Listening to refugee bodies: The naturopathic encounter as a cross-cultural meeting place

Judy Singer
Southern Cross University

Publication details
Singer, J 2008, 'Listening to refugee bodies: The naturopathic encounter as a cross-cultural meeting place', PhD thesis, Southern Cross University, Lismore, NSW.
Copyright J Singer 2008
Listening to refugee bodies: The naturopathic encounter as a cross-cultural meeting place

Judy Barbara Singer  Dip Applied Sciences (Naturopathy)
Thesis submitted to fulfil the requirements of Doctor of Philosophy in the School of Arts and Social Sciences, Southern Cross University
July 2008
Declaration of authorship

I certify that the work presented in this thesis is, to the best of my knowledge and belief, original, except as acknowledged in the text, and that the material has not been submitted, either in whole or in part, for a degree at this or any other university.

I acknowledge that I have read and understood the University’s rules, requirements, procedures and policy relating to my higher degree research award and to my thesis. I certify that I have complied with the rules, requirements, procedures and policy of the University (as they may be from time to time).

Print Name: ________________________________________

Signature: ________________________________________

Date: ________________________________________
Abstract

This thesis examines the meanings of naturopathy through the experiences of twelve women with refugee backgrounds involved in naturopathic treatment at the Victorian Foundation for Survivors of Torture (Foundation House), a refugee torture and trauma rehabilitation service in Melbourne, Australia. The findings of this research show that the naturopathic encounter provided a transformative and meaningful meeting place for healing, a place in which the women felt at ease and in place.

At Foundation House naturopathy has been practised alongside counselling since 1989, two years after the organisation’s inception. The women I interviewed for this project came from diverse sociocultural backgrounds and a wide range of countries including Iraq, Iran, Yemen, Afghanistan, Somalia, Burma and Serbia.

The thesis brings together two contemporary fields of practice: Western models of refugee health care and traditional medicine. It argues for the place of non-biomedical approaches in refugee health care in a Western setting. The thesis takes an interdisciplinary approach to theorise the naturopathic encounter. The distinction between holistic and reductionist perspectives on health, illness and the body is underpinned by the theoretical work of medical anthropologists Nancy Scheper-Hughes and Margaret Lock and that of medical sociologist Aaron Antonovsky. A cultural studies perspective, influenced by the work of embodiment scholar Elspeth Probyn is employed to theorise these women’s experiences of the naturopathic encounter.
This qualitative study is based on in-depth interviews and draws on grounded theory as an approach to data analysis. Descriptions of respite, renewal, and healing in the naturopathic encounter are cited as the most observable themes emerging from the women’s stories. These themes represent a health-oriented, as opposed to a disease-focused, perspective. Importantly, a health-orientated approach is congruent with the core tenets of naturopathic philosophy. Listening to the body is a crucial therapeutic tool in the naturopathic encounter, where primacy is given to supporting and strengthening health-creating strategies. I argue that this orientation disrupts the existing dominant biomedical approach to refugee health care.

I draw on the work of Probyn to theorise the movement from the naturopathic encounter (NE) to the naturopathic meeting place (NMP). Central to this transposition is Probyn’s articulation of the body’s awareness of being in and out of place. This awareness lends itself to an understanding of the connectedness between past and present in the bridge-making that these particular refugee women have engaged in across cultures in the NMP.

The thesis addresses an important but often neglected focus in refugee research: the resilience and agency of refugees. This positive aspect of refugee recovery is revealed in the research by theorising the women’s stories through Probyn’s embodiment analysis and cognisance of the ‘everyday’ as a productive and creative process. The research interrupts the ubiquitous image of the ‘disempowered refugee victim’. It highlights the practical wisdom and agency of these particular women that is often overshadowed in the complex resettlement process. It makes a call for further health-orientated research to broaden and deepen our understanding of the refugee experience.
Acknowledgements

A strong team stands behind this doctoral thesis. I thank the many people who have supported me through its genesis and fruition. In particular, I wish to acknowledge the support of the people listed below, to whom I am forever grateful.

My principal supervisor, Dr Kath Fisher, guided me through the thesis with generosity of spirit and unfailing encouragement. It was through Kath’s steady and astute guidance that I was able to find and express my voice. I am especially appreciative of Kath’s incisive critiquing, her keen sense of structure and intellectual rigour, and her remarkable capacity to facilitate the learning process. I shall sincerely miss working with her.

Thanks also to my co-supervisor Professor Sandy Gifford at Latrobe University. Her enthusiasm for this project and her breadth of knowledge have been invaluable in the development of this project and in extending my thinking.

I would like to thank my co-supervisor, Associate Professor Baden Offord. From our first conversation during Orientation Week many years ago through to completion, Baden’s commitment to human rights issues and his enthusiasm for this project have always boosted my spirits.

I wish to thank the staff and practitioners at Foundation House for readily assisting me during the recruitment phase. Their validation was critical to the success of the project. Thanks also go to the management team for endorsing the project. To Paris Aristotle I owe special thanks for his willingness to participate in the research and for instilling in me, many years ago, the importance of ‘documenting the work’. My thanks go to the interpreters who worked with me during the interviews. Their professionalism and warmth enabled the rich dialogue to emerge.
I would also like to express my appreciation to the natural therapies team, Heidi Wegner, Angela Woodburn, Bernie Farrell and Jenny Adams. The participants’ words in this thesis are testimony to their dedication and healing skills.

My dear ‘eagle-eyed’ friend, Assunta Hunter, offered astute critiquing, academic generosity, a constant stream of articles and references, and a ready boost of confidence whenever I needed it.

My dharma sister Jenny Adams, made many valuable comments and her camaraderie has been an ongoing inspiration. Much of this thesis has grown from the rich years we shared together at Foundation House.

Fellow PhD traveller Shé Hawke has been a constant friend. Shé made Bourdieu accessible, introduced me to the work of Elspeth Probyn and has been generous in sharing her knowledge.

David Corlett was always ready with many normalising ‘PhD conversations’. Julia Byford, Anita Jawary, Sue Andrews, Tina Bedford, Jess Friedmann, Tulsie Bisht and Kim Webster offered me critical feedback and plenty of encouragement.

At Southern Cross University I am grateful to Professor Judy Atkinson for believing in me and for giving me a place to begin this journey, Paul Orrock and Sue Evans for encouraging me early on to take up postgraduate studies at SCU, to Rob Garbutt and Joan O’Connor for help with my ethics application and to Jenny Pittman for initial writing assistance.

The library staff at SCU, especially the Document Supply team, never complained about tracking down endless references, and the Graduate Research College team offered on-going support. John Revington proofed the work and offered editorial advice and Kurt Otto assisted with technical support.

