C O M M E N T A R Y

West African refugee health in rural Australia: complex cultural factors that influence mental health

JQ Nyagua[1], AJ Harris[2]

[1]*Migrant Resource Centre (North), Launceston, Tasmania, Australia*
[2]*Anne O'Byrne Centre, University of Tasmania Department of Rural Health,*
Launceston, Tasmania, Australia

A B S T R A C T

Health and mental health practitioners in rural and regional Australia are increasingly being presented with the challenge of working cross-culturally. Due to a diversity of cultures, generic approaches are needed that take account of culture without requiring the practitioner to have detailed knowledge of each person's background. However, there are many practitioners from diverse backgrounds now working in Australia at various stages of enculturation into Western practice. The cultural grounding of one practitioner from West Africa is used to highlight potential areas of misunderstanding, and to offer an accessible point of departure for culturally sensitive practice and formal research opportunities.

Key words: Australia, culturally appropriate health care, refugees, West Africa.

Introduction

In 2004, the Australian Government implemented a policy of settling a greater proportion of its planned intake of 13 000 refugees and humanitarian entrants in 12 identified regional areas[1]. This policy has been reaffirmed recently by the establishment of two more regional settlement sites[2]. In addition, as international attention shifted from European conflicts, the proportion of entrants sourced from African countries increased from 23% in 1999-2000, to 55% in 2005-2006, with a recent increase from South-West Asia[3]. Launceston, Tasmania, is one of the regional locations initially selected, and has the distinction of being the regional settlement site with the greatest proportion of entrants relative to the respective state's overall intake: 38% over the past 5 years[4].

These two developments in settlement policy are examples of globalising trends which are increasing the need for cultural competency among health practitioners in rural and regional areas.. Many practitioners in such areas have limited previous exposure to culturally different client groups, and access to reliable expertise can be problematic. There is, therefore, an urgent need to establish appropriate referral pathways and practitioner training for the health, social, legal and financial needs that often present in a complex context of language, cultural difference and history of displacement and suffering[5,6].

Unfortunately the evidence base for such work is limited. In the dominant Australian culture that holds individualistic assumptions about society, and assumes English literacy, routine requirements for research ethics clearance such as written informed consent and privacy, are difficult to meet. Many of the new entrants identify with collectivistic ideas of ethical practice, and emphasise oral traditions, which can create complex and discouraging dilemmas for potential researchers and their ethics committees[7].

Nonetheless, ethnographic and qualitative methods have been fruitfully used to examine the cultural specificity of emotions[8], and such methods are increasingly important in assessing and formulating approaches to health and mental health care in Western society, particularly in relation to refugee resettlement[9]. For example, trauma symptoms may need re-conceptualisation with consideration of the influence of cultural features such as collectivistic, as distinct from individualistic, identities and practices[10].

Procter[11] reports on an approach that allowed cultural expertise from Italian, Persian and Cambodian practitioners to be incorporated into the treatment of clients from these backgrounds. However, for Western researchers, the more challenging aspects of other cultural traditions, such as spirit-based beliefs, will require an openness to the guidance of non-Western colleagues and clients in order to overcome stereotypical responses[12]. Post-modern discourse has also generated approaches which are accessible to practitioners as well as researchers: for example narrative practice provides guidance on how to elicit, document, and make use of taken-for-granted expertise, knowledge and beliefs that have been influential in the life of a person and which may not become evident in the context of the Western scientist-practitioner model[13].

Accordingly, this article draws on the first author's experience of traditional beliefs and practices in remote villages in his native Sierra Leone, where his cultural grounding included participation in, and observation of, a wide range of traditional interventions. He later worked in this setting as a primary healthcare practitioner after completing studies overseas. His healthcare role combined his Western training and knowledge with strategic collaboration with traditional healers to ensure comprehensive service delivery to the local population. This expertise has been developed in his subsequent work with a broad range of cultural groups in Australia.

