Healing in Immigrant Communities of the African Diaspora of Boston

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The work of the Boston Healing Landscape Project focuses on intersections of culture, religious worldviews, and different understandings of illness and healing in the African diaspora communities of Boston.[1] This year, the members of our team have developed studies that explore the complex interplay between race, culture, religion, and immigrant realities. A common variable, for example, is that all immigrants of African descent find themselves involuntarily positioned within the racial frameworks of the United States. Therefore, one piece of each inquiry involves how these immigrants experience American culture in racial terms. Each study addresses issues that are simultaneously particular to a specific group in Boston, and potentially generalizable to the experience of related diaspora communities in other parts of the United States.

The first of these studies raises a classic question in medical anthropology, namely, how to understand the cross-cultural experience and understanding of depression.[2] However, the discipline has also challenged the imposition of categories developed within biomedicine—such as "depression" itself—due to the related risk of skewing indigenous ways of classifying and assigning meaning to experience.[3] Moreover, the medicalizing of such experience has been a particular issue in relation to studies involving women.[4] As an alternative, Andrea Allen is exploring the typology of sadness as defined by immigrant women from Brazil. These types may or may not include depression. In turn, she is asking women how they address each category of sadness and, in particular, how the range of religious resources do and do not play a part in what women choose to do.

Commentators in American media routinely note that the culture has become desensitized to violence through its increasingly graphic representation in the news, movies, and video games. The effects of exposure to violence on children and young adults have led to government hearings and to wide popular concern.[5] Children and young adults afflicted by the effects of poverty are often even more vulnerable.[6] Yet few studies look at how immigrant children may also bring with them the experiences of having been previously exposed to conflict and violence in their country of origin. In the second of this year's studies, Melicia Charles examines how Haitian adolescents and young adults in Boston describe their perceptions of conflict and violence and how these experiences have affected them. She asks how they have drawn on religious resources as one way of coping with such experience.

Even with the intense representation of violence in the media of the United States, it is still different from the trauma of dislocation caused by war that some immigrant groups have suffered in their country of origin.[7] The "Lost Boys," a group of young men from the Southern Sudan, arrived in Boston in 2001. They came from refugee camps in Kenya, where many of them had lived for years. They found a small community of Southern Sudanese elders in the city. Each generation confronts different issues, but one shared issue is that of cultural transmission and retention. In the third of our studies, Azande Mangeango explores how these two generations experience American culture and the process of becoming American, while also continuing to find their own different religious and healing traditions important. She asks, in particular, how each individual envisions ensuring the continuity of traditions.

Meanings of "Sadness" and the Use of Religious Beliefs and Practices by Brazilian Women in the Boston Area—Andrea Allen

The "Mental Health: Culture, Race and Ethnicity" supplemental report to the Surgeon General's Report on Mental health issued in 1999 concluded that minorities are less likely than white patients to receive accurate diagnoses and proper treatment for mood disorders, due to factors such as racism and discrimination. Additionally, a most revealing finding of the study was that ways of defining and

describing symptoms of emotional distress may differ, based on the ethnic and racial demographics of the patient.[8] My study explores the articulation of emotional distress and its relationship with religious beliefs and practices among Brazilian women in the greater Boston area.

In the last decade there has been a great influx of Brazilian immigrants to the United States due to economic and social conditions in Brazil. Unfortunately, the 1980 and 1990 U.S. censuses were not accurate indicators of the Brazilian population in the United States. According to one scholar of Brazilian migration to the United States, Maxine Margolis, there may perhaps be 350,000 to 400,000 Brazilians in the United States.[9] A large number of these immigrants live in New England. An official of the Brazilian Immigrant Center in Allston, Daniel Tavares, has estimated that about 150,000 Brazilians are living in the New England area, with 70,000 individuals living in the greater Boston area and in Worcester and Middlesex Counties.[10] The presence of Brazilians is also vividly felt in other cities in Massachusetts, such as Cambridge, Somerville, and Framingham. Medical professionals within the field of mental health, and especially general practitioners in urban centers of New England, are therefore likely to come into contact with Brazilian patients.

Yet despite their presence in New England, in New York City, and in West Coast cities such as San Francisco, Brazilians could be considered an invisible minority in the United States as a whole and within the overall Latino community in this country.[11] Linguistically and culturally, Brazilians differ from other Latin American countries, because Brazil was a Portuguese colony whose society was deeply influenced by African traditions and cultures. During the colonial era, 40 percent of the enslaved Africans sent to the Americas became inhabitants of Brazil. Consequently, there are more people of African descent in Brazil than in any other country in the Western Hemisphere, and second only to Nigeria in the world.[12] The Brazilian community in the greater Boston area is therefore an example of a group that fits into both categories of being Latino and having members of its community be a part of the African diaspora.

