dealing with political subversives who resisted colonial domination. For example, when documenting mental illness among Kenya’s white minority, Jackson (2013) discussed “going native” as a term used when a white settler was inflicted with mental illness. This discourse underscores the general use of psychiatric language to depict natives as psychiatrically unstable. As a rule, specific racist and situational disorders were coined and disseminated throughout the general, scientific, and medical communities to advance political and colonial agendas.

Psychiatric colonization was not limited to the African continent – it had a strong link with chattel slavery and was transatlantic in nature. For example, during the antebellum period in North America, psychiatrists created disorders such as “dysaesthesia Aethiopis,” and “dраОетомания” (Jackson, 2001. pg. 9). Slaves seen as mischievous, lazy, and with poor workmanship were diagnosed with “dysaesthesia aethiopis” whereas “dраОетомания” was a diagnosis reserved for runaway slaves. Treatment for such conditions ranged from whipping to other inhumane forms of torture (Jackson, 2001; Metzl, 2009). Therefore, biopsychiatry served as strategy for maintaining the system of chattel slavery.
In the African context, Kenyan colonial psychiatrists, J.C. Carothers and H.L. Gordon, created psychiatric labels, such as “bradyphysis” (backwardness) and “amentia” (lack of intelligence) for the Kenyan natives, while claiming that the native’s contact with the Western educational system predisposed them to “dementia praecox” (Mahone & Vaughan, 2007; McCulloch, 1995). Gordon also doubted the “educability of Africans” (Campbell, 2007; Mahone & Vaughan, 2007), arguing that native Africans’ intelligence level was equivalent to that of a lobotomized European, and that educating Africans was a waste of time and resources. He advocated for continued colonization (Mahone & Vaughan, 2007; McCulloch, 1995).

Physicians were very effective as political agents, who justified the oppression of colonized citizens by shifting the discussion from a sociopolitical, justice or economic perspective to an individualized pathological one. Such was the case during the Mau Mau (a movement credited with the achievement of Kenyan independence) uprising in Kenya. Colonial physicians, such as John Wilkinson and Michael Kirby, in 1954 and 1957, respectively, were the first to expertly write on the resistance movement from a psychopathological viewpoint (McCulloch, 1995).

At the height of the Mau Mau rebellion, the colonial government sought the advice of J.C. Carothers, a well-known colonial psychiatrist in Africa and one-time chief psychiatrist at Kenya’s Mathari Mental Hospital (McCulloch, 1995). As an expert on “African mentality,” Carothers provided a detailed analysis of the “troubled mind” of the Kikuyu, one of the largest ethnic groups in Kenya, from which the Mau Mau drew most of its support (McCulloch, 1995). In his landmark article, “The Psychology of the Mau Mau,” he created a pathologized “Kikuyu personality” and almost entirely ignored the underlying occupation, exploitation, and racism of the colonizers, recommending forceful and coercive methods to deal with the uprising and the community at large (Mahone & Vaughan, 2007). Despite his overt racist and prejudicial views about Africans, the World Health Organization hired Carothers as an African mental health
consultant, thus legitimizing and normalizing his racist views about Africans (Carothers, 1970; Fernando, 2010).

During colonial times, the Department of Mental Health in Kenya was under the authority of the correctional department, a historical connection that appears to have institutionalized the deeply held stigma and criminalization of persons with mental illness. In colonial Africa, The Mental Health Act and its predecessor, The Lunatic Act, were used as political tools to deal with independent fighters across the continent. Notable examples include the incarceration of Kenya’s Elijah Masinde, a prominent freedom fighter and the founder of the spiritual sect Dini Ya Msambwa (Faith Through Spirits of Our Ancestors) at Mathari Mental Hospital after he had been declared insane (Ibrahim & Morrow, 2015; Mahone, 2006).

A second example is the case of Nonthetha Nkwenkwe, the South African spiritual leader who was committed to a psychiatric facility in 1922 due to her influence and the threat she posed to White minority rule (Edgar & Sapire, 2000). The political reason for psychiatrizing Nonthetha was made plain when the presiding judge alluded to the fact that a judgment of insanity would help to deflate her movement. She eventually died in Pretoria Mental Hospital in 1935 (Edgar & Sapire, 2000).

The Somali spiritual leader and war hero Sayid Mohamud Abdullah Hassan was declared the “Mad Mullah” by the British colonial government in Northern Somalia for his strong opposition against the British and Italians who were occupying his native country (Ibrahim, 2017; Lewis, 2003). These cases illustrate the degree to which psychiatry colluded with colonial regimes. Furthermore, in many parts of Africa, colonial governments restricted or outlawed African healing systems and threatened healers with arrest and punishment as a means of colonizing and depriving Africans of their sacred and important cultural healing and educational systems (Edger & Sapire, 2000).

The widespread use of psychiatric nosology and treatments as a potent and violent weapon of colonization was widespread across Africa, as evident in French colonized Muslim
North Africa, where psychiatric interventions such as unmodified electroconvulsive therapy (ECT), which is ECT without anesthesia, were often used as interrogation and intimidation tools against Algerian fighters during their bloody war of independence (Keller, 2007).

More recently, during the civil rights movement in the United States, the term “protest psychosis” entered the psychiatric lexicon with respect to African American men who entered the forensic and psychiatric system (Metzel, 2009). Metzel (2009) succinctly describes how schizophrenia evolved from a non-violent psychiatric illness dominant within the white majority and mostly ascribed to women, to an overwhelmingly violent and African American male disorder by the 1950s. In the United Kingdom, studies showed that black men were overwhelmingly diagnosed with schizophrenia in the 1980s; they were also diagnosed with what British psychiatrists termed Cannabis psychosis. Black men in the United Kingdom were viewed as violent and often detained and treated under the Mental Health Act (Fernando, 2010; McGovern & Cope, 1987). The role of the media, the medical establishment, politicians, and security services in creating the “dangerous black male” as a pathological type paved the way in the United Kingdom for the excessive use of forensic and mental health laws as the preferred choice for treating racialized Africans and other ethnic minorities (See Bhui et al, 2003; Singh et al, 2007).

The emergence of the “protest psychosis” and “cannabis psychosis” in the US and UK, and claims of “dementia praecox” in Africa, function to partly explain the over-diagnosis of schizophrenia and the subsequent institutionalization of blacks and ethnic minorities throughout North America and the UK (see Fernando, 2010; Lawson, Hepler, Holladay, & Cuffel 1994; McGovern & Cope, 1987; West et al., 2006). Lawson et al. (1994) discussed the over-diagnosis of schizophrenia among African Americans as partly due to clinician and cultural mistrust between black patients and white psychiatrists due to historical and existing racial injustices and traumas.
These linkages between Western diagnostic practices and colonialism and racism may explain why black and ethnic minorities tend to underutilize mental health services in Western countries. They may do this because of the structural stigma and discrimination they face within institutions of psychiatry, because of the intergenerational suspicion that results from the colonial legacy of psychiatry, and/or because of the harmful effects of faulty diagnosis and intervention rooted in colonial and racist practices (Fernando, 2010).

**Transcultural Psychiatric Framework**

Transcultural psychiatry, as it is known in contemporary times, has evolved from its initial roots in colonial or ethno-psychiatry during the colonial period. As explained above, the colonial period was a time when European powers explored and ultimately colonized most of the Global South. Transcultural psychiatry’s knowledge base and classification of mental disorders emanates from European and Euro-American perspectives where any behavioral disorder or psychopathology uncommon in Western society was seen as peculiar and/or exotic (Tseng, 2006). These non-Western conditions were reported not only by psychiatrists and medical doctors but also by anthropologists, Christian missionaries, journalists, military personnel and explorers (Tseng, 2006).

Tseng (2006) traced the evolution of transcultural psychiatry into three main periods from the 1890s to the present day. He stated that the initial practice was to label psychiatric phenomena uncommon in Western cultures as peculiar, atypical or exotic psychiatric disorders; in the 1970s they were renamed “culture-bound syndromes.” According to the psychiatric classification schema offered by the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM) from the 1980s, non-Western mental illness was classified as culture-related specific syndromes (Tseng, 2006). The DSM, now in its fifth edition, classifies non-Western psychosocial illnesses as cultural concepts of distress and they appear
in the appendix. In that sense, such culture specific syndromes exist outside the “normal” classification of mental disorders (APA, 2013; Kirmayer & Minas, 2000).

The DSM 5 only lists nine cultural specific conditions in the appendix, even though many such culturally expressed illnesses exist across the globe (APA, 2013). For example, the DSM 5 does not mention Jinn possession, a spiritually and culturally relevant illness among Muslims across many cultures. Jinn or evil spirit possession is the belief in the existence and affliction by malevolent spirits (Ahmed & Amer, 2012; Al-Issa, 2000). Further, the DSM 5 does not provide detailed descriptions of such disorders, and although the DSM 5 acknowledges diverse explanatory models and cultural and spiritual healing approaches, many cultural and spiritual healing practices are outside the purview of the Western biomedical mental health system. These examples show the limits of the biomedical framework, including the limits of transcultural psychiatry which claims to be a framework that wholly accommodates the needs of ethnic minorities and understanding their psychosocial illnesses to identify the appropriate services.

In contemporary transcultural psychiatry, psychosocial illness is seen not solely as the result of biological factors, but also influenced by social, spiritual and cultural determinants (Kleiman, 1995). Thus, people experience psychosocial illness differently in different cultures, and culture influences how certain behaviors are pathologized, experienced, and expressed, as well as defines the appropriate healing approaches (Kirmayer, 2005; Kleiman, 1995; Tseng, 2006). Kleiman, a leading psychiatrist, in his influential book, Rethinking Psychiatry: From Cultural Category to Personal Experience, discussed the importance of cross-cultural variation in mental illness across societies and that such diversity in expressing illness has significance in the prevention, diagnosis and treatment of mental health issues globally (Kleiman, 1995).

Therefore, from a transcultural perspective, the biomedical framework, which mainly focuses on the biological aspects of psychiatry and illness perspectives grounded in Western society, may not be universally generalized to other cultures whose illness narratives are
different. Hence the transcultural psychiatry framework posits the value of understanding psychiatric illness in the context of specific cultures (Kirmayer, 1989, Kleiman, 1995).

During the past three decades, two different forms of transcultural psychiatry emerged. One has advocated for a universalist approach to psychiatry, where cultural expression across cultures are minimized. The argument for universality is that mental illnesses, such as schizophrenia, depression and anxiety occur globally and across cultures, hence a universal approach to diagnosis and treatment is possible. The second group called for a relativist approach, where such cultural differences are viewed significant enough not to be ignored (Draguns 1997; Kirmayer, 2005; Kirmayer & Pedersen, 2014).

It is within the universalities approach that a new paradigm in the form of global mental health emerged in the early 2000s (Patel & Prince, 2010). Global mental health focuses mostly on scaling up biomedical mental health treatments in Low and Middle-Income Countries (LMIC). Because of the new focus on mental health in the Global South, scholars, policy makers and international organizations have come together to form the Movement for Global Mental Health (MGMH) (Collins et al, 2011; Patel & Prince, 2010)

The MGMH targets the Global South and is based on a series of articles published by Lancet in 2007 that identified mental illness as a leading cause of disability across the globe (Collins et al, 2011). The MGMH claims that most of those affected by mental, neurological and substance abuse (MNS) disorders live in LMIC, of which 75% or more of those with MNS do not have access to mental health services (WHO, 2010). The WHO in response produced a framework dubbed the Mental Health Gap Action Program (mhGAP) to guide governments and health service providers in “scaling up” treatments for MNS (2010).

The WHO study used a metric system called disability-adjusted life years (DALY) to quantify the total years of life lost to mortality and morbidity for each given disease. In their findings, mental illness is projected to be among the most disabling diseases by 2020 – hence the global significance and the rationale for Western biomedical interventions (Patel & Prince,
2010; WHO, 2010). However, the WHO mhGAP campaign has faced fierce criticism from scholars and authors (see Watters, 2010; Summerfield, 2008; Fernando, 2011; Mills, 2013) who questioned or outright criticized the WHO study with respect to the validity of the tools used to measure mental illness across cultures, as most of these were developed for Western populations. Another concern about the MGMH is the centrality of psychopharmacology as the main driver for scaling up mental health treatments in the Global South (Fernando, 2011; Mills, 2013; PANUSP, 2011).

Critics also claim that the current campaign, if left unchecked, will globalize the westernization of distress in the form of the biomedical psychiatric paradigm, thus suppressing diverse understandings of human distress and feelings, and eventually erasing culturally appropriate ways of coping with those challenges. Such concerns are central to the proponents of relativist approaches to transcultural psychiatry (Fernando, 2011; Summerfield, 2008; Watters, 2010).

**Refugee Mental Health Framework**

The current global number of refugees is unprecedented as more conflicts rage across the world. Many of these conflicts are in Africa, the Middle East, and South Asia. According to the United Nations High Commission of Refugees (UNHCR), the number of people violently displaced from their homes is the highest in history and stands at 65 million people (UNHCR, 2016). Of the 65 million displaced people, more than half remain internally displaced, while 23 million are registered as refugees with the UNHCR (UNHCR, 2016).

Over the past few decades, Canada and other Western countries have witnessed increased immigration of non-European refugees from the Global South (Jeon, Yashioka & Mollica, 2001). The increase in the numbers of refugees is a consequence of war. In response, research among refugees has focused on psychological trauma and associated psychopathologies, such as PTSD, anxiety, and depression. Research and clinical work in this
area has largely utilized a biomedical paradigm. This approach is similar to the framework used to study and treat other forms of trauma-induced psychological distress, such as what might be experienced in the military, in firefighters, in law enforcement, in situations of domestic violence, or during a natural disaster (Jeon, Yashioka & Mollica, 2001).

PTSD as a diagnostic category officially appeared in the third edition of the DSM in 1980. Nevertheless, trauma-related pathologies related to war veterans have been documented since the Second World War as shell shock or war neurosis (Scott, 1990). PTSD emerged during and immediately after the Vietnam War (Summerfield, 2001; Scott, 1990). Under the current 5th edition of the DSM, PTSD has been moved to the newly created section of trauma and stress-related section of the manual. In the 4th edition of the DSM, PTSD was classified as part of the anxiety disorder spectrum (APA, 2013). In the updated edition, PTSD as a diagnosis is considered for individuals who were exposed to life threatening situations, experienced or witnessed death, serious injury or sexual violence in either singular or multiple episodes. In addition, such exposure causes recurrent distress and significantly impairs the individual’s normal functioning socially, occupationally or otherwise (APA, 2013).

However, the emergence and inclusion of PTSD in the DSM has not been without controversies. Critical scholars (see Scott, 1990; Summerfield, 2001; Young, 1995) poked holes in PTSD as a valid biomedical condition. They claim PTSD emerged from the social and political upheaval of the Vietnam War. Scott (1990) argue that PTSD lacked a solid scientific foundation to qualify as a medical disorder. Moreover, Fernando (2011), Summerfield, (1999), and Watters (2001) challenged the validity of PTSD as an appropriate diagnosis in humanitarian and refugee settings in the Global South where the culture and social prevalence are radically different than in Western society.
The systematic and scientific study of refugee mental health is new and mostly concentrated in Western countries, though most refugees in contemporary times come from non-Western states (Jeon, Yashioka & Mollica, 2001). Refugee experiences have been grouped into three categories: pre-migration, transit, and post-migration periods. Each stage brings associated psychological stressors and challenges (Kirmayer, Gudzer & Rousseau, 2014; Warfa et al, 2006). The pre-migration period occurs in the homelands of refugees, where they face extreme political, religious, or ethnic violence and torture. This period may be a short crisis that leads to an exodus or a long political or civil war; in either case, refugees may face severe or chronic shortages of essential foods, water, and other amenities that can lead to severe deprivation. Several studies have shown that pre-migration issues, such as the violent expulsion of refugees from their homes, villages, and countries as well as threats, deaths, sexual assaults, and starvation, affected their mental wellbeing. These experiences can lead to psychological problems, such as PTSD, depression, and anxiety. Traumatic experiences can also worsen the mental health of those with pre-existing mental health conditions (Ager, 1993; Jeon, Yashioka & Mollica, 2001; Warfa et al, 2006; Waters & Ingleby, 2004).

During the second phase, most refugees are either interned in camps or accommodated as urban refugees in neighboring countries where they remain for years. The few studies conducted on refugees in conflict zones generally point to a higher level of mental illness. For example, a study by Mollica et al. (1999) showed that one in every four Bosnians suffer from some form of psychiatric illness because of the ethnic and religious war that engulfed the Balkan region the 1990s. Similarly, one of the few studies on mental illness carried out in Somalia paints a similar or even worse picture (WHO, 2010). Even though these studies have shown a greater need for mental health interventions, few international organizations, including United Nation (UN) bodies, have considered mental health interventions as part of the emergency aid for refugees and displaced individuals. Although many of the physical
protections and provisions of essential needs of life, such as food, water, and medicine, can ameliorate the mental anguish associated with deprivation and insecurity, no operational framework for mental health interventions existed as part of aid packages until recently. International agencies, working through the Inter Agency Standing Committee (IASC) platform, developed specific guidelines for psychosocial and gender-based violence interventions in emergencies. This framework is now widely used by international organizations when providing support for refugees and internally displaced persons (IASC, 2007). It provides broad guidelines for addressing psychosocial needs in emergency settings, from the initial setup stage, to coordination, assessment, monitoring, evaluation, and the protection of human rights on the most vulnerable groups, such as the elderly, women, children, and those with pre-existing mental health conditions (IASC, 2007).

Even with these new guidelines, divergent voices have emerged on how to approach the issue of mental health intervention with populations so culturally different from those in the West. The refugee mental health framework operates from a Western biomedical paradigm that does not sufficiently address the explanatory models of psychological distress and societal trauma of different societies and cultures, nor does it address the sociopolitical and economic realities of these populations. Instead, it defaults to narrowly focusing on biomedical clinical diagnoses and treatments that may not be congruent or relevant to these groups (Bracken, Giller & Summerfield, 1997; Summerfield, 2008; Watters, 2001). For example, Watters (2001) & Summerfield (2008) critiqued the generalization of Western forms of distress, overemphasizing the cross-cultural similarities of certain conditions such as depression, while at the same time minimizing the vast difference between cultural variations of illness. In addition, Watters (2001) highlights the dual function of biomedical disease classification as a medical intervention, and importantly as a concrete evidential way of soliciting for funds to support refugee population in Western settings or in refugee or internally displaced camps.
In the third phase, post-settlement brings forth the difficult challenge of adapting to a new culture and lifestyle. Individuals face language barriers, unemployment, discrimination, isolation, and racism. These experiences significantly increase their already high levels of accumulated stress. Studies done among resettled refugees in Western countries have for the most part focused on pre-immigration issues such as experiences of violence, torture, sexual assault, and deprivation. Few studies have focused on the stresses and associated challenges faced during the post-settlement period (Watters, 2001). However, researchers increasingly acknowledge and focus on post-settlement issues and their effects on the mental health of individuals. Studies show that refugees arriving with higher levels of psychological traumas are less likely to integrate with host communities; they face greater difficulties when adapting to their new home countries (Hansson, Tuck, Lurie & McKenzie, 2010; Watters, 2001).

**Transnational Framework**

Transnationalism generally refers to the interactions and multiple ties between people and or institutions across borders. It is a multidisciplinary field of study and involves diverse topics such as the global movement of commerce, labor, migration, intergovernmental, and non-governmental organizations (Vertovec, 1999). In contemporary times, the transnational movement of people, goods, and ideas have intensified due to advances in technology and communications. These advancements have made physical and virtual movements easier, cheaper, quicker, and more convenient. The interconnections between people across geographical spaces have become a matter of real-time (Vertovec, 1999). Transnationalism is multidirectional rather than unidirectional, and the movement of people, goods, medicine, and ideas involves a back and forth motion across continents and states. One of the most studied areas of transnationalism involves the flow of financial remittance from diasporic immigrants in the north to their kin in the south. Similarly, the movement of international aid and biomedicine
from the Global North to the South has been extensively studied (Basch, Schiller & Blanc, 2005).

In the context of health and mental health, transnationalism involves the physical and/or virtual movement of people, medicines, healing techniques, ideas, and advice across continents, regions, and countries. Transnationalism involves the search for treatment that may include biomedical medicines, herbal, spiritual and cultural approaches, and forms of healing. Yet, the practice of transnational health is diverse and employed differently by different groups. There are, however, some underlying commonalities to these practices, such as searching for either an alternative solution to unsatisfying services or searching for services in a different locality when they are non-existent in the current locality. In the African context, some studies on transnational mental health practices exist. These studies have shown strong links between African immigrants in Western countries and their ancestral homes. They add to a growing list of literature on transnational health and mental health practices and show a changing landscape in health practices (Hampshire & Uwuso, 2013; Janzen, 2012; Krause, 2008; Murphy & Mahalingam, 2004; Saraiva, 2008; Tiilikainen & Koehn, 2011).

The above studies discuss transnational health and mental health practices as complex, multi-directional, multi-layered, situational, and dynamic in nature. When examining transnational health practices among immigrants living in France, England, and Portugal from the West African countries of Senegal, Ghana, and Guinea-Bissau, scholars discuss the complexity of transnational health practices by categorizing them into three main groups: biomedical, herbal, and spiritual practices (Carvalho, 2012; Krause, 2008; and Saraiva, 2008). All three forms move back and forth from West Africa to Western countries, depending on the circumstances, meanings, values, and associations.

For instance, (Krause, 2008) discusses the movement of pharmaceutical products from Africa to Western countries. This is done for individuals in Western countries without legal
residence papers and who lack access to the healthcare system. In other cases, individuals travel back to Africa for specific healing rituals (Carvalho, 2012; Saraiva, 2008). Similar trends have also been reported among Southern African immigrants in Britain; due to immigration status or the lack of it, these immigrants depend on their kin back home for their conventional medicines. Meanwhile, those with proper legal status and secure income send pharmaceutical products back home in addition to financial remittance (Thomas, 2010).

