"Mental Illness" Symptoms as Extensions of Strategic Social Behaviour: The Case of Multicultural Mental Health

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Abstract

To better analyse transcultural mental health issues, a model of social relationships is presented that allows more complex formulations of the differences between some western social strategies and those of non-western, or collectivist groups. This requires more lengthy and detailed observations of clients and their communities whether or not the particular version of analysis presented here is accepted. An example is given of low self-efficacy in depression and how different contexts can lead to similar-looking symptoms but through very different forms of social relationships. Two case studies are presented of 'mental' health issues with Somali women and how 'individual' treatments could be conceptualised as changes made in the community. In the first case some of the western treatments were successful in the short-term, while in the second case non-western treatments worked and western help was eschewed. We conclude that assessments and treatments for 'mental' ill-health will only be as good as the social analyses made, and more detailed analyses are needed regardless of one's perspectives when dealing with transcultural groups.

Keywords: mental health; cultural; refugees; communities; depression.

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For many years there have been calls for new approaches to mental health, as people have become dissatisfied with medical models for a variety of reasons (Bentall, 2003; Tew, 2005; Wagner, Duveen, Themel, & Verma, 1999). Many of the proposed new approaches have been too simplistic, and have amounted to little more than a rejection of "western" or "medicalized" mental health notions. These are commonly critical without useful or elaborate suggestions to replace current models and treatments (see the debates in Double, 2005). For example, it is increasingly common to reject DSM (Diagnostic and Statistical Manual for Mental Disorders, American Psychiatric Association) classifications or the use of psychiatric medications, but alternatives are rarely specified especially for those currently undergoing treatments, and for whom withdrawal might be dangerous or life-threatening.

It is just as clear, however, that western medicalised approaches to addressing mental ill health are not working for a number of 'groups' in western societies, especially indigenous, poverty-stricken, ethnic, and other marginalised groups (Ferns, 2005; Guerin & Guerin, 2012; Smith, 2005; Walker, Johnson, & Cunningham, 2012), and something needs to change. Such groups are overrepresented in mental health statistics even though they also seek help less for 'mental health' problems. This is more serious than just ideological problems with current mental health systems and treatment, since even the current treatments are not working. Such groups often fall between the cracks and get no useful treatments of any kind.

Finally, with increasing emphasis on the promotion of mental wellness and the early prevention of mental illness, rather than interventions after the fact, the focus has gone off of the individual and more on the contexts in which individuals grow and live. This change in focus has also led to approaches looking beyond the current ones, although our approach is very different to those listed above (Fromene & Guerin, 2014a, b; Guerin, Elmi, & Guerin, 2006; Guerin & Guerin, 2012; Guerin, Guerin, Tedmanson, & Clark, 2011).

The aim of this paper is to consider that current mental health models and treatments revolve too much around the notion of individuals who control their own behaviour and that what is needed are some new models of mental health that take into account wider social contexts. A number of such proposals have been made but when looking at the finer details there are either still individualistic assumptions present, or the details are missing of how social factors can be taken into account for what appear to be very private and individual's behaviour changes. This paper will focus on the mental health of ethnic or multicultural groups but the analyses will be applicable in different ways to indigenous, poverty-stricken or other marginalised groups.

Current Multicultural Mental Health Solutions

There are several ways that multicultural groups have dealt with the lack of understanding within mental health treatments about their specific and determining contexts. First, "cross-cultural" models have been tried in which slight variations on current models have been made by adding a 'cultural' component to the standard treatments. The treatments are really unchanged but practitioners learn a little about the particular 'culture' of the person and supposedly raise their awareness of the communities. Sometimes, however, this amounts to little more than either lip service to cultural factors or a fascination for exotica (Guerin & Guerin, 2012). Basically, nothing has really changed. A large number of these approaches also suffer from focusing on a verbalization of 'culture' rather than on observing the social contexts and practices of the group of people, so this usually amounts to "cross-national" additions rather than more subtle and diverse distinctions that might be called cross-cultural. The epitome of this is "Asian Counselling" since the "Asian" group comprises of between 2 and 4 billion very diverse people, depending upon how you count.

