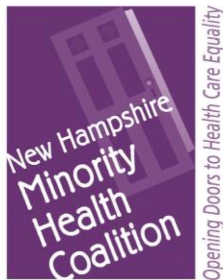


Final Research Report

Exploratory study of the social adjustment and well-being of Latino and African immigrant and refugee families in NH

Project and Organization

The purpose of this study is to better understand what helps immigrant and refugee families from Latin America and Africa settle into their new life in New Hampshire. For those who struggle to adjust, experiencing some form of mental distress, we explore how this is expressed in their own cultural context and consider what kinds of services might be most appropriate for them. We hope that what we have learned from this study will contribute to the development of more effective mental health services to better support newcomers from Latin America and Africa. Specifically, we offer these study findings to inform the Endowment for Health in the development of its mental health theme.

Little research has been published about the mental health of refugees in the United States, and even less is known about the mental health of children from refugee families. Research on immigrants is more available and has shown that, contrary to expectation, recent immigrants have often been found to have lower rates of substance use, depression and other mental disorders than those born in the United States, even among their own ethnic groups (U.S. Public Health Service 1999; Gordon-Larsen, Harris et al. 2003; Hogan and Commissioners 2003; Ryan, Gee et al. 2006). Unfortunately, the rate of mental health problems rises the longer foreign-born Hispanics live in the United States. For example, the literature describes a “Mexican paradox” where recent immigrants from Mexico have rates of psychiatric disorders similar to those in Mexico (and lower than those of the U.S. general population), whereas Mexican Americans born in the United States have rates similar to the general population in the U.S. (Franzini L, Ribble JC et al. 2001; Gee, Ryan et al. 2006).

In contrast to immigrants, refugees often have special mental health issues arising from their extraordinary experiences of fleeing from their home countries. Over 50 years ago, the United Nations defined a refugee as "a person who is outside his/her country of

nationality or habitual residence; has a well-founded fear of persecution…and is unable or unwilling…to return there for fear of persecution."(UNHCR 2002) African refugees are at especially high risk for post-traumatic stress disorder (PTSD) and chronic depression due to the highly stressful conditions they typically experienced before, during and after their flight from their home countries.(National Child Traumatic Stress Network 2004.) In addition to the chaotic, traumatic and often violent conditions that caused them to flee their home countries in the first place, refugees must also cope with acculturative stress as they attempt to adapt to a very different way of life in the U.S. For those originating in urban areas, adjustments may predominantly take the form of learning English and adapting to new surroundings. For other African refugees coming from less westernized tribal areas, the American way of life may be utterly foreign to them.

Children from these families must often bridge two widely disparate cultural worlds – that of their parents and the traditions of their home country, and the *new* cultures and institutions relating to school and young people their age in the U.S. Because the mental health of children of refugees and immigrants has been studied so little, we do not know how different the social, psychological, and emotional challenges are that affect refugee children compared to adults, or what impact these stressors have on their short or long term mental health

This exploratory study of the social adjustment and well-being of Latin American and African newcomers to New Hampshire will address cultural influences as described in the Surgeon General's report on mental health (U.S. Public Health Service 2001) In examining the social adjustment of immigrants and refugees in our study, we asked Latin American and African parents about the following:

- Cultural Identity – home country, ethnic and tribal identification
- Social adjustment to life in U.S.
- Support networks – family, religious and social groups
- Views of mental health & therapy – including perceptions of the local community mental health center
- Transition and adjustment of children to school

Challenges

Cross-cultural research is always challenging. In this study, we crossed many language barriers, interviewing immigrants and refugees from 17 different countries. Whereas all Latin Americans could be interviewed in Spanish by the Latino analyst on staff, the many languages spoken by Africans created more logistical challenges. The African interviewer typically had to coordinate with several different interpreters to schedule interviews. While logistics such as these made the African interviews more labor intensive, we did succeed in recruiting Africans from a wide variety of tribal and ethnic groups from across the continent, conducting interviews (with the aid of trained medical interpreters) in a dozen different African languages.

While coordinating with several interpreters and study participants, we observed first-hand a phenomenon referred to in the cultural competency field as variations in "time orientation." Difficulties in cross-cultural communications are often attributed to value differences regarding punctuality versus taking time to nurture relationships. On several occasions, an interpreter or participant (and sometimes, both) would not show up for an appointment for an interview. Later, the interviewer would be told that the appointment was missed because something came up with family or friends. The person who broke the appointment always seemed to expect the interviewer to take this in stride, as though this were perfectly normal and acceptable behavior.

Even though the interviewers came from similar backgrounds, it was still challenging to build trust and rapport with some of the participants. Nearly half of the Africans declined consent to audio-record the interview, not seeming to trust our assurances that the recording would be kept confidential. Some African men objected to questions about wives and children, believing that only men should speak for the family. The mental health screening questions that were asked during the community health survey were too personal for some respondents. People from certain parts of Africa (most notably, the Sudanese) were more likely to refuse to answer these questions, which in turn was a barrier to their entry into this study's community sample.

In contrast, some of the Latinas became emotional during the interview when recounting their impressions of therapy, turning the interview itself into an impromptu therapy session. These women were currently in therapy, and so were perhaps at an especially vulnerable point in their lives. That they could trust the interviewer with more intimate details than she had asked them for was a testament to the high level of trust and rapport they had

attained. Nonetheless, these sessions were challenging in that they were more time consuming, more strenuous for the interviewer, and more complicated to analyze.

Other Latin Americans were more circumspect, concerned about anonymity because they lacked proper documentation and so feared deportation. Some Africans seemed suspicious of research in particular. Past experiences with oppressive governments made the Africans especially hesitant to speak freely about the difficulties of adjusting to life here. One woman shared her worries that if she were to criticize the American way of life during the interview, that information might somehow adversely affect her application for a green card. Another explanation for the reticence of many Africans to appear to criticize their host country is a norm common in many African cultures against "offending the host." Similarly, norms against sharing non-Western beliefs with outsiders may have suppressed responses to questions about the cultural meanings ascribed to their distress and the traditional ways of healing used to address them in their native cultures.

Evaluation & Final Analysis

Methods

To develop culturally appropriate questions and the best means to address them, we began by consulting with community leaders and other cultural advisors. We have learned from our advisors about the major stressors of adjusting to life in New Hampshire and how Africans and Latin Americans may express distress differently from Americans. This understanding guided the way we asked people from various Latin and African cultures about their experiences coming to the U.S. Interpreters and other cultural advisors made recommendations for how the information would be collected, as specifically as how to phrase questions respectfully in each native language.