Due to the influences of language and culture, however, Brazilian Americans have routinely been overlooked in Latino discourses. For example, several studies have been done specifically looking at Latinos and depression in the United States. One study compared suicide rates and the relationship with major depression among whites, blacks, Mexicans, Cubans, and Puerto Ricans in the United States.[13] Another study analyzed the relationships among depression, social interest, and acculturation of Latinos from at least fifteen Latin American countries.[14] Both studies failed to include Brazilian Americans.

Ethnographic studies have shown that there are a variety of ways that cultures describe emotional states and feelings. More specifically, these expressions do not necessarily have direct English equivalents.[15] Hence, mental health diagnoses may become problematic for American clinicians when treating patients from other cultures whose primary language may not be English.

Ethnic or racial groups also have unique cultural traditions and heritages that may reflect or intersect with specific religious ideologies. The diversity of religious or spiritual expressions is another factor that the medical community may encounter when dealing with Brazilian patients. Various forms of Christianity—Catholicism, Pentecostalism, and Protestantism—constitute the religious background of Brazilians. In addition to the practice of Christianity by Brazilians, Umbanda, Candomble, and Spiritualism are also religions that are part of Brazilian society.

Research focusing on culturally defined emotional states and related recourse to religion is important because some individuals may rely on their faith as a primary source of healing. As these individuals encounter biomedical clinicians, misunderstandings and lack of knowledge on the part of the clinician may decrease the possibility of a patient finding satisfactory health care. In order for the medical community to be aware and cognizant of the notions and concepts about cultural perceptions of emotional states and mental illness, and the influence of religious beliefs and practices that Brazilian women bring to a doctor's office or a clinic, research is necessary.

Indeed, medical anthropological literature indicates that there is a significant relationship between mental health care and religious beliefs and practices. For example, a study was conducted in Campinas, Brazil, that investigated the correlation among religious affiliation, mental illness diagnoses, and hospital stay of Pentecostals and Catholics.[16] Several articles or reports investigated the role of Afro-Brazilian religions as sources of mental health care.[17] However, all of these studies were conducted in Brazil, and not the United States. Also, they did not primarily focus on women.

This study will contribute to the growing knowledge of how ethnic or racial groups, specifically Brazilian women in the United States, talk about

culturally based ways of describing and expressing feelings and/or symptoms that come under the broad heading of "sadness," or "tristeza." We will also ask how women may employ spiritual beliefs and rituals as one way of responding to these feelings. There is a range of emotional states and expressions of sadness in all communities and societies. Comprehending how Brazilian women form notions surrounding emotional well-being will provide physicians necessary information in order to give culturally competent health care to their patients.

Religion and Resilience: Perceptions of and Responses to Conflict by Boston's Haitian Adolescents and Young Adults—Melicia Charles

Boston has one of the larger populations of Haitian immigrants in the United States. The Haitian community continues to be one of Boston's fastest growing ethnic groups. The community remains close-knit and maintains many of its cultural ties to Haiti, specifically in the case of religion. Religion has played an important role in Haitian social and psychological frameworks. Within the culture, religion has been relied upon as a support system during difficult times.

Haitian immigrants have to endure adjusting to a new country and culture, where they often are socially and economically marginalized. Haiti itself is seriously affected by poverty, HIV/AIDS continues to decimate the population, and thousands of people have died as a result of political turmoil in the country.[18] Many Haitians have migrated to the United States in search of a better life. However, issues of conflict, both social and political, may remain a strong presence in the lives of those of Haitian descent, even as they adjust to the new American culture. In addition, adolescents and young adults of Haitian descent—even more than older generations—straddle both Haitian and American cultures. They are raised in the Haitian community, but have contact with mainstream culture through school, the media, and the surrounding physical environment. Both cultures have a significant influence on their development.

Youth of Haitian descent make up about one-fourth of the population of Boston public schools.[19] These individuals sometimes observe conflict in schools and in the community. Tensions with other ethnic groups may sometimes involve conflict. We are interested in learning about Haitian adolescents' and young adults' perceptions of such events, and the strategies to which they turn to help them deal with the experience. We hypothesize that different spiritual/religious traditions may function as one important resource. Our study will therefore also focus on how Haitian adolescents and young adults define and avail themselves of the different resources available to them, including spiritual/religious resources.

This project hopes to study how these multicultural and religious resources play a role in how adolescents and young adults of Haitian descent view, define, and process issues of conflict. The goal of the project is to gain an understanding of their views on these topics, and of how they address witnessing conflict, in order to contribute to clinician training in providing culturally competent health care to this population.

Spiritual Beliefs as a Source of Healing among Southern Sudanese in Boston—Azande Mangeango

This project proposes to observe and engage communities of African descent in the Boston area in order to uncover how individuals use alternative and complementary methods of healing in conjunction with various religious beliefs. The information obtained will be used to assist the medical community in providing culturally competent health care. The information will also be integrated into future health education materials. In addition, the study will assist the medical community in attaining a comprehensive understanding of the link between medicine, health, and belief systems within the Southern Sudanese community.