Thanks to Patrick Burnett for helping me make the connections between my inner world and the task at hand, to Peter O’Connor for teaching me that in the space of ‘not knowing’ the potential for understanding is created and to David Hollingworth for timely insights along the way.
I especially want to thank my mum and my aunty Ducì and many dear friends who were unfailingly interested in my project: Ann-Maree Bortoli, Azita Deljo, Jan Batty, Jennifer Blackie, Kiora O’Gaìa, Kris Latona, Lenore Cooper, Lorraine Cussen, Mike Bromhead, Nadine Liddy, Naomi Radunski, Ondine Spitzer, Ruth Rechner, Shelley Kerr, Tracey Potter and Wendy Bunston and the Fowlers Lane community, the Robinson-Gales’, O’Regan-Walshs’, and the Burns’ for cheering me on with good humour and entertainment.

To John Khourey, my deep thanks for unconditionally accepting me being ‘at the desk’ more often than not, for providing delicious meals, companionship and love.

Lastly, this thesis hinges on the willingness and generosity of the women I interviewed. My deepest thanks to them for their enthusiastic engagement in our conversations, for their trust and for the open and heartfelt ways they shared their personal stories and wisdom. They taught me so much.

In that this thesis emerged out of the suffering of people from refugee backgrounds, I can only hope it will contribute to promoting the dignity and agency of refugees worldwide.
In honour of my mother, Ann, my aunty Ducı, and the women in my lineage;
and to the women in this thesis who so generously and
enthusiastically shared their stories and knowledge.
# Contents

Declaration of authorship........................................................................................................ i  
Abstract ...................................................................................................................................... ii  
Acknowledgements ................................................................................................................ iv  
Prologue.................................................................................................................................. xii  

Chapter 1  Introduction ........................................................................................................... 1  
  Frasa’s story ............................................................................................................................. 1  
  Impetus for the research .......................................................................................................... 6  
  Framework – theory and methods ........................................................................................... 8  
  Outline of thesis ....................................................................................................................... 9  

Chapter 2  Refugee health care and naturopathy: Terminology and context .................... 12  
  Terminology ............................................................................................................................ 12  
  Refugees .................................................................................................................................. 12  
    Who is a refugee? .................................................................................................................... 12  
    Definitions of torture and trauma ......................................................................................... 14  
  Health care systems ................................................................................................................ 16  
    Biomedicine .......................................................................................................................... 16  
    Ethnomedicines ..................................................................................................................... 17  
    Traditional medicine ........................................................................................................... 17  
    Complementary and alternative medicine (CAM) ............................................................... 19  
    Naturopathy as defined in this thesis ................................................................................. 20  
    Medical pluralism ................................................................................................................ 24  

Context: Refugees and Western health care practices .......................................................... 26  
  Refugees in Australia .............................................................................................................. 26  
  Psycho-social services for refugees in Australia .................................................................. 27  
    The role of Foundation House ............................................................................................ 28  
  Refugee health care and cultural relevance ............................................................................. 28  
    Studies in cross cultural refugee health care ......................................................................... 30  
    The case for medical pluralism in culturally meaningful refugee health care ................. 32  
  History of Western health care practice .................................................................................. 34
Health care before the 19th century: The age of holism ........................................ 34
Professionalisation of biomedicine ..................................................................... 35
The establishment of biomedical hegemony ....................................................... 36
The countercultural response to biomedical hegemony ...................................... 37
Biomedicine's response: Mainstreaming non-biomedical practices .................... 38
Traditional medicine – whose knowledge counts? ............................................. 39
Impact on naturopathic knowledge ................................................................ 41
Summary ........................................................................................................... 41

Chapter 3 Conceptual frameworks and research literature in refugee health care 43
Anthropological and sociological concepts in refugee health studies .................. 44
Holism .............................................................................................................. 44
  Tensions between holism and reductionism .................................................... 46
Salutogenesis ..................................................................................................... 50
  Health on a continuum .................................................................................. 51
  Salutogenesis and naturopathy ...................................................................... 52
Antonovsky’s theories and health research ......................................................... 53
Refugee research using a salutogenic approach .................................................. 54
The refugee body .............................................................................................. 58
Place and space ............................................................................................... 60
Healing principles in traditional societies .......................................................... 65
  Congruence/rapport ....................................................................................... 65
  Balance .......................................................................................................... 66
  Interconnectedness: ‘Return to one heart’ ...................................................... 67
Humoral principles: Hot/cold theories ............................................................... 68
Conclusion: Making the case for naturopathic treatment in refugee health care .... 70

Chapter 4 Methodology .................................................................................... 74
Overview of methods of sampling and data collection ......................................... 75
Appropriate research methodologies for refugee research ................................. 76
  Refugee-specific issues ................................................................................... 76
  Linguistic and conceptual communication issues and strategies ................. 78
  Translation issues – preparing background material .................................. 79
  Interpreting cross-culturally ........................................................................ 79
  Justification for using in-depth interviews ................................................... 83
Research context ............................................................................................... 85
  The role of Foundation House in the research process ................................ 85
  Background of researcher: The insider/outsider tension .............................. 86
Recruitment process ......................................................................................... 89
  Recruiting participants ................................................................................ 89
  Selecting participants: Negotiating with Foundation House ....................... 90
  Number of participants ................................................................................ 91
  Introducing the women ............................................................................... 92
  The process of recruitment at Foundation House ....................................... 92
Chapter 5  Foundation House ................................................................. 115
Background context: Establishing torture trauma services in Australia ... 116
Foundation House .............................................................................. 117
  Introducing naturopathy .................................................................. 119
  Implementing and managing the natural therapies program ............ 122
  Creating the Foundation House space ............................................. 124
  Integrating the natural therapies program ...................................... 126
  Structure of the natural therapies program ...................................... 130
  The referral process for naturopathy ................................................. 131
Conclusion ......................................................................................... 134
Postscript: Current challenges ............................................................. 134

Chapter 6  ‘Myself and my body are very happy’: The refugee body in the naturopathic encounter ................................................................. 136
Biomedical inadequacy: The gap in health care for refugees .................. 137
  Explanatory models ........................................................................ 139
The naturopathic encounter ................................................................. 142
  Deep care ...................................................................................... 144
  Attending to the body in the naturopathic encounter ......................... 145
The refugee body ............................................................................... 147
  Lani’s story .................................................................................... 149
  Vesna’s story ................................................................................. 151
  Mary’s story .................................................................................. 152
  Sita’s story .................................................................................... 153
Metaphors for the body: Healing the social body .................................... 155
Embodied cultural knowledge: Interconnecting home, mothers and herbal remedies .......................................................... 162
  Traditional medicine knowledge ..................................................... 163
    Humoral principles: Hot/cold theory ............................................. 163
    Medical pluralism ........................................................................ 165
  Connections to home ....................................................................... 167
  Connection to mothers .................................................................... 169
Reconnecting with self.................................................................171
Summary ..................................................................................174

