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WORKING WITH AFRICAN IMMIGRANTS WITH MENTAL ILLNESS: A CULTURAL PERSPECTIVE

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ABSTRACT

In the last three decades, many refugees and other immigrants have moved to the United States. Many of them have experienced mental health challenges but only a few of them seek professional help for various reasons. This is a qualitative study that utilized documentary analysis to explore whether the use of psychotherapy in working with refugees and immigrants from Africa with mental health challenges was efficacious. In this study, textbooks, and journal articles from the PsycINFO academic database in the last 15 years that have shown or addressed the limitations, critiques, barriers to effective psychotherapy from the dominant culture, and challenges of psychotherapy were analyzed.

Keywords: African refugee's African immigrants, mental health, psychotherapy

1.0 INTRODUCTION

In this millennium, a stark reality that social workers, case workers, and human service workers are faced with is how to work effectively with refugee families experiencing mental health problems. This is because from the late 1950s until the very recent past therapists used skills that have been effective for people of the dominant culture. The problem now is how to deal with people from other parts of the world or minorities with different cultures, especially those from Africa. With the increased advent of cultural diversity which is now a fact as the U.S. melting pot for people with diversified cultures. It is important that working with people from various backgrounds be tailored to the changing times, methods, and needs

This paper posits that psychotherapy could not be an effective tool in dealing with African refugee families facing mental health problems like depressive disorder, post-traumatic stress disorder (PTSD), and adjustment disorder for the following reasons. The model is Eurocentric and not applicable to many African refugees, asylees and immigrants, it does not address the cultural components of people from different backgrounds, and it is mostly used by people who are not aware of the nuances of other non-mainstream ethnic groups or people fleeing persecution. According to the National Association of Social Workers (NASW, 2019) for instance, a refugee is a person who flees persecution for protection in another country. This

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person is so designated by international law and his or her entry into a host country is determined by internationally cooperating governmental and private agents. Such a person comes with a plethora of challenges which if not properly addressed will hinder his or her adjustment and coping in the new homeland (Teboh, 2015). It is within this backdrop that this research suggests that other methods of intervention and not just psychotherapy be used when working with refugees and immigrants from Africa.

2.0 LITERATURE REVIEW

The review of this literature addresses the limitations of psychotherapy and how it is an insufficient tool used to help refugees and immigrants from Africa who suffer from mental illness. It also explores the unique cultural challenges these Africans experience, thus justifying why something else is needed as therapy instead of psychotherapy alone; or at all. According to Sweeney (1994) "psychotherapy was created by Western Caucasian men in their own image" (p. 390). Psychotherapy is a relational intervention that is used to aid clients in solving problems of living. In psychotherapy, a spoken conversation is primordial, and this is used to improve the mental health of individual clients or the family unit (Granvold, 1996; Prochaska & Norcross, 1994; Painter & Scannapieco, 2015; Sweeney, 1994; Tseng, 2001; Tseng & Streltzer, 2001). Unlike drug therapy, psychotherapy produces no side effects although it may take longer than drugs to produce efficacious results. Psychotherapy encompasses a wide range of techniques and practices (Granvold, 1996; Prochaska & Norcross, 2003; Painter & Scannapieco, 2015; Sweeney, 1994; Tseng, 2001; Tseng & Streltzer, 2001). Psychodynamic therapy and humanistic therapy focus on helping people understand the internal motivations for their problematic behavior. Over the years, cognitive-behavioral therapy has been widely used and it fits well in dealing with individuals of the dominant culture.

2.1 Culture and Psychotherapy

Psychotherapy for a long time emphasized white male society's definition of healthy mental states and consciously left out minorities who lived in the United States at the time or failed to investigate the contingencies of the future in dealing with immigrants (Nichols & Davis, 2021). Erroneously it was assumed that or originally seen as universally applicable to all human beings not taking into cognizance the cultural backgrounds of clients (Sweeney, 1994; Tseng, 2001; Tseng & Streltzer, 2001). It soon became evident that therapies based on white middle-class assumptions did not fully address minorities. The civil rights movement followed by the Women's Rights Movement was pivotal in making therapists know that clients were different in many instances and these differences needed to be taken into consideration (Sweeney, 1994). Indeed, with the recognition of minorities, psychotherapy needed a transformation as well; women demanded to be included in psychotherapy and female psychotherapists clamored for feminist therapy and in the 1970s saw an upsurge of feminist mental health organizations (Nichols & Davis, 2021; Sweeney, 1994).