Research participants were interviewed face-to-face by Latino or African researchers who were trained in the protection of human subjects and qualitative interviewing techniques. When necessary, the assistance of a trained medical interpreter who speaks the participant's primary language was also obtained. Interviews were audio-recorded with the consent of the participant, although most of the Africans declined to give their permission to be recorded. Interviewers also debriefed with the interpreters to learn about any non-verbal cues or other subtle messages that may have been given during an interview.

Communication is a complex combination of spoken word, euphemisms, facial expressions and other forms of body language. The interpreters, acting in their role as cultural advisors to the project, were invaluable to the research team in offering their observations and insights from these interviews as well.

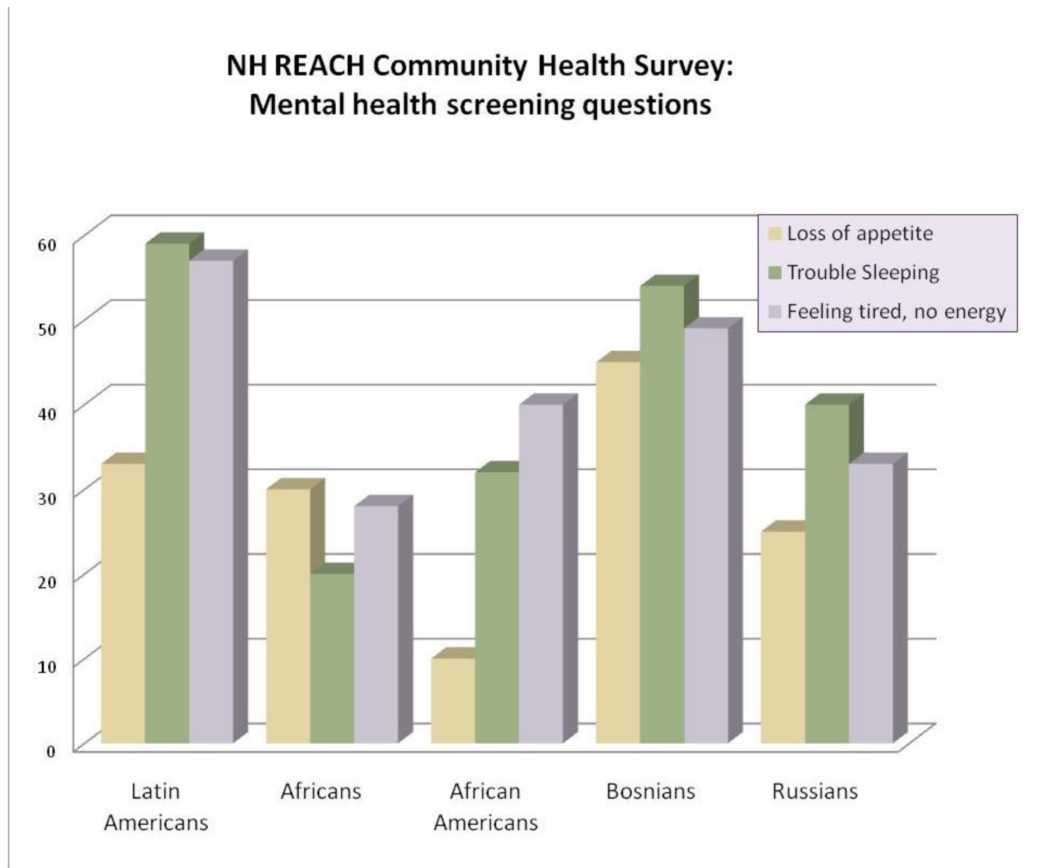
The transcriptions and contemporaneous notes taken during and after the interviews form the basis of the study. The participants' words, as translated into English by the Spanish interviewer and the African interpreters, were the qualitative data that was analyzed using the N6 software package. Transcripts were coded using the software's auto-coding function for expected keywords and the in-vivo coding function to identify emerging themes from the interviews. Quotes from the participants (omitting any specific identifying features of the person to preserve confidentiality) are highlighted in pull quotes in the Findings section, below.

Participants

Latin Americans and Africans living in southern New Hampshire were invited to participate in the study through two key partnerships. First, as the agency who hosted the NH REACH 2010 program, we had the opportunity to link this study with the Community Health Survey (CHS) we were conducting at the same time in southern New Hampshire. Interpreters were trained to do standard interviews with Limited English Proficiency (LEP) immigrants and refugees regarding their access to healthcare, diet and exercise habits, and other health-related topics. African Americans were also included in the CHS as another important focus population from the NH REACH 2010 initiative. While a full mental health screening was outside the scope of the survey, a review of the literature revealed that three signs of distress are the most commonly experienced around the world: loss of appetite, sleep disturbances, and lack of energy (Burgess 2004; Minnesota Department of Refugee Health 2004; Refugee Mental Health Program 2005; Ringold 2005).[1] During the CHS interview, interpreters asked if anyone in the person's family had experienced any of these universal signs of distress since coming to the U.S. Latin Americans and Africans who reported one or more of these signs of distress, and who had a child living in their home, were then invited by the interviewer to join this study.

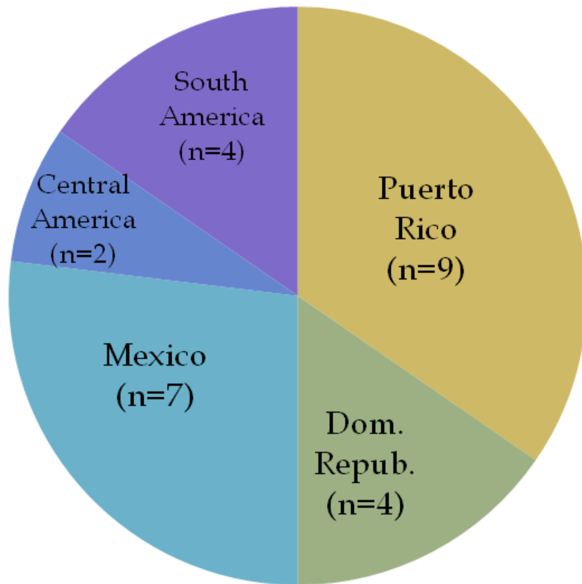
---

[1] These three indicators are used internationally with refugee populations to screen for possible post-traumatic stress disorders or other mental health issues. Locally, interpreters were trained to emphasize that we were asking about problems that lasted for at least two weeks, rather than isolated incidents of insomnia, for instance. The question regarding lack of appetite emphasized that we were asking about periods of time when they did not have an appetite even for "foods they usually enjoy."