Chapter 7  The naturopathic meeting place ........................................175
Raza’s story ....................................................................................175
Habitus: lineage of knowledge ..................................................177
The fluidity and multiplicity of habitus ......................................178
Theorising the naturopathic meeting place ................................180
Resettlement, liminality and the NMP .........................................181
A shared cosmology ....................................................................184
An ethics of care ..........................................................................186
‘Return to one heart’: Non-Western conceptions of health, illness and the body.187
Probyn’s reconsideration of habitus: The ‘feeling body’ ..............190
Resonance of habitus ..................................................................195
‘Familial habitus’ .......................................................................196
Being in-place .............................................................................200
‘Genetic knowledge’: Being ‘at-ease’, being ‘out-of-place’ ..........204
Summary ....................................................................................209

Chapter 8 ‘She made it feel like I’m in my home’: Concluding discussion........211
Frasa’s story revisited .................................................................212
Contributions of this research to refugee health care practice ....216
Contributions to theory: Interdisciplinary research ..................218
Further research possibilities ......................................................220
Reflections on the research process ...........................................221

References .................................................................................227
Naturopathic Reference List ........................................................250
Appendix 1a  SCU ethics application ............................................252
Appendix 1b  VFST ethics application ..........................................262
Appendix 2  Introductory letter to staff at VFST .........................280
Appendix 3  Introductory telephone script (VFST staff) ..............282
Appendix 4a  Subject information sheet (English) ......................284
Appendix 4b  Subject information sheet (Arabic) .......................288
Appendix 4c  Subject information sheet (Dari) ..........................292
Appendix 4d  Subject information sheet (Farsi) ..........................296
Appendix 4e  Subject information sheet (Croatian) .................300
Appendix 5  Introductory telephone script (Researcher) .............304
Appendix 6  Participant details form ............................................305
Appendix 7  Interview guide ..........................................................306
Appendix 8  Introducing the researcher to the participants ............309
Appendix 9  Coding framework .....................................................310
Appendix 10 Example of coded transcript ....................................312
Appendix 11 Biographical details ..................................................315
In the early 1900s my great-grandparents wanted to migrate to America from Hungary. Along with many other Eastern European Jews, they were fleeing poverty and persecution, seeking a better life in the New World. My great-grandfather went ahead, leaving his wife and four children with the promise that he would send for them as soon as he had found work and established himself. After a year, he had a job, savings and accommodation for the family. He wrote to my great-grandmother, instructing her to sell up everything and travel with the children to America. After more than a year’s separation and many arduous months at sea, when the ship docked at Ellis Island, New York, my great-grandmother finally reached her longed-for destination.

During the routine medical check that all intending immigrants were required to pass, one of the children, my grandmother Berta, was found to have an eye infection. As the medical authorities considered this to be an unacceptable health risk she was forbidden to leave the ship. My great-grandmother refused to leave her young daughter and in the chaos and confusion, made worse by her inability to speak English, my great-grandmother and all her children were shipped back to Europe without ever having seen or spoken to my great-grandfather. Who knows what he thought? I imagine him, perhaps with a bunch of flowers in one hand, waiting for his wife and children, standing on the docks for hours, the crowd thinning until finally he was alone, confused, angry, distraught. What happened to my
great-grandmother, barred from her new life, from safety and love by incomprehensible circumstances? And the children – confused and distressed. Berta, the little girl with the eye infection, how did she carry her fate?

My great-grandparents never saw each other again, nor spoke another word. The strong thread that had kept them connected across the world was brutally severed. How did they live with this unrelenting nightmare, stuck forever in a half life?

By some means my great-grandmother and her children survived back in Hungary. Life went on. Berta, the little girl with the eye infection, eventually grew up and married. In an uncanny twist she gave birth to a daughter, my mother, who was born blind in one eye. Was the infected eye of my grandmother transmuted into her own daughter’s affliction? Was her daughter’s partial blindness a continual reminder of her own childhood trauma and the ensuing events that found her mother and siblings deported back to Hungary and a life of struggle and persecution? Embodied trauma eventually finds its way to the surface. My grandmother could not avoid her fate; the motif had been laid. My mother’s blindness became a tightly guarded secret. Not even my mother’s siblings or, years later, her husband, would be trusted with this secret.

I came to understand this thread of blindness as the physical manifestation of the many layers of grief and suffering that permeate my family’s story. Another layer is Holocaust survival.

Several years after being forced to return to Hungary, my family endured the brutality of Nazi-occupied Budapest. By this time my great-grandmother had passed away and my grandmother Berta had become the matriarch of the family. In the chaos and terror of Budapest in 1944 she insisted that her three daughters, now in their late teens, would have a greater chance of survival if the family dispersed and went into hiding. Her son had already been incarcerated in a forced labour camp and she knew the girls would be in far worse danger if they stayed at home. After all, they were a prominent Jewish family – it was only a matter of time before they too would be deported.

Frantically, tenuous arrangements were made and my grandmother implored her daughters to leave the family home. She literally pushed them out the door. Just hours after they unwillingly left, Nazi soldiers pounded on their door. My grandparents were spared only
because of the kindness of their influential gentile neighbour who owned the block of flats where they lived. He was able to convince the soldiers that my grandparents worked for him as the caretakers, and he insisted on them staying to carry out their duties.

The three girls survived: Duci the eldest had a precarious existence based at a Red Cross safe house, whilst my mother and her younger sister Gilly fled from one attic to another, never knowing if and when they would be caught. Finally the war ended and the family was reunited – emotionally shattered but alive.

Just as my great-grandparents had sought a new life in America, fifty years later, my grandmother now urged her children to seek refuge in another new land. She was determined to get her family as far away as possible from the country that had so violently betrayed them. She sold whatever valuables she had managed to hide and organised their illegal exit from Hungary, paying ‘people smugglers’ to get them across the border.

Once in Vienna my mother and her siblings sought refuge with the Red Cross and eventually obtained visas for Australia. When the ship docked, this time in Melbourne, she and her siblings were free to begin their new life, a freedom that had been so cruelly denied her mother and grandmother. One of my mother’s enduring links to her traumatic past is her blindness, a blindness that kept this story and the tumultuous emotions that went with it hidden for such a long time.

It was only in my mother’s later years, when she was threatened by glaucoma and the possibility of complete blindness, that she felt compelled to tell me her secret. I was stunned by the sorrowful connections. My grandmother’s infected eyes seem to have contaminated her family’s lives. Responsible for the deportation of her mother and siblings from America back to Europe, she carried this legacy deep within, eventually giving birth to a half-blind daughter. Unquestioning, my mother accepted her own legacy of shame. Instinctively, she knew her blindness was a curse. It was as if my grandmother’s unspeakable grief and shame revealed itself in her daughter’s blindness.

