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'We don't have to go and see a special person to solve this problem': Trauma, mental health beliefs and processes for addressing 'mental health issues' among Sudanese refugees in Australia

Michael Savic[1,2], Anna Chur-Hansen[3], Mohammad Afzal Mahmood[1] and Vivienne M Moore[1]

Abstract

Background: The impact of trauma on refugee mental health has been a particular focal point for research and treatment in Western contexts, despite uncertainty about the degree to which this corresponds with refugees' needs, mental health beliefs and healing mechanisms.

Aims: This study explored the mental health beliefs of resettling Sudanese refugees in Australia.

Methods: In-depth qualitative interviews were conducted with Sudanese community representatives and with a range of health and social work professionals who were not necessarily Sudanese.

Results: The concept of trauma was not universally considered to be salient for Sudanese refugees. Key informants, especially those in refugee-oriented services, emphasised stoicism and a desire to move forward and questioned the appropriateness of Western psychological therapies. Processes that exist within the family and the Sudanese community to deal with stressors like loss, grief and social isolation were explained.

Conclusion: Dialogue between services and community members is needed to ensure responses to refugee mental health are sensitive to the diversity of needs and mental health beliefs of refugees. This will enable workers to ascertain how individual refugees understand their experiences of distress or sadness and to determine whether community strategies and/or professional responses are appropriate.

Keywords

Refugees, Sudanese, mental health, trauma, resilience, explanatory models

Introduction

Health-related research with refugees has tended to focus on a pathology model of mental health (Ryan, Dooley, & Benson, 2008), with emphasis placed on pre-migration experiences of trauma. These experiences are thought to render refugees vulnerable to psychological distress and mental illness as they resettle in new countries (Schweitzer, Melville, Steel, & Lacharez, 2006; Silove, 1999). The development of a body of 'evidence-based' practice and programmes means that trauma-centric service delivery appeals to funders and aligns with a managerial approach to health services (Westoby & Ingamells, 2010). However, this also means that 'diverse forms of engagement with families and communities to rebuild social and cultural life' (Westoby & Ingamells, 2010, p. 1761) have been largely neglected. Furthermore, by localising and pathologising distress within the individual (Marlowe, 2009), refugees have been framed as burdensome among policy makers (Pupavac, 2006).

Long-standing research underscores the importance of post-migration experiences for the well-being of resettling refugees. For example, adjustment to the new socio-cultural context (Berry, Kim, Minde, & Mok, 1987; Wille, 2011) and changing family dynamics and gender roles

[1]School of Public Health, University of Adelaide, Adelaide, SA, Australia
[2]Discipline of Psychiatry, School of Medicine, University of Adelaide, Adelaide, SA, Australia
[3]School of Psychology, University of Adelaide, Adelaide, SA, Australia

Corresponding author:
Michael Savic, Turning Point, 54-62 Gertrude Street, Fitzroy, VIC 3065, Australia.
Email: michaels@turningpoint.org.au

(Deng & Marlowe, 2013; Harris, Spark, & Watts, 2015; Marlowe, 2012) as well as host-country reception (Losoncz, 2011; Nwadiora & McAdoo, 1996) have been shown to be relevant. Resettlement stressors include unemployment and underemployment (Murray & Skull, 2005), housing problems and residential mobility (Harte, Childs, & Hasting, 2009), inadequate social support networks (Schweitzer, Greenslade, & Kagee, 2007), concerns about family abroad and obligations to send remittances (Baak, 2014; Savic, Chur-Hansen, Mahmood, & Moore, 2013; Schweitzer et al., 2006) and difficulties in accessing health services (Lamb & Smith, 2002).

From this perspective, refugee 'recovery' is primarily a social process rather than a biomedical one (Summerfield, 1999; Westoby, 2008). Additionally, while many refugees have adapted to difficult circumstances without the aid of health professionals (Steel, Silove, Phan, & Bauman, 2002), refugee coping and healing have received relatively little academic attention compared to refugee pathology (Marlowe, 2009).