The bar chart above shows the percentage of respondents from the major population groups in the CHS survey who reported each sign of universal distress.

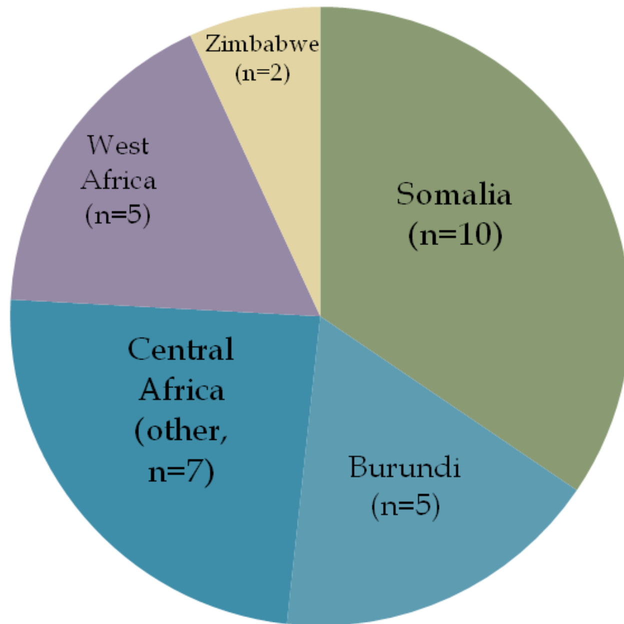
The second partnership which was key to the study's success was with the Mental Health Center of Greater Manchester (MHCGM) to invite their clients from Latin America and Africa to participate in the study. The in-treatment sample included four Latino parents of children who were receiving treatment and two Latino adults who were in treatment themselves and who had a child living in their home. Seven African parents were referred from MHCGM to the study, four of whom had children currently in treatment at the mental health center.



Latin Americans

Qualitative interviews were conducted with 26 Latin Americans, all but three of whom were parents of children under 18. As shown in the pie chart on the left, study participants came from across Latin America. While reliable population estimates are lacking, especially for undocumented immigrants who may be reluctant to be surveyed for the Census, studies of Latinos in southern NH suggest a similar diversity of nationalities (Camayd-Freixas, Karush et al. 2005). Half of the study participants were from the Caribbean, with over a third from Puerto Rico. The next largest group is from Mexico. We also were able to recruit Central Americans from Guatemala and El Salvador and South Americans from Colombia, Peru, and Uruguay into the study.

Typical of most health-related surveys, most of the Latino participants were women (only three Latino men agreed to be interviewed). To protect confidentiality, no other demographic questions were asked of this small sample.



Africans

Because they form a large and visible tribal group of refugees in southern New Hampshire, the Somali-Bantu were a major focus of study. All ten of the Somali participants were from the Bantu tribe. We also focused on recruiting refugees from Burundi, as they are newly resettled in NH. Study participants also came from other Central African countries including the Democratic Republic of Congo, Rwanda, and Tanazania. West Africans in the study came from Liberia, Nigeria, and Cameroun.

This variation in nationalities of study participants is similar to the African refugee population in southern New Hampshire (with the notable exception of the Sudanese who were not successfully recruited into in this study). According to official reports, over 40 percent all the refugees settled in New Hampshire, in the state since 2000 have been from three African countries: Somalia, Sudan and Liberia.(Office of Refugee Resettlement 2004)

Findings

The transcriptions and notes from the 55 qualitative interviews conducted for this study were analyzed for common and divergent themes. Using the N6 software, Cecilia Tamayo-Creamer, the native Spanish-speaking research analyst on the project, translated the transcripts from her interviews and coded the English versions as the primary data. The African interviews were more challenging to analyze, because over half those interviewed declined to consent to have their sessions audio-recorded. For these cases, Thandi Tshabangu-Soko, the African research analyst on the project, relied on her notes and recorded debriefing sessions with the interpreters instead of actual interview transcripts. These notes were considered primary data for the African interviews and coded in N6 following the same methodology that was used to analyze the Spanish transcripts.

Themes among Latinos

After introductions regarding their family and home country, we asked participants what it was like for them to come to the United States. The 26 Latinos interviewed seemed to fall into two groups of similar experiences. The first group reported some difficulties adjusting to all the changes in their lives at first, a classic kind of culture shock at all the differences in lifestyle, culture, language, community, climate, and so on. Some remember feeling homesick, missing the family and community they left behind. Others also missed hearing their own language everywhere, every day. One summed it up saying, "I missed everything, I felt anxious and wanted to go back home." This first group reported that they grew to like living here, with time. They particularly appreciate that they can earn more money here to provide for their families.

The other group reported a kind of honeymoon phase where American life seemed like a dream come true when they first arrived here. For many of these Latinos, they became gradually aware of all the things they sacrificed to come here. The cultural differences between their new community and their home countries became more stark as time went on. For some who lack official documentation to remain here legally, this growing feeling of homesickness is exacerbated by fears that they could be deported any day.

> *I think that I am more afraid now than in the beginning, because I didn't know anything from here, everything was new and exciting….Now, I am afraid that they are going to come and knock on the door and make us leave.*

For these undocumented workers, their precarious status combines with a sense of being unwelcome by the mainstream society to create added stress in their lives.

All of the Latinos we spoke to, regardless of their feelings upon coming to the U.S., said that they gain strength from their family, both those who came with them to NH and those who remained in their home countries. Social support creates a buffer for some of the stressors of adjusting to life in the U.S. Most said they call their families back home at least once a week and send money to support them whenever they can.

Conversely, the challenges of adjusting to life in the U.S. can also be worsened by social isolation. For newcomers who don't speak English or have any friends or family living nearby, this can be especially burdensome. Several of the Latinas we interviewed explained that they haven't had any opportunities to make friends or to learn English because they stay at home while their husbands work and their children go to school.

> *"Just being in the house all the time makes me depressed. I decided to study English, so I will be able to go out and vent."*
> *"People here spend too much time in the house…it's very different in my country."*

Some of these women may wish to learn English, but have difficulty finding the time to take ESL classes. While their husbands can learn English from their coworkers, and their children learn at school, women who are full-time homemakers have no such natural outlet. Some of them complained that their husband and children did not have the patience, energy, or time to help them practice English at home. So, some women remain limited in their English proficiency, even after living in the U.S. for many years.

Other Latinas choose to work outside the home, enjoying a new-found buying power they didn't have in their home countries. The employed Latinas we interviewed are proud to be able to help support their family, and pleased to have "un dinerito" (a little bit of spending money) for themselves. However, this does not appear to create any tension in their marriages, as these women continue to honor their husbands as the head of the family, with the most authority, regardless of income or employment status.