West African beliefs

My country of origin is Sierra Leone, on the west coast of Africa, between Liberia and Equatorial Guinea. Its capital, Freetown, was named for the freed British slaves who were landed there at the end of slavery in 1807. It was a British colony from 1808 until independence in 1961. The majority of the country's population are members of pre-existing African tribes, such as Mende, Tenme and Limba. However Freetown has a large population of Creoles (descendants of the freed slaves who had been traded from many African countries), and migrants, particularly Lebanese. Many people, including myself, were displaced during the 10 year civil war in the 1990s.

English, the official and government-used language, is spoken only by educated Sierra Leoneans. French is taught in secondary schools because of the country's many French-speaking neighbours. Most people speak their local language and also Kriol or Creole, the legacy of freed slaves, and a mixture of primarily English, Yoruba and African languages. In remote villages only the local language is spoken. Mende dominates in the south and Temne in the north.

For the majority of the village population, traditional beliefs are the most important. Islam is the most widely practised mainstream religion, and perhaps 10% of the population identify with Christianity. Most Muslims and Christians also follow traditional beliefs and practices, which in my experience have similarities across Sierra Leone and in many other African countries.

In these traditional beliefs, the boundaries creating categories such as the sick and the well, the living and non-living, natural and supernatural, seen and unseen, conscious and unconscious, are much more fluid. Past, present and future may weave one into another. Dreams and visions can have equivalent status to day-to-day reality. Distinctions are still made, and of course many strong opinions held, and defining taboos and cultural expectations exist. However, there is also implicit acceptance of transforming forces that can cut across categories, and this is a feature of traditional healing.

The health and mental health problems of people with these beliefs are seen very differently. Any explanations for sickness, both Western and traditional, are embedded in ways of believing and seeing, social values, philosophies and artistic expression. If you do not know how a person sees their problem, you will not understand their response to it. In order to compensate for cultural blind-spots, it can be helpful to develop a stance that allows causation of illness to be attributed both to 'things we see and things we don't see'. Otherwise, we can fail to see, acknowledge and account for important aspects of our clients' experiences.

Some important potential influences on West African clients that are likely to remain 'unseen' by Western eyes, include:

- ancestral influence and hereditary curses
- disruption of customs and social relations
- breach of taboos on sexual relationships
- spirit possession
- sorcery, witchcraft and intrusion of objects
- affliction by gods
- family influences

Ancestral influences

The ancestors in West Africa are the departed of up to five generations. They are in a state of personal immortality and the process of dying is not yet complete. They are the custodians of family affairs, traditions, ethics and customs. Offence in these matters is ultimately an offence against the ancestors, who retain some agency after death. Failure to pacify the ancestors leads to misfortunes and illness.

The spirits of ancestors may appear in dreams; for example, in a dream the ancestor may be facing away from the person, which indicates that the spirit is annoyed. The person may have broken a taboo or failed to show respect. In such a case the person may seek advice from an elder, medicine man or priest in the village. They may cast kola nuts or perform

some other divination, and will pronounce a ritual to appease the angry spirit.

One reason for the respect shown to elders and to older members of the community is that they are understood to be more closely connected with the ancestors, and are therefore the source of information about ancestral traditions. This is especially the case in societies where there is no written lore. In villages where Christianity and Islam are common, the Bible and K'oran will be respected for the same reasons. This shows how familiar categorisations (in this case Muslim/Christian) can become less important in different cultural contexts.

Disruption of customs and social relations

Many customs are expected to be followed, and failing to follow these customs will bring a disturbance to the family. Welcoming guests, showing honour to parents, death rituals, and gender-based behaviour are examples of these customs. Family conflict is common after arrival in Australia, because traditional systems are disrupted by legal requirements such as Centrelink (social security) payments to women and children, and interventions by child protection, which give much power to children. In addition to the conflict and distress generated by the practical problems of engaging with new systems, people will also be distressed by the potential, unknown consequences of contradicting their customs.