This is a tale of embodied transgenerational trauma. As the great-granddaughter, my own threads of connection to this story were revealed a few years ago during an optometry appointment. As on the ship about to dock in New York, the doctor routinely ran some
standard tests. The results produced a bodily experience of inevitability … ‘early onset glaucoma.’ Like my great-grandmother, I was devastated by the unexpected outcome of a routine procedure. But the consequences for me were brutal in a different way. In that moment, I felt ensnared by my family story, my body binding me to the pain carried in my lineage. The grief of separation and loss had permeated through the generations and was deposited in me. Like glaucoma, grief and loss are transmissible, an inheritance. I felt the claw of unresolved grief clutching at my body, identifying me with the generations of grieving women in my family. Weeping through suffering eyes is my genetic inheritance of sorrow.
CHAPTER 1

Introduction

Many refugees come to countries of resettlement carrying the distress of upheaval and loss in their bodies. As was the case for my own family, the lineage of embodied suffering highlights the interconnection between physical symptoms and the emotional and social distress of dislocation. In this thesis, twelve women’s stories give voice to the capacity of the body to communicate what is often unspeakable. Their stories throughout the thesis are a testament to how suffering can become inscribed onto the body. Similar to my own story of embodied grief, these women’s physical symptoms were often entwined with painful memories of past trauma and severed connections with loved ones and were embedded in the loss and disruption of their social worlds. I begin the thesis by introducing Frasa, one of the women whose story touches on these themes.

Frasa’s story

Frasa is a Muslim woman from Afghanistan. Prior to the political violence that shattered her life, Frasa worked as a school teacher and enjoyed a fulfilling family life. Before the Taliban arrived I was a teacher, and I found myself a bit different after the Taliban arrived, I found I had a bit of depression from that time. Like her mother and grandmother, she was born and raised in Kabul. The first and only time she left her beloved city and her extended family was when she and her children fled in fear for
their lives during the Taliban rule. In our interview Frasa felt compelled to speak of these events: *You said at the beginning of the interview that this conversation is not connected to your refugee status, but I have to say something [about this] to you.*

Frasa explained how her brother-in-law’s involvement with the previous government had automatically placed the family in grave risk. Her husband, already fearful for his own safety, had fled their home and was in hiding when Taliban soldiers came to their house searching for him. *They put a gun at the head of my nine-year-old boy and said ‘where is your father’.* Before leaving with whatever valuables they could find, the soldiers threatened Frasa, saying they would be back for her. Once the soldiers left she fled with the children. They too went into hiding, moving from one place to the next, staying only a few days in different places. Frasa was three months pregnant with her fourth child at the time. Through family contacts she eventually discovered that her husband had been caught and arrested and he was now imprisoned. To ensure her children’s safety Frasa undertook a perilous escape from Afghanistan, crossing the border into Pakistan. After many difficult months fending for her family in a refugee camp she was finally reunited with her husband. He had survived the horrors of a Taliban prison and remarkably had been released, psychologically damaged but alive. On discovering that his family had fled to Pakistan, he too made the dangerous journey. After several years in a refugee camp in Pakistan the family eventually received humanitarian visas for Australia.

Frasa described to me how she became unwell as a consequence of the political and social upheaval that occurred in her country:

*The first time that I found myself as a sick person I was in Afghanistan and it was during the Taliban, the time of the war and my family flee the country … I was isolated from my family for the first time and I found myself different.*
Frasa's most profound sense of ongoing distress came from being separated from her mother. In the chaos and desperation of fleeing Afghanistan the family scattered. Her mother and two of her sisters received humanitarian visas for a European country, while Frasa and her immediate family were accepted for Australia, thus their irrevocable and terminal separation:

*When I got isolated from my mum I thought the world is gone, I thought the world is finished ... I pray that I can save money and get my citizenship and travel to see my mum. She is very old now.*

Throughout our interview Frasa spoke with heartfelt admiration and love for her mother. *When I speak with my mum, the actual conversation give me the comfort.* The importance of this relationship for Frasa was exemplified in the stories about her mother's skills as a herbalist. *Mum raised her ten kids and she was the family doctor. She was giving the traditional medicine first. We got a little farm and she grew some special herbs.* She explained to me that her mother learnt *herbal therapy from her mother. My grandmother was the best.* Frasa's grandmother was an accomplished herbalist who had *a special box with tiny little boxes inside that hold different herbs inside of the box.* This had been passed on to Frasa's mother.

Frasa also had extensive knowledge about the use of herbal medicine. She had been educated in the craft by her mother and grandmother and she knew what herbs and foods to use to treat a variety of illnesses. She proudly told me how she treated her own children with herbal remedies and how she was still regularly in contact with her mother to discuss health issues:

*I keep taking my children to herbal therapy. For example, when they [her children] get the diarrhoea I actually treated it by myself, if they got the chest problems or some cold or flu I just treated my children by myself and they got better.*

In our interview Frasa had a straightforward way of telling me about how she and her family used both herbal remedies and Western medicine to treat their ailments. *I received both. Traditional treatment from my mum ... When it was serious matter, then I would attend the medical doctor. And we had a very good medical doctor.* Although
her manner was unassuming, the importance of herbal knowledge in Frasa’s life was revealed in the stories she told of her life in Afghanistan. Herbal medicine was intimately entwined with memories of her mother and grandmother and her memories of home. *My Mum actually give herbs to the people and the people get well very quickly.* Using herbal medicines was deeply familiar for Frasa, which brought a sense of comfort in her everyday life. *Very important part of life, my treatment, is herbal therapy.* This comfort is literal through the relief of symptoms, but also this approach represents the connection she has with her lineage and thus enables her to preserve the very special bond she has with her mother. To have access to herbal treatment in Australia in the context of the official resettlement process was therefore highly significant.

At Foundation House, a refugee torture and trauma rehabilitation service in Melbourne, Frasa was referred for naturopathy by her counsellor. The referral was made because she was experiencing health problems that were not responding effectively to biomedical treatment, and because she was fearful of becoming addicted to the pharmaceutical medications that had already made her feel very unwell. However, the referral had far greater meaning for Frasa:

> At the first time I arrived here I was very sick, very depressed, the doctor prescribed me medication for 11 months, the prescription was a very strong antidepressant medication. That time I had to change the medication many times and one would make me very dizzy, and I found I was very unhealthy, I lost my appetite, I lost my weight, I lost my sleep, I lost everything at the time … when I got prescription from the doctor, I worried a lot, I got worried that I am getting addicted to the medication. And they keep saying to me, when I go to the doctor, you must take your medication, you must take your medication. And I was thinking, I’m getting addicted. It was a fear, a worry in my body. I discussed my situation with my social worker, and I said to her that I am going to die, it’s my end of life, and she introduced me to Kate [naturopath] and when I visited Kate I think she gives me a second life.