As social workers, we must deal with individuals from other cultures (Painter & Scannapieco, 2015) and candidly it is no easy task for clinicians to command the nuances of the cultures of their clients. Remarkably, "cultural issues often permeate the psychotherapeutic process in more subtle ways" (Tseng, 2001, p. 10). A counselor or therapist who leans heavily on some form of intervention like behavior techniques may be seen as coercive and manipulative (Sue

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& Sue, 1990). Therefore, leaning toward cultural aspects of psychotherapy is of primordial importance as the therapist needs to adjust, expand, or modify his or her understanding and manner in dealing with each client taking into consideration the client's cultural background (Tseng, 2001).

Thus, Matsukawa (2001) points out that immigrants with divergent backgrounds bring varied and contrasting values, especially in the areas of interpersonal relations into the social microcosm of a psychotherapy group. In therapy, the situation should be conducive for Africans to reveal their cultural values and meanings ascribed to certain behaviors (Matsukawa, 2001). Indeed, the trend should not be an outright denunciation of their behavior but a gradual process for the client to understand that the public domain requires or at least expects people to behave in a particular way.

2.2 Culture

In trying to situate the problem, it is important to look at the definition of culture.

> Culture has been defined as a pattern of basic assumptions, invented, discoursed, or developed by a given group as it learns to cope with its problems of external adaptation and internal integration that has worked well enough to be considered valid and therefore, to be taught to new members as the correct way to perceive think and feel about those problems. (Schein, 1983, p. 9)

The social work dictionary provides a useful point also. It defines "culture" as the "customs, habits, skills, technology, art, values, ideology, science, and religious and political behavior of a group of people in a specific period" (Baker, 1999, p. 144). Thus, "culture takes diverse forms across time and space. This diversity is embodied in the uniqueness and plurality of the identities of the groups and societies making up humankind" (UNESCO, 2001, p. 2). Pinderhughes (1994) defined culture as the "total of living built up by a group of human beings and transmitted from one generation to another" (p. 274). Overall, every society has values, norms, beliefs, attitudes, folkways, behavior, styles, or traditions that mold individuals and even the groups to which they belong (Lonner, 1994, cited in Schriver, 2004; Sue & Sue, 1990; Tseng, 2001). The transmission of culture can happen in two ways. Through socialization, the elder generation can teach younger members of society, values, norms, and roles that could make them function well. Transmission can also occur through enculturation by "implicitly or subtly" teaching culture to the younger generation in an everyday process (Lonner, 1994, cited in Schriver, 2001; Sue & Sue, 1990).

2.3 African Immigrants

At the start of the 20th Century, many Africans immigrated to the United States as free men, unlike their predecessors who came to North America bound in chains. These men left Africa in search of education, fortune, and romance. Nyang (1998) puts them into four categories: (1) Students who came with the support of white Christian Missionaries. (2) Then were other students who came to study secular and sacred knowledge, and for one reason or another, conjugal entanglements with White American and African American women led to their decision to permanently stay in the U.S. (3) Seamen and stowaways who sailed to the United

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States either on American ships or foreign ship and (4) through United States migration programs.

The U.S. Committee for Refugees (USCR) was founded in 1958 to coordinate the United States' participation in the United Nation's International Refugee Year (1959). In the early forty years, USCR worked for refugee protection and assistance in all regions of the world. Repressive governments, internal conflicts, and opposition to reforms led to massive human rights abuse and displacement in Africa. Since the early 1970s, USCR has been a leading voice on behalf of uprooted people in Sudan and Uganda. USCR reported on the desperate flight of Ethiopian refugees and was one of the first to warn that conflict in Somalia would lead to famine. USCR has also provided ground-breaking reports on brutal wars in Mozambique, Rwanda, Burundi, Congo/the Democratic Republic of the Congo, Sierra Leone Liberia, and the Republic of Côte d'Ivoire. In the last decade, many Africans have immigrated to the United States as the U.S. provided a safe abode for many of them fleeing the throes of war or the carnage and devastation.