These customs can remain important even for highly educated people after long residence in a new country. I found this to be true for myself. I was very disturbed that I had not been able to provide the proper ritual for the deaths in my family. I could not settle in Tasmania until I had found a way for these rituals to be performed on my behalf, and I arranged for a video tape of the ritual to be sent to me so that I could participate. I have been much more at ease since.

Breach of taboos on sexual relationships

Village life is highly organised around social relations and roles that maintain harmony and goodwill among families, as well as the health and wellbeing of all community members. Customs are strengthened by inflexible taboos, many of which relate to sexual relationships. Breach of these taboos can directly or indirectly affect health and wellbeing. Once, in my village in Sierra Leone, a man was convinced that his ancestors intended to kill him. He was so distressed that he contemplated suicide. He was taken to the health centre where he revealed that he had had sex with one of his father's wives, a taboo.

In my first language of Mende, 'Humoi' is a word with two related meanings. It is the word for both incest, and for the devil figures, using masks and raffia, whose role it is to perform the rituals that remove the curse of incest. The Humoi is very secret, and admission is by special initiation. In my village a woman lost three children less than one year old, and the husband's family became worried about the cause of this problem, suspecting a curse. Our fortune-tellers, or counsellors, who are known for their ability to recognise the different signs of psychological distress, put to the woman that she had done something which was hidden. She acknowledged having had sex with an uncle before she was married. Payment was made to the Humoi in goats or bushels of rice or palm oil, and the ritual was performed. All the villagers lined the road to the river and whipped the woman as she walked along. At the river the Humoi leaders performed the cleansing ritual.

Spirit possession

Spirit influence is very real for many West Africans. Harming spirits are believed to inhabit rivers and dark forests, and move around at night. Some forests are known to be so dangerous that, if you are able to enter and return, it can only be because you have a great power to fight the spirits. Because of the spirits in the river, a pregnant woman is not allowed to bathe there; bathing at night even in the compound is also risky. I have seen cases of fits that are

attributed to a woman breaking this taboo. She will be told, 'Oh, you have annoyed the spirit of the river because you went and bathed there'.

Such bathing may also cause possession of the unborn child, with the outcome of abnormalities such as Downs syndrome, bow legs or extra digits. Due to the appearance of a Downs syndrome child, the baby might be believed to be a snake, and left in the forest overnight. If the child disappears, it is concluded that it has indeed turned into a snake and passed into the forest.

When I was growing up there was a widespread belief that machines such as aeroplanes and ocean-going ships were created by a special race of white people with devil-like tails. It was a matter of accepted fact that the deep waters of oceans and rivers were inhabited by the most powerful spirits known, and it was reasoned that these special white people had great powers and were in connection with these powerful spirits. When a great bridge was built across a river, it was assumed that the builders had been able to put the spirit of the river in a bottle until the bridge was safely finished. Imagine the experience of someone with such beliefs who travels by aeroplane to Australia. How might they be helped to feel less vulnerable to the anger of the ocean spirits?

Sorcery, witchcraft and intrusion of objects

In one striking case I observed, a woman described in detail how she could feel a lizard moving around in her stomach. The lizard had been put into her through sorcery, but no traditional healer had been able to cure her. The woman had concluded that the sorcery was very powerful and that she would need a great power like Western medicine to overcome it. X-rays were taken of her but they showed no lizard, and no cause could be found for the discomfort. The doctor had 30 years' experience in my country, and told the woman that we would operate to find the lizard, which was obviously very cunning to hide so well from the x-ray. She arranged for an anaesthetic, and for a superficial cut to be made and sewn up again. She told me to get a lizard from the

compound, which we covered with blood as if it had been inside the body. When the woman came out of the anaesthetic, she was shown the lizard dangling from the forceps and fighting. She reported a complete cure.