> Since I received the herbs from Kate, a tea, when I drink the tea, I go to sleep really well. And the other herbs help my headache, my appetite is better now. Everything is better now … And my mum said to me, it’s my mum’s conversation that I remember, my mum said
to me ‘if the herbal therapy is not going to help you, it’s not going to make you worse’ … I believe in my mum a hundred per cent … she did have a small garden and she knew every plant that was in it.

Just as Frasa’s body expressed her refugee-related trauma, so too, her body revealed the potential for healing experienced in the naturopathic encounter. The particular circumstances that made it possible for someone as traumatised as Frasa to experience healing in the naturopathic encounter is the locus of my exploration in this thesis.

Frasa’s story raises many of the questions this thesis seeks to address about the importance of providing a broad range of health care approaches that includes culturally meaningful practices for refugees in a Western resettlement context. Currently, health care for refugees is predominantly the domain of biomedicine. While biomedicine makes essential contributions to refugee health care, namely the treatment of specific diseases, this thesis questions its effectiveness in other areas. In particular, the thesis questions the appropriateness of an exclusively biomedical approach in treating the complexity inherent in chronic ill health and the experiences of ‘dis-ease’ – the sense of feeling out of place in one’s body that often accompanies refugee trauma and dislocation.

One of the challenges of providing meaningful cross-cultural refugee health care practices in Western settings is to make available approaches in which the broader social determinants of health are addressed. As Frasa’s story demonstrates, the challenge is to address the ways in which physical symptoms can represent the trauma inherent in the refugee experience.

In order to address such challenges, some scholars argue for a broader interdisciplinary approach (Littlewood 1990; Watters 2001). In this thesis I examine the meanings of naturopathy within an integrated service delivery model through the experiences of twelve women engaged in naturopathic treatment at Foundation House. The thesis draws on the broader understandings of displacement, embodiment and the notions of healing within a medical anthropological and medical sociological framework. It explores the place of naturopathy in attending to the broader social and personal context of ill health in a refugee health care framework.
While non-biomedical approaches are alluded to in the literature as potentially beneficial, there is little research investigating such practices in the context of refugee health care. Nonetheless, within some torture and trauma rehabilitation services in Australia, naturopathy has become an increasingly accepted treatment strategy over the past decade.

My original intention in this research was threefold: to reveal, from the perspective of these particular women, the meanings and experience of naturopathic treatment in the recovery process in order to better understand the role of naturopathic treatment in this context; to locate these experiences in the context of providing health care for refugees in a Western setting in order to explore the potential role of naturopathic approaches within the existing refugee health framework; and to investigate the place of traditional medicine within these women’s lives in order to create an opportunity for these women to give voice to an important aspect of their cultural identity.

**Impetus for the research**

I started working as a naturopath with refugee survivors of torture and trauma in 1992. Responding to a request for volunteer naturopathic practitioners from Foundation House’s recently established natural therapies program, I joined the team, and twelve months later took over the position of natural therapies coordinator.

At Foundation House my practice-based knowledge developed over ten years of naturopathic work with refugees and showed me the importance of providing a pluralistic approach to health care for refugees that included non-biomedical modalities. In my role as a naturopath, my knowledge developed empirically and without the opportunity for critical reflection. In order to credibly document this work I took up the position of postgraduate researcher. In making the decision to shift from ‘practitioner’ to ‘researcher’ I resigned from my position at Foundation House and embarked on this academic path.

As I have stated, this research also arises from my clinical work at Foundation House. The years I spent immersed in this field were formative in shaping my world view and sociopolitical understandings of refugee health issues, and the place of traditional medicines
such as naturopathy in this context. I readily acknowledge that my lived experience has informed every aspect of the project, from conceptualisation to analysis. In the process, my assumptions have been challenged and my understandings deepened.

In my role as a naturopath at Foundation House I had a long-standing aspiration to document the remarkable stories of healing that I had witnessed. At the heart of many of these stories was my clients’ surprised delight to find me prescribing herbal remedies similar to those they were accustomed to using in their home countries. For me, our shared connection to herbal medicine brought us closer together, helping to bridge cultural differences – in this space we shared a common language. One client’s experience in particular had a deep effect on how I understood the role of naturopathy in this context, and inspired my desire to examine and document this work:

‘Fahim’ is an Afghani man whom I first met a short time after he was released from 18 months in one of Australia’s notorious detention centres. Fahim was referred to me for naturopathic treatment by his counsellor specifically because he was experiencing severe stomach pains and nothing pathological had showed up on any medical tests. Although his doctor was caring and sympathetic to his plight, she was not able to make any biomedical sense of the extreme symptoms he described.

In our first consultation Fahim and I talked extensively about his concerns. He told me that since fleeing Afghanistan, he had not been able to make contact with his wife and children who were still in Afghanistan. He was aware that fear for his family’s safety exacerbated his health problems. Fahim explained how some foods made his symptoms worse, which led us into a discussion about the cooling and heating properties of foods and spices, and I made some dietary suggestions based on these principles. At the end of the consultation I prescribed a herbal tea blend that contained a mix of calming digestive herbs. Fahim was very interested in this mixture as he was accustomed to drinking herbal teas in Afghanistan. As I explained the herbal tea blend, he picked out one of the herbs from the bag, which happened to be fennel seed. He looked at it with recognition, and then chewed on the seed. As the taste flooded his
Chapter 1: Introduction

mouth his facial expression changed from a tight strain into pure delight. He told me with tears of joy in his eyes that when he was a child his mother would make him fennel tea whenever he had stomach pains.

Fahim’s experiences of naturopathy, like Frasa’s, illustrate that many refugees resettled in Western countries have strong and meaningful connections to the traditional healing practices of their home countries.

Framework – theory and methods

Exploring the experiences of naturopathic treatment for refugees in a Western setting brings together two contemporary fields of practice: refugee health care and traditional medicine. In this qualitative inquiry I take an interdisciplinary theoretical approach to analysing the twelve in-depth interviews I conducted with refugee women. Based on a review of the literature, the early chapters draw particularly on medical sociological and medical anthropological perspectives to inform the sociocultural and historical context of the research. I specifically draw on Nancy Scheper-Hughes and Margaret Lock’s (1998) work on the ‘three bodies’ – the multidimensional interaction of the self with the social and the political. Taking this analysis into a refugee-specific setting, some academics, for example Coker (2004b) have developed the notion of the ‘refugee body’ – the fusion of physical pain with the social, political and cultural factors that define the refugee experience. This embodied perspective underpins the theoretical basis of the later chapters. Consistent with a grounded theory approach (Patton 2002), it was the emergence of the themes that led me to the area of embodiment theory.