For example, one Latino we interviewed spoke glowingly of his wife's professional accomplishments here in the U.S. He says he is proud of his wife for developing her own housecleaning business, and he is glad his family now has two incomes to better provide for their children. He even broached the subject of their household finances himself, volunteering the fact that his wife manages the money for the family, paying all the bills and writing the checks. This, too, was mentioned with pride, explaining how pleased he was that she's such a capable manager of their household and her business.

"My wife did not work in Peru,
because she could not find a job.
But now she works, and yes, my wife has changed…. it is because now, she makes her own money… now she can buy anything, she feels happy to make her own money.
She takes care of the money and all the [household] checks ….
My wife all the time says, I brought you here, thanks to me, we are here,
and I agree it was worth it to come,
for what [our children] are receiving."

In contrast, other Latino husbands refuse to allow their wives to work outside the home, according to interviews with both men and women. These couples seem to prefer a more traditional arrangement where the wife takes care of the home and children and the husband works. Some of these women reported feeling lonely, particularly in contrast to the social lives they enjoyed with family and friends in their home country. Since they do not speak English or drive, some reported that they do not interact with anyone outside the family.

"I do not drive and my husband does not want to teach me….
I do not go out during winter….
I only go to church when he can take me,
and we do not stay after the Mass….
I just say hello to my neighbors to be polite,
I can't really talk with them
because I don't speak English."

Transitions to U.S. Schools

Much of the interview time was devoted to hearing from parents about their children's experiences in American schools. Twelve of the Latino parents had children who had attended school in their home countries prior to enrolling in school in New Hampshire. For these children, their transitions focused around learning English. Many of the parents applauded New Hampshire schools for their quality and caring teachers. The figure below depicts how many of these twelve parents mentioned each of the themes noted. The larger the size of the circle, the more parents discussed this theme. The number in each circle indicates how many parents brought up each theme in response to open-ended questions. The darker shade of blue indicates more difficult challenges raised by the parents in the interview.

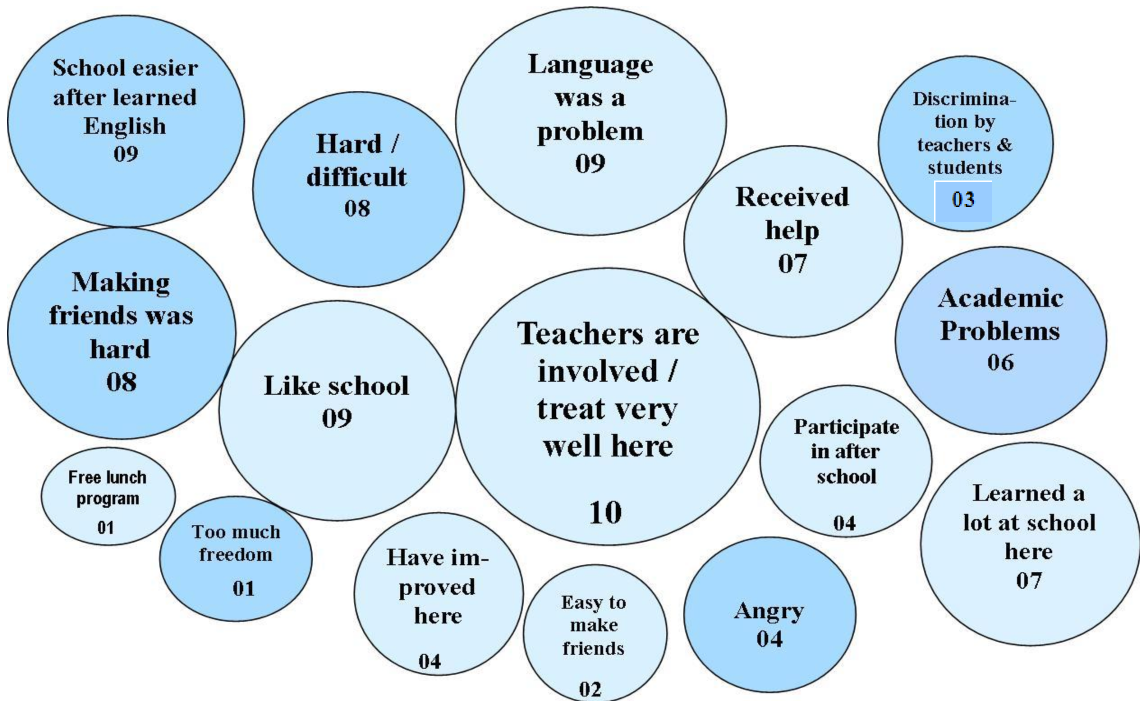


Figure 1. Themes from Latin American parents whose children began school outside the U.S.

One of these parents, who has been living in this country for many years without documentation, relayed the story of her son who is about to graduate from high school. She told of his frustration over his lack of opportunity because he is not a U.S. citizen. Although he has lived here since he was a small child. and has always been a good student with a high grade-point average, he is not eligible for financial assisstance to attend college here, nor is he be able to find a good job. His mother is worried about him, because her son doesn't feel he belongs anywhere, neither here in the U.S. where he has lived all his life, nor back in Mexico where he was born and remains (legally) a citizen. She says he feels angry and trapped between two worlds.

In contrast to those whose children were born in Latin America, the nine Latino parents whose children were born in the U.S. reported few adjustment issues with school. The figure below depicts the most common themes for those parents, highlighting how their children generally identify as Americans and enjoy school here. The green shade indicates comments about the child's sociability, whereas the blue were comments specifically pertaining to U.S. schools.

