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Refugee Mental Health Practice in Rural Communities: Understanding Cross-Cultural Differences

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This brief is a summary of the findings reported in Kandiah, L. (2018). Refugee mental health: a review of literature on treatment, practices and recommendations. *Journal of Ethics in Mental Health, 10,* 1-19.

Introduction

Current Canadian data on Syrian refugee resettlement indicates that while Canada's major metropolitan areas are hosting the majority of arrivals, smaller and rural communities are also taking in large numbers (Government of Canada, 2017). The availability of settlement services, including mental health treatment and specialized services, is substantially lower in rural areas than in Canada's larger urban centers (Ashton, Pettigrew, & Galatsanou, 2016; Canadian Mental Health Association, 2009). Increased migration to rural Canadian communities has already strained existing social services in these areas while the lack of culturally-tailored services has also been highlighted as an issue. This brief seeks to address this service deficiency.

Refugees arriving in rural and urban Canada often come from regions of the world that differ from Canadian society with regard to values, customs and priorities. These disparities can be explained in terms of cross-cultural differences and the variations in belief systems and knowledge interpretation that exist across cultures, populations and individuals. Scholarship on the topic of mental health practice has indicated that there often exists a disparity between the mental health needs of refugee populations arriving in a host country and the ability of mental health practitioners to meet these needs. These disparities and their implications are examined below. It is hoped that this overview will provide rural mental health practitioners with insights on how their treatment frameworks can be developed to improve treatment receptiveness among refugee populations. The concepts discussed below are not exclusive to refugees in rural communities; however, given the settlement service deficiencies in rural Canadian communities, mental health practitioners in these communities can benefit from learning of these dimensions and adjusting their approaches.

The first dimension in the disparity between mental health practitioners and refugee clients is a lack of understanding of cultural differences. This cultural dimension can be broken down into five interrelated categories: medicalisation of refugee experiences; failure to understand individual perceptions of trauma; inadequate recognition of the role of community in healing; failure to understand mental health stigma; and an inadequate understanding of power dynamics. The second dimension is a mismatch between the need to address past traumatic experiences versus the need to address current stressors.

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Cultural Dimension

As part of the cultural dimension, the first finding in the literature is the concept of medicalisation, which refers to *the prevalence of mental health workers to diagnose the emotions and experiences of individual refugees as medical illnesses*. Scholars have argued that there is an assumption in Western mental health practice that refugees who have faced displacement and violence are suffering from mental health illnesses and that these illnesses must be confronted and treated (Savic et. al., 2016; Summerfield, 1999; Summerfield, 2002; Summerfield, 2003). This assumption is inaccurate as individual refugees' perceptions of their own health may not reflect this belief, and this belief may clash with their cultural values and belief systems. The experiences and perceptions that refugees bring with them to their host communities must be acknowledged and understood as a testament of their resilience, not necessarily as a call for mental health intervention (Kira & Tummala-Narra, 2015; Marshall et. al., 2016).

Second under the cultural dimension, individual refugees' perceptions of their experiences often clash with those of Western mental health frameworks. The context in which trauma occurs, the relationship between victim and perpetrator, and feelings of betrayal, injustice, and accountability substantially influence perceptions of mental health and the effectiveness of treatment (Martin et. al., 2013; Summerfield, 2003). This sociocultural and sociopolitical context must be acknowledged by practitioners who treat refugee populations as it influences the current needs and health of treatment subjects.

Thirdly, individualised Western mental health frameworks often fail to acknowledge the important role that community members and family bonds play in healing among some refugee communities. While Western mental health frameworks hold the individual as ultimately accountable for confronting mental health issues, this does not hold true among those cultures in which individual mental health is often a collective responsibility and community issue, as has been observed in Sudanese and Somali refugee communities, among others (Ellis et. al., 2010; George, 2012; Gozdziak, 2004; Kira & Tummala-Narra, 2015; Savic et. al., 2016). A failure to acknowledge the importance of community in individual healing can undermine the mental health of individual refugees and hinder their ability to adapt in a new environment.

Stigma is a leading cause of mental health treatment avoidance in many cultures. Numerous scholars have indicated that individuals across many refugee communities often do not seek mental health treatment due to misconceptions and potential consequences in their respective communities. Such consequences include social and familial isolation, and fears of being viewed as unstable, dangerous, crazy, sick, useless, unintelligent, or as victims (Marshall et. al., 2016; Savic et. al., 2016; Shannon et. al., 2015). For practitioners, understanding the nature of stigma is necessary in order to make mental health treatment accessible and acceptable. Making services accessible through acceptable channels in consultation with refugee communities and leaders is one option that practitioners can consider (Marshall et. al., 2016).

Understanding the power dynamic that exists between practitioners and refugees, and the practitioner-subject relationship, are important considerations. As treatment providers, mental health practitioners are authority figures. For refugees who have faced social, economic, religious or political oppression, their trust of authority figures may be minimal and highly

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suspicious (Marshall et. al., 2016; Shannon et. al., 2015). Fears that confidentiality will not be respected, and that family members in their countries of origin may be harmed can substantially influence individual refugees' willingness to share their experiences (Shannon et. al., 2015). Given such challenges, it is important for practitioners to be aware of how individuals with such experiences may perceive them. Practitioners must build rapport with refugee clients and establish a relationship where both clients and practitioners are at an equal level, providing clients with the needed comfort to share their experiences (George, 2012; Summerfield, 2003).

Past versus Present Trauma

The second dimension that has been noted by scholars regarding the disparity between Western mental health frameworks and refugee subjects is the issue of past versus present trauma. Numerous scholars have found that the mental health stress often faced by refugees in host communities has less to do with their historical experiences and more to do with the stressors and difficulties they face after migration, including finding housing and employment and encountering discrimination (Beiser & Hou, 2016; Keel & Drew, 2004; Murray, Davidson & Schweitzer, 2010; Nicholson, 1997; Savic et. al., 2016; Shedlin et. al., 2014;). However, Western mental health treatment approaches often prioritise pre-migration experiences due to the inaccurate but firm belief that these experiences determine post-migration health, which often clashes with the needs of refugees. Studies conducted by Savic et. al. (2016), Keel and Drew (2004), and Shedlin et. al. (2014) clearly indicate that for resettled refugees, discussing their past experiences was often not seen as necessary or useful, instead finding themselves more concerned with the resettlement process in their new communities. Nicholson (1997) similarly found that post-migration stressors among 447 Vietnamese, Cambodian, Hmong and Laotian refugees in the United States were substantially more consequential as mental health indicators than experiences before migration.

Given that the mental health of individual refugees is often most prominently influenced by their post-migration experiences, altering mental health practices to adhere to these needs is crucial. Mental health practitioners must not focus exclusively on past experiences to the detriment of discussing migrants' resettlement processes and ease of transition into Canadian society.

Recommendations

Rural mental health practitioners looking to address this population's needs must acknowledge the limitations of a one-size-fits-all approach and be open to learning how refining their approaches in accordance to different cultural norms will improve effectiveness and individual refugees' receptiveness of treatment. This involves, but is not limited to, educating themselves about the culturally-specific social norms, community dynamics, and family ties that guide clients' behaviours and needs, and adopting culturally appropriate treatment frameworks as exemplified by Ellis et. al. (2010), Griner and Smith (2006), and Möhlen et. al. (2005). Successfully enacting such changes can help mitigate service deficiencies in rural Canadian

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communities by providing individual refugees with appropriate services that facilitate their transition into Canadian communities. A failure to enact these changes can affect the health of migrants as specialized rural settlement services continue to be insufficient for refugees' needs.

Author's Biography

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