The distinction between ‘pathogenesis’ and ‘salutogenesis’ proposed by medical sociologist Aron Antonovsky (1987) provides a useful framework for explaining the philosophical and ontological underpinnings of naturopathy. Antonovsky’s work is particularly important as it offers a paradigmatic shift away from the disease-based focus of biomedically orientated refugee health research, thus further locating the thesis within a holistic and health-orientated epistemology.
Theorising the experiences of the naturopathic encounter, I take up the concepts of space and place. These issues are critical for most refugees like Frasa, whose circumstances are often defined by displacement. Having been ‘out of place’ in the refugee experience leads to an exploration of ‘place’ at a deeper level. I consider these concepts through the lens of humanistic geography, medical anthropology and cultural studies. I argue that there is a dovetailing effect between concepts of place and notions of embodiment that are accentuated in the naturopathic encounter.

Having laid the theoretical groundwork in the early chapters, I analyse the emergent themes primarily through the work of embodiment scholar Elspeth Probyn (2005). I draw specifically on Probyn’s (2005) re-consideration of Bourdieu’s (1990b) work on habitus in my analysis of the naturopathic encounter. Probyn’s conceptualisation of habitus offers an ‘everyday’ understanding of the ways in which the body carries and contains the complexity of our lived experience. I argue that the explicitly feminist orientation in Probyn’s work is particularly relevant to the alternative landscape of this thesis where the agents investigated, the naturopaths and refugee women, are considered marginal in Western society.

Outline of thesis

Chapter Two outlines key definitions and locates the thesis within relevant contexts. I locate the thesis within areas of refugee health discourse which argues that meaningful crosscultural health care for refugees requires an interdisciplinary approach in which the interlacing of sociocultural understandings of the body is critical. Informed by medical sociological and medical anthropological perspectives, I review the historical and sociopolitical influences that have created biomedical hegemony and the consequent marginalisation of traditional ethnomedicines. My intention is to locate contemporary naturopathic discourse in relation to these socio-historic events.

Chapter Three begins with an account of the variance between holistic and reductionist perspectives on health, illness and the body. As a foregrounding, this chapter sets the paradigmatic tone of the thesis. Underpinning this discussion is the work of medical sociologist Aron Antonovsky (1987) whom I introduce in this chapter. I also introduce the
theoretical work of anthropologists Nancy Scheper-Hughes and Margaret Lock (1998) on the ‘three bodies’ and provide an interdisciplinary review of concepts of space and place which lay the theoretical foundations for the later chapters. In the final section of this chapter I discuss the relevance of naturopathy in providing meaningful refugee health care.

In Chapter Four I outline the particular qualitative research approach I implemented to conduct this research project. After an overview of the specific issues inherent in conducting research with refugees, such as linguistic concerns and working with interpreters, I detail the research design and methods I employed, including the recruitment process, sampling and data analysis. In this chapter I briefly introduce my participants and give an account of my experiences in the interview encounters. This narrative demonstrates the reflexivity embedded in my methodology and analytic processes.

The purpose of Chapter Five is to locate and describe the research site at Foundation House. I begin by reviewing the establishment of torture and trauma services in Australia and pay particular attention to the historical circumstances that led to the establishment of Foundation House. In this chapter I explain the rationale that underpinned the decision to incorporate naturopathy within Foundation House’s service delivery, and go on to detail the organisational structure of the natural therapies program. This background explains Foundation House’s unique health care context and its reasons for successful interdisciplinarity.

In the sixth chapter I use the women’s narratives of their naturopathic treatment at Foundation House to describe the main themes as they emerged from the thematic analysis. The first theme, described as ‘biomedical inadequacy’, underlies the main reasons that the women were referred for naturopathic treatment and which makes explicit the current gap in health care for refugees discussed in Chapters Two and Three. The chapter then deals with the themes emerging from what I term the ‘naturopathic encounter’ – the culturally mediated interactions between naturopathic practitioners and refugee women.

The women brought their refugee bodies into the naturopathic encounter and experienced respite and renewal. Most of them also brought to these encounters their embodied cultural knowledge, revealed through stories of connections to home, mother and herbal medicines.
Chapter Seven brings together the women’s narratives with the theoretical lenses and type of analysis I have employed. In this interdisciplinary analysis, the understanding of the ‘three bodies’ proposed by Scheper-Hughes and Lock (1998) is the fundamental assumption from which I begin my analysis. In this chapter I aim to deepen this analysis by drawing on the work of embodiment scholar, Elspeth Probyn (2005), whose reconsideration of Bourdieu’s work on habitus allows me to theorise the naturopathic encounter, transforming this space into a meeting place.

In Chapter Eight I revisit Frasa’s story and weave together the themes and theories explored in the thesis and note the contributions this research makes to interdisciplinary research. I finish the chapter with my reflections of the research process.
The purpose of this chapter is to define key terms and to describe the background contexts of the thesis topic. I provide a brief overview of the historical context of refugees in Australia and note the establishment of specific torture and trauma rehabilitation services for refugees. Underpinned by mostly sociological and anthropological perspectives I contextualise the evolving interest in holistic approaches to refugee health care in Western countries of resettlement. In the final section I put forward an historical overview of the development of naturopathy, and present an analysis of what I argue are serious contemporary issues confronting the knowledge base of traditional medicines.

**Terminology**

**Refugees**

*Who is a refugee?*

As of 2007 there were an estimated 32.9 million ‘people of concern’ to the United Nations High Commission for Refugees (2007:2). ‘People of concern’ includes different categories of people of which ‘refugees’ is only one. In the 1951 Convention Relating to the Status of Refugees (the Refugee Convention), article 1A (UNHCR 1951), states that a refugee is a person who has a:
Chapter 2: Refugee health care and naturopathy: Terminology and context

[W]ell-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, is unable or, owing to fear, is unwilling to return to it.

The meaning of the term ‘refugee’ has been challenged since the Refugee Convention was developed in 1951. These changes are evidenced in a report produced in 2006 by the United Nations High Commissioner of Refugees (UNHCR) in which the term ‘refugee’ now exists alongside several other categories, collectively known as ‘persons of concern to UNHCR’ (2007:16). These categories include: refugees, asylum seekers, returnees, internally displaced and stateless persons (UNHCR 2006, 2007). The UNHCR (2006:16–17) defines these groups as follows:

**Refugees** include persons recognised under the 1951 Convention relating to the Status of Refugees, its 1967 Protocol, the 1969 OAU Convention Governing the Specific Aspects of Refugee Problems in Africa, those recognised in accordance with the UNHCR Statute, persons granted complementary forms of protection and persons granted temporary protection [see UNHCR reports for further details].