Sudanese refugees

Conflict in Sudan has resulted in mass refugee movement, with Sudanese community and family networks separated and dispersed throughout the globe (Schweitzer et al., 2006). Not only have many Sudanese been exposed to conflict and upheaval, they have often spent time in refugee camps in neighbouring countries (Department of Immigration and Citizenship, 2007). It is also important to appreciate that Sudanese refugees are not homogeneous but are composed of many different cultural, language and religious groups (Schweitzer et al., 2006).

Tempany (2009) conducted a literature review of mental health research with Sudanese refugees internationally. She found that differences in research findings reflected the methodologies employed: quantitative studies identified high rates of Western-defined psychopathology among Sudanese refugees, while mixed-methods and qualitative research highlighted the resilience of Sudanese refugees, who were found to report 'more concern with current stressors such as family problems than with past trauma' (p. 300).

Tempany (2009) concluded that there are few studies available regarding appropriate interventions and service responses. This study aims to contribute in this respect. In particular, we addressed the question of what Sudanese community leaders and health service providers think the mental health needs of Sudanese refugees are and how these should be addressed.

Methods

A qualitative approach was used in order to gather information-rich data from a range of perspectives, through in-depth, semi-structured interviews with a range of stakeholders. The University of Adelaide Human Research Ethics Committee approved the study.

Key informants

A total of 20 key informants were interviewed, 14 of whom were women. All were over 18 years of age and were familiar with issues around refugee mental health and/or the Sudanese community. Six key informants were mental healthcare providers (i.e. psychiatrists, mental health nurses and mental health social workers), five were primary healthcare providers (i.e. general practitioners and primary care nurses), four were health service managers, three were social workers and two were policy makers. A total of 12 key informants worked in refugee-specific services, while the remainder worked in mainstream services.

Of the 20 key informants, 14 were born in Australia or other English-speaking countries, and 6 were born in Sudan. Five out of the six had arrived in Australia as refugees within the last 20 years. The other Sudanese key informant arrived in Australia within 5–10 years as an economic migrant. The Sudanese key informants identified with various ethnic identities such as Dinka or Nuer, but all identified themselves with the broader level of identification as South Sudanese. All of the six Sudanese key informants worked in the health and resettlement system and were also elders or community leaders.

In-depth interviews

A total of 25 interviews were conducted between February 2008 and February 2009. Saturation, the point at which no new themes emerged, was determined through a process of comparing themes emerging from newly collected data with themes from earlier interviews. Interviews were semi-structured and in-depth, ranging in length from 45 minutes to 3 hours. All interviews were conducted by the first author at the workplaces of key informants and were audio-recorded. Interviews covered areas including mental health needs and resettlement experiences, current responses to addressing these needs, issues associated with service access and provision, including gaps and barriers, and possible improvements to the health system.

Data analysis

Interviews were transcribed and analysed using the Framework approach to thematic analysis (Ritchie & Spencer, 1994). This involved coding data in NVivo (QSR, 2007) and devising a thematic framework – a structure for organising themes – based upon all identified themes. The process of developing and refining the thematic framework was iterative. It involved consulting the data, maintaining an audit trail, considering the linkages between

themes and discussing interpretations of the data among the research team. Analyst triangulation, attention to negative cases and the incorporation of multiple viewpoints, along with the use of an audit trail for reflexivity, were among strategies employed to enhance rigour.

Results

Key informants predominantly viewed the mental health needs of Sudanese refugees in terms of practical resettlement stressors, adjustment to a new socio-cultural context and coping with events and stressors abroad. Collectively, these issues were interpreted as the need to rebuild social worlds. Three key themes related to mental health issues were discussed: trauma, mental health beliefs and the role of the Sudanese community in addressing stressful life experiences and mental health issues.