The importance of certain meanings, values, and associations attached to specific treatments are also evident in the flow of medicines from Africa to the West, where some individuals prefer certain pharmaceutical products from their home countries rather than similar drugs available in their adopted country; they cite their preferred choice as more effective and potent in treating specific ailments (Krause, 2008; Thomas, 2010). Similar cross-border health care practices have been studied among uninsured or underinsured Mexican Americans in the United States. These individuals make routine trips across the border to Mexico for their medical check-ups. Some immigrant Mexican Americans prefer the distinct medical culture in Mexico (Horton & Cole, 2011). It is estimated that more than half a million residents of the United States crossed the border to Mexico in 2011 for medical treatment (Horton & Cole, 2011).

In other circumstances, the transnational flow is not limited to patients or medicines. Some healers and herbalists, having noticed the economic potential of this new phenomena, extend their global reach by setting up satellite offices in major Western cities to cater to the health, psychosocial, and spiritual needs of their fellow countrymen and women, as well as other related ethnic groups (Krause 2008; Tiilikainen, 2011). Examples of globalized traditional healers include those from Ghana, Guinea-Bissau, and Somalia, who operate herbal and or spiritual services in major Western cities such as Toronto, Paris, Stockholm, and London, among other places (Krause, 2008; Tiilikainen, 2011; Wedel, 2011). In some cases, consultations, treatments, and follow-ups happen exclusively in the virtual world. Patients and
their families connect with healers back home and then remedies are sent through express freight delivery companies such as DHL or FedEx. Spiritual prescriptions, on the other hand, are sent via text, video phone, or social media platforms to the recipients.

Studies indicate that the main forms of transnational practice for mental health and illness involve herbal and spiritual treatments, rather than biomedical ones (Krause, 2008; Thomas, 2010; Tiilikainen, 2011; Wedel, 2011). Several explanations have been offered to explain why herbal and spiritual treatments remain the choice for many in the African diaspora. The most important reason involves the non-conforming explanatory model of mental illness offered in relation to the biomedical paradigm that emphasizes the biological causation of mental illness (see Krause, 2008; Thomas, 2010; Wedel 2011). As per these studies, many participants believe in a spiritual and or metaphysical causation that has its roots in religion and the spirit world; hence, they prefer herbal and spiritual forms of healing over biomedicine and Western forms of psycho-pharmacotherapy or talk therapy, which are deeply rooted in Western nosology and paradigms.

Another factor, according to Kane (2012) and Wedel (2011), is that the institutionalization of those deemed mentally ill in European countries drives individuals away from psychiatric treatment. When institutionalized, patients are often isolated from family members. Many individuals have identified social isolation as a counterproductive and harmful way of treating illness. In many African cultures, health and illness is a family affair. During illness, family support, advice, and community treatment are an important part of the healing process (Kane, 2012; Wedel, 2011). In the case of Somalis in the diaspora, studies have been undertaken in Finland and Sweden that support the findings discussed (see Guerin, Guerin, Diriye, & Yates, 2004; Molsa, Hjelde, & Tiilikainen 2010; Tiilikainen, 2011; Wedel, 2011). In addition to problems with the explanatory model and issues with institutionalization, Somalis tend to avoid the medicalization of distress and prefer alternative ways of addressing it. Many
prefer spiritual healing to address distress. Just like other African communities in Western
countries, Somalis engage in intra-state and inter-state transnational healthcare practices in
which they move back and forth. They do this within Europe and North America, but also to East
Africa and the Middle East, to visit spiritual healers (Svenberg, Skott & Lepp, 2011; Wedel,
2011).

Other factors contribute to the engagement in transnational healthcare practices among
Somalis in Western countries. Factors include the prevalence of lower expectations due to
institutional discrimination, racism, cultural obstacles and language barriers that Somalis must
confront when accessing proximal health services (Chalmers & Omer-Hashi, 2002; Svenberg,
Skott & Lepp, 2011). Overall, evidence suggests that Somalis in Western countries feel
dissatisfied with the health care services in the countries they live in. Studies conducted among
Somali women in Canada showed that they reported outright discrimination and disrespect
when utilizing reproductive health services in the cities of Toronto and Ottawa (Chalmers &
Omer-Hashi, 2002). Other studies in Finland, the United States, Britain, and Sweden revealed
similar discontent among Somali patients who accessed the health services in their respective
countries (Carrol et al, 2007; Svenberg, Skott & Lepp, 2011; Wedel, 2011). Incidents of doctors
overriding Somali patients’ health decisions, such as their preference for natural birth over use
of surgical and medication assisted deliveries, have been reported in one Canadian study
(Chalmers & Omer-Hashi, 2002; Deyo, 2012). Somalis culturally prefer a holistic approach to
health and healing, and often combine biomedical and spiritual healing interventions when
doctors and nurses declined or stopped an ongoing spiritual healing practice in a hospital, thus
interrupting the healing process. These systemic and structural forms of discrimination, and the
lack of acknowledgement of other cultural ways of healing by the Western health care system
often discourage Somali immigrants and refugees in Western countries from seeking help earlier when illness strikes.

The choice of the transnational framework for this study is supported by the growing literature in this field, especially within African diaspora communities. I considered the fact that the availability of health and healing services otherwise not available in Western countries influences the movement of diasporic Somalis from Western countries to East Africa. The findings of this study confirm the existence of active transnational healing practices among diasporic Somalis, including Somali Canadians. My fieldwork in Kenya revealed a flourishing transnational health and healing sector focused on Somali diaspora clientele.
Chapter 3: Study Methodology

Research Methodology

The choice of research method is influenced by several factors: the theoretical framework, questions to be asked, the need for inductive or deductive investigations, the state of existing knowledge, the population type, their accessibility, and unique experiences, among others (Creswell, 2013; Denzin & Lincoln, 2018). For this study, qualitative methodology was preferred because of the dearth of research on the subject matter and the subjective nature of the research questions, including experiences, beliefs, and feelings. While inductive methods can provide quantifiable and generalizable results, pertinent and personal experiences cannot be accessed in this manner. This is because of the stigma associated with psychosocial illness, the informality of treatment approaches preferred by the respondents, and importantly, the status of the participants as refugees, a poor, illiterate, and ethnic minority.

As described in Chapter Two, in the transcultural psychiatric framework, psychosocial illness or challenges are typically understood through cultural lenses (see Kirmayer, 1989, 2005; Kleinman, 1995), which makes an interpretive inquiry more appropriate for studying the experiences of individuals, families, or communities with shared experiences of culture and religion. Specifically, I chose an ethnographic approach to explore and understand Somali Canadian experiences with psychosocial challenges. Ethnography is a qualitative design of inquiry based on the study of culture (Denzin & Lincoln, 2018). Ethnographers want to explore the knowledge individuals use to interpret behaviors and their experiences within the context of their culturally constituted ways of life (Creswell, 2013).

Creswell (2013) emphasizes the role of ethnography in the study of cultural groups using prolonged and detailed observations to present participants’ views. Somalis are an ethnic group who share common features of ethnicity, common language, geographical origin, and religion. Based on their commonalities, general attitudes, values, behaviors, and ways of knowing,
Somalis are considered a cultural group (Denzin & Lincoln, 2018). Ethnographic inquiry focuses on culture to explore the beliefs and experiences of a cultural group through different data generation methods, such as in-depth interviews and field observation. For that reason, ethnography is an appropriate method of inquiry to study Somali Canadian experiences with psychosocial challenges, their access and barriers to mental health services in Canada, as well as how they seek culturally appropriate healing services outside Canada. An ethnographic methodology not only provides researchers with insight into the lived experiences of Somali Canadians, but also captures the complexity and diversity of factors that shape such experiences (Creswell, 2013).

Therefore, the choice of ethnography fits well with transnational health framework used to understand and analyze the illness narratives of the participants, their help-seeking behavior locally in Canada but also in Kenya where they seek psychosocial and spiritual services deeply rooted in their cultural practices and beliefs. Transnationalism as discussed in chapter two involves the back and forth movement of patients, healers, medicines and healing products in real and virtual work across the Global North and South. By engaging in culturally relevant and enriching activities, culture forms the central theme of these activities and hence the need for an ethnographic methodology that captures the rich cultural data.

Research Methods

To undertake this ethnographic study, I used interviews and fieldwork (participant-observation) as methods of inquiry. Interviews and participant-observation have traditionally been the main methods of inquiry for conducting ethnographic qualitative research (see Van Den Hoonaard, 2012; Bernard, 2006). For this study, I developed a semi-structured interview guide with a general list of questions to guide the in-depth one-on-one interviews with participants, found in Appendix A. The interview guide was developed in conjunction with two native Somali speaking community members based in Vancouver who provided feedback on
the choice of terminology and words to best describe the conditions to be discussed during the interviews. One of the community members is a well-known media consultant who develops and translates written, audio and video materials in English, Somali, Oromo and Swahili languages. Both individuals worked in the resettlement sector and have expertise in the Somali language in the context of interpretation and translation.

For the fieldwork in Nairobi, I utilized participant-observation methods. I visited spiritual healing centers, addiction cultural rehabilitation facilities, and a medical clinic. As described by Van Den Hoonaard (2012), field observation ranges from passive to active participation depending on the degree of the researcher’s engagement with the participants. The field study was carried out through intensive immersion in the field for a short period of time -- three weeks. Although in most ethnographic fieldwork, the duration of field study is often extended and could go on for a number of months or even years, this study utilized a more rapid ethnographic assessment where the researcher conducts interviews and fieldwork in a short period of time due to constraints on time and resources.

However, rapid ethnographic assessment is a valid and appropriate approach for this study given that, due to my positionality, I was able to deeply engage many actors and access issues in depth within a short period of time. In fact, rapid ethnography has been used in health-related research that requires immediacy in finding out outcomes rather than the time consuming ethnography as mostly deployed in anthropological and sociological studies (Ackerman et al, 2017; Vindrola-Padros & Vindrola-Padros, 2017).

In this study, I chose to be a participant-observer where I visited and spent at least three to ten hours in each facility for each interview, mingled with the staff and clients, interviewed participants, observed the activities within the facility, took part in a cultural healing session and took photos (with consent). I also observed the day-to-day lives of people in their neighborhoods
and held conversations with community members. In some cases, I visited some facilities more than once to interview respondents on different days and times, as such I visited most facility at least twice and some I visited more than twice. The repeated visits provided me with a perspective and familiarity of the facilities and the people on different days and times. In fact, for the facilities I visited more than twice, I was seen as a familiar face which reduced the barriers and afforded me more freedom and accessibility to respondents and the facilities in general.

**Sampling Methods**

I used *purposive* and *snowball sampling* methods. These methods are implemented by collecting data on members of the target population that can be located. Upon locating the first few participants, I requested support with further recruitment; I asked the interview participants to connect me with their acquaintances (Bourgeault, Dingwall & Vries, 2010; Rubin & Barbie, 2005). These sampling procedures are used for exploratory purposes. The snowball technique is an important and commonly used method in research on minority and hard to reach populations (Bourgeault, Dingwall & Vries, 2010; Rubbin & Babbie, 2005). Biernacki and Waldorf (1981) suggest that snowball sampling is applicable for studies on sensitive and private issues, as it requires insiders to locate people for the study. As the focus of this study is mental health and substance use, it features questions regarding stigmatized illnesses and non-formal treatment methods. As a result, participants may prefer anonymity and trusted referrals from families and close friends. This method takes advantage of the social networks of identified participants to provide the researcher with an expanding set of potential contacts (Bourgeault, Dingwall & Vries, 2010). In this way, this sampling method is suitable to study the target population.

However, despite its usefulness, purposive and snowball sampling comes with limitations since respondents are generated through links of those interviewed and therefore there are risks of bias in the sampling. This includes interviewing only members with similar
characteristics, such as members dealing with the same psychosocial challenges, or from a particular group of Somalis, of the same clan or tribe who share unique social cultural and economic circumstances that may propel them to view and address their psychosocial challenges in a similar manner (Richie, Lewis, Nichols, Ormston, 2013).

**Data Collection Procedure**

**Qualitative Interviews**

I conducted in-depth interviews guided by sets of questions. In-depth, semi-structured interviews were preferred for this study because they allowed interviewees to share experiences, views, and understandings of their situations on their own terms and in their own language without the researcher putting limits on the specificity of the area under the study (Van Den Hoomaard, 2012). The interviews were conducted in English, Somali, or Swahili depending on the preference of the interviewees. All interviews were conducted by me and I speak all three languages fluently. Interviews were conducted at the preferred site chosen by the interviewees. All but four interviews were recorded with full consent of the participants. Each session took about 30 to 90 minutes. For the four interviews where consent was not obtained for audio recording, the interviewees were reluctant to share their experiences on record and preferred that I jot down important highlights during the interview. After the end of each of the four interviews, I immediately wrote details of our conversation while seated in my car for those done in Canada or in my hotel room in Eastleigh, Nairobi, to capture most if not all of the key issues discussed. Throughout the interviews, names and personal details were anonymized and redacted from the transcription.

**Field Study**

The second method of data collection used was participant-observation in Nairobi, Kenya. Field visits, observations, and interviews in Nairobi involved substance use cultural rehabilitation centers, spiritual healing sites, and a medical clinic. In addition, I conducted a
home visit to a diaspora client and interviewed her in her Nairobi home. I was connected to her through her family members in Canada, who were also interviewed for this study. This provided an opportunity to follow-up with another participant who travelled for psychosocial treatment in Kenya. In the field study description, I provide detailed description of the field sites visited in Nairobi, Kenya.

Research Settings

Metro Vancouver

Metro Vancouver was chosen as the Canadian site, as it is my home town and I know the Somali Canadian community in Metro Vancouver well. I moved to Metro Vancouver in 2010 as a foreign skilled worker employed by one of the major regional health authorities to work as a community mental health and addiction clinician. Before the actual move to Vancouver, I asked around for the Somali community; a family friend connected me with a Somali Canadian community elder living in Surrey. I decided to move and settle in Surrey, a suburb of Metro Vancouver where most Somalis live, to be part of the community.

I am an active member of the Somali and Muslim community in Metro Vancouver. I have worked closely with community-based organizations and local mosques on psychosocial and substance use issues. On many occasions, I have provided educational talks and clinical support in diverse settings such as mosques, family homes, and special community events. I was a member of the Muslim advisory committee for the Ministry of Children and Family Development of the province of British Columbia.

This direct interaction with the community on mental health, substance use, and family issues has provided me with valuable insight into the challenges facing the community. At the same time, it has also helped me to understand how individuals and communities collectively support each other.
Most Somalis migrated to Canada as refugees after the collapse of the Somali government in 1991 and settled in Toronto and Ottawa in the province of Ontario. Since then, a significant population has moved to Western Canada, attracted to the oil boom in Alberta for better economic opportunities (Jibril, 2011). However, Somalis are spread across the country and constitute one of the largest African Canadian communities living in Metro Vancouver, especially the suburb of Surrey.

**Nairobi, Kenya**

The fieldwork section of this study took place in the metropolitan city of Nairobi, the largest, most developed city in East Africa. The city is also the capital seat of the national government of Kenya and the commercial hub for the country and Eastern Africa. Historically, the city emerged in the late 1800s as a colonial outpost and railway station in British-ruled Kenya. It slowly increased in population, activity, and significance during the twentieth century. Today, the city is divided into three sections. The first consists of the wealthy suburbs of Westland, Muthaiga, and Gigiri. The second includes the suburbs of Eastland, South C, B, and Langata, which are inhabited by the middle class. Finally, several massive slums cater to about 60% of the working poor population, such as the Kibera and Mathare slums (Obonyo, 2014). The city’s population has steadily increased over the years due to increased rural to urban migration as more rural Kenyans moved to Nairobi for employment and business opportunities. According to the latest national census of 2011, the metropolitan population is estimated to be five million (Obonyo, 2014).

Over the last quarter century, Kenya has become a beacon of stability in a troubled region. There are active conflicts across many neighboring nation-states such as South Sudan, Somalia, Ethiopia, and Eritrea. Due to these surrounding conflicts, Kenya has welcomed hundreds of thousands, perhaps even millions, of refugees from neighboring countries. In fact, the country hosts one of the largest refugee camps in the world: the Dadaab refugee camp in
the Northeastern region (UNHCR, 2012). At its peak, the Dadaab refugee camp was home to about half a million Somali refugees. The country is also home to the Kakuma refugee camp situated at the North-western region bordering South Sudan. This camp has hosted mainly South Sudanese refugees for more than two decades. Furthermore, most international organizations working for Somalia have their offices and residencies in Nairobi due to the security situation in Somalia (Campbell, 2006).

Kenya also hosts thousands of urban refugees who settled in urban centers such as Nairobi, where they are either registered as urban refugees with the UNHCR and Kenyan authorities, or simply reside and make a living in urban cities without legal documentation. The latter is the case for thousands of Somali, Ethiopian, and Eritrean refugees who live in Eastleigh, the bustling suburb of Nairobi. Eastleigh is often called “Little Mogadishu” due to the high number of Somalis who live there, both Kenyan Somalis and Somalis from Somalia and Ethiopia.

Kenya’s relative stability, its own significant ethnic Somali citizenry, its robust and independent media, open market system, and the fact that it hosts thousands of Somali refugees, has made it attractive and welcoming for Somalis. Several businesses, schools, and cultural and spiritual healing services serve diaspora Somali clients and consumers (Campbell, 2006; Im, Caudall & Fergusson, 2016; Hertz, 2007)

The suburb of Eastleigh is overpopulated and often cluttered with garbage due to poor waste management and planning. It attracts corrupt police and immigration officers who target vulnerable undocumented refugees. Corrupt officers extort money from refugees by threatening them with the risk of arrest or deportation. In fact, as a Kenyan of Somali ethnicity, I have been profiled several times by the Kenyan police who regularly and randomly stop any Somali-looking individual and ask them to identify themselves by showing the Kenyan national identity card or
other legal documents such as a passport or alien refugee card issued by UNHCR in the case of refugees. Due to the threat of arrest and forced bribery, I made sure to carry my Kenyan identity card or Kenyan passport with me at all times. Even though I am a dual Kenyan and Canadian citizen, I avoid carrying my Canadian passport, as some rogue police officers confiscate foreign passports, especially those of Western origin, and demand bribes since there is a general belief that Westerners are wealthier than locals. For refugees in Kenya, carrying their UNHCR issued alien refugee card and a bit of cash is a daily reality in case they are stopped by police. They constantly face profiling, extortion, and indiscriminate detention and arrest by Kenyan security forces (Campbell, 2006; Im, Caudall & Fergusson, 2016).

Despite these circumstances, Eastleigh remains a favorite destination for thousands of diasporic Somalis from Western countries. Fresh arrivals continually pour into the city in a bid to escape conflicts in their home countries. In addition to Eastleigh, several neighborhoods in the Eastland part of Nairobi attract significant numbers of Somalis, including diasporic Somalis returning for business opportunities, politics, or to raise their children in a more traditional community setting (Campbell, 2006; Hertz, 2007; Im, Caudall & Fergusson, 2016).

Businesses in this suburban area thrive thanks to the diversity and flow of diaspora remittance from refugee communities across the Western and Gulf countries. However, Eastleigh has also been associated with significant security problems such as terror attacks, which have been blamed on the Somali militia group, Al-Shabab. Several gangs operate within Eastleigh and the neighboring slums (Abdirahman, 2016; Ombati, 2016; Unuoha, 2013).

One of these gangs is the dreaded and violent Superpower criminal gang, which mostly operates from Eastleigh. Most of its members are Somalis. The founders of this gang originally came from Western countries, mostly youth from United States, Canada, and the United Kingdom. As per my findings, most youth were either deported by their respective governments
in North America and Europe due to criminal and drug involvement or brought back by their families for drug and cultural rehabilitation, only to fall through the cracks and become involved in gang life in Nairobi (Abdirahman, 2016; Ombati, 2016). These are important findings of this research project and will be discussed in Chapter Five.

**Positionality of Nairobi as Preferred Research Site**

Nairobi is an appropriate research site for field work and data collection because the city hosts several substance use rehabilitation programs, as well as spiritual, and cultural healing centers. As mentioned earlier, Eastleigh hosts thousands of Somali refugees and attracts many more Western Somalis, making it an ideal transnational space for Somalis to live, work, and heal.

As a researcher, I have a long history with the city of Nairobi, as I trained as a registered psychiatric nurse at the School of Psychiatric Nursing of the Kenya Medical Training College (KMTC). The Psychiatric Nursing campus is situated in the largest psychiatric hospital in Kenya, Mathare Mental Hospital (Mathare Lunatic Asylum in colonial Kenya), about five kilometers north of Eastleigh. The suburb of Eastleigh remains a cultural home and favorite destination for most Kenyan Somalis, who hail from the North-eastern province of Kenya. The North-eastern region is where I was born, grew up, and worked as nurse for eight years before moving to the United States and later to Canada.

**Participant Selection**

Participants in Vancouver were contacted through word of mouth and posters at local mosques. Initially, I contacted four individuals previously known to me and who had consulted me regarding psychosocial issues affecting their family members. In fact, my first contact was a community leader who in 2011 requested that I contribute to a fundraising event to send a Somali-Canadian man to Northern Somalia for psychosocial and spiritual healing. This man, in his late 30s, was homeless and dealing with significant mental illness and substance use; family
members were preparing to send him back to Somalia for spiritual and traditional healing. I had known the man in question, as he frequently panhandled at a Tim Horton café in my Surrey neighborhood where Somali men, including me, frequent for coffee and socialization.

I asked the contacted individuals to participate and share their experiences with me as part of this research project. All but one agreed and consented to the study. The three initial interviewees connected me to other individuals, and in most cases, interviews involved at least two-family members. The interviews in Vancouver included sixteen family members and three individuals who self-reported living with mental illness and who have received psychiatric care and spiritual healing. The family members interviewed were fathers, mothers, brothers, and sisters. In addition, four interviews from my pilot study of imams in Metro Vancouver were included in this study. For the four imams, a follow up interview was done with three imams who work directly with the Somali community in Metro Vancouver.