Second, some groups have tried to use the mental health system in their own way, often by having people from within the community trained as professional mental health agents through traditional programmes

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and working from there. This again is more of a band-aid approach—however well they work—and not a re-thinking of mental health itself.
Finally, some multicultural groups have begun working out their own versions of what mental health is and how to treat such problems. While important for the future, these are also usually band-aid revisions because they do not really change much of the way other professionals think about mental health. More of a problem, however, is that most mainstream professionals do not take such treatments seriously and the new models mostly have little credence in government bureaucracies so there is not the funding to practice such treatments on a wider scale.
From these points we can see two main questions for a social model of mental health: how do we 'put' cultural practices and their differences into mental health models without being simplistic about diversity; and how can events that seem extremely private and individual—in a word, mental—be thought of as social in a thorough and meaningful way. The first of these points will be addressed here for multicultural or transcultural practice.

A Framework for Mental Illness and Wellness

The main issue, to both incorporate 'cultural' components and to allow the 'mental' to be viewed as social, is that mental health lies in the social strategies, contexts and details of life. As many have argued (e.g., Bentall, 2003; Double, 2005), "mental illness" can be seen as a set of reasonable life strategies built up through difficult situations. These might be: situations or circumstances that only allow a restricted range of options within which to behave; strategies that work short-term but become chronic and embedded in life (e.g., initial attention-getting strategy becoming permanent and part of a person's "identity" or role); or social contexts in which there is little personal influence and so strategies are forced unwillingly on people.
What this means is that any version of 'mental illness' is only as good as the analysis of the social strategies, contexts and details of life. With only common sense or simplistic analyses of social life, only simplistic versions of mental illness and its treatments will result. Psychology and psychiatry have not been diligent enough in describing the life contexts for their analyses (Guerin, 2001a, b). This has occurred through: the use of personality dimensions as simplistic short-cuts and essentialistic approaches; the use of abstract concepts such as "mental", "inner" or "cognitive" processes that can only indirectly be turned into observations; and the use of short-term or cross-sectional observations and non-participatory methods.
For instance, seeing clients even three times a weeks for 50 minute sessions means there is no participation in the person's life and context; the methods are repeated cross-sectional methods and not truly longitudinal or participatory; most of the context is verbally reported by the client and therefore restricted and changed in the telling; and the dominant observational focus in session is the person themselves three hours a week, which leads to more personality attributions and focus onto the 'individual-as-cause' than on exploration of the social contexts of the problem (Guerin, 2004).
Many of the common theories and practices of psychology mitigate against finding social roots to "mental" issues and are individualistic. Given our interest in finding more appropriate 'mental health' interventions for 'other' groups and cultures, we need to provide more analytic details for a 'social' interpretation of 'mental health' symptoms and patterns and, where possible, integrate conceptually (as well as in practice) any traditional interventions with current interventions as appropriate. Social and contextual approaches and literature in psychology that are consistent with this aim include Bronfenbrenner's ecological model (2004), Tew's (2004) *Social* Perspectives *in Mental Health*, and other work from the UK such as that from Cromby, Harper & Reavey (2013) and Bentall (2003, 2009).

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Social Strategy Analysis

Elsewhere we have integrated what we know about the social strategies of life from all the social sciences (Guerin, 2004), pulling together what is known from psychology, social anthropology, geography, sociolinguistics, demography, sociology, and other social sciences. This suggested some important dimensions to the social strategies we use in life in which the forms of social relationships were pivotal. It also suggested ways of embedding analyses of language use into the strategies of social life rather than considering them isolated 'texts' or as cognitive representations, as is usually done. This latter replaces cognitive metaphors with discursive approaches, but this cannot be covered in the space here.

Five of the main dimensions of social strategies are: *relationship reciprocity*—how people exchange resources and actions to maintain the forms of relationship; *what you can get done*—the extent to which things can be done for you in different relationships; *your personal influence*—how much you can influence people by who you are and what you do; *monitoring*—how much you can observe and check on the strategies people have; *accountability and responsibility*—how much you and others can be held responsible for actions. What is important to outline here is how these (and other) strategies are remarkably different with different forms of relationships. That is, the properties of different social relationships and the strategies available through those strategies are themselves sufficient to explain our social behaviours, including the analysis of 'mental illness' symptoms. They have also been useful for drawing out interventions and treatments (Guerin, 2005).

Three Forms of Social Relationship

The main point so far is that strategies and contexts of life evolve from the social properties of the types of relationships we are in, and that 'mental illness' can be profitably viewed in this way. The focus of social analysis should be on social relationships and what they can do rather than individuals and what they can do. The three major types of relationship that will be presented here in Table 1 are those of 'western', 'capitalist' or 'stranger' relationships, those of close family and social networks, and those of close or kin-based communities.