Trauma

Key informants expressed a range of views about the role of trauma in resettling Sudanese refugees' experiences of forced migration. The views of health service key informants from mainstream services, in particular, revealed a tendency to consider trauma as implicit in the 'refugee experience'. Resettling Sudanese refugees were considered by many to be likely to have experienced a number of traumatic events. Many of these events, such as rape, direct or indirect exposure to violence, the unnatural death of a loved one, torture and extreme deprivation, would have been experienced prior to migration – during flight or while in refugee camps.

Health service key informants from mainstream services, in particular, perceived a negative emotional impact of having experienced traumatic events as almost inevitable. Effects articulated included nightmares, flashbacks and an inability to sleep, which was considered to impact well-being and everyday functioning. For example, trauma may result in impaired ability to concentrate and learn at school or in English language classes, impaired ability to undertake practical activities associated with everyday life and impaired ability to function in a family environment, including emotional inaccessibility to significant others. Such key informants were likely to medicalise the negative effects of traumatic events, interpreting them through the lens of post-traumatic stress disorder (PTSD) or other psychological labels. In this way, PTSD was seen as an end point in an almost unavoidable trauma trajectory for many refugees, which underpinned resettlement difficulties.

Some Sudanese key informants felt that PTSD and other medicalised explanations of the impact of trauma were useful, but these key informants were health professionals who were routinely exposed to such concepts. In contrast, many Sudanese key informants questioned the applicability of the trauma concept:

> Trauma, I don't know if they (Sudanese) would understand it as trauma. They can say 'yes the person had a bad experience', and sometimes 'yes they have reflection of what had happened' but they wouldn't have a particular name, saying a 'trauma' or anything like that. (Key informant 8 – Sudanese woman)

Some key informants emphasised the point that, despite the likelihood of having experienced traumatic events, the need to address trauma may not necessarily be a high priority for refugees when viewed in the context of other needs. This view was particularly expressed by key informants working in community health services who were more likely to provide care to refugee clients than key informants working in mainstream services. Community health service key informants took a holistic approach to care, underscoring the influence of treatment philosophy on perceptions of the salience of trauma in refugees' experiences:

> So there doesn't seem to be enough focus on the link between these social problems that they actually experience as a result of migration or resettlement. So to give them that opportunity to air or to express their experience of trauma is therapeutic of course but more helpful than anything is that support in all those aspects; the social aspects of their lives. (Key informant 12 – Community health service GP)

Some key informants considered the consequences of traumatic events to be affected by the ability of resettling refugees to rebuild their social worlds as well as individual resilience. It was common for health service provider key informants working in community health settings to remark that trauma issues could only be dealt with once needs associated with rebuilding social worlds had been met.

While some health service key informants constructed Sudanese refugees as vulnerable and traumatised, they also highlighted their coping abilities. Many pointed to the high tolerance for hardship that Sudanese refugees are likely to have as a result of their past frequent exposure to extreme events. As one key informant suggested:

> I think particularly people for whom their subsequent one or two generations have, experienced nothing but war and difficulty, you know, calling it trauma; it's just the way it is, it's just life. And they don't see it as something that you deal with. (Key informant 2 – Mental health nurse)

An interview with a Sudanese key informant further encapsulates this idea of the normality of hardship and also suggests that there may be an element of stoicism in Sudanese cultures:

> Within the Sudanese community you'd think that's normal and you have to cope with it. So long as it is not immediately life threatening, you just think it is normal and you can go

> around with it. Yeah so that's how it is. (Key informant 3 – Sudanese man)

This might also partially explain the tendency for resettling Sudanese refugees not to seek help from formal mental health services.

If trauma-related and other mental health issues emerged, they were generally thought to do so in the long-term, according to health service key informants. This was when the intense activity associated with the practicalities of resettlement and living in a new society was thought to subside. In other words, even if refugees had successfully undertaken activities such as learning English, enrolling in school or training and finding a house and a job – activities which demonstrated their agency and mastery of a new social world – they were still seen as vulnerable to the negative consequences of past trauma.