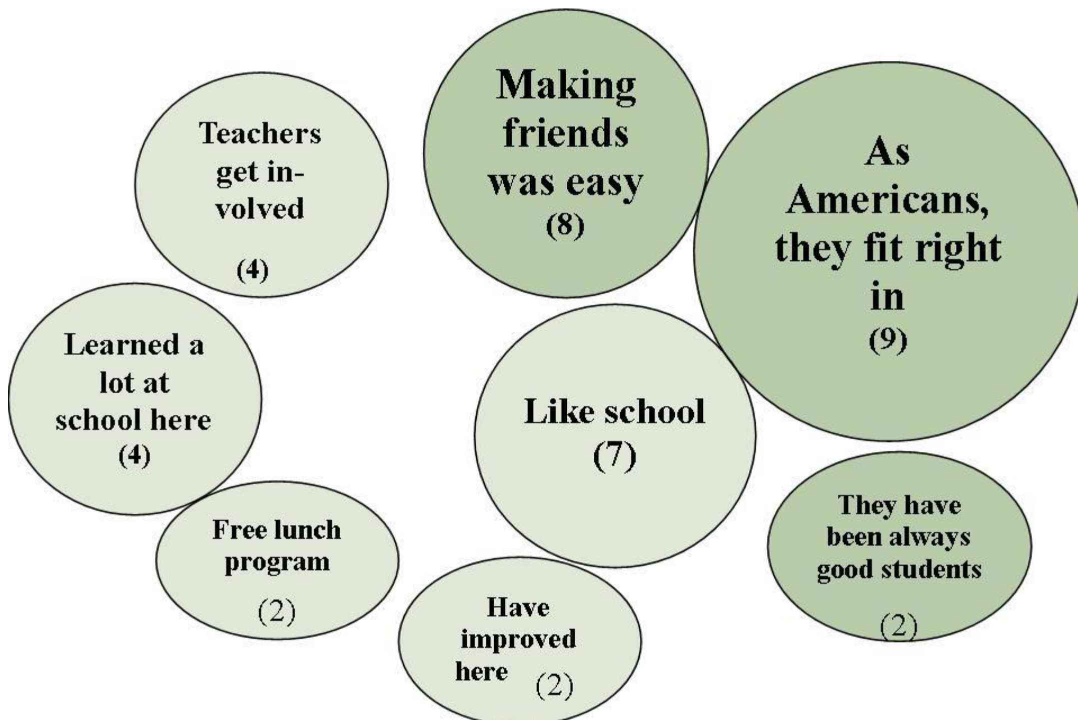


Figure 2. Themes from Latin American parents whose children were born in the U.S.

While the Latin American parents we interviewed seldom reported any problems with their children, a few did discuss discipline problems, especially with their adolescent children. Some believed these problems were caused by too much American freedom, while others pointed to a bad temperament of a particular child in the family.

> *"Teachers called to the house because my daughter likes to argue a lot at school…she's terrible ('Es tremenda')".*
>
> *"Here, students do whatever they want, but not in Puerto Rico."*

These different viewpoints on freedom formed an interesting theme among the Latin American parents we interviewed. The quote, below, loses something in translation. The parent uses two Spanish words, both sharing the same Latin root, *libertat,* meaning freedom. She is distinguishing between true liberty (as protected by the U.S. Bill of Rights, for example) and the license to do whatever one pleases without regard to rules or customs of appropriate behavior. Several parents expressed similar views, particularly about raising adolescents here in the U.S. They came to America in the belief that anything is possible here, but their children sometimes take this to an extreme. Some Latino youth take an exaggerated view of "anything goes in America," adopting an attitude that they are free to do whatever they please, without rules or limits on their behavior. The absence of extended family, and the tight-knit community their parents left behind in their home country, exaggerates the values of the dominant culture on freedom and independence, leaving some youth without the direction they need to guide them into adulthood.

> *"There is too much freedom ('Libertinaje' meaning, licentiousness) here, not just liberty ('Libertad'), but too much [wonton] freedom…."*

Latin American perspectives on mental health and therapy

We asked all the Latino respondents about what their views of mental health and illness. Those who were recruited from the Community Health Survey tended to see mental health as synonymous with being crazy ("loco") and couldn't imagine themselves or anyone in their family going to a mental health center. The quotes to the right are examples of how people from the community sample answered the question, "what does the phrase, 'mental health' mean to you?"

> *"I don't know. It's for crazy people, or those that have some kind of mind problem."*
>
> *"Someone goes to a mental health center to find out if they are crazy or what."*
>
> *"It means someone who can't think straight."*

This stigma against anything associated with the term, "mental health" is well documented in the literature. To overcome this barrier to treatment, the National Council of La Raza recommends the following:

> "**Become cognizant of and address the stigma associated with mental health illness in the Latino community.** To facilitate patient adherence to mental health treatment, health care systems must allow time for providers to explain the importance of treatment and develop *confianza* (trust) between the patient and the provider. The patient should be provided with an overview of mental health disease prevalence so as not to feel further isolated and fearful of unhealthy mental status. Furthermore, linguistically-appropriate support groups can be established to reduce feelings of stigma and isolation, increase adherence to treatment, and facilitate successful low-cost mechanisms to manage mental illness" (Rios-Ellis, 2005:21).

In sharp contrast to those from the community sample, the six Latinos who were referred by the mental health center (MHC) had a much different view of mental health. All reported very favorable attitudes towards the services that they and/or their children had received. They said they felt welcome from the first time they came to the mental health center, in that staff spoke Spanish and treated them with respect. MHC clients understand mental health to relate to stressful life situations or problems, and said the center helped them to cope. They said they would encourage other Latinos like themselves to seek help at the mental health center. They recommend the center for support in adjusting to life in the U.S., in coping with personal loss or relationship problems in the family, or for dealing with feelings of loneliness, depression or anxiety.

> *"[The center is for] people that have emotional problems …that do not get adjusted to live everyday …or children who cannot learn."*
>
> *"It is not only for people who are crazy. Mental health means we can have a problem and we may need support….."*
>
> *"[The center] can be for people who have mind disorders, but it can also be for common people like you and me."*

Themes among Africans

Most of the Africans interviewed for this study were resettled into New Hampshire as refugees. Their pre-flight and relocation experiences varied widely, from how they fled their home countries to where they were initially relocated, before finally resettling here in New Hampshire. Many of those interviewed remember very little about their home countries, having relocated to refugee camps as children. Others fled as adults, relocating to villages, towns, or cities in other countries before being placed in refugee camps.

Many of the themes we heard locally from Africans living in New Hampshire reinforced the findings and recommendations from the National Child Traumatic Stress Network's Refugee Trauma Task Force, as reported in their two white papers published by SAMHSA (National Child Traumatic Stress Network 2004a and 2004b). The flight from one's home country leads to the loss of family, community, and social support networks. Even after relocation into a refugee camp, safety remained a primary concern. All ten of the Somali-Bantu families we interviewed reported that they did not feel safe in the refugee camps, particularly at night.

Resettlement to New Hampshire brought new challenges to adjust to the American way of life, and many of the study participants continue to experience cultural bereavement years after leaving Africa. Many had found it hard to put into words all that they miss, saying simply, "Our way of life." One woman explained: "We miss everything: Our family gatherings, our food, our church, hearing our own language, being able to visit anyone at anytime…our way of life." A woman from another African country especially feels the loss of her way of worship: "I miss mass at our church. I miss praying and singing at my parish, with people I know and in my mother tongue."