Each year also, 50,000 immigrant visas are made available through a lottery to people who come from countries with low rates of immigration to the United States who meet the requirement of having a high school diploma or 12 years of course of elementary and secondary education or 2 years of work experience. Remarkably all these groups come to the United States with divergent cultural backgrounds and with time as they encounter mental health problems, they encounter social workers and other therapists who try to help them in alleviating their health problems.

2.4 Mental Health Problems

It has been easy to diagnose refugees from countries that had civil wars with posttraumatic stress disorder (PTSD). Posttraumatic stress disorder is an anxiety disorder that can develop after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened (APA, 2000; Ehntholt & Yule, 2006). Many people with PTSD repeatedly re-experience the ordeal in the form of flashback episodes, memories, nightmares, or frightening thoughts, especially when they are exposed to events or objects reminiscent of the trauma (APA, 2000). Anniversaries of the event can also trigger symptoms. People with PTSD also experience emotional numbness and sleep disturbances, depression, anxiety and irritability, or outbursts of anger. Feelings of intense guilt are common. Most people with PTSD try to avoid any reminders or thoughts of the ordeal. Over the years, many Somalians and other African refugees have been misdiagnosed with PTSD easily as soon as they indicated in sessions that they witnessed civil wars in their countries before coming to the United States. Thus, once diagnosed, treatment is generally through cognitive-behavioral therapy, brief therapy, group therapy, and or exposure therapy, in which the person gradually and repeatedly relives the frightening experience under controlled conditions to help him or her work through the trauma. Several types of medication, particularly Selective Serotonin Reuptake Inhibitors (SSRIs) and other antidepressants, help to retrieve the symptoms of PTSD.

3.0 METHODOLOGY

According to Ary et al. (2019), the use of documents in exploring a phenomenon is important. However, documents are underused in qualitative research (Merriam & Tisdell, 2016). Ary et

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al. (2019) state "document analysis can focus on written or text-based artifacts (textbooks, novels, journals, meeting minutes, logs, announcements, policy statements, newspapers transcripts, birth certificates, marriage records, budgets, letters, e-mail messages, etc.) or nonwritten records" (p. 438). To this end, this study focuses on qualitative documentary analysis. This is a method involving a systematic examination and interpretation of written, visual, or electronic documents (Bowen, 2009).

Specific to this study, however, textbooks and journal articles from the PsycINFO academic database in the last 15 years that have shown or addressed the limitations, critiques, barriers to effective psychotherapy, and challenges of psychotherapy were analyzed. Data were collected by searching the keywords "limitations of psychotherapy" from the PsycINFO academic database. The search was limited to 15 years and yielded 63 peer-reviewed journal articles. These were reviewed and 20 were found to meet the requirements of this study and their findings have been presented below.

3.1 Data Analysis

As suggested above, 20 articles were reviewed, and three main themes consistently surfaced as limitations to psychotherapy. First, the recurrent themes identified were the method was a bit old and did not pay attention to rigorous research methodology. This theme is properly captured by one of the authors reviewed for this study. Schmidt and Benno (2013) state "the earliest reviews of these psychological therapies included studies with mostly low methodological quality" (p. 265). The next recurrent theme determined in the review of the articles was that psychotherapy did not pay proper attention to the cultural ramifications of ethnic groups outside of the mainstream group: namely Caucasians in the United States who have European heritage. Zilberstein (2014) posts that when working with children who have attachment issues, therapists must pay attention to the "child's attempts to make sense of relational patterns and strategies to get attachment needs met" (p. 93). This is because these "serve as rough guides of a child's expectations of and approaches to the self and others" (p. 93).

As important as these key takeaways may be for psychotherapy, this however, does not pay attention to the "conscious memories, preverbal and nonconscious experiences, habitual patterns of interactions, and individualized thoughts, feelings, and fantasies about previous experiences that the child may not recall" (p. 93).