**Asylum-seekers** are persons [having fled to another country] who have applied for asylum or refugee status [under the 1951 UN Convention, or the 1967 Protocol], but who have not yet received a final decision on their application.

**Internally displaced persons** (IDPs) are persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalised violations or human rights or natural or human-made disasters and who have not crossed an international border. Because IDPs have not crossed an international border, their legal situation, as well as the international response to their plight, differs significantly from that of refugees. UNHCR statistics are limited to conflict-generated IDPs.
Returnees refer to displaced populations (mainly refugees and IDPs) who have returned to their country of place of origin.

Stateless persons are persons not considered as nationals by any State under the relevant national laws.

The meaning and applicability of the original 1951 Refugee Convention definition, nearly sixty years later, and the categorisations of ‘people of concern’ has become the focus of contemporary scholarly debate and concern. Undeniably, the rapidly changing geo-political situation since the 1950s has considerably affected the circumstances that now lead a person to become a ‘refugee’. Of particular concern to some scholars is that at present the vast majority of people in ‘refugee-like situations, who are in need of protection from persecution, are contained within the borders of their country and are therefore not covered by the Refugee Convention’ (Kneebone & Allotey 2003:2). As noted by some scholars, the original definition does not reflect the current global context (Kneebone & Allotey 2003; Voutira & Dona 2007; Zetter 2007). Although this critical debate is beyond the scope of this thesis, it is important to acknowledge the complexities and contentions inherent in asking the vexed question ‘who is a refugee?’ (Colson 2003; Harrell-Bond & Voutira 1992; Kneebone & Allotey 2003; Zetter 1991, 2007). While this debate is important and I accept the importance of many of these issues, for the purposes of this thesis I use the term ‘refugee’ to refer to people seeking refuge from persecution irrespective of national borders.

Definitions of torture and trauma

The following definition of torture is taken from Article 1 of the United Nations ‘Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment’ cited on the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) website:

Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering

---

1 The Journal of Refugee Studies (2007) Volume 20(3) has several papers dedicated to this topic.
is inflicted by or at the instigation or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.

For the purposes of this thesis, the term ‘refugee trauma’ refers to:

[T]he pain, distress and suffering that [people] experience relating to, or arising from, their refugee journey. This usually includes war or civil conflict, and/or violence motivated for religious, ethnic or political reasons (FASSTT 2006).

In this thesis I use the expression ‘refugee experience’ to convey the extensive range of physical, emotional, spiritual and sociopolitical distress and suffering that people endure through the process of becoming refugees. Implicit in this term is the understanding that the majority of refugees have experienced ‘refugee trauma’. This may have included:

Prolonged periods of deprivation, forced removal from their homes, the loss of loved ones or a perilous escape from their homelands … very few refugees have emerged from their experiences without having endured or witnessed some form of physical or psychological violation (VFST 1996a:6).

It is estimated that:

Twenty five percent of refugees have been physically tortured or subjected to severe psychological violation prior to their arrival in Australia, seven in ten will have been subject to less severe, but nevertheless traumatic experiences in violent circumstances (FASSTT 2006:9).

In this thesis I make the argument that the complexity of health issues resulting from the refugee experience requires a broad approach to health care. I use particular terms, such as biomedicine, traditional medicine and naturopathy. I define my use of these terms in the next section.
Health care systems

Biomedicine

In this thesis, biomedicine is understood as the dominant medical model in Western industrialised nations (Hahn 1995; Helman 2007), and increasingly so throughout the developing world (Bodeker 2001; Root Wolpe 1990). Kleinman (1995a:26) argues that what is specific to biomedicine is ‘the scientific paradigm that is at the core of the profession’s knowledge-generating and training system’.

Within a Western cultural context the Enlightenment of the seventeenth and eighteenth centuries laid the foundations for the development of modern Western thought, and in particular scientific knowledge. The reductionism inherent in a scientific understanding has enabled the development of knowledge at a cellular level, articulating the biochemical causation of disease states. Without doubt, disease-based medical knowledge is of paramount importance. Many scholars attribute Pasteur’s formulation of the ‘germ theory’ in the 1860s and 1870s as the defining ‘moment’ in the development of biomedicine (McKee 1988). Berliner et al. (1984) cited in Weiss and Lonnquist (1994:19–20), accurately describe the scientific notion of disease causation as being based on the understanding that ‘all disease is materially generated by specific etiological agents such as bacteria, viruses, parasites, genetic malformations, and internal chemical imbalances’. Berliner (1975) suggests that the quintessential aspect of the decline of holistic medicine is exemplified in the split between mental and physical illness. Notwithstanding recent scientific developments in the area of psycho-neuro-immunology (Adler, Cohen & Felten 1995; Samson 1999), it would seem that the transfer of this new level of scientific understanding into clinical diagnostics and practice has been limited.

Explained later in this chapter, a confluence of historical and sociopolitical factors has led to the development of a biomedical hegemony and the consequent marginalisation of ‘other’ medicines. Underlying biomedicine’s powerful position is its claim to ‘expert’ knowledge, as well as the state-sanctioned position it holds in society (Illich 1977). It is also referred to as orthodox medicine, Western medicine or allopathic medicine.
Chapter 2: Refugee health care and naturopathy: Terminology and context

Ethnomedicines

In anthropological discourse the concept of ‘ethnomedicine’ is used to differentiate diverse medical systems without implying hierarchical privilege (Kleinman 1995b). An ethnomedical framework emphasises ‘the study of any form of medicine as a cultural system’ (Brown, Barrett & Padilla 1998:15) and focus is directed to the meanings people give to their experience of using different healing systems to treat their health concerns within their particular cultural setting (Brown, Barrett & Padilla 1998; White 2004). This position, I suggest, is particularly useful for the cross-cultural refugee health context of this thesis. However, this analysis is contrary to the biomedical view that tends to see biomedicine as ‘not one medical system among many [but] the standard to which all other medical systems should aspire’ (Cunningham & Andrews 1997:12).

Traditional medicine

In the World Health Organisation’s (WHO) ‘Global Atlas of Traditional, Complementary and Alternative Medicine’ (Bodeker, et al. 2005), Shein & Maehira (2005:xii) define traditional medicine as:

[T]he sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health, as well as in the prevention, diagnosis, improvement or treatment of physical and mental illnesses.

Further categorising the notion of traditional medicine, scholars have created subdivisions that reflect the diversity of knowledge and forms of practice that exist within traditional ethnomedicines (El-Gendy 2005; Helman 2007; Kleinman 1980). These include: popular or folk medicines; traditional-oral or non-codified traditional medicine; traditional-written or codified systems; and complementary and alternative medicines. How these subcategories are defined will vary within different sociocultural contexts2. What is important is that traditional medicines constitute a body of knowledges and practices; they are not idiosyncratic.