When asked what they liked most about living in the U.S., all the Africans we interviewed said that what they appreciate most is how safe they feel here. Compared to the wars and ethnic violence they left behind in Africa, all are grateful not only for their own safety, but most especially for that of their children. Somali-Bantu were particularly emphatic on this point, grateful for their freedom of movement.

> *"I love the freedom here, to go anywhere and not fear…."*
> *"Here in America, you can go all over and no one harasses you."*

When asked what they don't like about living in New Hampshire, some of the Africans said they don't like being so dependent for their basic needs. They want to be able to provide for their families and wanted us to recognize the work they were able to do in Africa. Many noted that they used to own land, and miss growing their own food and living in homes that were their own. Some had professional careers that they take great pride in, although they can no longer practice their profession here in the U.S. Even the refugee camps offered more independence than some have found here in New Hampshire.

> *"I was independent in the camps,*
> *I worked the land to feed my family.*
>
> *Now, I'm helpless and dependent."*

Shifting Family Roles

Loss of the support of extended family and clan often exacerbates the clash of traditional cultural norms with U.S. American egalitarian values. Confusion and conflict within the family as to the proper roles and rules of behavior governing women and children in particular are commonplace among African refugee families. Expectations of freedom and equality for women, as men may struggle to maintain their provider role, combine to increase marital tensions.

When asked if children have more power here in the U.S., one African man bluntly replied with the quote on the right.

> *"Yes children have power,*
> *and women do, too.*
> *Women have a lot of power here*
> *and they can make a man's life miserable."*

Likewise, traditional expectations of deference to parental authority are often at odds with the American ethos of increased independence for adolescents. Similar to the theme found among Latin Americans (see discussion on "Libertinaje" above), many African parents complained that their children have become increasingly difficult to handle as adolescents.

> *"Yes, children have more power here. We can't punish children as we did [back in Africa]."*
>
> *"Yes, children have a lot of power here, and it is unhealthy. I cannot tell my 15-year old daughter to do anything anymore."*
>
> *"My children no longer respect me. They do not listen to anything I say."*

One African mother told the story of how her son had changed after living here for about a year. She reports his behavior changed once he realized the power he has here in the U.S., compared to Africa. She tried to set limits on his behavior, setting a curfew on school nights, but she said he continued to come and go as he pleased. One night, he left the house without permission. Since he hadn't returned by his curfew, the parents tried to set a consequence by locking him out of the house. Their son's response was to simply go back to the school event he had attended without permission, and report to a school employee that his parents would not let him enter his house. The staff person then called the police to report the parents for child neglect. Other parents had similar stories of what they viewed as American schools undermining their parental authority over their children.

Many African parents complained that rules against physical punishment in the U.S. give their children too much power over them. We heard several stories of children calling the police to report their parents after an altercation, sometimes just to win a verbal argument. (By contrast, none of the Latin American parents we interviewed reported their children had called 911 in this way.) This appears to be a growing problem amidst a range of African ethnic groups, not only the Somali-

> *"When I discipline my children, they call 911….When the police come, there is no interpreter and I am not sure of what they are saying…. I feel embarrassed and humiliated when police come and listen to my children and I'm seen as a bad person when all I did was try to get this child to behave in the right way…."*

Bantu, but also refugees from Burundi and other central African countries. Among all the African parents we interviewed, misunderstandings of the laws that protect children against abuse were their most commonly reported concern.

In general, faster acculturation by children is facilitated by their acquisition of the English language and exposure to mainstream American culture in school. This leads to increased tensions and disciplinary issues with their parents. This so-called "acculturation gap" was reported as a problem by many of the African parents we interviewed. Because children learn languages faster than adults, those whose parents do not speak English have additional power in the family as brokers of communication with the outside world. This holds true even though all of the African parents we interviewed understood the importance of medical interpretation and were comfortable communicating through interpreters in formal settings. On a daily basis, however, older children are often relied upon to interpret for their parents when the phone rings or someone from outside the community knocks at the door.

Several of the Africans interviewed expressed frustration at the way English is taught in English as a Second (or Foreign) Language classes. Some said they had attended every class and graduated from the course without gaining any really proficiency in English. Considering that many (if not most) of the Africans in this study speak at least three languages, they clearly have the aptitude to learn English. It appears that some aspects of the teaching techniques and course materials of ESL/EFL classes need to be revised to make them more effective with African students.

> *"I went to the ESL classes and completed the course, and couldn't understand English. I went back again… and graduated again, but I still can't understand English."*

Lastly, perhaps due to not only to their faster adoption of English, but of American norms as well, African youth often clash with their parents regarding rules governing their social life. One Somali mother was appalled to see what she viewed as American girls chasing after her son sexually. Likewise, some African parents report that their daughters have asserted they have a right to go out with friends, and even to date boys without adult supervision, because "that's how it is here in America." Societal expectations of independence and acceptance of dating as a natural part of growing up can thereby clash with African norms and taboos the parents may still hold dear from their own upbringing in Africa.

Transitions to U.S. Schools

In contrast to the Latin Americans, most of the African parents we interviewed had children who were born outside the U.S., many of whom had never attended school prior to enrolling in school in New Hampshire. Since these African families were resettled in New Hampshire directly from refugee camps in Africa, their children had an especially difficult transition to becoming a student in an American school. Children who grew up in refugee camps have had their psychosocial development and their academic education interrupted by violence and relocation. Some have no understanding of how schools work, how to be a student in a formal classroom, or what involvement is expected of parents in their children's education.

The figure below depicts how many African parents raised each of the themes noted. The graphic is color-coded as follows: brown bubbles indicates health and safety concerns, green ones show positive comments about life in N.H., and blue ones contain recommendations for the schools here.

Figure 3. Themes from African parents about children's educational experiences

One of the African interpreters told us about a common misunderstanding between parents and their children's American teachers. In many African cultures, the norm is that the parent turns over authority of the children to their caregivers for the duration of the school day, and then resumes responsibility when the children leave school. To these parents, it would seem rude for them to interfere with their children's teachers at school. So, they are confused when they are invited by a teacher to volunteer in the classroom. They see no need to interfere in the teacher's work, and feel they would be expressing a lack of confidence if they were to somehow become involved in school events.

In contrast to those who had raised children in refugee camps in other African countries, the ten Somali-Bantu parents we interviewed had all stayed with their children in refugee camps in Kenya. As opposed to their homeland, the Kenyan refugee camps offered education to all camp residents including the Somali-Bantu, to prepare children for the Western world. According to those parents whose children attended classes in Kenyan refugee camps, the education was quite beneficial and eased their children's transition once they came to NH. Unfortunately, not all parents chose to send their children to school in the refugee camps. Some feared for their children's safety, while others simply did not see any value in education, especially for girls.