Participant selection in Kenya was carried out through influential community gatekeepers, who introduced me to one of the main proprietors of the substance use treatment centers. The introduction opened the door to access other drug rehabilitation programs and spiritual healing centers. I interviewed 14 individuals in Nairobi. Of the 14 respondents, three were youth with substance use problems treated at substance use rehabilitation facilities (dhagan celis), one was a mother treated at home for mental health issues, and there were three spiritual healers, four addiction counsellors, one psychiatrist, and two community workers. In total, I interviewed 37 individuals for the entire research project. I included the two community workers after the initial field visits revealed the existence of significant gang problems among diaspora youth. The two community members are active in addressing the gang problem within the community; one of the community members is involved in a rehabilitation program for street entrenched youth in Nairobi, including some from Western countries.
Data Analysis

In this section, I describe the analytic method I employed, thematic analysis, and the steps taken to analyze the research data. Thematic analysis is defined as a method for identifying, analyzing, and reporting themes within data (Braun & Clarke, 2006). It involves searching across the data set for recurrent themes and issues of potential interest to the researcher in the transcribed data, field notes, and journals (Braun & Clarke, 2006).

The qualitative data derived from this research came from two main sources: interviews and fieldwork in two distinct geographical locations that is, Canada and Kenya involving various categories of respondents as described earlier in the methodology section. The use of multiple methods including in-depth interviews and field work aided in achieving data saturation by bringing different perspectives and experiences to the study questions (Fusch, & Ness, 2015; Guest, Bunce & Johnson, 2006). Fusch & Ness (2015) further state that data saturation can be achieved through the richness of the data and through attaining some loosely agreed upon number of interviews ranging from a minimum of fifteen respondents. In addition thick description of field studies and detailed transcription can help with saturation.

Bekhet & Zauszniewski (2012) mentioned two types of methodological approaches to achieve triangulation, that is; across method or within method, where the former represents mixed quantitative and qualitative methods, and whereas the later indicates combining two methods of either quantitative or qualitative. As an ethnographic study, I choose to employ both interviews and field study to provide rich data and to achieve data saturation and triangulation.

Triangulation of the data was also achieved by interviewing respondents from diverse cultural, educational and professional backgrounds such as Canadians from refugee background from the Somali Canadian community, first generation Somali Canadians with limited exposure to their parents’ home countries, addiction counsellors from Kenya who are non-Somalis and spiritual healers with established healing facilities that serve large Somali
clientele from East Africa and other parts of the world. The results from the interviews of health professionals and spiritual healers in Kenya, in addition to field visits of the various health and spiritual services in Kenya, provides a broader understanding of the transnational practices of psychosocial and spiritual healing in the context of diasporic Somalis.

The data from Kenya, illuminates the experiences of service providers who share their knowledge and expertise of providing services to diasporic Somalis coming from North America and Western European countries, therefore strengthening the reliability and validity of the data from the Canadian participants (Bekhet & Zauszniewski, 2012).

I interviewed 37 people, including 23 in Canada and 14 in Kenya. In addition, field observations to a residential home, cultural and spiritual healing centers, and a medical clinic summed up the field study section of the study. The interviews of family members based in Metro Vancouver and their loved ones living with psychosocial illness were drawn from nine families and numerically identified as Family #1, Family #2, and so on. I grouped the families together to ensure anonymity, analytical convenience, and to compare their shared similarities and differences. In the results section, I provide verbatim excerpts from families and discuss them in the family category. Spiritual healers were identified numerically as Imam 1, 2, 3 and so on.

The analysis entailed achieving coherence and structure in the data, while ensuring that the accounts in the data were retained (Miles & Huberman, 1994). Achieving coherence, structure, and valid meaning from the data was done through several stages, starting from transcription through coding. Coding represented the most important analysis stage in this research. Codes connote nodes or tags assigned to units of meaning identified as important in the data for analytic purposes (Miles & Huberman, 1994). Using NVivo analytical software, I created nodes to identify sub-themes in the transcribed text. By using NVIVO, I created two
categories for each data set, that is, interviews and field notes. I then used the same nodes to analyze both sets of data together. These sub-themes were then tagged against data segments. I later created broader themes that are in line with the study objectives and aligned the sub-themes as they related to the broader themes. Coding also involved extracting themes from the original texts and grouping them thematically for further analysis. This process was carried out across and through all the transcripts. Coding this research was an ongoing, dynamic process, subject to constant revision.

**Ethical discussions and informed consent**

This study involved adults of eighteen years of age and over. Participants were provided with a recruitment statement that explained the study and the voluntary status of their participation. Throughout the recruitment process, I ensured that participants willfully participated and did not feel coerced. Participants were asked to sign an informed consent form or provide verbal consent and received explanation that there was no financial compensation for participating in the study. The study’s ethics protocol was approved by Simon Fraser University’s Research Ethics Board.

Confidentiality and Risk Involved

To reduce the risk of a confidentiality breach, no personal or identifying information, such as names or addresses, were collected. All fieldwork notes and interviews were anonymized as well. The risks involved in this study were minimal. The research procedure did not present any known risks to the subjects of the study. However, because some painful and traumatic personal stories may have been shared, a potential for emotional pain existed. As a result, I developed a referral resource for individuals who required an urgent referral or follow-up medical care (Appendix B).
In undertaking this research, I have been cognizant of my role as a community member but also my privilege as a dual Kenyan and Canadian citizen who is highly educated, holds professional degrees and has worked extensively in the healthcare systems in both countries. I came to appreciate the trust participants, their families and service providers bestowed on me during my research. As such, I have been careful to protect their identities and not jeopardize their sense of safety. The participants for the most part viewed me as one of their own and as such shared with me extensive information, I felt privileged and fortunate but also acutely aware of the huge responsibility to maintain that trust.

It is also important to clarify that during the selection of respondents for the interviews, I started with those whom I knew. Most of these were people that I knew, advice, suggestions or connections to services for them or their loved ones dealing with psychosocial illnesses. I was therefore cognizant of the power and privilege dynamics, as some may feel compelled to consent to participate in the research due to my earlier services to them. However, I made it clear that they had no obligation to consent if they did not want to and that I would continue to provide advice, suggestions or connect them to services if they wished to request again.

**Study Limitations**

In discussing the study limitations, the choice of methods, that is, purposive and snowball, means that the findings are not generalizable beyond the selected individuals and sites visited. As mentioned earlier, snowball and purposive sample is used for exploratory research and the sample selection is limited to the specific study subjects that are either known to the researcher or are selected for their participation through other subjects and hence is not considered the broadest selection criteria (Ritchie, Lewis, Nicholls & Ormston, 2013)

In addition to the methodological limitations, my positionality as a well-educated male, and health professional may have affected the respondents’ responses to the questions. One of
the possible impact of my male gender role, is that women may not have felt coming forward for interviews- in fact, most of my interviewees were male. As a healthcare practitioner who has worked with Somalis, I understand the reluctance of females coming forward to interact and be interviewed by a man. From my clinical experience as well as from the literature it is known that Somalis are conservative in their cultural and religious practice and as such Somali women prefer to be attended to by female health practitioners (Chalmers & Omer-Hashi 2002). Since this study involves sharing personal health stories with a male researcher who also happens to be a healthcare provider, potential women participants may have hesitated to come forward.

Further, as discussed in Chapter Five, I faced challenges in recruiting some of the spiritual healers, and this could be due to mistrust of biomedical health professionals by traditional and spiritual healers in the context of Africa, where historically during colonial times, African traditional and spiritual healers were criminalized and stigmatized by colonial governments (see Ibrahim & Morrow, 2015; Ibrahim, 2017). Therefore, my status as a western educated health professional may have been experienced as a threat by some of those practitioners who declined to take part in the research project.

Demographic Description of the Respondents

Spiritual Healers

I interviewed seven spiritual healers: four Canadians based in Metro Vancouver who all have been in Canada for more than fifteen years. The four Canadian imams were interviewed as part of the pilot study conducted earlier and all four work with the Somali community in Metro Vancouver. In terms of their educational and professional backgrounds, Imam 1 has dual graduate degrees in secular and Islamic studies, Imam 2 has dual degrees in Islamic studies and counselling psychology, Imam 3 has dual degrees in Islamic studies and health sciences, while Imam 4 has a doctoral degree in Islamic studies. Overall, the Canadian imams possess
excellent academic and professional qualifications and diverse experiences, having studied and worked in the Middle East, North America, and Africa.

Of the three spiritual healers interviewed in Kenya, two have practiced in their field as healers for more than 10 years. They operate their own treatment facilities in Nairobi. In continuation with the numerical identifiers, Imam 5 is a graduate from an Islamic university in Saudi Arabia, whereas Imam 6 trained at local Kenyan Islamic academic institution. The Saudi-educated healer (Imam 5) operates a spiritual and naturopathic center, where he treats an average of about 500 diaspora clients from Canada, the United States, and European countries per year. Imam 6 operates an Islamic healing center that solely focuses on Islamic healing and herbal medicine. Imam 7 was employed as the resident spiritual healer for one of the drug rehabilitation centers (dhagan celis). He trained in Kenya’s local Islamic institutions and has worked as a spiritual healer in his current job for three years. As the resident spiritual healer in a drug rehabilitation program, Imam 7 works five days a week; his daily routine includes leading prayers for clients and providing one-on-one and group spiritual healing counselling sessions. Imam 7 also oversees the preparation and administration of herbal medicines used at the center for detoxification as part of the treatment regime for new clients.

Family Members

The interviews with family members explored their views and beliefs on illness and the challenges their kin previously or currently face. I also explored decision-making processes within the family and the consensus or the lack of it around diagnosis, types, and locations of treatments or care. In some cases, at least two or more members of the same family were interviewed, which led to rich details of inter-family dynamics regarding the issue of psychosocial and spiritual illness. The interviews revealed how their perspectives affected their care for loved ones. All family members interviewed were based in Metro Vancouver and
actively involved in the care and support of the individual with psychosocial illness; they have intimate knowledge of the illness and form part of their support network.

I classified the families numerically to ensure confidentiality. The table below shows all the family members interviewed and their relationships.

*Table 1: Families Interviewed and Their Relationships*

<table>
<thead>
<tr>
<th>Family number</th>
<th>Family members interviewed and their relation to the family member with lived experience</th>
<th>Gender of family member with lived experiences and if interviewed (yes or No)</th>
<th>Number of family members interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family #1</td>
<td>Brother and Sister-in-law</td>
<td>Woman, Yes -interviewed in Kenya while undergoing treatment</td>
<td>3</td>
</tr>
<tr>
<td>Family #2</td>
<td>Father, Mother, and Sister</td>
<td>Man, Yes</td>
<td>4</td>
</tr>
<tr>
<td>Family #3</td>
<td>Mother and Brother</td>
<td>Man, No</td>
<td>2</td>
</tr>
<tr>
<td>Family #4</td>
<td>Mother and Brother</td>
<td>Man, No</td>
<td>2</td>
</tr>
<tr>
<td>Family #5</td>
<td>Father</td>
<td>Man, Yes</td>
<td>2</td>
</tr>
<tr>
<td>Family #6</td>
<td>Father</td>
<td>Man, Yes</td>
<td>2</td>
</tr>
<tr>
<td>Family #7</td>
<td>Father</td>
<td>Man, No</td>
<td>1</td>
</tr>
<tr>
<td>Family #8</td>
<td>Father</td>
<td>Man, No</td>
<td>1</td>
</tr>
<tr>
<td>Family #9</td>
<td>Father</td>
<td>Man, No</td>
<td>1</td>
</tr>
</tbody>
</table>

**Individuals with Psychosocial and/or Substance Use Problems**

Exclusion criteria for the participants included minors under the age of 18 and those with significant acute psychological illness that could affect their judgement, decision making, and capacity to provide informed consent. The process of recruiting and interviewing individuals
dealing with psychosocial illness was challenging, since some were under the age of 18 years and others were dealing with significant conditions, such as psychosis, autism, or concurrent psychiatric illness and addiction. As a result, they could not consent to an informed and voluntary participation in the study. Therefore, I interviewed seven out of the nine individuals with psychosocial illness and/or substance use problems. Three were living in Canada and four in Kenya. Of the three interviewed in Canada, one had been to East Africa for spiritual healing and two planned to seek treatment in East Africa, particularly in Kenya. Of the four interviewed in Kenya, three were treated as in-patients at drug rehabilitation centers and the fourth was a mother living with her children in Nairobi who received psychiatric and spiritual care from a psychiatrist and spiritual healer.

Health Professionals

During the field visits in Nairobi, I interviewed five health professionals (a medical doctor and four addiction counsellors). The addiction counsellors worked at drug rehabilitation centers popularly known as *dhagan celis* by the Somali community.

These rehabilitation centers are fairly new approaches to supporting Somali individuals with substance and alcohol use problems and mental health problems. All four addiction counsellors were Kenyans, trained as counselling psychologists. They held bachelors' degrees from some of the top universities in Kenya. They had years of experience and were certified as addiction counsellors by Kenya's National Authority for the Campaign against Alcohol and Drug Abuse (NACADA), a statutory body mandated to address and govern issues concerning alcohol and drugs.

While researching transnational psychosocial services in Kenya, I realized that diasporic Somalis also visited Nairobi for medical services. I was able to find a medical clinic that served diaspora clients. I interviewed a medical physician with board registration and an active practice
in Nairobi. The physician operates a clinic that provides general medical care for the local
community (urban Somali refugees and Kenyans) and diaspora clients who travel from different
parts of the world for the purpose of receiving psychosocial treatments. The diaspora clients
treated at this clinic visit to continue with their ongoing treatment while accessing spiritual and
traditional healing in Nairobi or happened to be in the country for family trips or business
matters.

**Description of Field Visits**

**Field Site #1-Home Visit**

In Nairobi, I first interviewed a mother of three children who had moved to Kenya from
London. While in Canada, I interviewed her family members (her older brother and his wife) and
developed a good understanding of her situation. Nevertheless, I wanted to hear about her
personal experience of living in a Western country, becoming psychologically unwell, and
moving back to Kenya for spiritual and psychiatric care. The respondent, *Ciisha*[^11], is a member
of Family #1 and lived in a relatively affluent part of Nairobi in a well-managed gated townhome
with her three children, aged 11 and younger. She has lived in Nairobi for two years (since early
2015) at the time of the interview. She had been treated for bipolar disorder by a Nairobi-based
psychiatrist. She was on a regular low-maintenance dose of lithium carbonate (mood stabilizing
medication). At the time of the interview, *Ciisha* had remained psychiatrically stable, with no
relapse for more than 12 months, and had good family support. Her children attend a private
international elementary school. Despite the family’s description of her illness as caused by jinn
(evil spirits), *Ciisha* appeared comfortable with the psychiatric diagnosis and treatment that she
perceived to have worked well for her. She shared her experience dealing with bipolar illness. In
a span of three years beginning from 2013, *Ciisha* described three major episodes of psychiatric
illness. Her mental illness (bipolar disorder) developed while living in London and with no prior

[^11]: I have assigned synonyms to all the participants and did not use their real name.
history of psychiatric illness. During each episode, Ciisha was flown to Kenya by her husband and a family member. According to her narration and that of her family members, the third trip to Kenya was very chaotic; she was floridly psychotic, manic, and disruptive during the boarding of the plane. The airline crew even declined to fly her for safety purposes. Eventually, however, she flew back in matter of days after having been medicated sufficiently by a physician in London.

Field Site #2 - Global Psychiatric Services in Nairobi

I visited a medical and psychiatric clinic in a busy neighborhood in Eastleigh, Nairobi. The clinic serves residents (Kenyans and urban refugees), as well as diasporic Somali clients from Western countries. The doctors, nurses, and community health workers at the clinic attend to physical and psychosocial illnesses, but specialize in treating psychological illness with a focus on trauma-related psychological conditions. The staff also run youth groups for at-risk refugee and diaspora youths to discourage them from joining criminal gangs. The youth group runs cultural Somali dancing and poetry classes. I had the opportunity to participate in an evening session and participated in traditional Somali dance (daanto) with the youth.
The clinic has been operational for more than two decades, since the collapse and disintegration of the Somali nation-state. The clinic remains a mainstay for the local neighborhood. The clinic’s staff has witnessed the changes in the demographics of the suburbs, as they absorbed more and more refugees from neighboring countries. In addition, the doctors at this clinic see greater numbers of newly arrived diasporic Somalis who seek their services, including telephone or call-in services where patients or family members based in Western countries call and seek counselling services or book appointments in advance.

**Field Site #3 - Transnational Healing Center**

The third field visit took me to a spiritual healing and naturopathic clinic in a Nairobi suburb. The site hosted a unique tele-healing program in which the practitioner, Imam 5 operates weekly global teleconference sessions for diasporic clients in North America, Europe, and other parts of the world. The clinic is positioned along a dusty main street in a busy

![Figure 4: Cultural dancing at cultural healing center (Cultural healing center in Nairobi, photo taken with consent).](image-url)
shopping center and could easily pass for a convenience store, as the only sign on the door identifies it as an herbal shop. The facility has a small consultation office for clients (individuals or groups) and doubles as a tele-health clinic. Several shelves are stocked with herbal medicines, nutritional remedies, vitamins, books, compact discs (CDs) about herbal treatments, vitamins, nutritional remedies. Islamic healing, however, occupied most of the remaining space of the facility.

The treatments at this facility include Qur’anic healing conducted by a sole practitioner. Unlike Field Site #4 (described below), no accessories, such as stereos and loudspeakers, are used as part of the treatment. Imam 5 works in close collaboration with specialist doctors within Nairobi to whom he refers patients for further medical check-ups and treatment. The transnationality of this clinic was evident, as diaspora clients visit from all over the world. Tele-spiritual and alternative healing treatments are offered, along with global educational services for those unable to physically visit the center. In addition, the practitioner regularly travels to Western cities to serve new clients and follow-up with existing clientele who return to their Western homes after their initial visits.

*Field Site #4-Cilaaj Spiritual Healing Centre: The Post-War Healing Phenomena*

The fourth field visit was to a cilaaj (from the Arabic word healing) spiritual healing center situated in a nondescript and dusty part of Nairobi that borders one of the most extensive slum dwellings in the city. This cilaaj is a busy healing center with a large number of female clientele. Along with the emergence of new diseases and conditions in the post-war Somali world, new forms of treatment and healing have also sprung up. The main forms of treatment at a cilaaj are Qur’anic healing and herbal therapy. Many such centers exist across Nairobi and other Somali dominated areas of East Africa. Islamic healing and other traditional healing practices, like saar and mingis, which involve singing and dancing that have been practiced in the Horn of Africa for
ages (Al-Adawi et al, 2001). Yet, the modified and modernized forms of the cilaaj healing system are a new phenomenon that gained popularity in the recent post-civil war era.

This new cilaaj therapy is based on Islamic spiritual healing, but incorporates technological and biomedical equipment to improve diagnosis or fortify interventions. In this center, treatment sections are gender-segregated and popular among women. According to Imam 6, this site receives hundreds of diaspora clients every year. Most come from Scandinavia, the UK, and North America. The healers of this cilaaj operate a global and regional network of healing centers across the Western world and East Africa. They visit different cities in North America, Europe, and East Africa for healing camps.

The typical treatment procedure in this cilaaj begins with a consultation with a spiritual healer, who takes a detailed oral history, carries out some diagnostic tests using the Qur’an, and administers herbal medicine. After developing a working diagnosis, the client is transferred to a treatment area, where specific verses of the Qur’an suited for the diagnosed condition are read for the individual or group of people. Qur’an therapy is typically delivered through a CD or cassette player connected to loud speakers, and in most cases, a dose or doses of herbal medicine are administered orally, sniffed, or applied topically to the body. It is believed that the use of loud speakers augments the spiritual healing process and the exorcism procedure. They drive out the jinn’s that poses the patient, since jinn’s are averse to loud Qur’an recitation.

Field Visit #5-Dhagan Celis Rehabilitation Centers (Drug and Alcohol Recovery Centers)

My final field studies in Nairobi included visits to four drug rehabilitation centers. Three were situated in the Eastland part of Nairobi and the fourth in a southern suburb. Except for the geographical differences, all four centers operate from a biopsychosocial and spiritual framework in which an interdisciplinary team of addiction counsellors, spiritual healers, medical doctors, and teachers provide comprehensive rehabilitation services.
All four drug rehabilitation centers or dhagan celis are staffed by a multidisciplinary team of professionals of program managers, addiction counsellors, spiritual healers, and teachers. They are supported by consultant psychiatrists and physicians who hold clinics for clients as requested by the team. The diversity in staff recruitment seems to work to the advantage of the youths from Western countries who appear to relate well with highly educated and English-speaking professionals. Each of the four sites had a significant number of clients, with from 40% to 80% from Canada, the United States, Western Europe, and Australia. Of the four facilities, only one had a limited 6 beds reserved for women and girls while the remaining 3 facilities only catered to men and boys. During my visit there were no diaspora female clients in treatment and the four female clients in treatment were from the local Somali Kenyan and refugee community. In fact, all four facilities were established in response to the needs of the diaspora community who return to Kenya with their children, keeping them in their homes or those of relatives in Kenya.

The treatment and rehabilitation programs at these facilities are holistic and encompass spiritual healing, herbal medicine, counselling, and Milati Islami (Islamic-themed Alcoholic and Narcotics Anonymous). Figure 5 below (p.66) shows a brochure at one of the facilities. These rehabilitation facilities are for-profit and operated by businessmen and women who engage in global outreach to market their services and recruit diasporic Somali clients by visiting Western cities. The proprietors also advertise their services on exclusive internet-based Somali television channels widely available in Canada and across the world for Somali viewers.