Measles is believed to be carried in a pouch by a witch, and children are afflicted when it is scattered. Owls and cats might be witches. If an owl is heard hooting and a child dies nearby, people will say it was 'eaten' by witches. It is the life energy that is 'eaten'. A witch in the form of a boa constrictor can be held responsible for symptoms of polio: it has 'eaten' the paralysed body part.

Working in primary health care, we would enlist the local healer and have them identify the children who needed an amulet to protect them against measles. We would ask that he also arrange for these children to be present at the clinic on the day of immunisation so that our powers could join forces and together stop the power behind the illness. If we were to condemn the traditional practices, the power of the traditional healer would be strong enough to make the people fear us, and they would not come to the clinic. If people think you do not accept them, they will not come. Also, when something happens and we are not there, where will the people go for help? They need to preserve the source of help that would be there at any time. In this way, instead of reducing the traditional healer's status, we even added to it, because he was now supported by Western powers.

Affliction by gods

During the war in Sierra Leone, religious authorities organised frequent prayers in churches and mosques asking God to pardon the country because they believed the war and suffering were punishments for what the leaders had done against God. Such a concern is simply taken for granted and nearly everyone will participate in such prayers.

For most West African people, diseases are not purely physical experiences - they may also be mystical or religious. People in the villages will talk freely about these aspects of experience because they belong to their world. No

matter what the scientists might say, it is a normal part of life. Nothing harmful happens by chance, everything is caused by someone or something, directly or through the use of mystical powers or witchcraft.

Family influences

In collectivistic cultures like Sierre Leone, regardless of the identified source of any problem, it is likely to be seen as a social phenomenon, and has significance for immediate community members: 'If I am sick, my family is sick also'. For example, some people believe that illness can befall a relative due to a person's wrongdoing. People also believe that some diseases can be transmitted from one generation to another, as long as the stains of a fault have not been cleared. Many collective rites exist, the aim of which is to stop the transmission of some diseases that run in the family.

Discussion: aspects of an integrated approach

Well before science and modern medicine, people were trying to fix their problems. Now, if you try to bring a solution which contradicts their solution, that is a threat. There are many sources of confusion even in the way you approach a client. In going to a traditional healer, a person will expect to describe their problem, and will expect questions asking for more detail of aspects of the problem, as well as their ancestry and family connections. There will most likely be a ceremony for divination, and the explanation may then be that this problem is happening because of this event in the family or ancestry, and that a particular action is required. Or there may be a natural remedy or protective amulet given. A client expecting that kind of response may be confused by the sympathetic engagement of a social worker or counsellor. They might not trust a practitioner who does not propose a solution.

People who have arrived in Australia from rural West Africa are likely to look for traditional methods in preference to the Western health system. By the time they come to the Western service, they may believe their problem is an

extremely dangerous one that has resisted the powers of all the other healers or methods they have accessed already. There may be shame or fear that has more to do with this perception than with the actual problem. They may be afraid of the setting; unlike with traditional methods, they might feel that they do not have choice. The sometimes magical qualities that Western treatments can have may also evoke fear about the possibility of equally powerful curses, as is the case for witchdoctors.

In mental health care, it is vital to make a careful assessment of symptoms associated with trauma reactions or psychiatric conditions, because these symptoms may also be attributed to metaphysical causes such as witchcraft, spirit activity, curses, or breaches of taboos. Unifying responses may be helpful: in the case of trauma, symptoms may be acknowledged within both systems to be the result of the wrong-doing by others. These harming agents were strong but the person survived, and we need to restore the client's power with rituals that might include breathing and relaxation training.

The issues of fertility, birth and the health of the child are of great importance to most West Africans of rural origin. Problems with fertility, or the health of a child are blamed on spirits, curses or the breach of taboos. If a child with an abnormality is born after settlement in a Western country, the family may be reluctant to allow the child to come home in case the other children are also vulnerable to the spirit. It may take some time for the family to consider that Western medicine could offer a remedy to or explanation of such a problem. Dismissing the traditional belief or the outcome of divination or prayer will most likely result in the client going elsewhere.