The third theme noted from the articles reviewed is that the model may not be suitable for all forms of mental illnesses. This theme ties in with the premise that it lacks the central weight needed to address some of the kinds of issues or mental health challenges that refugees and immigrants from Africa may experience. Leichsenring et al. (2015) as cited by Tolchinsky (2023) for instance questions the efficacy of psychodynamic psychotherapy in that it "is established from some clinical conditions in rigorous meta-analyses; however, evidence is lacking for post-traumatic, obsessive-compulsive disorder, bipolar, and schizophrenia spectrum disorders" (p. 1). Tolchinsky (2023) then goes further to suggest that one of the "possible reasons for such lack of evidence is that the model used in addressing these conditions is insufficiently complex, which results in suboptimal accuracy in understanding of these phenomena" (p. 1), especially when the cultural backgrounds of those affected are not taken

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into consideration. It is these key limitations of psychotherapy that beg for other forms of therapies with refugees and immigrants as suggested.

3.2 Cultural Therapy

However, African immigrants with mental health problems would always need culturally specific therapy to gain proper health care. Thus, a client's current worldview is greatly shaped by past familial and cultural experiences. Therefore, for social workers to develop the most accurate picture possible of a client's issue and experience, it is necessary to help expand the therapist's understanding of the situation to include familial, cultural, and social factors (Berte, 2016; Tseng, 2001). Thus, knowledge of cultural factors and the subsequent skills in dealing with them during the psychotherapeutic process is very important as it will make the therapist make appropriate interpretations of the patient's feelings and behavior (Berte, 2016; Tseng, 2001; Tseng & Streltzer, 2001).

It is not a hidden fact that culturally appropriate and useful psychotherapy has been mystified, misinterpreted, unrecognized, and seen as a monolithic whole over the years. According to Tseng (2001), there should be clear distinctions between culture, race, ethnicity, and minority. Indeed, from my own experiences, these nomenclatures are used interchangeably and incorrectly not only by commoners but by educated people as well. In the case of Africans, there are 54 countries on the African continent, and Nigeria is Africa's most populous country with 226.2 million people (Sasu, 2023). The number of languages currently estimated and cataloged in Nigeria is 521. Although there are marked distinctions in culture among the Yoruba, Hausa, and Igbo people, all the other tribes have their cultural practices that are completely different from the others.

Race these days is culturally perceived and socially constructed (Kottak, 1999). Culture, therefore, refers to the practices and value systems of a social group with the same ethnicity (Berte, 2016; Tseng, 1997). Thus "every individual as a member of a group or a society has his or her cultural mode, regardless of his or her race, ethnicity, or minority/majority status" (Tseng, 2001, p. 6). Therefore, using specific therapies in a culturally consonant way is important to stimulate therapeutic involvement. Despite the universality of cognitive-behavioral therapy, close examination reveals that no psychological therapy is immune from cultural influence. It becomes necessary that interpersonal therapies need cultural adjustment greatly. Therefore, the therapist should become familiar with the culture of the client especially if the client and the therapist are from distinct backgrounds (Bernstein, 2001). Bedell et al. (1997) stated that it is increasingly important for therapists to have assessments and treatment skills suitable for the population of clients. For instance, in group therapy, a few people gather to discuss problems under the guidance of a therapist. By sharing their experiences with other group members, they eventually realize that their problems are not unique. This works very well for people of the dominant culture. In the case of refugees or other immigrants, the fear of being stigmatized greatly inhibits them from accessing mental health services let alone sitting in groups to share their problems. There is a common adage in Sierra Leone that states shame kills faster than a disease. Thus, a Sierra Leonean refugee diagnosed with PTSD, or any other mental health problem would prefer to suffer in silence than to openly receive treatment in a mental health agency.

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3.3 Non-Prior Traumatic Experiences

Many African immigrants in the last decade have immigrated to the United States as refugees from countries like Somalia, Ethiopia, Sierra Leone, Congo, Liberia, Côte d'Ivoire, and Burundi to name some. All of these may present psychological effects. Unlike economic immigrants, refugees do not make a voluntary choice to leave their country. According to Gavagan and Brodyaga (1998) on arrival, refugees enter the over-compensation stage. At this stage, they mobilize all their energies to enable them to live amicably in the new country. This period is also referred to as the honeymoon period (Gavagan & Brodyaga, 1998). Within a few months or years, they enter a decompensation stage, this is when they are faced with the realities of living in the "other world" the developed world. At this stage, the glorious expectations vanish in thin air, and they come to understand that the communal lifestyle they had is no longer present and household compositions are completely different (Potocky-Tripodi, 2003).