As a native Somali speaker with deep roots in global Somali affairs, I maintain my community connection in part through these Somali channels, which form part of my cable television options. These channels are accessed through a one-time TV modem purchase. The Somali channels host TV programs, such as daily local and global news, Somali movies, and religious-themed sessions punctuated by commercial advertisements for diverse enterprises.
ranging from manufacturing, wholesale, service industries, education, and health in Africa, Europe, North America, and Middle East. As a diasporic Somali and a consumer of global Somali TV channels, I had prior knowledge of the existence of some forms of the transnational dhagan celis programs across the East African region that cater to Western-based Somali clients, but I was very surprised to find out about the existence of well-established institutions such as the substance use and behavioral rehabilitation programs in Kenya.

The rehabilitation programs I visited were fairly accessible and visible because most of these centers are formal treatment facilities licensed by the Kenyan government through NACADA, its statutory regulatory and enforcing agency. Even though spiritual, traditional, and cultural healers do not require licenses to practice in Kenya, some of the centers approached were reluctant to take part in this research project. My understanding is that they exclusively operate from a spiritual healing perspective and are generally uncomfortable with practitioners and researchers from the mainstream biomedical system; their mistrust could be attributed to the historical and contemporary tension with its roots in the colonial project (see Ibrahim, 2017).
Figure 5: Brochure of Dhagan celis program in Nairobi

Daily Programme
* Quran Therapy
* Madrasa
* Psycho-Therapy
* Psychiatric Analysis
* Guiding & Counselling
* Islamic Speeches
* One on One Programme
* Milati Islamic
* Detoxification
* Herbal Medication E.T.C
Chapter 4: Medical Returnees: Somali Canadians Seeking Psychosocial Services in East Africa

Introduction

The role of religious institutions and leaders in providing essential psychosocial and spiritual care, especially in the Judeo-Christian faith, has been well documented (Ali, Milstein & Marzuk, 2005; Koenig, 1998). Research shows that religious leaders often provide some form of psychosocial care to their followers (Orton, 2008). The health care systems in the Western world have historically collaborated and integrated spiritual care as part of a holistic approach in which hospital and clinical chaplaincies provide support to the sick and recuperating (Hamza, 2007; Orton, 2008). These systems continue to do so today. In fact, clinical pastoral education developed formal professional training and an educational program to enhance the spiritual care of patients across the continuum of care (Orton, 2008). However, for the most part, these programs are not inclusive of Muslims.

Few, if any, instances exist in which healthcare chaplaincy programs have expanded beyond their traditional Judeo-Christian services, even with increased immigration of Muslims and other faith groups such as Hindu, Buddhist or Sikh (Orton, 2008). Furthermore, only a handful of studies have been conducted within Muslim communities in North America to understand the role imams and other Muslim spiritual leaders and healers play in relation to the psychosocial needs of Muslim populations (Abu-Ras, Geith & Cournos, 2008; Ali, Milstein & Marzuk, 2005). The few studies conducted within Muslim communities in North America and the UK reveal that imams and other Muslim spiritual leaders often play a significant role in addressing the psychosocial needs of their congregants (Ali, Milstein & Marzuk, 2005; Dein, Alexander & Napier, 2008). This role increased dramatically after the tragic events of September 11, 2001, when close to 3,000 people lost their lives when airplanes smashed into the Twin Towers of the World Trade Center in New York City. This extraordinary act of violence
led to even more violence against those of the Muslim faith, both on U.S. soil and abroad in the so-called “war on terror” declared by then U.S. President George W. Bush (Ali, Milstein & Marzuk, 2005). Muslims across North America and other Western countries suddenly became the targets of public and media backlash, state security harassment, and discrimination at all levels (Ali, Milstein & Marzuk, 2005; Ibrahim & Alkusayer, 2016).

Studies conducted in Europe reveal that Muslim respondents rely on spiritual healing for their mental health needs and in some cases, seek psychosocial and spiritual healing services outside their new countries for further treatment (Carroll, 2004; Guerin, Diriye & Yates, 2004; Molsa, Hjelde & Tiilikainen, 2010; Wedel, 2011). Two studies reported the existence of transnational psychosocial and spiritual services among Somalis living in Europe (see Wedel, 2011; Tiilikainen, 2010), who returned to Somalia for such services. However, no studies on this phenomenon currently exist in the Canadian context. In this chapter, I will first discuss the preference for spiritual healing and the central role of spiritual healers in providing psychosocial services in British Columbia. I then follow up with findings from Nairobi where Somali Canadians seek transnational services.

This chapter examines: (a) psychosocial issues affecting individuals and their families, (b) ways of coping with those challenges at individual, family, and community levels, (c) resource availability in their local community in Canada, (d) psychosocial and spiritual practices available in East Africa and the reasons Somali Canadians travel for such services.

**Background**

Islam is a way of life and as such, the Islamic faith guides Muslims in many aspects of their lives. It is believed universally that the framework which guides many aspects of Muslims’ lives is derived from four main theological sources, presented here in hierarchical order: (i) the Qur’an, which is believed by Muslims to be the word of God as revealed to the Prophet
Muhammad; (ii) the Hadiths, which are the sayings and deeds of the Prophet Muhammad; (iii) the Qiya or analogy; and (iv) the Ijma or consensus (Pridmore & Pasha, 2004).

The Qur'an states that: “We reveal from the Qur'an that which is healing and a mercy for the believers,” (Qur'an, 17:82) and the prophet is quoted saying that, “Allah does not just send any disease alone, but he also sends down a cure for it” (Al-Saheehyn, as quoted by Ameen, 2005). Many verses in the scriptures (Qur'an and Hadith) discuss health and wellness, including mental health and the use of Qur'anic and prophetic healing techniques. These approaches were used by the prophet and his followers since the beginning of the Islamic faith (Ameen, 2005).

The religious scriptures, in addition to the beliefs of many Muslim cultures, explain some of the causes of psychosocial and spiritual illnesses as: spirit possession (jinn), witchcraft (sihr) and evil eye (ayn), for which treatment constitutes spiritual healings such as incantation (ruqya) and the recitation of verses of the Qur'an either by the individual, family members, or imams and other religious healers (Dein, Alexander & Napier, 2008; Ahmed & Amer, 2013). This narrative of spiritual causality has a profound effect on the understanding of illness and the help-seeking behavior of individuals. Indeed, in many Muslim-based cultures, these beliefs have become one of the most important attributes of psychosocial or mental illness, even in contemporary times (Al-Issa, 2000).

**Psychosocial Help-Seeking Behavior**

Current studies reveal that Muslims identify both biopsychosocial and spiritual causes of psychosocial illness (Abu-Ras, Geith, & Cournos, 2008; Ahmed & Amer, 2013). For example, a study by Abu-Ras, Geith, & Cournos (2008), reported that a significant number of Muslims seek spiritual healing before seeking biomedical health services, while others may concurrently utilize both (Rozario, 2009; Eneborg, 2012). In the Western world, few studies on Muslim mental health issues and practices existed prior to the events of September 11, 2001. This scarcity of
literature reflects a lack of interest by Western researchers and the inaccessibility of Western academic journals to researchers from Muslim nations due to language and writing-style barriers. It is also true that the majority of Muslim clinicians and researchers are Western-trained. Therefore, they may face conceptual and methodological dilemmas in working and researching among Muslims who may use different cultural ideas and explanatory models of disease and illness (Ahmed & Amer, 2013).

The few studies available suggest that majority of Muslim respondents believed in spiritual causality (jinn, witchcraft, or Sihr and the evil eye), and that locally available faith healings tended to be utilized mostly by the Muslim faithful (Abu-Ras, Geith, & Cournos, 2008; Ahmed, & Amer, 2013; Dein, Alexander, & Napier 2008). A cross-sectional study in New York in 22 mosques (N=124), in which the majority (70%) of Muslim respondents had some college education, noted that 84% endorsed spirit possession as the cause of mental illness and that their primary support for a mental problem would be a religious healer (Abu-Ras, Geith & Cournos, 2008). Studies in Britain indicate that Muslim respondents underutilize the mainstream mental health system (Dein, Alexander, & Napier 2008; Eneborg, 2012). Spiritual healing services are common among the Muslim community in the UK, to the extent that healers advertise their services in local community newspapers. Some of these healers ask for exorbitant fees, and consumers pay them, choosing to bypass the free National Health Services; these practices attest to the significance of these culturally and spiritually relevant services (Dein, Alexander & Napier, 2008; Mullick, Khalifa, Nahar & Walker, 2012). Research studies among Somalis in the United States, Europe, and New Zealand (Arkko & Gahan, 2010; Carroll, 2004; Guerin, Diriye & Yates, 2004; Molsa, Hjelde & Tiilikainen, 2010; Wedel, 2011) found that Somali respondents preferred spiritual and traditional healing approaches for psychosocial illness.
These studies stressed the need for a concerted effort by mainstream mental health service providers to collaborate with local imams and spiritual leaders to bridge the gap and improve services to the Muslim minorities in their communities (Abu-Ras, Geith, & Cournos, 2008). Furthermore, imams increasingly encounter individuals with complex social and psychological problems (Abu-Ras, Geith & Cournos, 2008). Nevertheless, imams may lack the educational and professional training necessary to effectively deal with such issues. In some instances, imams are themselves new immigrants with limited language proficiency and knowledge of available community resources. This further constrains their effectiveness in rendering essential psychosocial services to their congregants (Abu-Ras, Geith, & Cournos, 2008).

Immigrants are less likely than non-immigrants to seek mental health services due to language and cultural difficulties, lack of awareness, barriers to existing mental health services, and structural and institutionalized discrimination based on race, religion, language, and immigrant and refugee status (Ellis et al. 2008; Hansson et al., 2010). For Muslims, the post-9/11 era effect of Islamophobia has added a new layer of barriers to the already existing barriers that new immigrants and ethnic minorities face. As a result, they resort even more to spiritual and community-based solutions for their psychosocial needs (Hossain, Ross-Sheriff & Tirmazi, 2010; Ibrahim & Alkusayer, 2016).

As the title of this chapter states, Somali Canadians seek psychosocial services in East Africa. Here I examine this transnational phenomenon through a transnational health framework. I explore the reasons behind such transatlantic health-seeking practices and the types of psychosocial and spiritual services accessed in Kenya. But first, I discuss the participants’ perspectives on their healthcare challenges, their explanatory narratives, and approach to seeking help. In addition, I describe the important role of imams or spiritual healers as service providers. The findings in this chapter are from two interlinked studies; the pilot study
on the role of imams on providing psychosocial support to Canadian Muslims and the main
doctoral study that interviewed Somali Canadians on their challenges with psychosocial illness,
their strategies to deal which include both local and East African location.

Study Findings

I have grouped the themes from the data analysis under the four study objectives
described earlier (see p. 69) to provide clarity and ensure easy flow of the findings from Canada
to Kenya.

i). The psychosocial issues affecting individuals and their families

Interview questions asked about the main psychosocial issues affecting individuals and
their family members. The responses were varied and covered several psychosocial ailments,
such as jinn, (psychosis, schizophrenia, mood disorder), evil eye, and autism spectrum
disorders. I grouped these under two themes: spiritual and cultural narratives of psychosocial
illness, and autism.

(a) Jinn, Sihr, and evil eye: A generational gap in spiritual and cultural narratives and counter-
narratives.

In describing their experiences, the majority of respondents displayed diverse
understandings of the psychosocial issues affecting themselves or their family members. Those
who were Canadian-born or raised in Canada, as well as those with higher education levels,
were more accepting of a biomedical diagnosis. On the other hand, recent immigrants, those
with limited formal education, and older generations attributed psychosocial illness to spiritual
and cultural factors.

In Family #2, respondent Abdirahim, a 20-year-old university student, understood
depression as his illness, though at the moment of the interview, he did not think he required
medications or spiritual healing. Both medication (anti-depressant) and spiritual healing has
tried both but he was reluctant to continue with either. Abdirahim explained that his illness
developed as a result of family conflict and bullying at school. He believed his condition was transient and would eventually improve if he got out more, exercised, and focused on his studies. In his words,

“I don’t think it was an evil eye. I was in a program in high school and everyone was as motivated as me, so I don’t think it is an evil eye” … “been out there more, exercising, pushing myself more. I need to eat better and not sleeping too much”.

His parents, in contrast, saw his illness as a case of malevolent or evil eye. Both parents shared that Abdirahim was a rising star in his school, both in academics and in sports, but that he slowly lost interest in school activities, started to self-isolate in his basement room at the family home, and even neglected his personal hygiene. His parents believed such unusual characteristics in an otherwise normal child could be the work of an evil eye of jealous individuals.

Other family members, notably the younger family members, appeared to reluctantly agree with the parents, but mostly gravitated toward the biomedical explanatory model. Abdirahim’s elder sister Habiba (graduate educated) states:

“But dad thought he needed Quran, for possible evil eye due to how good he was at school and sports and how he is now changed.”

At the same time, Habiba struggled with her own understanding of his condition by stating that,

“I thought about the same and also jinn possession, but I also thought of mental illness.”

These different ways of thinking about psychosocial illness, such as depression, bipolar disorder, and schizophrenia appear to be a common thread across the participants interviewed.

In Family #1, the parents strongly believed that their daughter Ciisha was possessed by jinn and needed spiritual healing. Yet, Ciisha and younger members of the family had a pluralistic view of the complexity and the different narratives surrounding her illness. When
explaining the complexity of her illness and the difference between the younger and older generation within the same family, Yaqub, an elder brother of Ciisha explained:

“Culturally, there is a belief that mental health issues have spiritual connection and the cause is sometimes seen as jinn possession and the priority is to deal with it spirituality.”

Yaqub worked in the mental health system as a trained and licensed professional. He expressed the overall belief within the community, but also added his own view:

“I agree with the spiritual explanatory model and its treatment, as I have seen successful spiritual healing and have lots of respect for that, but as a trained psychiatric nurse I was able to give my inputs that a medical review will be important.”

The second family member interviewed in Family #1, Mumina, was also a health professional. She reflected on the deeply held traditional and cultural knowledge within the community, but also appreciated the importance of including a biomedical perspective to complete the whole picture. As she put it,

“My own beliefs were around traditional causations such as sihr and jinn and the choice of treatment as Quran, but as a nurse I come to understand the biomedical piece of it.”

(b) Autism: Conspiracy, Confusion, Causality, and Care

Another phenomenon that has rattled the Somali community across Western countries is the rise in autism among Somali children. For the families (#3 and #9) dealing with autism, understanding the diagnosis and causes of autism were diverse within these families. Their views reflected what has been described in the literature and media. For example, a parent of Family #3, Asha, a mother with an autistic child, strongly believed that a childhood vaccine administered to her son at the age of 18 months was the cause of his illness. She explained:

“He just stopped talking. The muteness and development of the autistic symptoms started the same day after the immunization. I am very sure it is the immunization. He was given four different shots the same day claiming he was late for some of his scheduled shots.”
While her Canadian-born adult son understood the idiopathic nature of autism per the medical literature, he acknowledged the controversies around autism and childhood vaccinations, especially the MMR vaccine.

In the case of Family #9 with an autistic child, the father, Hussein, a well-educated and informed man, was concerned about the possible connection between autism, vaccinations, and some antibiotics. In responding to the questions of diagnosis, understanding, and causality, Hussein thought that autism could be triggered by vaccines or some antibiotics. But he was also aware of the current knowledge gap regarding the exact cause of autism spectrum disorder. He stated:

“...autism, as per my research, antibiotics may trigger autism. No one knows what causes autism but biologically you may be susceptible to it and may need something to trigger and a lot of antibiotics may trigger but I am not an expert.”

The suspicions and concerns around childhood vaccinations and autism had a negative effect on immunization for the two families interviewed. In the case of Family #3, the mother believed that all childhood vaccinations were harmful and, hence, stopped any type of vaccinations, including childhood immunizations. Family #9 decided to significantly delay all childhood immunizations except for those required at birth and six months. These findings illuminate the quantitative study conducted in the state of Minnesota, where vaccination rates among Somali children have dropped dramatically in the last few years (Hall, 2017). This drop has been blamed on fears around autism. In fact, it appears such fears and concerns exist in Canada, as explained by Asha, parent of Family #3:

“I told my husband that I am not content with what’s going on in this province regarding the kids and immunization. Every Somali family I have seen have about 2 kids with autism or such illness that are associated directly with immunization.”

From the respondents’ view, anti-vaccination proponents played a role in entrenching such beliefs around autism and childhood vaccinations. The parent of Family #3 cited the story
of controversial scholar Andrew Wakefield, who visited Minnesota in 2011, and the current U.S. President, Donald Trump, who claimed during the presidential campaign that vaccines may have a role in the increase of autism in the United States. The mother, Asha, felt validated by Donald Trump’s claims:

“I listened to Donald Trump talking with a medical expert and he was saying that immunization is harmful to kids, and the medical expert agreed with Trump. Because the expert stated that in the past kids use to receive few doses of vaccines and now multiple vaccines are administered. Trump talked how young kids are taken for immunization and come back and behave like my son does after his shots.”

ii). Ways of coping with psychosocial challenges at individual, family, and community levels.

There was one theme under this objective: spiritual healing as the first line of care. The spiritual healers and family members interviewed preferred spiritual healing when dealing with psychosocial illnesses before seeking help from the mainstream mental healthcare system. Of interest were the strong beliefs attached to the power of God (Allah). As explained by Imam #1:

“We have many people who have mental health issues in the community, so we sit with them, we examine these issues from a religious perspective, and, many times, we help them through, you know, through supplication, through prayers, because our religion teaches us to connect to Allah. We know that whatever happens, happens due to the will of God; so, he’s the one who causes all of these things and he’s the one who heals mental issues, mental problems, and many other problems, so we try to motivate these people to be patient and to connect themselves to Allah; and many times, it helps them a lot.”

Imam #2 shared a similar theological narrative:

“Among Muslims, there is acceptance of ‘Qadr’ (the will of God) and so we generally accept illness and other misfortunes … so if someone is depressed it’s seen as the Qadr of Allah.”

The respondents stressed Qadr (will of God) as fundamental to accepting the illness, because acceptance provides hope and the belief that the illness is temporary, and that help will come through God and faith. They also expressed the hope and belief that the simple act of praying and reciting verses from the scriptures could be the solution.
As described earlier, the choice of psychosocial services appeared to be linked to beliefs regarding the causes or contributory factors in psychosocial illness, such as jinn and evil eye. Thus, most families interviewed opted for spiritual healing. In working with families and individuals dealing with psychosocial illnesses, the imams explained why spiritual healing is often regarded as the first line of care:

“... because they feel Islam can treat these illnesses very well as they strongly believe in the supplications from the Quran and from the teachings of the Prophet. In the Islamic literature, that we believe in, there is a treatment for mental illness because you need to connect these people spiritually to the creator and when you connect them to the creator, their confidence level will be stronger, and they feel good about themselves, and when they feel good about themselves, they feel the supreme power, which is the power of God is with them and it will help them to overcome this weakness that they feel, their internal weakness, and absolutely that we experience many times, these kinds of methodologies successfully working and helping many people to get better.”

Imam #1

According to imams, family members, and some with lived experience, they believe that strong \textit{imaan} (faith) often means better mental health and wellbeing. \textit{Caalim}, the father of Family # 2, shared that the lack of a strong connection with faith is sometimes believed to bring in malevolent (evil) spirits or jinn. \textit{Caalim} defines mental illness as: “...spiritual illness that may affect those who go astray”.

Interconnection between faith and mental health compels the faithful to rely on their faith and spiritual healers for their psychosocial needs. Such inclination is why faith healers are an integral part of the continuum of care for some Muslim communities, including Somalis (Wedell, 2011; Dein, Alexander & Napier, 2008).

Imams note the choice of spiritual healers as the first line of contact. \textit{Imam #1} explained how a family consulted him to provide spiritual care to a family member dealing with psychosocial illness:

“...then I went with my friend to that family after we broke our Ramadhan. We went to the home and the wife was possessed by jinn, so we went in their
living room, she was completely gone, she was frightened from a long time ago, and we started reading Quran on the lady, and we continued reading for about two hours. She never went to hospital.”

Imam # 2 corroborated this account by stating that in his mosque, they had specific days of the week for spiritual healing, where large numbers of people would come to seek treatment:

“... the mosque had specific days for ruqyas, the number of attendants were so many, with entire room filled. It’s the people’s perception, they feel cured when Quran is read upon them, situation when people react to Quran, and speaking in tongues; this is evidence of sihr and jinn.”

He states that such communal healing in congregation is increasingly becoming the norm in several mosques in Canada.

iii). Service availability in local communities in Canada

Respondents discussed the complexity of the health care system and the institutional barriers they faced in navigating and accessing the health care system in Canada. There were three themes under this objective. (a) Institutional barriers and lack of trust (b) lack of inclusive spiritual care in the healthcare system, and (c) mistrust of systems (mental health, police, and child welfare)

a) Institutional barriers and lack of trust

The families interviewed discussed the lack of family involvement in caring for their loved ones when accessing services in the healthcare system. They perceived incompatibility between their family-centered approach to care and the health care services’ focus on individuals. In particular, the lack of culturally appropriate services and the deficiency of cultural competency among health and social service providers were a significant barrier for the families interviewed.

Family #1 elaborated:

“...I think the lack of such culturally relatable services is a huge issue. The aspect of trust with the mental health system is lacking.” Yaqub.
Similar views were expressed by individuals with lived experiences of illness and their families, as endorsed by Family #1:

“The doctors and nurses do not allow for us to be part of the treatment plan, and the system alienates the family and that is why back home is the option.” Yaqub.

A member of Family #2 also shared her frustration with the attending doctor, stating that:

“The doctor dismissed me although I am the one who brought him to the doctor. It shows the individualistic focus on treatment, which may not be helpful for families who are very interconnected.” Habiba

In the case of families dealing with autism, the lack of access to local resources was profound. The lack of understanding of the condition, compounded by misinformation, has caused considerable suspicion and fear within the Somali community, and reluctance to engage with the healthcare system. As explained by a member of Family #3 who has an autistic child: “I was in shock and I quickly picked up my kid and moved to East Africa.” Asha

After realizing her child was displaying mutism and a lack of eye contact, this family took their son to the local Canadian hospital. The mother lamented that the healthcare system did not provide adequate information and treatment options for her autistic child.