> *"The problem with the American education system is that they consider a child's age, not her ability.*
> *My daughter had never attended school, but they put her in 6th grade ....The gap was very big."*

African perspectives on mental health and therapy

As was found among the Latin Americans we interviewed, Africans varied in their views of mental health based on their personal experiences with the local mental health center. Those who had been a client (or who had a child who had received services) from the mental health center were more likely to hold more positive views of what mental health means than did other Africans we interviewed. Several of the Africans who from the community sample said they simply did not know what we were talking about when we asked about mental health. One person guessed mental health services "must be for violent people." Some said that it meant a crazy person; one noted that back in Africa, people would just run away from someone who was crazy.

> *"Mental health, as I used to know it, was for someone who runs in the street naked ….I have since realized that here [in the U.S.] it does not mean the same, and the Mental Health Center has helped many people in my community."*

Others said they didn't "believe in mental health," some stating that mental health is a Western concept that is not relevant to Africans. Some of the Africans we interviewed, including some who had personal experience with the local mental health center, objected to the very idea of psychotherapy or psychiatric medications. This local theme is similar to the objections raised by international advocacy organizations who object to what they refer to as "the medicalization of human suffering" and the trauma model that is "dominated by a value system of humanistic psychology that promotes self-assertion, autonomy, and relativity in values…. very different from the values of many refugees…." (Godziak, 2004). The very application of the diagnosis of PTSD to survivors of war has been criticized internationally as culturally inappropriate:

> *"My father has PTSD from being tortured and mental health deals with people who are crazy, and those are two very different things."*

> "It [PTSD] is promoted as a basis for capturing and addressing the impact of events like wars regardless of the background culture, current situation, and subjective meaning brought to the experience by survivors. Thus the misery and horror of war is reduced to a technical issue tailored to Western approaches to mental health." (Summerfield, 2001).

This theme also resonates with knowledge in the literature about the cultural explanations of mental illness, including norms regarding the symptoms and etiology of such illness often so incongruous with the Western view of mental health (Minnesota Department of Refugee Health, 2004, NCTSN, 2004a, Lu et al., 1995). African belief systems emphasize spiritual causes, and many do not distinguish between physical and mental health. One of our interpreters explained it this way: in her native language, there is no way to translate a phrase like "peace of mind." Peace is the absence of war and violence: it occurs out in the world. Similarly, the term "mental health" sounds like an oxymoron in many African languages because health is a physical state of being; not of the mind, but of the body. Such cultural differences appear to have interfered with the therapy offered to some of the African clients we interviewed. Some complained about side effects of the psychiatric medications they were prescribed, such as weight gain and low energy. Others did not understand why they were referred to the mental health center in the first place, since they did not have the kind of mental confusion they associate with the need for such services.

> *"I do not see how the Mental Health Center helps people like me. I want a job, and they want to medicate me so I can stop thinking about getting a job….The medicine that I need is a job, that's all."*

In contrast, several of the Africans referred into the study by the Mental Health Center of Greater Manchester did report their family had benefitted greatly from the services they had received there. One wife of a client explained that the center helps people deal with stress and depression, noting this is an important service because "there's a lot of stress in this country." The most common benefit reported was the successful treatment of insomnia. Several people reported they were given sleep medication, which helped them feel better. Some parents reported similar benefits for their children who are in treatment.

> *"The Mental Health Center helped me a lot because I could not sleep before, and now I can sleep much better."*

Learning and Dissemination

Recommendations

Given the persistent stigma associated with the term, "Mental Health," common among Africans and Latin Americans, community-based support services will likely have a broader appeal to both populations than those offered through traditional mental health centers. To reach more immigrant and refugee families, screening and treatment may be more effective in more normalized settings such as schools and primary care medical practices.

Interviews with both Latinos and Africans revealed that many in their communities are more comfortable discussing health problems with their medical doctor. To open this gateway to treatment, primary care physicians need to be trained to screen for mental health problems in ways that are culturally sensitive to their immigrant and refugee patients. If the problem is framed as a common disease with a treatment available, many respondents indicated that people from their communities would be more receptive to getting the help they need. Both La Raza and the National Child Traumatic Stress Network strongly recommend primary care physicians receive cultural competency training in expressions of distress common to Latin Americans and Africans (Rios-Ellis 2005). Specifically, physicians should be trained to detect cultural idioms of distress as outlined in the cultural formulation of mental health for the DSM-IV by Dr. Francis Lu and colleagues (Lu 1995) which seeks to place the patient's experience in its proper cultural and social context. For example, patients complaining of fatigue or other somatic symptoms without a discernible physical cause (such as indeterminate backaches or headaches) should be referred for mental health evaluation.

Community Health Workers

Beyond the clinical setting, La Raza further recommends education and screening through a community-based approach. La Raza strongly advocates for *promotores* (community health workers) to be trained as educators in mental health. As trusted community members, *promotores* are in a unique position to provide support while diminishing the stigma associated with mental health treatment (Rios-Ellis, 2005). *Promotores* can then serve as the gateway to mental health centers by referring community members in need of care. They may also facilitate adjunct support groups for those currently in treatment.

An even less conventional approach is advocated by one of 16 centers in the U.S. sponsored by the United Nations Victims of Torture Fund. A leader in torture treatment, the Advocates for Survivors of Torture and Trauma (ASTT) promotes a community-based

treatment model they call "Healing the HEARTS of survivors" as a cross-cultural treatment framework. The model is innovative in its reliance on community leaders as direct service providers for trauma survivors. The emphasis is on building a compassionate alliance to re-establish a sense of interpersonal trust and safety often lost by refugees as a result of the violence experienced in their homelands. The model was designed by Dr. Karen Hanscom, a psychologist who won the 2001 International Humanitarian Award for this groundbreaking work. Designed for peer counselors to use in their own communities, the model was first piloted with *promotores* in Guatemala. The training program aims to support natural community leaders, the "warm, caring, intuitive people …who offer emotional support and guidance to others…[and] who can assist others in healing from the effects of trauma and torture" (Hanscom, 2001). These wise individuals from the community are trained in specific counseling techniques to help their fellow community members to cope with the effects of trauma. The basic components of the HEARTS model are displayed in the box below, excerpted from the ASTT.org website.