The men, coming to the United States see the demise of their patriarchal value system. In Africa, men are the dominant players in decision-making as the cultural values are strongly patriarchal and hence keep women in servile fear of men, especially in the rural areas of the country (Lamin, 2005). Women generally shoulder most reproductive, productive, and community management responsibilities, many of which are not remunerated or reflected in the national statistics (Lamin, 2007). Patriarchy contributes especially by imposing order and control and on the other hand, capitalism provides an economic system driven by the pursuit of profits (Walby, 1990). Thus, men for several reasons seriously dominate the private sphere. The father figure in the family system is common and families cope with such and forge ahead. In the public sector, women continue to lag men for many reasons. Thus the "state is neither hegemonic nor monolithic, but it mediates or deploys almost all the powers shaping women's lives- physical, economic, sexual, reproductive and political- powers wielded in previous epochs directly by men" (Brown, 1992, p. 29). Women find themselves in a subordinate position because of their level of education, family commitments, being single mothers, sexual harassment, lack of equality before the law, finding themselves in "traditional jobs", the state not recognizing their disability, lack of public toilet facilities and the required number of hours of work if they enter the public domain. Brown (1999) states "there is no single thread which when snapped, unravels the whole of a state or masculine dominance" (p. 16).

However, in a new environment like St. Cloud, Minnesota, the family system, and values change considerably as there is a shift from male, father figure dominance to an egalitarian setup in the family with the wives playing pivotal roles in decision making. In this vein, many men have failed to understand the winnowing of their powers and hence have a serious impact on their mental well-being. The very fact that they are not able to do the things they had done throughout their lives affects their well-being tremendously and subsequently depression or just vagrant thoughts or regret coming to the United States.

In Africa, the few women who enter the public sector must cope with the task of providing care for their children, their parents, and extended family members. Combining the two roles in the home and workplace becomes quite daunting. There is always a conflict between women's maternal and matrimonial obligations on the one hand and the commitment and devotion to duty that is usually necessary for the advancement of women in the modern-day competitive

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environment (Lamin, 2007). Besides, it is perceived that the provision of childcare facilities is for upper-class people or those in the middle class and not for the poor or those on the lower rungs of the public ladder. Generally, the charges or costs involved in taking children to and from childcare centers are a major barrier to women. Childcare continues to be a woman's role because of this; there are no campaigns to politicize men to shoulder equal responsibility with their wives in household duties. Thus, this becomes "a vital adjunct to women's active participation in production outside the home" (Swantz, 1990, p.151). Domestic work continues to be the sole responsibility of women with little or no assistance from their husbands (Boserup 1970, Stellman, 1977; O'Connell, 1994; Eade, 1997).

For the women and children coming to the United States is an emancipation from the yoke of suppression they had lived under all their lives in their domicile countries. However, in the United States, women also may be bedeviled by the affordability of childcare, lack of formal education, and the need to work extensive hours to make ends meet. Although women have labor-saving devices like microwaves, washing machines, and vacuum cleaners in their homes, their commitments and demands keep them far away from their initial goals, set in the first few months of arriving in the United States. For many women, their initial realization of securing a job and the need to rent an apartment alone seriously frustrates them. Thus, as the future turns gloomy, or goals hardly materialize then the likely spillover effect is mental health problems for them as well. Overall, there is also external pressure from parents and relatives out in Africa for financial assistance from the refugees who are in many cases barely living on meager incomes here in the United States. The severe financial difficulties and the difficulty in getting permanent residency status make many African refugees further depressed.

Looking at the DSM V TR criteria for adjustment disorder, adjustment disorder comes in as a better diagnosis than PTSD. According to Ehntholt and Yule (2006) applying Western and biomedical psychiatric classification to diverse cultures is problematic. Indeed, it is seen as an inappropriate form of labeling that generally distracts from a more contextualized understanding of distress and difficulty in adjusting to a new society and its culture (Ehntholt & Yule, 2006). Post-migration stress could be more devastating to many African refugees and immigrants than the traumatic experiences witnessed during the war itself. Generally, other post-migration distress comes about when people encounter obstacles to employment, social isolation, inadequate housing, language problems, racial discrimination, and General Educational Development requirements for securing jobs, menial jobs for survival, and learning to drive in fast-paced traffic. Some refugees with debilitating diseases had hoped of getting proper medical attention in the United States but the lack of proper health insurance and being cataloged in jobs that hardly offer them insurance takes its toll on them as well. If any of these remain unresolved heightens the psychological problems of refugees.