For Family #3, the confusion was not only about autism, but also the diagnostic and treatment procedures at the local Canadian hospital. The mother expected a thorough physical, hematological, and radiological examination for her autistic son. Instead, the tests involved children’s toys. The diagnostic procedure seemed alien and mundane to her. No immediate treatment, such as pharmacotherapy, was offered. As such, she decided to move to East Africa for a full medical check-up, in addition to medical and traditional forms of treatment. Her adult son, Derow, shared his mother’s bewilderment with the medical encounter:

“There was no treatment as such, maybe speech therapist, even for the diagnosis, it was very strange for my mother, they had toys and speech therapist. She never seen things like this. She assumed there will be blood tests, x-ray, CT scan etc.”
A Swedish study reported that during contact with the healthcare system, Somali patients and family members typically expect a thorough physical examination by a doctor and detailed laboratory and/or imaging diagnostic procedures as part of the investigation for all kinds of ailments (Svenberg, Scott, & Lepp, 2011). The lack of such elaborate examinations in an initial check-up may reduce their trust and confidence in the service providers and healthcare institutions (Svenberg, Scott, & Lepp, 2011).

The above quote from Derow shows the confusion and lack of information regarding autism in respect to diagnostic procedures as well as how such a knowledge deficit eventually led this family to travel back to East Africa in search of treatment for their autistic child.

(b) Lack of inclusive spiritual care in the healthcare system

Issues of accessibility of local health care services can be affected by the lack of spiritual inclusion within a holistic care model. Under a holistic care model families could continue with spiritual healing while their loved ones are hospitalized or cared for by the community mental health system. Some families shared their difficulties arranging spiritual healing sessions at the psychiatric unit, where hospital staff were reluctant to allow for the healing to proceed. Aware that the local health system does not acknowledge or support their spiritual healing, these families arranged spiritual healing at home after discharge.

(c) Mistrust of systems (mental health, police, and child welfare)

Another barrier to accessing services concerned “fear of the system,” a fear based on the experiences and perception that the mental health system criminalizes those with psychosocial illness and delegitimizes mothers who struggle with psychosocial illness by apprehending and giving away their children to strangers. The interviews revealed apprehensions about seeking mental health services due to the connection between psychiatric services, police, and the Ministry of Family and Children Affairs.
The father of Family #7 shared the following story about his efforts to get care for his son:

“I phoned the emergency 911 number to seek help for my son who was having a psychological breakdown, but the Royal Canadian Mounted Police (RCMP) showed up at my door. They attempted to handcuff him, but he resisted. In the end they subdued and took him to forensic psychiatric hospital where he was charged with attempt to disarm a police officer.” Shukri

The above testament of Shukri was supported by his son, Ali, who, at the time of the interviews, was on a community leave and out of the forensic hospital, but under the care of a community forensic mental health team. He narrated to me his encounter with first responders on that fateful day:

“I was kind of feeling anxious, very upset about everything in my environment. I hated going outside and wanted to stay inside. I was also working. My dad noticed I was not feeling well and he wanted me to be checked up and send me to the hospital just to deal with the pressure. He started to know something was wrong. He called the ambulance, cops come, and they arrested me and took me to the hospital … the forensic mental hospital, straight away.”

The very upset parent described that his son was criminalized for being ill and was incarcerated within the psychiatric forensic system for many years. This traumatic experience led the family to completely avoid contact with mental health services. Shukri shared that a second son with mental health issues was treated by a spiritual healer in Canada and then later moved to Kenya for specialized spiritual and herbal treatment, thus avoiding the mental health system in Canada.

Somalia is known as the land of poets (Scuglik, et al, 2007) and in an era of transnationality, in which Somalis live in cities and countries across the Global North and South, information often travels fast through kinship structures. For a transnationally engaged community that is active and in constant communication through social media networks, encounters like this with the system often spread across the world in a matter of hours or days.

Negative experiences in other parts of the world can also have an impact in Canada, as in the case of a family who avoided seeking mental health services for their loved one from the local
Canadian mental health system because of fear of criminalization, citing examples in other Western countries where the mental health and security systems interface. A family member states:

“A cousin in Australia was admitted to a psychiatric ward. That she was forced, and the experience was bad. Another uncle in Australia, he had mental illness, they got him to take pills and took away his autonomy and made him worse.” Habiba

The mistrust and suspicion of the mental health system appeared to include service providers and researchers. Some respondents made it clear that they were uncomfortable in sharing their stories with me because I work as a mental health clinician in the local health system. A respondent who personally reached out to me faced push back from her parents, as they were concerned my contact would eventually lead to forced treatment of their loved one. The respondent states:

“Even speaking with you took a lot of convincing with the family because my parents were very reluctant for me to approach you. My dad is very worried about the mental health system.” Habiba

For mothers with mental health issues, they feared the involvement of the children’s welfare department. Some respondents mentioned a recent high-profile incident in the United Kingdom\(^{12}\) where a child of a Somali British mother with mental illness was removed from her care and subsequently approved to be adopted by a white lesbian couple. The story was widely discussed in Somali communities and led to a protest in the United Kingdom. In the end, the adoption was halted to allow further consultation with the Somali community.

On interviewing members of Family #1, I learned that Ciisha, a mother with three young children, was quickly removed from London to Nairobi by her family after she developed significant mental health issues. Although the family acknowledged their preference for spiritual

care, which could eventually involve moving back to East Africa, the urgency in taking her back to East Africa in a matter of days was solely influenced by the fear of potentially losing custody of her children.

When explaining the dynamics and decision-making process around the mother with psychosocial illness, her children, and the health and social service system, her brother shared that:

“She was taken straight to Kenya because the fear was that if taken to a hospital or doctor, she will lose her kids and she will be given psych meds that will make her a zombie. … I told them that is not the case, since she is not a threat to her kids. The picture they have is that the kids will be taken away and given to a white couple or individual who does not share culture and religion with them.” Yakub.

In this case, the transnational movement involved both the individual with psychosocial illness and her dependent children, who became entangled within the Western mental health and social services bureaucracy. The intersection between mental health care, mental health laws, police, and social services as experienced by families interviewed are encounters alien to the Somali community and potentially a significant barrier to accessing services in Canada.

iv). **Seeking transnational psychosocial and spiritual services in East Africa**

In Chapter Two and Three I discussed in detail the transnational framework and how seeking psychosocial and spiritual services is developing into a global network of services that cuts across borders, thereby redefining traditional and spiritual healing by incorporating biomedicine and technology. I discussed how transnational healing now takes place in both physical and virtual spaces (Tiilikainen & Koehn, 2011). As a result, in the contemporary and globalized world, the possibilities for treatment appear unlimited, a fact not lost even for the newest entrants to the globalized transnational world—the Somalis. In fact, after the fall and collapse of the nation-state of Somalia and the dispersion of the Somali people across the world, scholars have referred to Somalis as a transnational community because they
reconfigure, reconnect, and restructure the traditional filial family and communal links to maintain cohesion amidst chaos and instability (Al Sharmani, 2010).

In this section, I describe four major themes derived from the interviews and fieldwork in Nairobi. First, I discuss transnational healing practices that involve the search for a cure or treatment for autism, a search that involves travelling to East Africa and especially to Somalia. Travelling to Somalia was beyond the scope of the fieldwork in East Africa. Nevertheless, I interviewed two families (#3 and #9) in Canada who have autistic children. Both families eventually travelled to Kenya and Somalia in the hope of finding better healing or treatment options for their autistic sons. I include their transnational experiences in this section and corroborate with interviews from practitioners in Nairobi regarding their experiences of working with diasporic autistic children.

a) Caano geel (camel milk), spiritual healing, and the search of healing for autism

If the occurrence of autism among diasporic Somali children has been a surprising and painful experience for parents, so is the search for a cure, a search that is taking Somali parents all over the world in the hopes of finding effective treatment or healing. As discussed in chapter one, the emergence of new diseases or challenges such as autism and substance use means that Somalis continue to search for cures and solutions. Autistic Spectrum Disorder, in addition to substance use and gangs, represent some of the most challenging medical and social dilemmas the community faces in diasporic settings.

The emergence of autism, the lack of prior cultural knowledge regarding autism, and the barriers to accessing services (diagnosis and treatment) in Western countries, coupled with the fear surrounding the role of government (e.g., childhood vaccination) as a possible cause for the illness, has established suspicion, mistrust, and desperation around autism. According to the findings of this study, one way to cope with the autism issue among the community has been to
search for cures and answers in East Africa through spiritual and traditional healing. The Somali community believes that camel milk has medicinal benefits for children living with autism spectrum disorder.

The two families with autistic children travelled back to Kenya and Somalia with their autistic sons for camel milk therapy and spiritual healing. Both families reported spending a considerable amount of time (more than two years) in East Africa. In describing his son’s wellbeing since being taken to Somalia, the father of Family #9, Hussein, reports that:

“His routine now includes a daily cup of camel milk at breakfast and dinner time. He is much calmer, together and we don’t know whether it’s the camel milk or other things, but it’s better.”

In addition to camel milk, both families reported that spiritual (Qur’an) healing was beneficial, especially the soothing effects of recitations during which both boys typically became calmer and listened attentively. As such, their treatment includes both spiritual and nutritional aspects in Somalia.

The search for spiritual and non-medical treatments and rehabilitation services by families is attributed to the lack of access of services for autistic children. In British Columbia, resources are limited and therapist services are expensive. In addition, both parents were unsure if any services were available once their sons reach 18 years and older. For the father of Family #9, “the aging out” issue was clear in his mind when he sent his child to East Africa because the family did not perceive any good options for their 17-year old son as he grows older. They worried about what the future would hold for him in British Columbia because funding for autistic children from the province was significantly lower from the age of six and potentially even lower for those older than eighteen. With both parents working and supporting family members in East Africa, the family could barely afford the expensive services of therapists and other support services in British Columbia. As a result, they opted to return to
East Africa, where they had support from extended family members and could afford to hire a support person if the need arises.

b). *Hapa na hapa* syndrome

*Hapa na hapa* is a Swahili word meaning “here and here.” *Hapa na hapa* syndrome first entered the East African medical lexicon to describe unexplained and diffuse body pains and an associated malaise that lacks an underlying medical diagnosis and physical cause (Ndetei, 2016). According to the medical doctor I interviewed in Nairobi, local medical professionals believe *Hapa na hapa* syndrome is a somatic manifestation of psychological conditions, such as depression or PTSD. The health professionals at this busy medical clinic explained how they have come to appreciate the need to address trauma in local refugee communities, but also among those in the diaspora who return for treatment at their clinic. One physician at the clinic explained the turnaround of events regarding trauma treatment in these terms:

“We discovered unique complaints with the Somali refugees such as lack of sleep, unexplainable pain, burning sensations, abdominal discomforts. We treat them, but they keep on coming back with the same symptoms. They don’t heal. Most of the people were not improving. Most of them were Somali, Ethiopian, and Sudanese refugees.” Dr. Abdirahman

With the increase in the refugee population in the neighborhood, they (doctors) have seen the frequent occurrence of new conditions for which patients return with the same symptoms. The treatments offered fail to ameliorate their medical complaints. The doctor shares that:

“When someone comes in with pain of upper abdomen, bloating if you treat with analgesics, antacids, i.e., symptomatic treatments, they keep coming back and [the] patient continues to suffer.” Dr. Abdirahman

For every patient revisit, the dilemma grew for the doctors and frustration mounted for the patients. These became cases of idiopathic etiology. According to Dr. Abdirahman, at the beginning the language around trauma-related illnesses and the biomedical explanatory framework of PTSD was not part of their knowledge base. Their clinical experience at the time
was insufficient to address the complex clinical manifestations being presented. The practitioners with years of medical practice in pre-war Somalia noted the rarity of such conditions during their practice there. They noted the subsequent rise in such conditions among the refugee community in Nairobi and among those returning from North America and Europe who could not access medical treatments in Western countries.

Amidst the growing frustration among service providers and their patients, doctors felt helpless and hopeless and began to think about closing the clinic. Eventually, the clinic decided to seek professional and academic support from the larger medical community and from universities in Kenya. These pursuits resulted in the provision of educational and clinical training in trauma-specific conditions. In explaining the dilemma, Dr. Abdirahman stated:

“At the time before this training, we were on the verge of closing the clinic because of feeling helpless and not being effective clinicians. Then after further training in psychotrauma, we understood the clients’ conditions and we started enjoying the work and we continue now.”

This support helped to re-focus and address conditions such as hapa na hapa syndrome more effectively. To explain why patients from Western countries come to see him in his Nairobi clinic, the doctor theorized that:

“Many clients from the West, I cannot say a certain number, but they are a lot. We ask them why they come from the US, Canada, Europe, my colleague and I discussed this in detail. Like this current one... (from the US), …she has been diagnosed well and treated but still comes here, while others have not been treated or diagnosed well, especially depression because of somatization, or anxiety or PTSD and we think the doctors don’t ask those questions. We think the institutions back home are not culturally friendly.”

Most respondents in this study endorsed a common experience in at least one way: they shared similar complaints regarding the lack of time, respect, and space given to express their concerns in the doctor’s room. In addition, they experienced the exclusion of family members from the clinical encounter, the ignorance or disregard of their illness narratives, and a lack of accommodation of their beliefs around illness and care. These issues seemed to be echoed by
the East African practitioners who treat diasporic clients in their facilities. In explaining this further, the doctor at this clinic continued:

“We asked them, and they tell us the doctors don’t listen to us, they cut you short. Clients and families like expressing themselves and telling their stories but they are ignored. Some clients relate their illness to jinn, evil eye, curse, and the doctors in their countries don’t listen to these explanations but we listen to their views. We have asked widely, and the majority say the lack of respect and not being heard to be a major decision of seeking help in East Africa.” Dr. Abdirahman.

At this clinic, the patients are offered the time and opportunity to express their feelings, stories, and beliefs, which are validated as part of the treatment protocol. At the same time, patients are provided with appropriate referral sources for spiritual and cultural healing services. Thus, an interdisciplinary collaboration and mutual respect exist between mainstream formal health services and informal indigenous and spiritual healing services.

Despite this promising collaboration, evidence from the field data reveals that the harmony is not universal between the two service providers and that there exists an underlying tension with respect to the epistemological and ontological differences between the spiritual/cultural framework and the biomedical paradigms. I discuss elements of both fractious relationships in conjunction with a spirit of collaboration in the content and context of the next two themes.

c) Our faith, our health: Completing the holistic cycle in transnational setting

According to many cultural practices within Africa, a holistic approach to health and wellbeing incorporates spiritual healing as a significant part of the healing process. In the contemporary and globalized world, many African individuals and families continue to engage in their ancestral and traditional ways of healing, often in conjunction with modern biomedical interventions (Atuado, 1985). Somali Canadians and other Western-based Somalis continue to incorporate spiritual healing as part of their treatment programs for physical and psychosocial
health. Some move back to East Africa in search of spiritual care services and to complete their recovery. In describing this piece of the puzzle, the medical doctor interviewed shares his views:

“Yes, for others despite successful treatment back home, they still come for spiritual or traditional healing. They feel it is not complete without going through spiritual and or traditional healing. They take their medications but continue with traditional healing.” Dr. Abdirahman.

During my visit to field site # Cilaaj-spiritual healing center, in Nairobi, I come to appreciate the importance of certain spiritual healing practices. While I was at the cilaaj, a Quran treatment session was in process for a group of men and women segregated into two adjacent rooms. I noted that the delivery method of the Qur’an was through a stereo player attached to two large speakers. As the cassette played the repeated verses, the healer applied herbal medicine (powders and liquids) on the foreheads and tips of the nose of several of the patients. Some of the patients would go into trance-like situations, speaking in tongues, fainting, or even mimicking seizures, while others mumbled and sweated profusely. The cathartic nature of the sessions, the change of demeanor, and behavior in pre, intra, and post treatment periods were simply fascinating and enriching to witness. The physical, behavioral, and emotional expressions and the release of underlying psycho-spiritual feelings, including stress and anger, allows the individual the liberties to express themselves in any form or shape in a safe place without sanction for their actions. This is itself a powerful form of healing and a break from a world of constraints, social norms, and controls, especially in a patriarchal society in which strict gender-based behaviors are socially enforced.

Although I did not witness any physical exorcism interventions, some healers employ simple physical interventions such as pinching the nose or tying the small finger of one hand, or more painful interventions of choking, beating, or blanketing of the jinn-possessed patient to drive out the malevolent spirits. Such physical treatments have been discouraged in recent years and are seen as harmful and ineffective, especially among young and Westernized clients who are opposed to any painful physical intervention. However, several respondents informed
me of popular new modern technological interventions within the *cilaaj* healing systems across East Africa. Apparently, there exists an electro-therapeutic gadget, which is typically attached to parts of the patient (the foot, hand, or scalp) to provide small doses of electric current stimulation. None of the healers interviewed, however, was willing to share if such methods were part of their treatment programs. Similar interventions have been reported by anthropologist Tilikainen (2012) while doing fieldwork in Northern Somaliland on spiritual healing practices. In fact, a family member of one of the interviewees in Canada mentioned to me that such electro stimulant therapy is available in the state of Minnesota, the U.S. state with the highest number of Somali Americans. The inclusion of technology signifies the ever-changing landscape of spiritual and traditional healing practices in Africa and in the diaspora, as healers position themselves and remain relevant in a globalized and technologized world where the consumption of newer technologies are incorporated into daily living.

Faith and health intersects; faith forms part of the respondent’s determinants of health and wellness. Faith in God was repeated countless times by spiritual healers, family members, and individuals dealing with health challenges in the Somali community. The importance of faith in God is explained well by a global spiritual healer interviewed in his Nairobi clinic:

“*I specialized in Islamic healing—that involves the soul, body, faith, and mind of the person. Islamically, we treat the person holistically. We strengthen the faith and spirituality of the person – that is the most important thing. A person has to have connection with God, understand illness and health come from God. That medicine and healing comes from God. People learn the skills of healing. Faith in God helps the person accept the will of God. Then after that, we look at the specifics of his illness. The prophet has treated himself and others using different treatment models.*” *Imam #5*

The passage above echoes similar understandings of psychosocial and spiritual illness expressed by other study respondents and adds depth to the preference for spiritually-focused care in communities in Canada or East Africa. *Imam #5* further describes the common conditions he attends to in his practice:
“Most of the clients are coming with psychological and neurological illness. They normally come immediately after hospitalized or treated for psychiatric illness, and mental illness is rampant among Somalis and so many come back to East Africa. … Somalis believe about Jinn rather than mental illness. Stigma also drives people to opt for the Jinn label since it’s less stigmatized.”  
Imam #5

The practitioner reiterated the importance of reducing the barriers to services by appreciating the diversity of services and relaxing the dogmatic rigidity around frameworks of knowledge and practice that inform different approaches to health care.

As his guiding philosophical principle, the practitioner appreciates and acknowledges the diverse care options available and the need to collaborate with different service providers for better health outcomes for the clientele. He works closely with doctors in Nairobi. He gives a case example:

“I had a client from [the] US with mental health and drug problems…. and we admitted to a private hospital for stabilization for five days, sedated and Quran healing. Sleeping is part of the healing. After five days, I referred him to a psychiatrist in Nairobi Hospital and continued with spiritual healing. He is now doing well and back to the US taking care of his family.”  
Imam #5

Most of the respondents reported that beliefs around psychosocial illness as spiritual illness, the stigma associated with a psychiatric diagnosis, and a fear of the mental health system and other governmental systems in Canada and other Western countries influenced their choice of services and their decision to return to East Africa.

d). Pathologizing psychopharmacology

Despite the deployment of medical technologies as adjunct therapies to spiritual healing, some forms of biomedical interventions are excluded and often categorized as harmful. Patients are often discouraged by some spiritual and herbal healers from consuming psychiatric medications while undergoing herbal and spiritual treatments. In fact, in some healing centers, the routine for new patients involves administering an herbal treatment that induces vomiting and diarrhea to clean out poisons, dirt, and pharmacological treatments before the actual
healing treatment commences. This approach contrasts with the collaborative approach described by the medical doctor and Imam #5, who work collaboratively across the divide. To explain the opposing view on collaborative care, Iman #6, who operates a spiritual healing center explained:

“As per my specialty as faith healer, the combination of drugs with spiritual healing is not the best since the psychiatric medications interfere with the healing process…. so, combining, will make full recovery difficult. So, its better we do full spiritual healing with herbal combination but no psychiatric medications.”

Some family members also viewed psychiatric medication as harmful, concerned that they may do more harm than good. Interestingly, the language used to describe the side effects of psychiatric medications appears similar across different families. Here are some examples:

“Everyone who takes psychiatric meds gets worse, makes you crazy, have physical effects.” Yakub, Family #1

“Some were on psychiatric medications and in psychiatric facilities in the West but when brought in by parents, the parents declined to continue with the medication, claiming it will make them zombies.” Alicia, addiction counsellor in Nairobi

“There is a belief that psych meds makes people stupid or zombie, zuzu. We really don’t know where this belief comes from. We talked to them, but the parents are very rigid on that. They say all they need is Quran therapy.” Alicia, addiction counsellor in Nairobi

The father, Dhugow, of Family #6 who was interviewed in Canada likewise expressed serious concerns about his son’s psychiatric treatment in Canada: “I hear they are given treatments that make them crazier.” He planned to take his son to Kenya for “Quran, camel urine and milk, see doctors there and also drug rehabilitation back home that I have seen people who have improved.”

Conclusion

The findings from the interviews and field study in Canada and Kenya provide new evidence from an emic perspective of a relatively new group of immigrants to Canada. The findings reveal the psychosocial challenges, cultural narratives, and some of the strategies (new
and old) Somali Canadians use to deal with these challenges at the family and community levels (Rozario, 2009; Eneborg, 2012).