Mental health beliefs

There was a tendency for non-Sudanese key informants to equate Sudanese mental health beliefs with African or non-Western mental health beliefs. While there may be some common threads, the accounts of Sudanese key informants point to a greater diversity depending upon factors like ethnic group and sub-group, exposure to Western culture and medical ideas, and whether people had lived in rural or urban areas prior to forced migration.

Sudanese key informants emphasised that the concept of depression was foreign. Issues associated with emotional distress, sadness and grief were not necessarily understood as abnormal, but rather were a part of everyday life, requiring 'everyday' non-professional responses:

> … when I first came and then I started hearing something called 'depression' I thought 'gosh that is white man's sickness, we don't have that' because we don't have a name for such a thing as depression, we don't. If I have problem or issue I talk to my aunt, my cousin, my grandma, my whatever, my neighbour and we talk about it and that's it, it's finished. So we don't have to go and see a special person to solve this problem. (Key informant 8 – Sudanese woman)

Here, depression is viewed as culturally bound to Western contexts, where its use as a popular term and diagnostic label has proliferated (Kokanovic et al., 2013). For this key informant, the lack of an equivalent term in her language reinforced the irrelevance of the concept and of seeking professional help to address sadness, when family and community support is seen as the appropriate avenue. Sudanese key informants working in refugee-specific and community health services reflected a philosophy of resistance towards the medicalisation of distress, along with a focus on broader social welfare issues.

For issues that were more likely to be considered 'mental health issues' within the Sudanese community, such as 'hearing voices' (Key Informant 6 – Sudanese man) or 'saying things that don't make sense' (Key informant 7 – Sudanese woman), people were reported to be equally as unlikely to seek help from a formal mental health service. This is largely due to the associated stigma. Sudanese key informants suggested that accompanying these mental health issues are derogatory labels such as 'madness' or 'craziness'. Having these mental health issues was associated with a particularly low status in society, impacting negatively the ability of such persons to contribute to the community, have their voice and opinions heard or taken seriously and their ability to marry.

Furthermore, given the communication networks that are likely to be utilised by Sudanese across the globe and in a locally prescribed geographic community, there may be a fear that once labelled as suffering from a severe mental health issue, everyone in the community will be aware.

Given the degree of stigma, there was a view among health service key informants, in particular, that mental health issues may manifest in other culturally sanctioned ways, including physical health symptoms or problems. Some also thought manifestations could include excessive alcohol use and domestic violence.

Some Sudanese and health service key informants thought that supernatural explanations may be more commonly invoked than psychological ones. However, the Sudanese key informants who commented on supernatural causes suggested that this is likely to be a more traditional explanation held by rural and/or less educated Sudanese. Again this highlights the diversity of views within the Sudanese community about mental health and the need for a diverse range of responses.

Health service provision and culturally appropriate responses were also discussed. Services focusing on addressing trauma, and consequently offering psychological help, represent a disconnect between what is offered and what is needed. Unsurprisingly, the result of this divergence is that few Sudanese people take up the offer of professional counselling or psychological help.

Role of the Sudanese community in addressing mental health issues

There appear to be processes within the Sudanese community to address emotional distress, loss and grief. Although Sudanese key informants underlined the potential cultural inappropriateness of professional counselling, this was not an outright rejection of the idea of counselling but of the Western mode. Sudanese key informants described what one coined the 'Sudanese way of counselling' (Key informant 7 – Sudanese woman).

Given the diversity within the Sudanese community (Baak, 2011), there are likely to be many Sudanese *ways* of counselling. Several key elements involved in the process were identified. These included surveillance and information

gathering, mobilisation of appropriate community resources and the provision of collective support and advice.

According to Sudanese key informants, community members look out for possible emotional distress, alcohol issues, family crises, social isolation and other possibly stressful events experienced by members of the Sudanese community. The death of a family member and a change in behaviour or personality were also factors thought to potentially identify someone as in need of counselling and support.