Table 1. Three Types of Social Relationships and their Main Social Properties Relevant to Interventions

Type of Relationship	Social Property	
Stranger Relationships	Form of reciprocity	Exchange with a society of strangers is done via money
	What you can get done	Typically by paying someone and in principle there are: no other social relationship involved; no other social obligations; and does not usually impact on other areas of life
	Personal influence	Depends upon having economic (resource) status, often contextualized as a show of commodities
	Monitoring	Will often not see them again, and others will not see each

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		other
	Accountability and who is Responsible	Mainly through public rule following and policing, institutionalized
Family/Friend Networks	Form of reciprocity	Specific supports that are returned
	What you can get done	Depends upon your networks and the reciprocity you provide. The people are usually relevant in other arenas of life
	Personal influence	Depends upon status within networks
	Monitoring	Will see some of the people regularly, but not others. The others will not all see each other regularly, except if family
	Accountability and who is Responsible	Through network members' attributions of responsibility and through some public rules and policing
Kin-Based Community Relationships	Form of reciprocity	Taken for granted obligations
	What you can get done	Depends upon the family social relationships. The same people will be relevant in most arenas of life
	Personal influence	Will be important and depend upon status in the family and community networks. Time spent talking therefore rather than rule following
	Monitoring	Will see most of the people regularly, and others will see each other regularly
	Accountability and who is Responsible	Through complex family systems with historical context frequently utilized

Before outlining more about the properties of these three forms of relationship, it is well to note that our point for this paper will be that psychology and psychiatry have been developed almost exclusively around

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'western', 'capitalist' or 'stranger' forms of social relationships, and this shapes the assessment, processes and treatments provided. Note immediately, however, that this is not arguing against such positions, as an anti-psychiatry position might, it is just arguing against applying them to everyone regardless of their social and cultural context. In the context of people living primarily in western or social network relationships, they may well provide the best procedures and treatment.

Societies of strangers. The predominant form of social relationship for most people living in western countries is that of stranger relations, or 'contractual relations' as sociologists call them. While most of us value our family and friend relationships more than strangers, on a day-to-day basis we probably have more relationships with strangers. Ultimately, this results from living in a society based on a capitalist economy, but the properties of such relationship define us and our social strategies. *Relationship reciprocity* is based on exchanges primarily done via money, with little or no social obligations beyond that. If I have a transaction with a bank clerk then this is paid for and I have no obligation to be nice to them beyond this and, indeed, it would look suspicious if I tried to invite them for dinner. *What you can get done* is typically defined by paying someone and does not usually impact on other areas of your life. To get my children looked after I do not have to have a family member as baby-sitter but I can pay a stranger to do it. Of course, we do not randomly pick a stranger but select characteristics relevant to monitoring, accountability, and influence. A family member might even take it as an insult if you tried to pay them. *Your personal influence* will depend typically upon having economic (resource) status, often contextualized as a show of commodities or impression management. For *monitoring* you will often not see the people again, and others will not see each other (and talk about you). So the people in the gym you attend will not go out of their way to meet and become friends with your work people or your family. Finally, for *accountability and responsibility* we appear to act as free individuals and take responsibility for our actions but there are police and other societal agents who take responsibility for some domains but in most others we are on our own. The appearance of freedom, however, comes from the independence gained from the use of money but this relies on a whole social system to work and so it is really socially-defined in any case.

Family and friend social networks. Of more reported value for most people in western societies are the family relationships and the networks of friends and acquaintances. Many people, however, do not keep strong relations with family beyond grandparents, parents, siblings and sometimes uncles and aunts, and may rarely see their more remote cousins. Even if they do see them occasionally, the point here is that everyday relationships to get things done and to cope with life work mainly through strangers but with more important ties to a small number of family members and friends who are seen often. We can already see that if life goes badly and the person is unable to cope, their life may be heavily reliant on strangers for support.

In terms of the social properties of these sorts of ties (Guerin, 2004), *relationship reciprocity* is found to revolve around specific network exchanges that are returned usually in other ways. This means that there are specific things family members do for each other but they are often reciprocated in other ways. *What you can get done* depends upon your networks and the reciprocity you provide. The people are usually relevant in only one or two other arenas of life, meaning that most family members would be involved with each other as well as you, but your friends are often not that connected to family members or other groups of friends you might have. *Your personal influence* will depend upon status within networks, and accumulated reputation. Your *monitoring* will depend on how much you see the people. Because the different groups of friends will not all see each other regularly, monitoring of you becomes less frequent. Something bad you do when with your friends will not necessarily get back to your family. Something with family, however, will usually find its way back to at least some family members but not friends. *Accountability and responsibility* are sometimes through public rules and policing, but more often kept

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within family and network members' contacts. Negotiating who is responsible for things within a family is often difficult, such as looking after aged parents.