This study identified new evidence that clearly shows negative ramifications of cooperation among mental health, criminal legal, and child welfare services. Criminalization of those deemed psychiatrically unwell and the potential involvement of non-health actors, like children and family departments in situations involving families with young children, were substantial barriers for Somali Canadians in accessing mainstream mental health and healthcare services in Canada. The involvement of non-health actors had real and serious consequences for some families whose loved ones were incarcerated while others feared losing their children. Such involvements further add another layer of stigma to conditions already laden with stigma, shame, and guilt.

The findings illuminate the challenges that Somali Canadians face in dealing with psychosocial issues and accessing services in Canada. It highlights the invisibility of Somalis and how their psychosocial needs often go unnoticed. A lack of knowledge exists within the healthcare system in Canada concerning their preferred approaches for healing and care with regards to psychosocial and spiritual conditions.

The study showed the significance of understanding diverse explanatory models of health and wellness especially for Muslim communities in order to provide culturally appropriate services. Findings highlight the importance of closely collaborating with cultural brokers, alternative and faith leaders in addressing issues of mental health service provision, psychosocial support and addressing inequities. The need to enhance the capacity of culturally appropriate community agents so that they can effectively address and mitigate various psychosocial needs of their respective immigrant communities could not be understated, as individuals and families from such communities had strong faiths in their cultural institutions and heavily relied on them for their psychosocial needs.
The imams were considered the primary resource of guidance for the immigrant Muslim communities and had high levels of trust and expectations thrust on their shoulders. Thus, it was crucial that imams possessed the right knowledge and tools to sufficiently and effectively assist those who sought help from them and to direct or refer them to the proper channels if the problems were above their expertise and capacity. Imams could benefit from information on the availability of mental health resources awareness, active collaboration and communication with health care services and social service providers.

There is a need for scholars and health practitioners within the Canadian society to rethink the role of religious and other ethno-cultural institutions in the context of health and other essential human services in order to address inequities and other barriers to essential services and to use such institutions as one of the ways to address such inequities.

Although the issue of autism within the Somali Canadians is almost non-existent in the literature, the findings of this study reflects concerns among the two families interviewed in terms of their feelings that they believe is widespread among the Somali community. The prominence of the autism situation could have come to the fore due to the political rhetoric during the United States 2016 election as explained by one of the respondents in addition to the anti-vaccination campaigners targeting Somali Americans in the state of Minnesota. Despite its prominence during this study, the results may not be generalized due to choice of methods and the limited number of individuals interviewed.
Chapter 5: *Dhagan celis* (Cultural Rehabilitation) as an Addiction Recovery Model: Somali Canadians Transnational Approach to Youth Substance Use

Introduction

This chapter discusses *dhagan celis* as a cultural rehabilitation model for substance and behavioral problems among Somali Canadians and other Somalis in Western countries. The chapter also provides new evidence from ethnographic data through fieldwork and interviews collected in Nairobi, Kenya on the challenges some youth face while undergoing cultural, spiritual, and medical care for their substance use or behavioral issues. Due to the lack of research on *dhagan celis*, I have expanded the background information on this topic to include information and discussions from the media, including social media.

*Dhagan celis* is a Somali word comprised of two words: *dhagan*, meaning culture, and *celis*, meaning to return or returning. As such, *dhagan celis* is loosely translated as return(ing) to culture (Omar, 2016). *Dhagan celis* has been theorized in the context of transnational families of diasporic Somalis, in which the cultural upbringing of children happens transnationally and challenges the idealized Western nuclear family tradition of two parents raising their children alone under one roof (Johnsdotter, 2015; Al-Sharmani, 2010). The new addition of substance use rehabilitation to the *dhagan celis* repertoire expands the *dhagan celis* landscape. In its earlier form, *dhagan celis* involved the upbringing of diasporic youth in transnational spaces through which they transverse East Africa and their home Western countries. In both instances, they typically stay with extended family members and or parents.

*Dhagan celis* has also been represented as a form of cultural learning wherein the return to East Africa is seen as a way to enrich the lives of youth, help them appreciate the opportunities they have in the Western world, and even engage in transnational Somali affairs.
by volunteering, doing business, or relocating to East Africa within the platform of nation rebuilding (Kleist, 2008; Osman, 2012). Thus, the concept of dhagan celis serves several purposes: ensuring intergenerational cultural learning, instilling a sense of responsibility, empathy, and hard work among Western-born teenagers, and in some cases, serving as a corrective measure for teenagers suspected of engaging in unwanted behaviors or those falling behind in their academic and social responsibilities (Johnsdotter, 2015; Omar, 2016; Osman, 2012).

Dhagan celis is gaining popularity among the diasporic Somali community in the Western world as a way to deal with post-resettlement challenges among youth. It involves cultural learning, instilling traditional values, maintaining language, faith, and connection to their East African heritage, and, as a transnational preventive and rehabilitative approach for youth dealing with behavioral and/or substance use problems (Osman, 2012; Omar, 2016; Tillikainen, 2011). The concept of dhagan celis has been covered mostly by British, Swedish, and Finnish media through the broad lens of reconnecting European Somali youth with their culture in East Africa (see Osman, 2012; Johnsdotter, 2015; Tiilikainen, 2011).

In 2005, Swedish broadcasting television aired the story of two Swedish Somali teenaged siblings taken back to Somalia for dhagan celis by their parents to learn about their culture while their parents and other siblings remained in Sweden (Johnsdotter, 2015). The story was widely discussed and viewed negatively by Sweden’s general population who criticized the parents for “dumping” their children in Somalia while they themselves lived comfortable and peaceful lives in Sweden. After the story, the Swedish government issued new travel documents for the two teenagers and facilitated their return. The story ignited debates over the rights of underage children and some policy changes occurred regarding issuing passports to children without parental consent to facilitate the return of youth in similar circumstances (Johnsdotter, 2015).
In Kenya the media has focused on the problematic involvement of diasporic youth in the local Kenyan gang wars (Hussein, 2015; *The Nairobi Star*, 2014). Although such an innovative transnational care approach is seen as a relief and possible solution to the youth drug and gang problem for Somalis from Western countries, it nevertheless comes with significant financial, logistical, and safety concerns for the parents, youth, and East African countries, such as Kenya, that host such cultural rehabilitation programs.

In chapter one, I discussed the new phenomena Somalis encounter in the Western world: substance use and gang involvement among their youth. These two issues affect Somali youth in Canada and other Western countries. Substance use among East African Somalis in the form of khat is widespread (Njuguna, Olieva, Muruka & Owek, 2013; Warfa et al, 2007; Odenwald, Klein & Warfa, 2010). Khat also known as *Catha edulis* in its scientific name, is a mild stimulant that is harvested from a leafy khat plant native to the Horn of Africa (Kenya and Ethiopia) and Arabian Peninsula (Toennes, et al., 2003). Historically, Khat was regarded as a traditional recreational herbal stimulant consumed during special events such as weddings and religious events by elders, but contemporarily its use cuts across age and gender among communities in Horn of Africa and the Arabian Peninsula (Toennes et al., 2003). Previously, the use of illicit street drugs was rare and viewed negatively among the Somali general population. Substance use in the context of alcohol and illicit drugs has intensified since the collapse of the Somali nation-state (Hansen, 2013). The exposure to and eventual increase in substance use has been attributed to the collapse of the nation-state, displacement, and diaspora living where alcohol, marijuana, and illicit streets drugs are available and accessible (Tillikainen, 2011; Osman, 2012; Omar, 2016)

Facing acculturation challenges, Somali parents have realized that their children are quickly adopting Western lifestyles. In the process, some youth use drugs and join gangs due to peer pressure and/or struggles with psychosocial challenges such as trauma, bullying, and
racism (Osman, 2012). With limited resources and a lack of access to services in their new countries, parents opt to address the problems of drugs, delinquency, and gangs by sending their children back to East Africa (Osman, 2012; Omar, 2016; Tillikainen, 2011).

Substance use is viewed by diasporic Somalis as a consequence of living in Western society and is understood as a negative Western cultural adaptation, as well as a matter of losing touch with Somali culture (Osman, 2012). Thus, many diasporic families resort to cultural rehabilitation programs in East Africa to re-introduce Somali and Islamic culture to their substance-using youth. With the exception of a single study (Tillikainen, 2011) on dhagan celis for youth dealing with substance use and mental health, little research on this topic currently exists, and to my knowledge, no studies have been conducted in the Canadian context. As such, this study will contribute important knowledge in understanding substance use among Somali Canadian youth, access to treatments in Canada, and the transnational cultural healing services available in Kenya.

Background

Studies have shown the negative correlation between adverse early childhood experiences, including trauma and deprivation, and long-term chronic health and behavioral issues such as substance use and mental illness. In particular, the adverse childhood experience (ACE) study showed that a high prevalence of early childhood trauma caused long-term effects in adulthood (Triffleman, Marmar, Delucchi & Ronfeldt, 1995; Felitti et al, 1998).

Past trauma has been associated with comorbidity of substance use and psychiatric disorders (Dube et al, 2003; Anda et al, 2004). However, little knowledge exists about substance use among refugee youth in Canada. Studies conducted in the United States, Thailand, and Australia indicate that refugees, especially youth, have increased risk for substance use due to their refugee experience and post-resettlement challenges (Brune, 2015; Lai, 2014; Posset, Procter, Galletly & Crespigny, 2015; Salas-Wright & Vaughn, 2014; Sowey,
The studies highlighted some of the factors associated with the refugee experience and substance use, such as challenges to adapting to new cultures, educational systems, and, establishing new social networks.

These challenges are more pronounced and often difficult for refugees who come from non-Western cultural and educational backgrounds, and who lived in rural settings or refugee camps with limited education and exposure to Western cultures (Hyman, Vu & Beiser, 2000). Such significant challenges impact negatively on the psychosocial wellbeing of youth who as part of their refugee experiences, already suffer additional stress of loss, deprivation, and disruption in childhood. Such stressful situations may predispose youth to use drugs and or alcohol as a coping strategy, providing momentary relief from their daily life challenges (Swowey 2015; Omar, 2013).

As discussed earlier, evidence exists that links trauma-related conditions and substance use. The link between trauma-related disorders and substance use has been discussed in the context of military veterans (Seal et al, 2011), domestic violence and gender-based violence (Jones, Hughes & Unterstaller, 2001), as a chronic effect of adverse childhood experiences (Dube & Felitti, 2003), and due to the effects of war and refugee experience (Lai, 2014). Refugee youth can be affected by all of the above, as victims of war, as child soldiers, and as victims of gender and sexual-based violence.

Research among African refugee youth and substance use remains sparse; however, some notable studies have been conducted in Australia that provide some data on this refugee subgroup. These studies (Horyniak, Higgs, Cogger, & Dietze, 2014; Posselt, et al, 2014: 2015; Swowey 2015) identified that substance use is a problem among immigrant youth of Sub-Saharan African descent, and described the challenges of accessing formal treatment services in Australia. The Australian studies highlighted the significance of trauma and post-resettlement challenges in adapting to Australian mainstream cultures, including poverty, inadequate
housing, problems with the educational system, and racism, among other structural and institutional challenges positively correlating with substance use problems.

Other studies among African refugee youth, especially Somalis, have been conducted in the United States (Ellis et al 2013; Ellis, Lincoln & Charney, 2010). These studies discussed specific challenges of the refugee experience and post-resettlement challenges in the U.S. context. However, substance use was not specifically discussed in relation to the refugee experience and acculturation stressors.

Despite evidence suggesting the link between trauma, psychological effects, behavioral effects, and substance use, no Canadian-specific pre-arrival orientation or post-resettlement programs on substance use prevention and/or treatments currently exist for youth or their family members. As a result, the Somali community in Canada has been forced to face the realities of their youth becoming involved in illegal street drugs, as well as gang involvement. Like many other refugees and new immigrants, the Somali community deals with significant pre-and post-resettlement challenges, such as language barriers, high unemployment, and challenges adapting to new cultures, ways of living, and new educational and health care systems (Makwarimba, et al, 2013).

Although there is an acknowledgement of low uptake of mental health services among refugees and immigrants, little is known about substance use and how refugee communities deal with it. Drug issues among Somalis in Canada have been discussed mostly by media in the context of gangs and criminal involvement among Somali youth in Surrey13, British Columbia, Ontario,14 and Alberta15. The media often frames this problematic issue as the lack of proper

14 https://www.thestar.com/news/crime/2012/09/21/toronto_somali_communitys_cry_our_kids_are_dying.html
integration of the Somali community into the larger Canadian society, failure of the younger generation in the educational system, and the criminality of black male youth involved in antisocial and criminal activities (Stachel, 2012). The media provides no discursive contextualization around trauma, substance use, mental health, and their negative impact on educational and successful integration into mainstream societies.

The Somali Canadian community is close-knit and conservative, and the issue of substance use, especially involving alcohol and hard drugs, are viewed through a moral lens that carries shame and stigma. Substance use becomes a problem for families as they confront not only the drug problem, but also the criminal legal system for their youth (mostly boys) involvement in gang and drug issues. With no prior cultural knowledge of how to deal with both drug problem, criminal legal system and the challenges of accessing addiction services in Canada, families draw on their faith and culture for possible solutions to drug problems (Ibrahim & Alkusayer, 2016).

A study conducted by the Toronto District School Board (TDSB) revealed educational challenges for Somali Canadian youth in the Greater Toronto Area (TDSB, 2014). The TDSB report revealed that Somali children in elementary and high schools are overrepresented in special education programs and less than 50% of Somali boys successfully transitioned from high school to university. The report also noted significant absenteeism and challenging behavioral issues with this group (TDSB, 2014). The report came on the heels of reports of gang-related violence and deaths among Canadian-Somali youth in Ontario, Alberta, and British Columbia. Nearly 50 Somali Canadian youths have died in gang wars in Ontario and Alberta in the past few years. The gang issue has been blamed on the significant dropout rate from school, drug involvement, poor housing, effects of intergenerational conflict, among other factors (Naji, 2012; TDSB, 2014; Stachel, 2012).

Although it is important to discuss and research the intersection between drugs and gangs, it is equally important to study and effectively intervene through education, prevention,
and prompt early treatment of substance use issues among newcomers and refugee youth. Early prevention and intervention could improve early recovery, and better health outcomes for refugee youth. In the case of traumatized refugee children and teens, and based on evidence of trauma among this population, limited evidence-based psychosocial and educational interventions are available, especially during the critical period of initial post-resettlement (Saxe, Ellis & Kaplow, 2006). The Trauma System Therapy (TST) model developed at Boston Children Hospital and now adopted by several states in the United States provides one of the few population-specific interventions available for traumatized refugee youth (Saxe, Ellis, & Kaplow, 2006).

A modified TST model called Supporting the Health of Immigrant Families and Adolescents (SHIFA) for Somali youth and their families was developed and implemented in the Boston area. The project was initiated in response to reports and evidence of significant psychosocial issues among Somali youth where integration and educational success was deemed dismal. The project is ongoing, but early results indicate positive outcomes for the targeted population (Elis at al., 2008). Despite the promising success of this intervention, it lacks a substance use component, an addition that could be beneficial for families and their youth.

In Canada, there is recognition of the need to address and support the mental health of refugees. Stakeholders such as the Canadian Mental Health Commission developed frameworks to support service providers working with refugees (Agic, McKenzie, Tuck & Antwi, 2016). Nevertheless, substance use prevention and treatment remain an outlier in many refugee-focused interventions (see Hansson et al, 2010; Agic, McKenzie, Tuck & Antwi, 2016).

Due to the lack of appropriate educational, preventive, and treatment services and support, Somali families turn to their cultural and support networks within the community, including the mosque (Ibrahim & Alkusayer, 2016). As the only study of its kind in British Columbia, the pilot qualitative study I conducted earlier on the role of imams in providing
psychosocial support revealed that families consult and seek support from imams as spiritual healers (Ibrahim & Alkusayer, 2016). In fact, due to the high need for counselling and support by the Muslim community in Metro Vancouver, some imams sought further training in counselling to meet the demand within the community (Ibrahim & Alkusayer, 2016). As I will discuss in the results section, some families take their children to East Africa for further cultural and spiritual rehabilitation. Although transnational cultural rehabilitation services exist in Kenya, no known studies have investigated the services offered and the experiences of service users. This study is the first to provide data and evidence on cultural rehabilitation programs in Kenya.

Much like the concept of dhagan celis as a matter of cultural learning, enrichment, and good citizenship through cultural immersion in East Africa, the transnational dhagan celis substance use recovery programs are geographically located in East Africa. Care involves a holistic approach to healing through psychosocial and spiritual rehabilitation. This study examined the experiences of Somali parents and youth regarding substance use in Canada. Here I report the findings from this study, including Somali Canadians’ use of transnational cultural and spiritual rehabilitation programs in Kenya.

**Results**

The focus on this chapter is substance use and the findings are discussed in a similar process as in Chapter Four, where I discuss results of the pilot study on imams’ roles but also include the experiences of family members and their loved ones dealing with substance use problems, their search for health and spiritual services in Canada and East Africa and some of the challenges the youth encounter in Kenya.

i) Post-resettlement and psychosocial challenges.

As part of the larger study on psychosocial challenges, I categorize substance use as psychosocial illness because most of the youth deal with concurrent mental health problems and addiction. I identified five themes under this objective: a) fading hope, b) triple whammy of
discrimination and racism in the school environment, c) cultural disconnection between parents and youth, d) emotional pain and self-medication, and e) the losing streak continues.

a) Fading hope

The parents whom I interviewed in Canada discussed their journeys and relocations to Canada and their hopes of providing better education and employment for their children. For example, the father, Dhugow, of Family #6 described his hope and aspirations concerning his children’s future: “I come to Canada with the hope that my kids will have better lives.”

Among the nine parents interviewed, five lived in refugee camps in East Africa for more than ten years, where most of their children were born or raised. The lack of upward mobility for their children in the refugee camps (in Dadaab and Kakuma in Kenya) was particularly distressing for many parents. The Dadaab refugee camp is located in the North-Eastern region of Kenya and houses about half a million people, mostly from Somalia (UNHCR, 2012). The Kenyan government enforces strict movement rules for refugees so refugees have very limited opportunities to move out of the camp.

Once accepted for resettlement to Canada, parents experience positive feelings of hope for their children. However, the euphoric feelings towards life in Canada often evaporate quickly once the reality of post-resettlement challenges hits families. Families shared their frustrations about the inadequate support for their children’s education and for integration. Children are placed in school programs according to their age, rather than their educational level, which makes it difficult for newly arrived children to adapt, integrate, and succeed. As one parent stated, “it sets them up for a failure.”

b) Triple whammy of discrimination and racism in the school environment

The findings reveal three layers of discrimination against Somali children in the school environment—being black, Muslim, and refugees. Participants reported that Somali students
face substantial levels of discrimination and racism within the school system that is perpetuated by other students, teachers, and school administrators. “In Canada, the only easy thing to do is drugs,” said Dhugow, the father of Family #6 with a 20-year-old boy who had only been in the country for four years and had already dropped out of school. The father talked about bullying and the difficulty of adapting to the educational system. He also spoke of how his son was easily recruited to drugs and low-level gang activities by members of the community who were higher up in the drug trade.

The parents also lamented about the disproportionate punishment their children receive for behavioral issues at school and how such long suspensions and expulsions have demoralized their youth’s educational aspirations. This assertion was supported by Farah, one of the youth interviewed: “I was bullied, called the N word, even at the BC Muslim School.” He further shared about the bullying and racism he had to deal with, and the difficulty of advocating for himself due to language barriers. He talked about the overwhelming emotional challenge of navigating the multitude of issues at the school, such as language, culture, and race. This led to a mental breakdown for him. The frustration and the lack of agency and support eventually pushed him to his limits. As a last resort, he defended himself by physically confronting the youth spouting racist chants and bullying. Eventually this physical response towards his aggressors led to many suspensions and five expulsions from different schools in the Metro Vancouver school district systems.

c) Cultural disconnection between parents and youth

“I get my medical marijuana from a dispensary.”

A father was baffled by his son’s response when questioned about smoking marijuana. The father could not fathom the idea of buying or getting bhang (marijuana) from a medical facility (dispensary). He was confused by the notion of bringing a dispensary or a clinic, which he only associated with “real” medical treatment, into the domain of drug use. For the families
interviewed, the cultural divide is further widened by suspicion regarding the role of the government (including the medical establishment) in “drugging’ children, by prescribing them marijuana, which parents view as an illegal and harmful substance. This shows the widening of cultural differences between parents and their children, as the youth learn to navigate the Canadian mainstream lives much more quickly than their parents.

d). Emotional pain and self-medication

The consumption of marijuana, alcohol, and opioids was one way that youth dealt with emotional pain and treatment. Two young adults of Family #6 and #7 claimed that smoking marijuana helped them deal with the stress, anxiety and struggles of “living the tough life.” Such diverse understanding and use of substances, legal or otherwise, often puts parents and their children at odds with one another. Parents viewed drugs as problematic, illegal, and harmful whereas some of the youth interviewed saw them as a form of treatment to deal with emotional pain.

e) The losing streak continues

“In my opinion, I have not benefited from Canada, and I don’t expect to benefit from it. I am aging and don’t expect to go back to school and get a career, but I was hoping my kids would benefit from the educational system here, but it failed them.” Parent of Family #8.