3.4 Implications for Social Work

Increasingly these days, "social workers can expect to work with individuals and families from diverse cultural backgrounds" (Sevel et al., 1999, p. 42). Social workers as an ethical standard of the profession need to be culturally competent (National Association of Social Workers, 1997, 2001, 2021), and using therapies that work well with immigrants is indeed significant (Berte, 2016). This would entail knowledge about the client's cultural background or country of origin. In many cases, the client's family or friends could provide vital information about

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the cultural practices or the impact of the new environmental setting on the client (Liddell et al, nd). The family in many instances acts as a buffer against stress and therefore family cohesion before and after the migration is a good predictor of mental alertness (Thabet & Vostanis, 1999). Cultural psychotherapy applies to every client for whom psychotherapy is appropriate (Tseng, 2001). Cultural sensitivity is an ongoing process, and it requires social workers to understand the cultures of their clients on a gradual basis until they become competent (Sevel et al, 1999). For effective practice, social workers should transcend their cultural norms, beliefs, and educational level and enter the realm of the client with an open mind. Thus, "the general goals of counselors must be congruent with the personal goals of the clients" (Corey, 2013, p. 23). For instance, at the beginning of the session ask the client about the cultural practices in his or her domicile country, the differences, and similarities with the practices of the United States, and then try to ascertain how the differences may be affecting the client. In this case, the therapist becomes a determined student of "culturally diverse client groups" (Sevel et al., 1999, p. 42).

Cultural therapy can be likened to client-centered therapy developed by Carl Rogers in the 1950s. The client-centered therapy provides no advice but restates the observations and insights of the client in a non-judgmental way. According to Zastrow and Kirst-Ashman (1997), social workers should not get a fixed opinion or construct a conception about any ethnic group. While some cultures can be easily determined by specific values, beliefs, and customs it will be erroneous to throw myopic knowledge at every member of the group as it denies the unique qualities an individual may have (Juliá, 1996; Queralt, 1996). There are many factors such as immigration and demographic patterns, acculturation, assimilation, socioeconomic status, and educational background that can cause significant differences within a refugee group that may encounter social workers (Juliá, 1996; Queralt, 1996; Sevel et al., 1999). According to Kamya (2005), "therapists need to understand African immigrants' sense of obligation to relatives in their country of origin" (p. 104).

3.4 Research

Social work educators and practitioners should continue doing work around cultural therapy. Thus, therapists and providers are to incorporate cultural therapy in their intervention with African immigrant families especially refugees who may have experienced pre-migration trauma, displacement trauma, and post-migration trauma.

Required Skills, Knowledge, and Techniques

1. Therapists should be willing to learn about the country the client is from. Therapists should always remember that there are 54 countries in Africa, with five main regions: North Africa, West Africa, East Africa, Southern Africa, and Central Africa. Africa is the second largest continent in the world, with approximately 1.3 billion people. There are about 3, 000 African tribes, each of which speaks its language or dialect (Gitonga, 2021).
2. The therapist should try to learn about the dominant cultural practices in the client's home country. What is the presenting problem or the precipitating factors for therapy? The therapist should utilize an eco-map also called ecogram (as developed by Ann Hartman in the 1970s).

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3. The therapist should utilize a genogram (as developed by Murray Bowen).
4. The therapist may need to do case management by linking clients to local resources that may not require a means test (eligibility requirement). According to Liddell et al. (n.d.), some policies may pave the way for negative experiences as refugees try to settle in their new homelands.
5. The therapist should explain to the client about policies in the state.
6. The therapist should provide coping strategies for the clients.
7. The therapist should assess the client's communication skills and ascertain if a translator will be needed.

4.0 CONCLUSION

This study utilized document analysis as postulated by (Ary et al. 2019; Marriam & Tiadell, 2016) to explore some of the ways therapists have worked with African immigrants particularly refugees from countries that have civil war and are based in the Mid-West. Thus, the study brings to the fore the significance of adopting cultural therapy when working with refugee immigrant communities.

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