Once potential 'cases' were identified, members of the community would then observe the identified individual informally. This was done as part of a process of gathering information about the problem and how members of the community could help:

> You don't go and ask, and say that 'I need counselling services' or 'I have a problem, I need counselling', you don't. Other people – it could be your aunty, your uncle, your friends – they will observe you and the changes that might be happening from your behaviours or from your dealing with things in life, from how you deal with your relationship or what. If you identified me with that problem you will discover other people and say 'this is how I observe her, there is something happening with her'. Then you will get other people also to watch me, to observe me. (Key informant 7 – Sudanese woman)

The next step in the process is what might be inferred to be the mobilisation of appropriate community resources. Prior to the provision of support and counsel to the individual experiencing a problem, Sudanese key informants described a process in which there is a matching of community members' expertise with the identified problem. This may include ensuring gender concordance between the providers of support and the recipient of support. Gender concordance may be particularly important in the context of the changing gender and family dynamics associated with resettlement that key informants discussed. For instance, situations where women were able to gain employment while their husbands or male partners were not could become a potential source of conflict and stress within families. Key informants thought that some Sudanese men may feel a sense of failure or resentment at the perceived loss of their traditional breadwinner role and that this may contribute to excessive alcohol use among men, family conflict and break-up.

According to Sudanese key informants, appropriate community supports would collectively approach the person experiencing a problem and visit them in their home. The community supports would present the information gathered and ask the person for their own version regarding what was happening to them. The community supports would then proceed to offer their support, advice and counsel. According to one Sudanese key informant, a 'counselling session' may proceed as follows:

> For example if you are grieving – maybe someone died or you don't know whether they're still alive or what – other people with a similar problem, will be identified, people who maybe are coping with their similar situation will come to you and say 'look at me, this is my story … so this is normal, it's not only happening to me, it has happened to so many people and it will happen to other people. It's not about you, it is natural; things do happen. It has happened, but open a new chapter in life because thinking will not bring a person back. Instead it will harm you and not bring a solution to your mind. You will raise your conscious mind that you've got other things to do rather than focus on this. It's time to look up to this. How are you going to deal with this things in life, about yourself in life' so this is our ways. (Key informant 8 – Sudanese woman)

For many resettling Sudanese refugees, getting on with life rather than dwelling on or 'thinking about problems' may be more helpful than many Western psychotherapeutic approaches. This may also account for low rates of utilisation of professional psychological help.

Another point of difference, as described by Sudanese key informants, is the notion of responsibility. In contrast to Western approaches where individuals are largely considered responsible for seeking the help of a counsellor or service, the Sudanese approach stresses the *community's* responsibility to seek out those in need of help and support them:

> We (members of the community) might not know exactly what is your problem but … we can't let you live with that alone; it is our responsibility to help you deal with what is burning you. (Key informant 8 – Sudanese woman)

As one health service key informant indicated, services can, however, integrate the notion of drawing on the resources of the collective into their responses via group programmes:

> Very often, particularly in the third world, it's very difficult to see women talking one to one but in a group setting of people of their own background they feel much more trustful and comfortable … So if they talk to each other and share their problems sometimes what one person has undergone can be of help to another person and they explain how to deal with a particular service so that's a very effective way of helping. (Key informant 14 – Psychiatrist)

Discussion

Cultural factors are paramount to the identification and treatment of a mental health issues (Kleinman & Benson, 2006). However, the currently fashionable notion that practitioners can be 'culturally competent' by learning rules around particular groups like 'refugees' is not supported by evidence (Kirmayer, 2012; Kleinman & Benson, 2006). There is no fixed definition of cultural competence (Bäärnhielm & Mösko, 2012). Rather, cultural competence

is an attitude, a willingness to understand that each individual brings his or her own explanatory model to the exchange and that this model has been shaped by culture. Through collaboration with clients and others from refugee backgrounds, mental health interventions can be developed that are culturally appropriate from a group perspective (Murray, Davidson, & Schweitzer, 2010), without losing sight of the fact that part of the clinician's skill base must include flexibility and responsiveness to individual needs while avoiding stereotypes.