The experience of loss and struggle as a refugee never ends for these resettled refugees, some of whom had become Canadian citizens. They experienced feelings of endless struggle and loss, beginning with the collapse and civil war in Somalia in 1991, the eventual displacement to neighboring countries, and subsequent stagnation for more than a decade in refugee camps. With resettlement in Canada, which they thought of a peaceful and stable democracy, many hoped for an end to their struggles. However, with the issues of drugs and gangs, they feel their loss and struggles are endless. There was a sense of losing hope as Dhugow, the father of Family #6 shared, “As the new war or struggle, I have lost my boys and I feel no need to be here anymore.”
Similar sentiments were expressed by other family members. In comparing their lives in Dadaab refugee camp and Canada, Fundi, the father of Family #8, shared how the feeling of powerlessness was creeping in now that the family appeared helpless to support their child, who as the father shared “... is lost to drugs and crime.”

ii. Access and barriers to services and information on substance use in Canada

Three themes are discussed under this objective; that is; a) lack of awareness of formal substance use services in British Columbia, b) stigma and c) Spiritual leaders as addiction counsellors.

a) Lack of awareness of formal substance use services in British Columbia

The families I interviewed were unaware of substance use treatment programs in Metro Vancouver. They relied on spiritual healing in Canada and/or cultural rehabilitation in East Africa. Because the parents believed that drug use was a deviant or immoral behavior, they thought that the best way to deal with it was through cultural rehabilitation. They talked of how drug and alcohol use is against their culture and faith. They emphasized how enforcing their culture and faith could amend such behaviors. They decried the influence of mainstream Canadian culture in corrupting their children’s moral values.

b) Stigma

Stigma is a significant barrier within the Somali Canadian community to addressing substance use among youth. Family members and leaders acknowledge issues of shame, guilt, and family honor as stumbling blocks in recognizing the existence of the problem and moving forward to seek help. Several respondents mentioned stigma as one of the reasons that youth were sent back to East Africa to deal with the drug problem. There, they attended a recovery program in Kenya or Somalia, where they received confidential treatment and then returned home after months or years. The addiction counsellors I interviewed in Nairobi identified stigma as a factor in the decisions of some families to send their children to Nairobi.
“Since the father is a respected person in the society, they don’t want the community to know his kid is using drugs, so they bring him to Africa. The family does not want their name to be tarnished so the only alternative is for them to hide their child in Africa.” Stanley, addiction counsellor in Nairobi

Parents acknowledged that the issues of substance use and gangs are taking a toll on the community, but as parents of families #6 and 9 no one discusses this problem in the public sphere. Everyone seems to be keeping these issues to themselves. From my own experience as a community member, other interested organizations notably the RCMP, have attempted to reach out to the Somali community but due to mistrust of the police, little success have been reported.

c) Spiritual leaders as addiction counsellors

Imams and family members interviewed discussed the important role played by the institution of the mosque and the vital support it offers families and their youth. Imams mentioned the approaches they use to support families. Their approaches include: one-to-one therapy sessions with youth, family therapy sessions, public education programs during Friday and Eid prayers, and youth events at mosques to which health and educational professionals. In some cases, police officers are invited to discuss about gang related issues.

The overwhelming need for spiritual counsellors and the rise in youth related issues such as substance use, parent-child conflict, and involvement in the criminal legal system has compelled some imams to further train as a counsellor by enrolling in a master degree in counselling psychology at a Canadian university as reported by imam #2.

“…cultural conflicts, issues with police, unstable parents and children relations. Conflict between kids and parents’ cultural divide, …I was dealing with a lot of a lot of adolescence problems, a lot of kids, social issues, and it was too much, it was a lot….”

Similarly, parents reported searching for spiritual and cultural healing in international settings. Due to the significant drug problem that Somali youth in Western countries face, innovative ideas have been developed. Across East Africa, particularly in Kenya and in the
Northern Somaliland region, many drug rehabilitation programs now exist, developed as a
to the escalating substance use problem among diaspora youth. These services are
 holistic in nature and will be discussed next.

iii. Transnational holistic rehabilitation services

Some of the parents I interviewed for this research reported that they had taken back or
were planning to take their child (ren) with substance use problems back to East Africa for
cultural and spiritual healing. For example, the father of Family #6 stated, “I am in the final
touches of taking my son to Kenya for spiritual and herbal treatment.” Likewise, the father of
family #8 explained how he twice took his son to East Africa, initially to Somalia and then to
Djibouti after he relapsed upon his return to Canada.

Under this objective, five key themes emerged from the interviews and fieldwork. These are: a) Global South solution for Global North addiction problem; b) biopsychosocial and spiritual care;
c) Milati Islami (Islamic-focused Alcoholic and Narcotic Anonymous groups), d) preference of
spiritual and herbal healing over biomedical interventions; and e) dhagan celis as a gang
prevention approach.

a) Global South solution for Global North substance use problem

Dhagan celis serves three functions for diasporic Somalis: an intergenerational cultural
continuity, an approach to prevention, and a disciplinary measure for at-risk youth who show
signs of delinquency, challenge parental authority, or perform poorly at school. Although these
three functions have been the most common from the early days, the substance use issue
appears to have taken the concept of dhagan celis to a new level, where formal and for-profit
institutionalized forms of cultural rehabilitation have developed in response to the surge in
problematic substance use among diasporic youth.

The substance use rehabilitation programs add new actors to the dhagan celis
landscape – spiritual healers, addiction counsellors, medical doctors, and in some cases,
teachers, become actively involved in the medical, cultural-spiritual, and educational rehabilitation of youth dealing with behavioral, cultural, and substance use issues.

According to the service providers, several factors drive the popularity of *dhagan celis* substance use programs in Kenya. The popularity of *dhagan celis* stems in part from elaborate global advertising by the proprietors to diasporic Somali communities and marketing initiatives that promote the programs as an ideal holistic care option for youth with behavioral issues and affected by substance use. An addiction counsellor, *Violet*, stated,

“I will say about 80% of our clients are from the West. We get more from the US and Canada, but also other African countries such as Zambia and South Africa. They are all Somalis. The directors advertised our services through the global Somali Universal TV and one of the directors here used to live in the West and had some connections in the West.” *Violet*

The approach to recruit global clients appears similar across rehabilitation programs; their main focus remains clients from Western countries as shared by *Stanley*, an addiction counsellor:

“The management normally advertise their services on Somali TV’s that are internet based and available all over the world about the treatment facility in Kenya and what we do. Then families call the number and get an admission through phone call and given the dates to come in. Universal TV is the one they use most. But there is no clinical assessment done during phone intake. I found some don’t have substance use problems but just behavioral issues at school and home. The owners push for the spiritual healing approach and because Somalis are a very oral community and words spread very fast.”

b) Biopsychosocial and spiritual care

My observations at all four rehabilitation programs reveal a holistic approach to care that utilizes a biopsychosocial and spiritual framework. At least three of the four rehabilitation programs added an educational component to their programs, where youth continue with their learning while in treatment. To conform to a holistic framework, all four facilities employed an interdisciplinary team consisting of a facility manager, addiction counsellors, spiritual healers, and teachers.
In emphasizing the holistic approach to care, Imam #7, a resident spiritual and herbal healer in one of the rehabilitation centres, describes in detail their model of care:

“Some have alcohol and drug problem only. It affects their well-being, schooling, relationship and day to day life. For this group we treat them by first detox by inducing vomiting and diarrhea and administered by the spiritual healers. Then they will be provided with counselling about drug problems and its effects done by counselling psychologists, while we do the spiritual healing and faith rebuilding back.

The second group are individuals with no substance use but have behavioral issues, parental conflict and school problems, for those we do more advice, faith rebuilding and importance of respecting the parents. No other treatments provided.

The third group are those with concurrent disorders and mental illness— (sihr, jinn or drug induced or others with just mental illness), for these groups, we do spiritual healing (specific for those with Jinn, sihr etc), herbal treatment, topical treatment and smudging. We see lots of improvement. We have microphones and tubes on the ears. We do early morning treatment at 8 am for the qur’anic healing. Others will be seen by psychiatrist for psychiatric treatment and provide that holistic treatments. Although we focus heavily on spiritual healing and the parents like that.”

c) Milati Islami (an Islamic-themed alcohol and narcotic anonymous self-help group).

The four residential facilities I visited in Nairobi have similarities with traditional Western residential recovery programs in that treatment involves a required period of residency, commitment to non-substance use during the period of residency, as well as individual and group counselling. In a bid to provide various support programs, my visits revealed that three of the facilities have started to implement an Islamic-themed AA self-help group called Milati Islami. This program has its roots in the United States, where African American Muslims established their own AA in the context of their Muslim faith (http://www.millatiislami.org/).

d) Spiritual and herbal healing over biomedical interventions

The fourth theme is the inclusion of spiritual and herbal healing, which appeals to parents desperate to re-orient their youth towards religious practices that do not condone or entertain substance use and related behaviors, like going to clubs, social drinking, and smoking
marijuana. All four residential programs provide herbal and spiritual care, both of which play a central role, whereas pharmacological intervention is only provided when necessary, especially to those with concurrent psychiatric diagnosis. In some cases, parents give firm instructions to the treating facility not to include psychiatric medications as part of the treatment for their child. For the most part, such parental wishes are respected by the service providers, as explained by an addiction counsellor interviewed in one of the facilities:

“Some were on psychiatric medications and in psychiatric facilities in the West, but when brought in by parents, the parents declined to continue with the medication, claiming it will make them zombies. There is a belief that psych meds make people stupid or zombie. We really don’t know where this belief comes from, we talked to them, but the parents are very rigid on that. They say all they need is Quran therapy.”

e). Dhagan celis as a gang prevention program

In interviewing parents and practitioners in Canada and Kenya, dhagan celis was seen as a preventive program for youth at risk of joining gangs or becoming entrenched in drug use. Removing these youth from harmful environments, placing them in an institution or homes far away from home, and involving them in spiritual, cultural and educational programs was seen as helpful and preventive.

Apprehension around drugs and gangs is fueled by the widely reported and high homicide numbers of Somali youth in Alberta and Ontario over the last few years. This apprehension was expressed by Brandon, an addiction counsellor, “It is also dangerous for the boys to get involved in gangs and drugs and [they] can be killed so they send them here.” This is a point also stated by Imam #7: “Some were born in the diaspora and have lost cultural connections to the faith, African cultures, and engage in drug and alcohol use. Most of them have drug and alcohol problems. They come, get treated for their drug problem and also learn their faith and culture and go back.”
iv. Challenges in transnational spaces for youth dealing with substance use

In the introduction, I discussed how in the Kenyan context, *dhagan celis* has been associated with diaspora youth involvement with criminal gangs especially in the suburb of Eastleigh. While immersed in the fieldwork, I come to understand, that the gang issue as a significant security problem and most of the people I talked with associated the *superpower gang* activities with diaspora returnees. Therefore under this objective, I will discuss two themes relevant to transnational cultural rehabilitation; a) transnational gangs, and b) Immigration huddles and risk of imprisonment related to immigration issues.

a) Transnational gangs

Data showed evidence of many transnational *dhagan celis* addiction treatment centers in East Africa. I visited four such facilities in Nairobi, but the total number could be as high as ten. Accumulatively, these four facilities hosted more than 200 youths, the majority of whom came from Western countries. In addition, hundreds more youth stay with relatives and family members across Kenya for cultural and substance use rehabilitation.

According to the addiction counsellors and community workers interviewed, the majority of the youth complete their rehabilitation programs and either return to their home countries in the West, or simply stay, attend school, or start businesses and families in East Africa. However, some youth fell through the cracks and ended up engaging in criminal and gang activities in Nairobi.

Addiction counsellors and community workers in Nairobi reported that youth are brought by their parents or relatives to Nairobi and often stay for longer periods than originally anticipated. In some cases, their passports or travel documents are confiscated upon their arrival and they are left with few avenues to travel back to their home countries. In the end, some of the youth who escape from the homes of their relatives in Kenya or who are discharged
from the treatment centers, end up on the streets of Eastleigh, a suburb buzzing with business, but also known as one of the major markets for contraband goods, including drugs.

Since 2015, the public has denounced the deterioration of public safety in Kenya. The Superpower gang has been accused of robbery and violent crimes against Eastleigh residents and the interior minister issued a “shoot to kill” against the gang members. Since then, several suspected gang members have been shot dead in Eastleigh for being suspected members of the group. During my fieldwork, there were at least four shooting deaths of young men by the anti-gang squad of the Kenyan police. One of the ring leaders from the diaspora was among them. Despite an outcry from human rights groups, the extrajudicial killings appear to be supported by the general population in Eastleigh, due to the anger and fear of residents towards the gang’s activities. Captions from the daily papers on the aftermath of the killings reveal the dislike for the gang members and general support for the extrajudicial killings.

**Interior Cabinet Secretary Joseph Nkaissery reveals 90 deadly criminal gangs in Kenya**

*By Cyrus Ombati | Published Fri, December 30th 2020 at 13:07, Updated December 30th 2020 at 13:11 GMT +3*

Among those named in the notice include the Gaza gang, which operates in Kayole, Superpower in Eastleigh and 42 Brothers, based in Eastlands, Acrobatic, Akapulo, Akili Za Usiku, American Marines, Bad Men, Black Latino, Bongo Rongo, Boston Boys, Bulanda Boys, Chapa Ilale, Chifu Kali, Chimoji Highway Gang, China Squad and Chini ya Mnazi.

Figure 6: Superpower among the lethal gangs in Kenya. Source: Standard Media
Kenyan police reportedly killed two teenagers in broad daylight—and much of the public approved

actions. Nairobi’s police commander Japheth Koome said on Saturday that the men who were killed were part of a local gang called Super Power that had targeted police. Koome later told The Star newspaper that the video “was acted” as a way to discourage him from going after criminals.

“As a community, with regards to this specific action of the police officer, I think 90% of the community are saying that he’s done a good job,” Ahmed Mohamed, a social activist in the Eastleigh area, told Quartz.

Figure 7: Extrajudicial killings of Superpower gang. Sources Quartz Media

b) Immigration huddles and risk of imprisonment related to immigration issues

The challenges of transnational healing bring me back to my initial observation regarding the 25-year-old autistic man arrested in Kenya for immigration fraud. Due to its porous border along Somalia, Ethiopia, and South Sudan, Kenya has always struggled with inflow of undocumented people from neighboring countries; a result is that regular immigration operations target undocumented individuals (Daily Nation16, 2015). However, the Kenyan police have also been accused by international human rights organizations for arbitrary arrest and extortion targeting Somalis and Ethiopians (Human Rights Watch, 2014). During my fieldwork, I

came to understand that diaspora youth were targeted by Kenyan security forces. While in Nairobi, I watched on Television, about two dozen youths some as young as 12 years old, arraigned in a Nairobi court accused of being illegally in the country and members of a criminal gang. After the court hearing, they were remanded and could potentially face years of imprisonment.
Conclusion

The study shows the struggles faced by Somali families and youth in the resettlement process and the challenges of the educational system that contributes to problematic substance use and gang involvement among Somali youth. These findings are supported by previous reports, such as the Toronto District School Board findings that show significant challenges for Somali youth in the educational system (TDSB, 2014).

I found that racism, discrimination and bullying to be a barrier to schooling for the families and youth interviewed for this study. These findings reflect what previous studies and educational reports within Canada and the United States have reported, some of which has been described in the literature review in this chapter (Stachel, 2013; TDSB, 2014; Omar, 2013). The same kinds of challenges appear to affect Somalis living in British Columbia. The reports have shown that adapting to the new educational culture is a major barrier for refugee school children and as a result, their upward mobility from basic education to post-secondary is hampered (TDSB, 2014; Naji, 2012).

As described in the findings, the gaps in cultural orientation during resettlement process, and the lack of settlement support regarding substance use leaves families and youth vulnerable to substance use. Some of the parents interviewed shared their desperation and loss of hope as their children drop out of school and become addicted to drugs and alcohol. Yet these parents face an uphill task in providing support to their children struggling with substance use. The lack of both the awareness of substance use treatment in Canada or knowledge about substance use adds to the desperation.

These challenges have prompted parents to seek cultural substance use rehabilitation treatments in Kenya, where such services have emerged in the last decade or so as part of the community’s approach to problematic substance use among their youth. I found that the dhagan...
Celis rehabilitation programs in Kenya as a community solution to the substance use problem but also a form of reclaiming their cultural identity through cultural rehabilitative programs.

The study offers new and important information on the failures of resettling countries, such as Canada and the risk and dangers to which these youth are exposed when parents send them back to East Africa for rehabilitation. The findings of the fieldwork show that diaspora youth from Canada, United States and Western Europe form a significant client population of these cultural rehabilitation programs, which signifies that these are not only a Canadian problem but all Western countries who resettle Somali refugees.

The findings also bring forth serious issues that need to be addressed. One important issue is that of nationality and rights. Many of the youth arrested and possibly tortured or even killed in the Kenyan war against gangs are Canadians, Americans, and Europeans who stay and live in Kenya while on tourist or education visas. From my experience while undertaking this study and from the news reports from Kenya, I found out that diaspora youth were targeted by Kenyan security forces in the context of security and immigration problems. So far, no known public acknowledgement or statement from the Canadian Global Affairs Ministry or the Canadian High Commission in Nairobi has been made on the issue, even though their stories have been well covered by the Kenyan national media (see Abdirahman, 2016; Hussein, 2014; The Nairobi Star, 2014)

The lack of governmental representation and diplomatic knowledge of these vulnerable youth illuminates their invisibility as citizens of Canada and other powerful Western nations. The infringements on their human rights, the loss of life, and the undue hardships due to their situations opens the debate around racism and citizenship. At the beginning of chapter one, I mentioned the case of the autistic Somali Canadian man arrested and detained in a Kenyan jail for three years. Nevertheless, the Canadian government revoked and denied his citizenship.
Returning youth face similar or even worse experiences in the streets of Nairobi and possibly in other East African cities, yet their story is absent from the national news.
Chapter 6: Conclusion and Implications

Understanding the Problem

This research was born out of an extraordinary period in my life. As an educator, I joined an international organization that trained health professionals in Somalia in 2006, at the height of the civil war. As explained in Chapter One, I was surprised by my observations at a psychiatric facility in Mogadishu where I encountered many individuals from Western nations. I wanted to know the reasons behind the movement of individuals from the West to Somalia for treatment.

It has been a decade from my initial observations to the present culmination of this research. I began by undertaking a master’s degree in social work, specializing in mental health, at Washington University from 2007 to 2009. Later, I enrolled in a doctoral program at Simon Fraser University in 2012. As a doctoral student, I have had the opportunity to read, discuss, and conduct research on psychosocial issues among diasporic and East African Somalis. In addition, I have had the privilege of working with and being mentored by scholars in the field of mental health and social justice. Within this critical academic milieu, I have conducted research and published a critical body of literature on colonial and post-colonial psychiatry in Africa (Ibrahim, 2017; Ibrahim & Morrow, 2015). Working on this critical scholarship expanded my perspectives and gave me appreciation for the relevance of intergenerational colonial experiences to the present-day experiences of racialized and marginalized societies in Western countries.

From the very beginning, my quest has been to understand why diasporic Somalis move back to East Africa in search of health care and healing. To answer this question, I was guided by the study objectives, to: (a) the psychosocial issues affecting Somali individuals and their families; (b) how people cope with those challenges at the individual, family and community level; (c) the appropriate resources available or the lack of them in their local community in
Canada; (d) the psychosocial and spiritual healing services available in East Africa and the reasons Canadian Somalis travel for such services; and (e) the challenges associated with transnational health and healing practices.

This study is the first conducted in both Kenya and Canada to understand the global movement of Somali immigrants in search of culturally appropriate health and healing services. My emic perspective adds value to the study. Using this approach resulted in lowering cultural, linguistic, and racial barriers to building trust with participants, families, spiritual leaders, and practitioners at field sites, and allowed me to access a deeper understanding of the complexities of the situations and conditions Somali Canadians face both in Canada and while seeking care and healing in Kenya. Still, being a biomedically-trained mental health professional in situations in which the biomedical mental health system and its service providers were viewed with suspicion meant that, in some instances, I was not trusted enough to learn details of their stories or practices.

The study identified many challenges that Somali Canadians face when dealing with resettlement, psychosocial issues, and access to services in Canada. Findings elucidated the invisibility of Somalis in Canada and how their psychosocial needs often go unnoticed and unmet. I found a lack of knowledge within the healthcare system in Canada about the cultural and spiritual healing needs of the Somali community, specifically there is dearth of Canadian literature pertaining to substance issues in the Somali community but also other refugee communities in general within Canada.

The results support some of the issues already discussed in the literature (Ali, Milstein & Marzuk, 2005; Abu-Ras, Geith & Cournos, 2008; Wedel, 2011; Molsa, Hjelde & Tiilikainen, 2010; Guerin, Diriye & Yates, 2004; Carroll, 2004) in relation to explanatory models. It illuminates the centrality of issues, such as explanatory models based on spiritual and cultural causation of psychosocial conditions, the choice of care in relation to such explanatory models, and barriers
to accessing mainstream biomedical services due to cultural and linguistic issues. Both the families, health and spiritual practitioners in Kenya, voiced their concerns regarding challenges Somalis face when encountering health providers in Canada. Participants mentioned the disregard of their illness narratives and the lack of been accorded time and attention to share their experiences. Some families also lamented the exclusion of families during treatment by Canadian medical providers.

Another important finding concerns the intersection between mental health, social services, and mental health laws. I found that some individuals and families experienced the criminalization of themselves or loved ones with psychosocial illness as stigmatizing, traumatizing, and untherapeutic. The issue of forced treatment and loss of autonomy during psychiatric hospitalization become evident to be a significant barrier for some to engage with the mental health system in Canada as per the findings of this study. While Wedel (2011) reported that some Somalis in Sweden avoid psychiatric services in Sweden for fear of been locked up in psychiatric institution. Moreover, Kane (2012), highlighted similar concerns among West African immigrants in France.

The involvement of child services in particular was seen as culturally insensitive and generated parental fears of losing one’s children. Findings demonstrated that Somalis value their cultural background and saw the involvement of child services and departments as an attempt to indoctrinate or erase their culture through adoption by non-Somali foster families as expressed by some of the families interviewed for this study. Families also mentioned the publicized England incident (pp. 83) involving the apprehension of Somali child who mother suffered from mental illness.

The study provides fresh evidence of the need to address substance use among refugee youth and trauma in the post-resettlement context. The few studies on refugee youth and
substance use support the need to address substance use as part of providing mental health services. For example, Lai (2014) argues for inclusive mental health services and addressing substance use as a cause and consequence of mental health in conflict areas. Lai (2014) documented the increase in substance use and addiction among refugee youths in Thai-Burma border, an increase associated with their refugee lived experience. Sowey (2015) and Posset, Procter, Galletly, and Crespigny (2014) found an increased likelihood of comorbidity of addiction and mental health problems among refugee youth in Australia, and suggested that specific interventions be targeted to populations as part of resettlement supports and continuum of care.