Kin-based groups and close communities. These relationships are characterised by close and regular contact with family and community who provide strong support in general. These forms of relationships are common in many ethnic and indigenous communities, as well as some western religious communities. The Amish, for example, inter-marry and keep most exchanges within family groups that build up the community. Support is given almost without thinking of it as obligation, and strangers are kept at bay. A key point about the properties of such social relationships for analysing social strategies is that 'individual' actions and behaviours can be seen to rely heavily on the family and community instead of some individual 'will', motivation, or cognitive processing.

Relationship reciprocity is the taken-for-granted obligations spread through a community, and as mentioned, these are usually not even thought about as a duty or obligation since they are so taken-for-granted. The reciprocity itself, however, is not easily observed except with participatory methods. *What you can get done* depends upon your family and community-family social relationships. The same large group of people will be relevant in most arenas of your life, so you are likely to work with a large proportion of relatives and be in groups (such as sports groups) with a large or exclusive proportion of relatives. This in turn means that your *personal influence* will be highly important and depend upon your status in the family and community networks and hierarchies. This is often a function of your age and gender or of your family's standing rather than any property of your own: if you do have a high status or reputation (perhaps as an elder) this depends upon your family and community more than you. *Monitoring* is interesting because you will see most of the people regularly, and the others will also see each other regularly independently of you. In turn, this means that *accountability and responsibility* work through complex family systems with historical context frequently utilized.

Social Conflict and Our Social Strategies

What these details mean is that how we organize, run and cope with our lives within relationships, both the strategies and social contexts, derive from these social properties. No person has only one of these forms of social relationships and everyone will have a different mix. Most 'westerners' have many stranger relationships each day and some family and friend network relationships around this. Further, when we have regular interactions with the same strangers (at shops, perhaps) we begin to add elements of friends and family relationships, although this can also result in conflict if it is taken too far or too much obligation is assumed. For most of our regular 'strangers' we have polite forms of stranger interaction (Goffman, 1963, 1967; Guerin, 2004).

On the whole, the social conflicts are likely to arise from "stress", lack of resources, or poverty, upsets in life arising from contradictory audiences, relationship conflicts or straight out resource conflicts, conflicts for those who are in more than one form of social relationship where they are not easily separated in practice, and especially in the specific cases of colonization, oppression and rapid westernization (Achebe, 1988). For each of these, the outcomes will be different for the different types of social relationships even if the "symptoms" look the same.

Finally, 'mental conflict' can also be seen as a more subtle form of social conflict (Guerin, 2001a). In these cases, the 'audiences' for the conflict are either not present or they are generalized and so the social control over thinking and talking are not easy to identify *in situ*, and so they get attributed to an unseen 'mental' agent (Guerin, 2001b, c).

How does this Relate to Multicultural Mental Health?

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The point, however, for this paper is that when we are 'finding life too difficult' (mental illness) from the practical (resource) and social problems of running life in this modern world, then our strategies depend on our histories and support from the different forms of relationships. The framework as presented provides several advantages. For one, it provides a more detailed analysis of the social strategies and contexts of life. It also actively shows differences between 'western' and close community relationships rather than tacking some 'cultural' components onto western models. It is evidence-based in social science research (Guerin, 2004), and, finally, this approach can make sense of 'irrational' or unusual patterns of behaviour or unusual beliefs.

Let us take an example of the reported lack of control or lack of self-efficacy found in depression. As outlined in Table 2, for each type of relationship this could arise in different ways. If *stranger relationships* are predominant, then the lack of control will be from a lack of money, lack of social support, lack of commodities and status, from remaining unmonitored by others, and from only getting reality checks when hitting up against social rules or police. In contexts where *family/friends networks* are predominant, the likely sources for lack of control would come from losing support from networks and family, from not being able to involve family or networks into other areas of life for support, and from family requiring obligations if supportive. Further, once status is gone it is a downward spiral to losing friends, others have little obligation to help elsewhere, and slipping between the cracks. If *close community relationships* are predominant, then we would expect effects from ostracism by family and community, if you lose family support then you lose control in most areas of life, or the same if you have lost your family (refugees), there might be little monitoring of conditions if outside family now, the whole family and community will know what is happening, the whole family can make you accountable and be accountable themselves, this can become a historical precedent for that person and their family, and this can bring shame on the whole family/community.