These beliefs, combined with the superior status of males in traditional culture, often mean that the women suffer most from the shame and stigma of a problem with birth or children: they will be blamed. There are a number of such documented instances, where women suffer due to inadequate rights, both in customary law and through legislation[14]. When a child has a deformity or disability, the

mother's potential fear of family and community blame needs to be given special consideration.

It will be necessary to do more listening, and to take the time to learn what your client thinks, what they have previously found to be helpful or protective, or what they know of the likely traditional responses to this type of problem, and how this will affect them. Children's misbehaviour, as with deformity and disability, will bring shame on the parents. Time needs to be taken to explore the importance of this to the parents; it does not help to try to explain that, in Australia, children have more freedom and Australian children also behave this way. That will lead to the parents losing hope, and forming the belief that you are against them.

It may help to assume that it is the Western system that conflicts with a person's beliefs, rather than the other way around. Taking this stance will lead to more basic explanations of the service you offer. Privacy and the systems that accompany technological interventions are examples of priorities in the Western tradition that can appear strange, and need thorough explanation. In Western systems a person can consent to treatment without involving their family or community. However, for people from traditional cultures, it may be necessary for the family or community to be involved in the decision-making; there may be, for example, a protective ritual that the community performs. Preventing these may lead to increased anxiety and poorer outcomes.

If a client becomes suspicious or confused, they will most likely avoid further contact, and seek out someone they trust, so it is necessary to have good relationships with community leaders, just as it was for me in Sierra Leone. Where will this person go if I lose their trust? How can I make sure I give them a proper chance to benefit from my service?

In many such situations in Launceston people come to me, even if they do not know me, to talk about their experience. Sometimes I can explain the confusion or encourage them to go back, but it is difficult if I do not know the practitioner.

The same will be true in any rural area in Australia: there will be someone, often a religious leader or an older person, who people go to. These people need to be sought out and a partnership formed with them in order to develop mutual trust and respect. As I did in Sierra Leone, learn not to resist them, and support their position in a way that obtains the best possible treatment for the client. This might be incorporated in your proposed treatment for a problem. By joining with your client, you might make a list together of things to do, for example, in dealing with a new-born child's deformity:

1. speak with the pastor
2. seek family agreement for an x-ray and proposed treatment
3. have other children sleep with the extended family
4. obtain an amulet from grandmother

This will be beneficial by reducing any anxiety that traditional beliefs are not being followed, and also show that there are many powers being drawn upon to defeat the problem.

More formalised assessment approaches can enable practitioners to work systematically with people from unfamiliar cultures suffering from complex problems, such as LeVine's 'LANDSCAPES' acronym[15]. This makes explicit the fluidity of cultural context across time and place, by inviting practitioners to account for the influence of:

Language and accent
Ancestry and indigenous identity
Nationalities
Disability (physical, social, and psycho-emotional)
Sexual roles and sexual identities
Community affiliations (family, belonging)
Age and development (including developmental delays)
Place and geography (relationship to water, land and topography)
Existential – systems of meaning including religion and spirit-beliefs

Social status(es), noting that status is influenced by factors such as ancestry, disability, sexual roles, age and development.

Such a model may be appropriate to use with a longstanding issue where no immediate solution is available. For example, in working with complex trauma, it is easy to be distracted by the 'knowledge' of the effect of exposure to war and torture, and the various techniques of psychotherapy that have an evidence base in Western populations. The tendency then to support the client in overcoming individual emotional and psychological consequences of the traumatic event may be too narrow an approach for many clients.