In this study, I found a service gap in addressing substance issues among refugee youth. The respondents’ lack of knowledge about substance use, the gaps in cultural orientation during the resettlement process, and the lack of settlement supports regarding substance use rendered families and youth vulnerable to drug use and criminal involvement. Access to substance use literacy, as well as treatments, were key for refugee families. As explained in Chapter Five, some Somali Canadian youth struggled with substance use and the families demonstrated a knowledge deficit about drug use, its prevention, and treatment. Their knowledge deficit put families in vulnerable positions where they lacked the capacity to support their youth. Some then turned to transnational cultural healing practices in East Africa, where youth may not always receive sufficient support. As a result, some fell through the cracks and continued to use substances or joined criminal gangs. Such vulnerabilities exposed these youth to risks of arrest, incarceration, or even death at the hands of other gangs or Kenyan police as reported in the Kenyan media and also from my fieldwork findings (Abdirahman, 2016).

Canada is currently dealing with a major public health crisis in the form of opioid overdose and substance use problems. As such, public health prevention, early intervention, and prompt treatment is even more important for refugee youth and their communities. With the
current mass resettlement of Syrian refugees\textsuperscript{17}, the influx of refugees crossing from the US border, and the annual resettlement of refugees from across the world, refugee families may urgently need support on issues of substance use.

**Revisiting the Theoretical Frameworks**

In Chapter Two, I described the theoretical frameworks, their strengths and shortcomings for understanding psychosocial issues among racialized groups. I explained the appropriateness of a transnational framework to understand and study the dynamic transnational approach of Somali Canadians when facing psychosocial and substance use challenges. Diasporic Somalis utilize a medium that enables them to access services otherwise inaccessible in their adopted countries. With advances in technology and communications, services, goods, and information, as well as transnational psychosocial and spiritual services now form an integral part of the holistic care available to diasporic Somalis.

As part of critical academic work, I have come to appreciate how the colonial processes of oppression and dispossession were not only carried out through military conquest, but also were supported by the colonial medical establishment that advanced domination and justified human suffering. In describing the intersection between colonialism and psychiatry, I explained how colonial psychiatry in Africa was a blatant weapon for colonization and a tool of oppression (Ibrahim, 2017). By weaponizing medicine and science, colonial psychiatry utilized biomedical knowledge and authority to pseudo-scientifically categorize and pathologize the colonized masses in Africa as less than human and, hence, worthy of being colonized and dehumanized (Ibrahim, 2017; McCulloch, 1995; Mahone, 2006). It is fair to say, then, that biomedical psychiatry was not a benevolent form of medical intervention during colonial times. The same can be argued in contemporary times because the institution of psychiatry barely changed in

\textsuperscript{17}https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/welcome-syrian-refugees.html
terms of mental health laws and practices in post-colonial Africa, as most African countries retained the same colonial institutional forms of care (Ibrahim, 2017; Ibrahim & Morrow, 2015).

This study has a theoretical significance with respect to the push for biomedical global mental health in the Global South. The transnational practices among Somalis and other African immigrants who choose to return to their countries of origin in search of traditional, herbal, and spiritual healing highlights three important dimensions of the debate around global mental health (Kane, 2008; Krause, 2008; Saraiva, 2008; and Carvalho, 2012).

First, transnational practices show that Somalis and African immigrants in Western countries still prefer non-Westernized mental health services instead of the mainstream treatments in their adopted countries. Such preference reflects what the literature already shows: that the majority of people in the African content utilize complementary, alternative, and traditional health services for mental health (Abbo, 2011; Abdullahi, 2011). Such preferences for non-biomedical services are also one of the reasons that immigrants and refugees underutilize mental health services in Western countries (Hansson et al, 2010, Kirmayer, Gudzer & Rousseau, 2014). Therefore, irrespective of locality, the provision of culturally appropriate services cannot be overstated.

Second, while the WHO and other international organizations have called for expanding mental health services in LMIC, critics of global mental health (Fernando, 2011; Mills, 2013; Summerfield, 2008; Watters, 2011) argue that globalizing biomedical mental health is unnecessary because psychosocial illness is deeply rooted in cultural contexts and best addressed within sociocultural realities. With the current campaign to scale up mental health services in a bid to reduce the treatment gap in LMIC, less attention is being paid to the significant role played by traditional and spiritual healers. Studies done in East Africa (Rappaport & Dent, 1979; Abbo, 2011, Musyimi et al, 2017) show the effective role traditional
Healers play in caring for their community's mental health needs. In fact, the Nairobi based, African Mental Health Foundation, the largest mental health research center in Eastern Africa, published series of research articles related to the significant central role occupied by traditional and spiritual healers in providing psychosocial services in Kenya (see, Musyimi, et al, 2017a, b, c). Further, these studies call for more collaboration between mainstream health services and the informal sector of traditional healers (Musyimi et al, 2016). Although this study did not evaluate the effectiveness of the treatments provided by Nairobi for diaspora clients, the testaments of the physician, healers and addiction counsellors show that diaspora clients have faith in their treatments and hence attract more clients from Western countries.

Even though the campaign for scaling up mental health services is geared towards the Global South, the debates are happening primarily in Western metropolises and among Western “experts.” Therefore, by approaching LMIC mental health from an imperial Western perspective, the WHO and its allies risk committing the same kind of historical mistakes such as hiring, J.C. Carothers, as their consulting mental health expert for Africa during the colonial period (Carothers, 1953; Summerfield, 2008; Carson, 1997).

Third, critical scholars like Fernando, (2011), Mills (2013), and Summerland (2008), including some of my previous research, (see Ibrahim & Morrow, 2015) have vocally written about the risk of globalizing biomedical psychiatry. In light of this, it could be argued that transnational mental health is a way of decolonizing mental health. In essence, by going back to East Africa for spiritual and cultural healings, transnationally engaged Western citizens of Somali origin are delivering the opposite message of the global mental health campaigners, that is, the biomedical mental health approach is not universal, and that there is need for culturally appropriate healing systems for the diversity of cultures.
In calling for a new balanced approach to global mental health, Kirmayer & Pedersen (2014), discussed the need to expand the global mental health lens and include community-based healing approaches. Likewise, the African Mental Health Foundation studies (Musyimi et al, 2016; Musyimi et al, 2017a, b, c) show that in the context of talk-shifting, traditional healers can deliver appropriate and effective mental health services in the Kenyan and to a larger extent the African context.

From a practical, organic and community-oriented approach, those engaging in transnational mental health services are in a sense already laying the framework for diverse or alternative approaches to mainstream mental health services. By bypassing the existing mental healthcare system due to the barriers discussed in the literature and the findings, Somali Canadians have shown remarkable agency by establishing their own healing programs in accordance with their culture and faith albeit in a distance but familiar land.

In the final section, I will discuss how research on transnational mental health can spur expansion of mainstream mental health services to not only acknowledge but also facilitate clients’ choice of diverse healing approaches.

**Recommendation for Research, Policy, and Practice**

Tiilikainen & Koehn (2011) studied immigrant health needs in Finland with a focus on Somali immigrants. They have called for transforming the boundaries of Finland’s healthcare and in general across the Western world by acknowledging the transnational aspect of contemporary immigrants in a globalized and deterritorialized world. My findings support such a call. In fact, in the Canadian context, transnational health care practices are barely researched and there exists no framework to guide health service providers in supporting clients who intend to utilize both local and translational health services.

There is an obvious and urgent need to update the training and teaching curriculum of health professionals in order to provide better informed services and supports for new
immigrants and refugees. During the course of this research project, I hardly saw anyone within the healthcare system or the academic and research milieu who was aware of transnational health practices among ethnic minorities. In fact, the most common reaction from audiences when I discussed my research area was surprise and astonishment.

Although the acknowledgement of diverse explanatory models exists within the mainstream biomedical paradigm, it does not address access to services in accordance with cultural relevance. It is thus not enough for the mainstream mental health system simply to acknowledge these differences; they must simultaneously accommodate the cultural needs of ethnic communities. For example, simple policies that accommodate spiritual healing within the healthcare system by permitting and providing space for family members to bring their own healers would go a long way. Such change in policy would enhance holistic care and satisfy the spiritual and cultural needs of Somali Canadian families. The lack of such accommodations may lead people to avoid Canadian healthcare services, and in some cases, it may lead families to travel far away in search of holistic care as illuminated by this study.

This study supports the importance of expanding mainstream mental health services in Canada by incorporating, collaborating, or at least acknowledging the existence of multiple and often parallel explanatory and healing systems to serve the needs of newly arriving immigrants. As the imams in British Columbia suggested, policy makers and service providers need to collaborate with community resources, including imams and the institution of the mosque, as a way to outreach and provide support to the community. Such partnerships between community and service providers may reduce barriers in accessing health care for Somali Canadians.

Collaborating and working closely with community members and spiritual leaders will likewise help to bridge the underserved communities and mainstream health care services. Evidence from an imam’s study demonstrates their important role in providing psychosocial
intervention within the community (Ibrahim & Alkusayer, 2016). Thus, collaboration with community links and resources, such as imams, will help to reduce health inequities and expand service access to underserved populations such as Somali Canadians.

This study also brings forth the ingenuity, creativity, resourcefulness, and resilience of Somali Canadians in addressing and mitigating psychosocial challenges within their community by re-creating community support in both Canada and East Africa. The East African solution shows a collective diasporic solution to a global Somali problem by creating and locating common services in a central geographical space accessible to all diasporic individuals. Creativity and resourcefulness have been aided by technological advancements, such as healing spaces that now increasingly occupy the virtual world through social media platforms.

Within this larger community effort, spiritual healing emerges in the diasporic spaces and in East Africa. With the preference for spiritual and traditional healing as a first line of care for psychosocial distress, families and individuals tend to seek these services within their new country, but also travel to East Africa to seek more specialized spiritual and traditional services. (Wedell, 2011; Tiilikainen, 2010). I therefore, further recommend, community partnership between health and social service providers in order to the tap into such community creativity by closely working with the community in co-creating services that can met their needs locally.

This study’s findings indicate that further research on transnational mental health practices is warranted. There is a need to explore the effectiveness of the interventions and services available in East Africa, such as dhagan celis rehabilitation programs. These programs are formalized and regulated by government agencies in Kenya and hence subscribe to certain administrative procedures, such as registration and licensing. It is much easier to collaborate and undertake research in such an environment. Such inquiries will help answer questions on the specific interventions, effectiveness of such interventions, and how to support those in the community.
Healthcare in Western countries continues to evolve and incorporate alternative and complementary health practices. Examples of such incorporation include yoga and mindfulness, and ancient Eastern healing and spiritual practices that have been researched and found clinically effective in treating some health challenges such as depression, schizophrenia, stress, and anxiety among others (Duraiswammy et al 2007; Pilkington et al, 2005; Smith et al, 2006). Although yoga is now widely researched and practiced across cultures and throughout the West, it has been historically practiced in Hindu and Buddhist spiritual and cultural context.

On the African continent, the majority still prefer traditional healers for their psychosocial needs (see Abbo, 2011; Abdullahi, 2011). This preference has been linked to increased transnational health practices among diasporic Africans from the Western, Southern, and Eastern regions of Africa (Krause, 2008; Murphy & Mahalingam, 2004; Hampshire & Uwuso, 2013; Thomas, 2010; Janzen, 2012; Saraiva, 2008; Tiilikainen & Koehn, 2011). Moreover, African healing systems are holistic in nature. They are deeply rooted in local cultures and beliefs concerning health and illness. These are attributes that fit well with the WHO’s definition of health as the complete state of physical and emotional well-being, and not just freedom from illness (Atuado, 1985; Kubukeli, 1999).

Other bodies of literature support the effectiveness and culturally appropriate nature of traditional healing methods; many researchers have called for these methods to be developed and systematized in order to achieve sustainable health equity (Abbo, 2011; Mkize, 2009; Abdullahi, 2011; Hillenbrand, 2006). Studies undertaken in Africa detail many forms of effective indigenous therapies, such as family counselling and psychotherapies in different forms, are practiced in traditional settings to treat neurological and psychological conditions (Mbwayo, Nedetei, Mutiso & Khasakhala, 2013). In studying East African folk psychotherapy, Rappaport and Dent (1979) pointed out that the traditional psychotherapeutic techniques utilized by Tanzanian healers could be more effective than Western psychotherapeutic methods.
These findings point for the need for collaborative community participatory research into community healing programs practiced within the Somali or other ethnic communities. If found effective, they can be provided to diasporic communities in their adopted counties to reduce the financial costs, logistical burdens, and other risks associated with transnational healing practices. Social problems, such as the emergence of gangs among diaspora youth in Kenya can be avoided by bringing services closer.

As Canada becomes more diverse, it is prudent that researchers, policymakers, and practitioners pay closer attention to the diverse communities that make up the fabric of this country and attend to their specific needs. Novel forms of care and treatment can be studied and, where appropriate, supported for certain communities, as seen in the case of First Nations communities in which indigenous healing forms part of the continuum of healthcare for those who choose to utilize their ancestral ways of healing (Kirmayer & Valaskakis, 2009).

References


UNHCR (2016). Figures at a glance. Retrieved from [http://www.unhcr.org/56655f4e0.html](http://www.unhcr.org/56655f4e0.html)


Appendix A. Interview Guide for individuals with lived experiences with psycho-social or mental illness

Thank you for your time, this is very important to me and the research I am doing. Let me start by asking a few details about you before discussing the topic of the day.

1. Your age, gender, time of immigration to Canada, length of time in Canada, former and current occupation
   
   This study is about psychosocial or mental health issues affecting Canadian Somalis and the ways they deal with them. I will start by asking you some personal health issues if you don’t mind.

2. I understand you have personally experienced psychosocial or mental health challenges. Could please if you are comfortable share what those challenges are/were.

3. Please share more, how your challenges/illness started, when, where and the diagnosis given, whether the diagnosis is/was biomedical or non-biomedical diagnosis or explanation.

4. What kind of support if any did you seek here in Canada and outside in terms of health care treatments and healings, be it biomedical, alternative and traditional healing approaches.

5. Please tell me about your experience with the health care system here in Canada and also in East Africa or other parts of the world where you sought treatment. What worked for you and the challenges you faced.

   Now moving to more general discussion

6. Please share with me your understanding of psychosocial or mental illness and how to deal with it.

7. In your view what are the appropriate treatments for mental health issues and addiction.

8. What services are available to the community in terms of health care and also community resources such as alternative and traditional healing care here in Canada?

9. Please share your thoughts on the challenges and barriers faced by the Canadian Somali communities in accessing health care services in Canada especially mental health services.
10. What suggestions would you provide in terms of service improvements in Canada to address the unique psychosocial needs of Canadian Somalis?

11. Is there anything you wanted to share that we did not talked about?

12. Thank you very much for your time and inputs.

**Interview Guide for traditional healers in East Africa**

1. Please tell me about yourself, your educational and professional background and how long you have been spiritual/traditional healer.

2. Tell me more about your work as a spiritual/traditional healer.

3. What are the psychosocial issues that come to your attention in respect to your position, how prevalent it is and how you deal with it.

4. In your experience have you come across individuals seeking psychosocial services coming from Canada and other Western countries in search of treatments for psychosocial or mental health issues from traditional, spiritual and or combination with Western medicine?

   Could you please share with me the reasons why individuals from Canada and other Western countries seek services from you and other providers of traditional and spiritual healers?

5. What do those services you and others provide look like? Please share more.

6. In your view, experience and knowledge, what services or interventions best work for psychosocial or mental health issues affecting those visiting your center?

7. What challenges do you and others in this business face offering psychosocial services especially in respect to Canadian and Western clienteles?

8. It can be expensive for Canadians and Westerners to travel to East Africa for treatments. Given your experience, how can this group be supported more?
9. What advice, suggestions and recommendations will you share with me and other health professionals?

10. Is there anything you wanted to share that we did not talked about?

11. Thank you very much for your time and inputs.

**Interview Guide for family members**

Thank you for your time, this is very important to me and the research I am doing. Let me start by asking a few details about you before discussing the topic of the day.

1. Your age, gender, time of immigration to Canada, length of time in Canada, former and current occupation

   This study is about psychosocial or mental health issues affecting Canadian Somalis and the ways they deal with them. I will start asking you some personal health issues about you and your family members if you don’t mind.

2. I understand you have a family member who is dealing with psychosocial or mental health challenges. If you are comfortable sharing, could you please share with me what those challenges are/were.

3. Please share more, how the challenges/illness started, when, where and the diagnosis given, whether biomedical or non-biomedical diagnosis or explanation.

4. What kind of support or treatment if any did your family member seek here in Canada in terms of health care treatments and healings, be it biomedical, alternative and traditional healing approaches?

5. How about seeking treatments in other countries, what kind of treatments? Tell me more about those treatments outside the country.

6. What challenges do people experience in seeking out of country services?

7. In your experience what services or treatments worked or not worked well for your relatives?

   **Now moving to more general discussion**

8. Please share with me your understanding of mental illness and how to deal with it.

9. In your view what are the appropriate treatments for mental health issues and addiction?
10. What services are available to the community in terms of health care and also
community resources?

11. Please share your thoughts on the challenges and barriers faced by the Canadian
Somali communities in accessing health care services in Canada especially mental
health services.

12. What suggestions would you provide in terms of service improvements in Canada to
address the unique psychosocial needs of Canadian Somalis?

13. Is there anything you wanted to share that we did not talked about?

14. Thank you very much for your time and inputs.

**Interview Guide for spiritual/traditional healers in Canada**

Thank you for your time, this is very important to me and the research I am doing. Let
me start by asking a few details about you before discussing the topic of the day.

1. Please tell me about yourself, when you came to Canada, your educational and
professional background and how long you have been spiritual/traditional healer.

2. Tell me more about your work as a spiritual/traditional healer.

3. What are the psychosocial or mental health issues that come to your attention in respect
to your position, how prevalent it is and how you deal with it?

4. In your experience have you come across individuals seeking psychosocial services
outside Canada like traditional, spiritual and or combination with Western medicine?

5. Could you please share with me the reasons why individuals from Canada seek services
outside?

6. What do those services in East Africa or other parts of the world look like? Please share
more.
7. In your view, experience and knowledge what services or interventions best work for psychosocial or mental health issues faced by your clients and Canadian Somalis in general?

8. Also could you please share the challenges and barriers faced by Canadian Somalis in seeking mental health services in Canada and East Africa?

9. What advice, suggestions and recommendations will you share with me and other health professionals?

10. Is there anything you wanted to share that we did not talked about?

11. Thank you very much for your time and inputs.

**Interview Guide for Health Professionals in East Africa**

Thank you for your time, this is very important to me and the research I am doing. Let me start by asking a few details about you before discussing the topic of the day.

1. Please tell me your background i.e. country of origin, your educational and professional background and how long you have been practicing as a health professionals both in Kenya and elsewhere.

As I explained earlier to you, I am studying why Canadian Somalis travel back to East Africa for psychosocial or mental health issues and I understand you treat some of them here in Nairobi. If you don’t mind, I will ask you to share about your work treating clients from Western countries including Canada.

1. Please tell me about your practice in Kenya and the rough percentage of clients you serve from Canada and other Western countries.

2. From your experience and what you have been told by your Western clients, could you tell me why they seek treatment outside their countries?
3. Share with me your views and experience of working with Canadian and Western clients.

**Now moving to more general discussion**

4. Can you share your understanding of mental health or psychosocial issues from Somali, Muslim and Western perspectives?

5. As an expert, a Somali and Muslim, what recommendations will you share with me regarding on how best to support Canadian Somalis seeking mental health or psychosocial treatments here in East Africa and also back home in Canada?

6. Is there anything you wanted to share that we did not talked about?

7. Thank you very much for your time and inputs.
Appendix B: Mental Health Services available in Metro Vancouver, Toronto and Nairobi

At any one point, that you feel or your family member feels an urgent need to seek health services, you have the right to terminate the interview process and seek appropriate medical help from your preferred health care provider. In the event that it’s urgent or you don’t have primary care physician here is a list you can choose from your locality.

Metro Vancouver

Vancouver Coastal Health Services—Vancouver General Hospital Emergency department

**Address:** 899 12th Avenue W, Vancouver, BC V5Z 1M9

**Phone:** (604) 875-4111

Surrey Memorial Hospital emergency

**Address:** 13750 96 Ave, Surrey, BC V3V 1Z2

**Phone:** (604) 581-2211

Nairobi-Eastleigh suburb

Mathari National Mental Health Referral Hospital

Thika Superhighway. Opposite Muthaiga Police Station

**OR**

Tawakal Medical Clinic Eastleigh Section 5, Nairobi
THE BC MUSLIM ASSOCIATION

Public Relations, Social Services

is

hosting

Fundraising Dinner

Promoting mental health awareness in the community

with

Vancouver General Hospital & UBC

Hospital Foundation

18 Mental health talk at Burnaby Mosque in Vancouver in 2013
The BC Muslim Association & Vancouver General Hospital

Keynote Speaker

Mohamed Ibrahim, RN, MSW
PhD Candidate & Fellow, Centre for the Study of Gender, Social Inequalities & Mental Health, Faculty of Health Sciences, Simon Fraser University
Substance Abuse Education
Part 2
Prevention Strategies

Friday 24th February at 8:15pm
(after salat’ul isha)

This follow up presentation features speakers who will share their frontline experience, and knowledge in talking about:

- Signs & symptoms of alcohol/drug use
- Family conversations about prevention
- Community support systems

Panel Discussion Participants

Br. Asad Asadullah – Coordinator HOPE/ASPIRE Counselling Services
Br. Mohamed Ibrahim – Addiction Counsellor, St. Paul's Hospital

Moderator – Irfan Sheikh