Sudan has been in the throes of a civil war between the North and the South since 1955, with a brief lull between 1972 and 1983. It is a multilayered conflict with various levels of causality. The war is, in some respects, religiously motivated. The North is predominantly Muslim and the South is predominantly Traditionalist ("animist") and Christian. The Government of Sudan is an Islamic fundamentalist government that has imposed *sharia*, Islamic law, upon the entire country—Muslim and non-Muslim alike. The war also has an ethnic dimension. Many of the Afro-Arabs in the North do not see themselves as "African" and distinguish themselves from the Southerners. The war is in many ways a war of identities: Who will determine the national identity of Sudan?[20] Is it an Islamic, Middle Eastern country? Or is it, as much of the South considers itself, a "Black African" country? Whether the reason is ethnic, religious, economic, cultural, or political for the different individuals involved, the Government of Sudan has waged a war against the citizen-

ry of the South since the time of the country's inception. Historically, the Arab North has had hostile relations with the Southern peoples, due to a history of slave raids into the South.

The brunt of the conflict has been borne in the South (an area the size of Texas), creating nearly five million displaced Southerners and leaving two million deceased. It has impacted all aspects of life in the South, where there is no electricity, a paucity of schools and medical care, and very little infrastructure. The government has allowed for and often encouraged unchecked raids on villages in areas such as Bahr el-Ghazal; it has bombed schools, churches, market places, and other civilian areas; it has displaced the Nuer people in Bentiu in order to exploit the oil. Ironically, the same oil profits enable the Government of Sudan to acquire more arms and, in turn, kill more Southerners.

In 2001, the UN High Commissioner for Refugees effected one of the largest migrations of unaccompanied minors into the United States, all of whom were Southern Sudanese. The majority of these young men, known as "the Lost Boys" have grown up in a refugee camp in Kenya (Kakuma). The conditions in the camp were extremely harsh. There were few adequate medical facilities, very little food, and virtually no educational opportunities.[21] We have chosen to work with the adult group of young men primarily because they now comprise the majority of Sudanese in Boston. Although Southern Sudanese are a recently arrived group to the United States, already the demographics have shifted. Until 2001, the Southern Sudanese in the Boston area were primarily families. Many of these families, however, having found Boston uninhabitable for working-class people, have migrated to other areas, such as Maine and New Hampshire. To date, at least forty Southern Sudanese originally resettled in the Boston area have left. Now, young men comprise the vast majority of Southern Sudanese living in Boston and the metro areas.

This particular group of young men, unlike the unaccompanied minors who were placed with foster families, have been treated as adult. They were given only a limited time to adapt and fit into life in the United States (in most cases eight months). During this time, they have been expected to become working, wage-earning, rent-paying immigrants, a difficult feat even for an American-born citizen. They are able to afford the high rents by living, at times, as many as six in a one-bedroom apartment. Many of them have brought little with them except for their cultural beliefs and practices. Given the conditions of resettlement, it would be unlikely that one would not find a significant number of transculturated health beliefs among this population.[22]

Our focus is on spiritual beliefs as a source of healing among Southern Sudanese in Boston. There is a plethora of traditions and beliefs within the Southern Sudan. While a number of Southerners are Christian, many still practice traditional beliefs as their sole "religion." There is a range of Christian experiences as well. Although the predominant denominations are Catholic and Anglican, there are some Presbyterians, Baptists, Seventh-Day Adventists and Pentecostals in Southern Sudan. The Southern Sudanese have carried this religious diversity with them to their new homes in the United States and other countries of the world.

Despite the fact that the young men may have grown up in camps away from Sudan, they were not entirely isolated from acculturation and socialization. The camps, being intergenerational, provided a semblance of a community in which the elders served as living examples and transmitters of culture.[23] We have therefore decided to include transmission of beliefs and acculturation of traditions in the United States as key components of the study. To this end, we will also interview the previously resettled, Southern Sudanese elder and adult population. The questionnaire we will use will determine whether or not the study participants are utilizing traditional health practices and, if so, will explore what kind and in what capacity. Even the non-use of traditional therapeutics will illustrate the extent to which displacement has affected these participants' familiar health beliefs and remedies.

This study is pertinent given the dire situation of the Southern Sudanese refugees and immigrants, the conditions under which they left the Sudan, and the fact that scant research has taken place among this newly arrived group. Understanding the health beliefs of this group and to what extent they draw upon traditional beliefs as a source of healing will assist the medical community to provide more culturally competent health care. Greater understanding will also be most beneficial to the medical and social service communities concerned with the effects of displacement on the transmission of cultural/spiritual-therapeutic beliefs and practices in a new land. Finally, this study will identify ways in which group identity and cohesion foment healing.