Explicitly addressing the possible influence of the LANDSCAPES factors in an assessment process demonstrates that the practitioner has an appropriate way of approaching the problem, while providing opportunities to explore the cultural differences between the practitioner and client. The practitioner will also be able to identify which aspects of the model provoke the most anxiety, and therefore require more sensitivity. Important ways forward may emerge spontaneously from such a process; for instance, instead of being restricted to identifiably traumatic events, it becomes feasible to explicitly address the loss associated with role status, use traditionally protective practices such as charms or sacred marks, participate in gatherings and family events, visit parks, natural areas, or farmland, or go fishing. Equally, it may become clear that psychiatric intervention is really required, or that the client is familiar with and favours a Western style of 'talk therapy'.

Conclusion

This article has attempted to provide some material to enable Western practitioners to develop culturally inclusive practices in the face of beliefs that challenge Western convention. However, Western culture is not without its own taboos, demons, ancestral influences and spirit beliefs. What opportunities might exist for West African knowledge,

thinking and feeling to be applied to intractable Western maladies?

References

1. Department of Immigration and Citizenship. *Humanitarian settlement in regional Australia*. (Online) 2007. Available: http://www.immi.gov.au/media/fact-sheets/97humanitarian_ settlement.htm (Accessed 17 February 2008).

2. Department of Immigration and Citizenship. Settlement planning and information delivery. *Annual Report 2006-07*. (Online) 2007. Available: http://www.immi.gov.au/about/reports/annual/2006-07/ html/outcome2/output2_1_1.htm (Accessed 17 February 2008).

3. Department of Immigration and Citizenship. *Australia's refugee and humanitarian programme*. (Online) 2007. Available: http://www.immi.gov.au/media/fact-sheets/60refugee.htm (Accessed 17 February 2008).

4. Department of Immigration and Citizenship. *Tasmania: settlement trends and needs of new arrivals 2007*. Canberra, ACT: Department of Immigration and Citizenship, 2007.

5. Duncan G, Rushbrook P, Pilotto L, Johnston H. Refugee resettlement in rural and regional Australia. *Proceedings, 9th National Rural Health Conference*; 7-10 March 2007; Albury, NSW; 2007; 123-124.

6. Campbell D. *Regional settlement of refugees: implications for policing, refugee entrants and host communities*. Briefing paper no 3. Hobart, TAS: Tasmanian Institute of Law Enforcement Studies, 2007.

7. Harris AJ. Development of culturally appropriate counselling for African men in Tasmania: background and progress to date. In: Q Le (Ed.). *Graduate research papers in rural health*. Launceston, TAS: University of Tasmania; 2007, 83-119.

8. Lutz CA. *Unnatural emotions: everyday sentiments on a Micronesian atoll and their challenge to western theory*. Chicago: University of Chicago Press, 1988.

9. Eastmond M. Refugees and health: ethnographic approaches. In: FL Ahearn (Ed.). *Psychosocial wellness of refugees: issues in qualitative and quantitative research*. New York: Berghan Books, 2000.

10. Fernando G. Working with survivors of war in non-western cultures: the role of the clinical psychologist. *Intervention* 2004; **2:** 108-117.

11. Procter N. *Speaking of sadness and the heart of acceptance: reciprocity in education*. Paramatta: Multicultural Mental Health Australia, 2003.

12. Bertrand D, LeVine P. Crime contre les esprits: Le mépris des esprits locaux comme déstabilisation mentale. [Spirit justice: local spirit encounters that destabilise mental health]. In: *Crimes Against Cultures*. Paris: Aux Lieux d'Etre, 2008.

13. Epston D, White M. Consulting your consultants: The documentation of alternative knowledges. In: Epston D, White M, editors. Experience, contradiction, narrative and imagination. Adelaide: Dulwich Centre Publications; 1992. p. 11-26.

14. Amnesty International. Sierra Leone: No one to turn to: Women's lack of access to justice in Sierra Leone 2005.

15. LeVine P, Sivamalai, S., & Harris, A.J. Cycles of settlement: generating responsive health services for refugees in rural Australia. A textbook of Australian rural health. Canberra: Australian Rural Health Education Network; in press.