Healing the HEARTS of Survivors

H – Listening to the HISTORY — Listening compassionately in a gentle environment, Attending to the flow and tone of speech, looking at the facial expressions

E - Focusing on EMOTIONS and Reactions – using reflective listening, Asking gentle questions, Naming the emotions you observe

A- ASKING about Symptoms – using your own style to investigate current physical and psychological symptoms

R - Explaining the REASON for Symptoms –Describing how the body reacts to stress, Emphasizing these are "normal" reactions "normal" people have to an "abnormal" event

T - TEACHING Relaxation and Coping Skills – Teaching relaxation techniques such as abdominal breathing, meditation, and prayer; Discussing how they have coped in the past, reinforcing old and healthy strategies while teaching new coping strategies.

S Helping with SELF-CHANGE – discussing the person's world view: the original view, any changes, adaptations or similarities; and recognizing positive changes in the self.

Parenting Support

We should note that many of the Africans interviewed for this study did not report any direct experiences of trauma. Much more common were issues around parenting. Given how different norms of behavior are in various African cultures, African parents are understandably confused by Family Law in the U.S.[2] Cross training of child protection case workers and parents is sorely needed to improve communication and clarify the rules for appropriate discipline in the U.S. Among many African refugees in New Hampshire, the child protective service system, with its governmental authority to separate children from their parents, is evocative of the oppressive governments they fled. To begin to restore their trust, interpreters should be used during child abuse investigations. Beginning with the initial police response to a 911 call, interpreters are needed so that parents with limited English proficiency will be less apt to be falsely accused of abusing their children. Likewise, African parents and adolescents also need help understanding the laws against consensual sex with underage partners. Some of the African mothers we interviewed were concerned that underage girls may encourage their sons to engage in sexual acts that could then be construed as illegal by the authorities. Many have heard of African boys who have been charged with sexual assault for having some form of sexual contact with younger girls.

The need for improved parent-child communications and disciplinary alternatives to physical punishment can be addressed through culturally competent parenting classes. The NCTSN recommends a particular evidence-based parenting program for African refugee mothers, along with school-based cognitive behavioral therapy (CBT) for their children who suffer from PTSD, depression, or anxiety (National Child Traumatic Stress Network 2004b). From their review of evidence-based interventions for children, they conclude:

> "Taken together, studies of interventions with traumatized refugees suggest that CBT may be a helpful tool to use with traumatized refugee children either in individual or group treatment. However, existing studies have demonstrated benefits of CBT with respect to symptoms but not overall functioning of the children. On the other hand, a psychoeducational and parenting program with mothers was found to be effective across a range of outcome measures including health, mental health, cognitive and psychological functioning. The intervention targeted mothers rather than children directly, and the findings suggest that this may be a promising direction for future intervention development with refugee children." (NCTSN, 2004b:10).

---

[2] We heard similar themes in a series of focus groups conducted by Lynn Clowes, cultural competency director at NHMHC, for the Cultural Bridges family violence prevention project. Liberian and Somalian parents reported that they were unsure what forms of discipline were allowed in the U.S. and were wary of government involvement in family problems.

References

Burgess, A. (2004). Health challenges for refugees and immigrants. Immigrant & Refugee Services of America. Washington, D.C. , Refugee Reports. **25**.

Camayd-Freixas, Y., G. Karush, et al. (2005). Latinos in New Hampshire: Enclaves, diasporas, and an emerging middle class. Latinos in New England: Yesterday's Newcomers, Tomorrow's Mainstream? A. Torres. Philadelphia, Temple University Press**:** 1-17.

Franzini L, Ribble JC, et al. (2001). "Understanding the Hispanic paradox." Ethn. Dis. **11**: 496-518.

Gee, G. C., A. Ryan, et al. (2006). "Self-reported discrimination and mental health status among African descendants, Mexican Americans, and other Latinos in the New Hampshire REACH 2010 Initiative: the added dimension of immigration." American Journal of Public Health **96**(10): 1821-1828.

Gordon-Larsen, P., K. M. Harris, et al. (2003). "Acculturation and overweight-related behaviors among Hispanic immigrants to the US: The National Longitudinal Study of Adolescent Health." Social Science & Medicine **57**(11): 2023-34.

Hogan, M. F. and Commissioners (2003). President's New Freedom Commission on Mental Health: Achieving the Promise: Transforming Mental Health Care in America., Rockville, MD: DHHS.

Lu, F. G., Lim, R., & Mezzich, J. E. (1995). Issues in the Assessment and Diagnosis of Culturally Diverse Individuals. . Review of Psychiatry J. M. R. Oldham. Washington, DC, American Psychiatric Press. **Vol. 14:** 477-510.

Minnesota Department of Refugee Health, M. (2004). Refugee Mental Health. Minnesota Refugee Health, self-published.

National Child Traumatic Stress Network, N. (2004a). Review of Child and Adolescent Refugee Mental Health: White Paper from the NCTSN Refugee Trauma Task Force, . Substance Abuse and Mental Health Service Administration, Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

National Child Traumatic Stress Network, N. (2004b). Mental Health Interventions for Refugee Children in Resettlement: White Paper II from the NCTSN Refugee Trauma Task Force, . Substance Abuse and Mental Health Service Administration, Rockville, MD: U.S. Department of Health and Human Services.

Office of Refugee Resettlement, O. (2004). Amerasian, Asylee, Entrant and Refugee Arrivals by Country of Origin and State of Initial Resettlement, FY 2003 and 2004. . D. o. H. a. H. Services, Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Refugee Mental Health Program, S. (2005, 12/3/2008). "Refugee Health Promotion & Disease Prevention Toolkit." Point of Wellness: Partnering for Refugee Health and Well-Being Retrieved May 15, 2007, from http://refugeewellbeing.samhsa.gov/Level2/ToolkitPart3.aspx#Screening1.

Ringold, S. (2005). "Refugee Mental Health." Journal of the American Medical Association **294**(5).

Rios-Ellis, B. (2005). Critical Disparities in Latino Mental Health: Transforming Research into Action. Long Beach, CA, National Council of La Raza (NCLR), Institute for Hispanic Health.

U.S. Public Health Service (1999). Surgeon General's Report: Mental health care for Hispanic Americans. Office of the Surgeon General, Washington D.C.: Department of Health and Human Services.

U.S. Public Health Service (2001). Mental Health: Culture, Race, and Ethnicity-A Supplement to Mental Health: A Report of the Surgeon General. Office of the Surgeon General, Washington D.C.: Department of Health and Human Services.

UNHCR, U. N. H. C. f. R. (2002). Special feature of the 50th anniversary of the 1951 Refugee Convention. , UNHCR.