The notion of trauma does not hold the same meaning for all Sudanese people, nor is it necessarily understood in the same context as the people offering psychological interventions. Moving forward with life in a resettlement context rather than dwelling on past experiences was considered most important to refugee key informants. A number of studies and commentators have also emphasised that, despite having experienced traumatic events in the past, the need to address these is often dwarfed by the need to cope with present-day stressors in resettlement contexts (Miller, Kulkarni, & Kushner, 2006; Ryan et al., 2008). In this study, refugees were seen as possessing resilience and personal coping abilities. Other studies have also emphasised refugee resilience (Khawaja, White, Schweitzer, & Greenslade, 2008; McCarthy & Marks, 2010; Rosseau & Measham, 2007; Schweitzer et al., 2007) and have highlighted how refugees are active in rebuilding their own social and emotional worlds (Harris et al., 2013; Westoby, 2008; Williams, 2006).

It has long been estimated that the majority of all illness episodes are managed, not within professional services but within families and communities (Kleinman, 1980). Formal health and social services are only one avenue through which resettling refugees may gain support. The 'Sudanese way of Counselling' provides an example of an approach to healing from a community level.

In contrast to the individual approach to counselling within the western paradigm, the 'Sudanese way of counselling' as described by Sudanese key informants in this research involves a collective approach. The group and its appropriate resources are drawn on within a 'Sudanese counselling' session. The persistence of individual suffering may reflect negatively on the collective, suggesting that the community has failed in its responsibility to seek out and assist one of its constituent parts. Given the stigma that may be associated with seeking help, the Sudanese approach protects individuals from the perceived shame of admitting they need help. Thus, there may be major barriers to seeking help for a mental health issue at a formal health service given different notions of responsibility.

Given the diversity of mental health beliefs within the Sudanese community, the 'Sudanese way of counselling' may not be appropriate or desirable for all resettling Sudanese refugees. It may be less accessible or relevant to resettling Sudanese refugees, who are disconnected from the Sudanese community. However, this study reinforces the calls of Westoby and Ingamells (2010) for a shift towards what they call 'a critically informed cultural approach to healing' (p. 1770), which recognises the influence of social, cultural and political processes on refugee mental health and recovery. Worker and organisational dialogue with refugees and their communities is considered central to this approach. The purpose of this, according to Westoby and Ingamells (2010), is to 'test assumptions, raise dilemmas, make the aspirations, expectations and legal requirements of both cultures explicit and provide the space to explore their implications so as to negotiate outcomes' (p. 8). Engaging in such dialogue will enable workers to ascertain how individual refugees understand their experiences of distress or sadness and whether community strategies and/or professional responses are desired, expected or are appropriate.

By virtue of their dual roles as community members and health workers, bi-cultural community health workers (CHWs) may be well positioned to facilitate both community strategies and professional responses. However, Watters (2001) notes the possibility that bi-cultural CHWs may be used by the service to translate refugees' articulated needs into a language more palatable to the service – that of the biomedical category. Thus, bi-cultural CHWs need to have sufficient time, resources and autonomy to enable them to undertake outreach and advocacy work in the community.

Conclusion

While this study is limited by its focus on one refugee community in one particular location, it identified an approach being utilised within the Sudanese community in Australia. More needs to be understood about such community strategies for addressing and coping with mental health issues among refugee and culturally diverse groups. Given the changes in gender roles that may occur as part of the process of resettlement (Deng & Marlowe, 2013; Harris et al., 2013; Marlowe, 2012), further research is needed to explore how community strategies might be experienced differently by refugee women and men. There is a very limited evidence base around what strategies are most likely to promote mental health and prevent illness in immigrant and refugee groups (Kirmayer et al., 2011). However, this study reinforces the need for service-community dialogue (De Jong & Kleber, 2007) to better understand and develop responses that are consistent with the diversity of needs and mental health beliefs of refugees.

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