Table 2. Three types of Relationships and the Possible Social Determinants of Reported Low Self-Control or Self-Efficacy in Depression

Type of Relationship	Social Sources for Reporting of Low Self-Control or Self-Efficacy in Depression
Stranger Relationships	Lack of money Lack of social support Lack of commodities Lack of status From remaining unmonitored Only get reality checks when hitting up against social rules or police Slipping between the institutional cracks with no other supports
Family/Friend Networks	Losing support from networks and family Not being able to involve family or networks into other areas of life for support (such as work) From family requiring obligations if supportive A downward spiral to losing more friends as things get worse Others have little obligation to help in other ways Slipping between the institutional cracks with no other supports

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Kin-Based Community Relationships	Ostracism by family and community If you lose family and community support then you lose control in most areas of life If you have lost your family (refugees) Little monitoring of condition if outside family and community Whole family and community will know what is happening Whole family and community can make you accountable Can become a historical precedent for that person, their family and the community Bring shame on whole family/community

Going back to one of our earlier points, most psychology and psychiatry has assumed western styles of social relationships, meaning frequent stranger relations and a few close family and friend networks. This is exemplified in clinical practices such as having regular, scheduled appointments to conduct one-on-one interventions with a stranger who is paid for their services, and keeping that relationship strictly confidential from any other parties including the closest family members. All these are reflections of the properties of stranger or western relationships and the way social strategies develop over time in these relationships. It is no surprise, then, that the most vocal groups complaining about western mental health approaches are those from highly kin-based communities, especially ethnic minority and indigenous groups within predominantly western societies.

Case Examples

The following two case examples are built from a real examples the two authors observed over many years of participatory involvement in a Somali community in New Zealand. We have combined a few examples so the case material cannot identify people in these communities.

This research was conducted in a small town in New Zealand between 2000-2006. The total population size of that town at that time was around 100,000 residents including approximately 800 Somali residents who had mostly arrived to New Zealand via humanitarian pathways through United Nations High Commission for Refugees programs. While many Somali were recent arrivals, some had arrived in New Zealand in the early 1990s, so had been living in New Zealand for over 10 years. All of the Somali people we worked with in community were Muslim and most spoke multiple languages, but Somali, Arabic, Swahili, Italian and English were the most common languages spoken.

Both authors were directly involved with the community in various capacities. One author was employed part-time with the refugee organisation and assisted with resettlement of a large number of Somali families. This position involved the coordination of volunteers, liaising with State housing and other departments and agencies (such as the education department for schooling and the St Vincent de Paul Society to organise donated furniture). Other community work, such as coordinating and providing health and fitness sessions for four years with Somali women and assisting with issues such as electricity supply, family reunion, and employment, meant that this author was heavily involved with the community. The other author taught English as a volunteer to a group of Somali men, including many of the elders of the community, and also helped run a week-long camp for the Somali boys. Overall, collectively thousands of hours were spent talking and participating with the people in this community.

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Case Example 1

The first person involved was a newly arrived African refugee woman in her early 20s who began complaining of not sleeping, depression-like symptoms and family conflicts. Her 'family' tried to welcome her when she arrived, but the relationships were very strained. Through a GP referral she saw a psychiatrist because her depressive symptoms were getting severe. The psychiatrist did not really understand the family conflicts but prescribed anti-depressants along with some CBT.

The client spoke English well, was fairly westernized in outlook, and was enrolled as a tertiary student at a local institution. CBT, medication, some physical activity and continuing her education all resulted in some improved quality of life for her although family relationships continued to have major problems. She occasionally still had severe symptoms and carried out a few 'strange' behaviours.