Conclusion

Each of these studies opens a particular vantage point on suffering, each one located in specific contexts of cultural origin, gender, generation, and race. Relocation to the United States generates a new

frame within which older ways of configuring self and suffering are rearranged in relation to new constellations of gender, race, and class. Religious healing, in some cases, is woven into these different experiences. It plays a part both in defining and explaining the specific form of suffering and in redressing it. Because no religion or form of religious healing is static, these studies illuminate how both take on new dimensions in the relocation.

Notes

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1. See Linda L. Barnes, Kenneth Fox, Eugene Adams, Janice Desir, Martin Epson, Melissa Hackman, Breai Mason, and Chioma Nnaji, "Healing in the African Diaspora Communities of Boston," in *Religious Healing in Boston: First Findings*, ed. Susan Sered and Linda L. Barnes (Cambridge, Mass.: Center for the Study of World Religions, 2001), 25–34. For the Boston Healing Landscape Project website, go to www.bmc.org/pediatrics/ special/bhlp.

2. See, for example, Arthur Kleinman and Byron Good, eds., *Culture and Depression: Studies in the Anthropology and Cross-Cultural Psychiatry of Affect and Disorder* (Berkeley: University of California Press, 1985); and Arthur Kleinman, *Social Origins of Distress and Disease: Depression, Neurasthenia, and Pain in Modern China* (New Haven: Yale University Press, 1986).

3. See, for example, Robert E. Bartholomew, *Exotic Deviance: Medicalizing Cultural Idioms—From Strangeness to Illness* (Boulder, Colo.: University Press of Colorado, 2000).

4. For example: Karen B. Levy, *The Politics of Women's Health Care: Medicalization as a Form of Social Control* (Las Colinas, Tex.: Ide House, 1992); Jacquelyn S. Litt, *Medicalized Motherhood: Perspectives from the Lives of African-American and Jewish Women* (New Brunswick, N.J.: Rutgers University Press, 2000); and Jane M. Ussher, *Women's Madness: Misogyny or Mental Illness?* (New York: Harvester Wheatsheaf, 1991).

5. See, for example, Senate Committee on Commerce, Science, and Transportation, *Marketing Violence to Children: Hearing before the Committee on Commerce, Science, and Transportation*, 106th Cong., 1st sess., 4 May 1999; and Senate Committee on Commerce, Science, and Transportation, *Television Violence: Hearing before the Committee on Commerce, Science, and Transportation*, 106th Cong., 1st sess., 18 May 1999.

6. See Alice McIntyre, *Inner-City Kids: Adolescents Confront Life and Violence in an Urban Community* (New York: New York University Press, 2000); and Valerie Polakow, ed., *The Public Assault on America's Children: Poverty, Violence, and Juvenile Injustice* (New York: Teachers College Press, 2000).

7. John M. Janzen and Reinhild Kauenhoven, *Do I Still Have a Life? Voices from the Aftermath of War in Rwanda and Burundi* (Lawrence, Kan.: University of Kansas, 2000).

8. Erica Goode, "Disparities Seen in Mental Care for Minorities," *New York Times*, 27 August 2001, sec. A1.

9. Maxine L. Margolis, "Transnationalism and Popular Culture: The Case of Brazilian Immigrants in the United States," *Journal of Popular Culture*, summer 1995: 29.

10. Chris Echegaray, "Brazilians Seek New Life in Area," *Telegram and Gazette*, 2 September 2001, sec. A1.

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12. Diane Kuperman, "Brazil: Stuck at the Gates of Paradise," *Courier* (Unesco), September 2001.

13. Maria A. Oquendo et. al. "Ethnic and Sex Differences in Suicide Rates Relative to Major Depression in the United States," *American Journal of Psychiatry*, October 2001: 1652–58.

14. Miranda O. Alexis and Debra L. Umhoefer, "Depression and Social Interest Differences between Latinos in Dissimilar Acculturation Stages," *Journal of Mental Health Counseling*, April 1998: 159–71.

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16. P. Dalgalarrondo, D. Caetano, and J. B. Laurito, Jr., "Religious Membership among Acute Psychiatric Patients: A Comparison between Pentecostal and Catholic Patients in Brazil," *Curare* 17 (1994): 19–24.

17. Carlos Caroso et al., "When Healing Is Prevention: Afro-Brazilian Religious Practices Related to Mental Disorders and Associated Stigma in Bahia, Brazil," *Curare* 12 (1997): 195–214; and Pamela Marie Foster, "Ritual Healing: An African-Centered Model of Psycho-therapeutic Intervention Based on Ndepp, Candomble and Urban Baptist Ritual" (Ph.D. diss., The Union Institute, 1996).

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