Through participatory research over a long time with her kin-based community relationships (this all took many months of informal talks and observations to obtain), the following points were found (see B. Guerin & P. Guerin, 2007; P. Guerin & B. Guerin, 2007 for more methodological details). Her 'family' did not know of her existence because she was the daughter from an affair her father had with her birth-mother before marrying his current wife. Her father brought her to New Zealand but left shortly after. She had therefore been left living with a step-mother who also had older children from the same father and others from her own previous marriage. So with eight 'children' in the house the client was the only one not a child of this step-mother living in the same house. None of this was reported to the psychiatrist because there were some complexities with immigration and citizenship issues and fear that these could be adversely compromised, and because she believed her position in the family could be made worse. We found that when things got tough in the family she was the one left out, and things were almost always tough for the family because they were refugees in a new environment. She had no other close contacts in the community for a variety of reasons, such as being from a clan that was not common in this group, slight differences in language accent, and the family complexities.

From the family's point of view, she was a stranger to them who appeared because of a relationship none of them were involved in. Some in the family became very close to her, while with others the relationship was very competitive—for the father's attention and for being successful, more generally. While the father could have supported her in this environment, he did not show much support even before he left and was not coping himself with a medically-treated 'mental illness'. Most of the family obviously gave first preference and loyalty to the others in the family whom they knew and who were more closely related.

She had previously tried traditional 'treatments', including Koran readings, but the failure was attributed to her and she was called 'crazy' by family and community members. She developed a reputation for this and was unlikely to find any man to marry within those allowable. While quite westernised, integration into other communities was not an easy option as much of her life was dictated by her father, although at a distance, and her loyalty to him was of utmost importance, particularly because of how that relationship may impact her mother. For her to become more distant or to separate from her new family might negatively impact her relationship with her father, which then could negatively impact on her own mother.

Case Example 2

The second case example, also built from a few real examples, concerns a middle-aged woman who was raising six children in her house in New Zealand including two older boys who were out a lot of the time and exhibiting behaviours that might eventually mix them up with the police. Three boys were at school and she had one teenaged girl. Her husband and almost all male members of the family had been killed during the civil war in Somalia, and she only had one sister with a husband who were living in Australia rather than New Zealand

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Having known the family for a number of years, it was reported to us at one point that the mother had become possessed of a jinni (spirit) and was hearing voices and had been chasing the children around the house with large knives, swiping at them. She was speaking strangely and not doing her usual routines such as cleaning and cooking. We were obviously concerned. The woman talked to her GP who prescribed her anti-depressants and referred her to a psychiatrist. The woman neither filled the prescription nor visited the psychiatrist and no follow-up from the health system was done, to our knowledge.
In terms of analysing the stressors and conflicts of life at that time, related to kin-based relationships, we found out through a long time spent talking informally with her (over years) that she knew exactly what her older boys were doing and was extremely worried about losing the family since she had lost all other males. She was contemplating sending these older boys to be brought up by her brother-in-law in Australia but could not bear the thought of breaking up the family having finally got them all safely together in one place. At the same time she was not participating very much in the community events and she was somewhat talked down to by others, despite her being very intelligent, because her clan membership was not one of the common ones amongst this community. We also found some of the community were talking down to her because there were no males around her, which made her potentially suspect. She was also having trouble with her daughter in arranging a marriage because of the lack of males and her clan association, and she was more worried about that because her daughter was at the peak time for marriage. Finally, like many refugees in New Zealand, she had been having financial trouble with bills and over-use of the telephone (keeping family and community ties strong locally and overseas).
After a short period following the knife incident, she was involved in the establishment of a prayer group with others in the community. This was significant first because by being able to arrange it in the first place, this meant she was beginning to be more accepted in the community and gain the status she should have been given. Second, following a three-night session of Koran readings given especially for what we would call problems of "mental illness" (Guerin, Guerin, Diiriye, & Yates, 2004), she reported that the jinni had gone and she never had any other symptoms even slightly resembling those previously (we knew her well for a few more years after this).

Discussion of Cases

In both cases briefly given, with an intimate and participatory knowledge of the community, and a broader conception of how to analyse behaviour as strategic and social, we found the plethora of strategies coming directly from the kin-based family and community contexts, which would not occur in stranger relationships, for example. In neither case was there a change in the person's 'mental' state from illness to well-being that could be called a "cause" of things improving. Instead there was a change in their social context from a state of conflict to another state and this social/community change improved things. While the women both had symptoms, one of psychoses and one of depression, both reported 'feeling' mentally fine most of the time because of their strong Islamic Faith that showed them that Allah must have a purpose for what they were going through.
The first woman was mostly concerned about her place in life since her westernisation was giving her an education and she knew she should be treated better than she was. The second woman was mostly concerned about her family and keeping it together and having a reasonable status for her family in the community. There were not problems in either case with their "perceived" lack of self-efficacy or sense of control. Without analysing the finer strategies of their lives in this way, the lack of control would have been professionally attributed to an inner or "perceived" loss of control whereas once we looked more broadly at the controlling factors, there was actual and real loss of control.
In terms of treatment for the first woman, she reported some of the western treatments as helpful, especially the CBT rather than the drugs. A side-effect of this, however, was that it pushed her into further thinking

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and acting independently of her family and the refugee community, and further into westernisation and individualism. Whether this is good or bad in the long run we do not know, as this would involve a value judgment and an even longer term tracking of how her life eventuates, but she has certainly become more remote from the community since, but her obligations keep her there. We conjecture that it was because she was already somewhat distant from the community that the Koran readings did not help her at the time and might have actually made her social situation worse (Guerin, Elmi, & Guerin, 2006).

In terms of treatment for the second woman, we will not know if the western treatments would have worked, but the traditional treatments worked fine. From a social analysis point of view, however, the cause of this is still partly deceptive, since we do not know how much the context of being able to set up the prayer group functioned as the actual treatment (see Guerin, 2005, on analysing cause and context, p. 28). She was certainly more respected in the community after this time so whatever was bringing that change about might have led to her being able to organise a prayer group and its success.

Summary and Conclusions

We do not have all the answers but have spent some years exploring forms of "mental illness" contextualised in communities rather than analysed in the abstract or through short-term research designs (Fromene & Guerin, 2014a, b; Guerin, Elmi, & Guerin, 2006; Guerin & Guerin, 2012; Guerin, Guerin, Tedmanson, & Clark, 2011). We have been extremely impressed by how much we have found out through using longer-term participatory methods most closely associated with social anthropology, which no one else dealing with the communities had found—even those who have known the same community well for a number of years but not truly participated (B. Guerin & P. Guerin, 2007; P. Guerin & B. Guerin, 2007). Conducting even regular short interviews would never have found out the social context details needed to understand what was happening for each of these women.

As mentioned earlier, this has led us to espouse that analyses of 'mental illness' are only as good as your analysis of the social strategies, contexts and details of life. What we have tried to do here is to outline a slightly more complex version of the social strategies of everyday life that incorporates a lot of dimensions that kin-based groups have but others do not. If analyses can be conducted along these lines, then we believe that better assessments and treatments are possible. This does not mean rejecting one approach to "mental illness" totally in favour of another, but means contextualising the clients' worlds to find a richer mixture. This is one reason we presented a real example of an "ethnic" group member who did find some western treatment valuable in her life.

What we have not done here, is to show how the strategies arising from stranger relationships are also socially-controlled, since this would take us further a field than we have space for here (Guerin, 2001b). In any case, our point here is that people living with very different social properties stemming from very different forms of social relationships require very different analyses and interventions. Our eventual aim is to integrate the traditional treatments of other groups into western treatments or to produce new treatments and approaches altogether for such groups. It must be remembered, nevertheless, that people in this world are changing from globalisation and we should never assume, as our first case study illustrates, that traditional treatments will always work best just because the person is part of a kin-based community.

Even if you do not agree with our particular version of social analysis here, we believe that this much detail of the specific social context is necessary in one form or another, and that this entails spending more quality time with clients and their communities. The material we gleaned in these cases would never have surfaced in a one-on-one session of western therapy or research interviews. The form of the stranger relationship with a "therapist", whether psychologist, psychiatrist or other, would not have allowed the

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material to be told, the clients might not even have been able to verbalize the rich material we observed over time. Also, as seen in the second case study, even if the issues had been understood from individual sessions, the interventions required participating with the community in any case. In the first case study, the more western intervention was felt to be helpful but still the client became more estranged from her family and community as a result, In the second case study it took a community intervention on a large scale to treat the individual woman (Guerin, Guerin, Tedmanson, & Clark, 2011).

In terms of the promotion of mental wellness and the prevention of mental illness, these analyses become even more crucial. As both case studies illustrate, the "individual" interventions required community and family change and preventing such issues would have needed long term advocates. While communities have often in the past had their own mechanisms for preventing such problems, the refugee communities are not what they traditionally were, and all the communities we are dealing with are embedded in a western context and have new issues arsing from this that they have not encountered before in the same way. Prevention and promotion work best in these cases by strengthening the communities, rather than targeting the individuals, but it must be kept in mind that most of these communities are also dealing with new problems not of their making.

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