---

2 The WHO’s atlas on traditional medicines provides a global perspective (Bodeker, et al. 2005). For an anthropological perspective see Helman (2007).
Although I take note of the WHO’s definition of traditional medicine, I also draw from the medical anthropological and medical sociological literature that critiques this term.

The expression ‘traditional’ in relation to medicine has been used disparagingly to describe healing practices that are seen to be antiquated and fundamentally in conflict with modernity. The philosopher Madan Sarup’s (1998:97) interpretation of the notion of ‘tradition’ however challenges this position:

> We often forget that tradition, too, is always being made and remade. Tradition is fluid, it is always being reconstituted. Tradition is about change – change that is not being acknowledged.

Although Sarup (1998) is not specifically referring to traditional medicine, extrapolating his theorising to this field offers a useful way to frame its evolving nature. Leslie (1992) states that traditional medical systems are not stagnant, closed systems. They are ‘intrinsically dynamic, and like the cultures and societies in which they are embedded, are continually evolving’ (1992:6). Traditional medicine knowledge is adaptive and informed and influenced by a range of different knowledges and sociocultural practices (Ernst 2002).

According to the WHO, in many developing countries traditional medicine is the primary form of health care (Shein & Maehira 2005). In some circumstances this is because biomedicine is inaccessible or unaffordable. Significantly, the majority of the world’s refugees come from developing countries and therefore traditional health care knowledge and practices play an important role in refugees’ understandings of health and illness (El-Gendy 2005; Neumann & Bodeker 2007). It is also important to note that in developing countries, even when biomedicine is readily available and accessible, many people prefer to use traditional medicines to treat certain health conditions (El-Gendy 2005; Lambert 1997; Whittaker 2000).

Moreover, use of non-biomedical health care is not limited to refugees or to people in developing countries, or non-Western societies. In contexts where biomedicine holds professional sovereignty, the popularity of non-biomedical healing practices has continued to grow, particularly in the last two decades (Bodeker 1999; Coulter & Willis 2004, 2007; Janes 1999; Saks 2003; Shein & Maehira 2005; Siahpush 1999). For example, in Australia
Chapter 2: Refugee health care and naturopathy: Terminology and context

it is estimated that seventy per cent of the population has used non-biomedical therapies in the past ten years (Shein & Maehira 2005:x). Across the globe in different sociocultural contexts, the rationales for using traditional medicine and biomedicine vary considerably. The fact remains however that both forms of medicine are equally in demand and sought after regardless of whether biomedicine is available or accessible3. Principles informing the practice of traditional medicine are elaborated in chapter three.

Complementary and alternative medicine (CAM)

The term ‘complementary and alternative medicines’ (CAM) is used by the WHO to classify the wide range of health care practices that ‘are not part of [a] country’s own tradition and are not integrated into the dominant health care system’ (Shein & Maehira 2005:xii). However, in some countries the terms ‘complementary/alternative/non-biomedical medicine are used interchangeably with “traditional medicine”’ (Shein & Maehira 2005:xii). Further contextualising these terms Bodeker, Kronenberg and Burford (2007:9) state:

‘[T]raditional medicine’ is used when there is a need to refer exclusively to the indigenous health traditions of the world, in their original settings, while ‘complementary and alternative medicine’ (CAM) refers to health care approaches outside the biomedical mainstream in industrialised countries.

However, as I have discussed elsewhere, the term CAM is problematic and I do not use it in this thesis to describe the non-biomedical practices employed at Foundation House (Singer & Fisher 2007).

My central concern with the term CAM, as also argued by Baer (2004), is that it did not originate from within the non-orthodox profession itself. Baer (2004) proposes that the term was endorsed by the biomedical elite in order to assert control over non-orthodox practices through grouping together a vast range of practices under the one umbrella. Importantly, what seems to be the central tenet underpinning the CAM construct is an approach which predominantly privileges a scientific, evidence-based method of employing natural medicines and techniques (Baer 2004).

---

Baer’s (2004) concerns are echoed by other scholars who argue that the imposed and implied uniformity inherent in the concept of CAM renders a smoother passage to cooption by biomedicine as it attempts to universalise a wide range of practices which hold diverse core beliefs and methodologies into a controlled and sanitised ‘other’ (Collyer 2004; Willis & White 2004). For example, although the practices of herbalism and homoeopathy share a similar holistic world view, they are based on quite different knowledge bases. What links them together under the biomedical construct of CAM is, according to Willis and White (2004:51), their ‘otherness in relation to orthodox’, rather than a shared methodology. For biomedical practitioners, the term CAM is convenient and linguistically efficient. However, I would argue that for non-orthodox practitioners, it fails to reflect the important epistemological differences across the range of their practices, and as documented in VanMarie’s (2002) research of herbalists in the UK, many such practitioners resist being lumped together under this umbrella.

**Naturopathy as defined in this thesis**

The term ‘naturopathy’ has been used in Western society since the early part of the twentieth century and is considered an eclectic system of health care. It is based on the notion of ‘nature cure’, that is the notion that the body has inherent healing tendencies which the practitioner enhances and assists. Many naturopathic principles date back to Hippocratic teachings (Myers et al. 2003). Di Stefano (2006:xxv) defines contemporary naturopathic approaches as:

... essentially educative and transformative in their intent. Patients are actively encouraged to become more informed in such matters as the role of diet and lifestyle upon health and sickness. Philosophically, the naturopathic approach is aligned to an holistic appreciation of our essential connection with nature and natural forces, and seeks through its various methods to enhance our self-healing capacities through the use of natural substances and lifestyle regulation.

In the Australian setting, the expression ‘naturopathy’ is used as an overarching term to describe the combined practice of Western herbal medicine, homoeopathy, dietary advice and tactile therapies, as well as a range of other healing modalities. Naturopaths are trained in these modalities and may often specialise in one particular discipline. In this case, the
practitioner is likely to use the title ‘herbalist’ or ‘homoeopath’ to identify their speciality. Some practitioners take a generalist approach, incorporating a range of modalities in their clinical practice which they use concurrently and hence use the title ‘naturopath’.

As distinct from CAM, described above, I argue that naturopathy is orientated towards a holistic world view and incorporates vitalistic principles into its diagnostic and treatment approaches (Baer 2004; Myers et al. 2003). Within this naturopathic framework, the practice of Western herbal medicine tends to be underpinned by a holistic approach and some practitioners draw from humoral theory in their diagnosis and treatment (Di Stefano 2006; Topps & Busia 2005; Trickey 2003). Thus, in its holistically orientated framework naturopathy is positioned closer to many of the indigenous and traditional healing systems than it is to the biomedical system.

A central tenet of holism is the notion of treating the whole person, rather than the uniform treatment of symptoms or disease states (Jagtenberg & Evans 2003), and value is attributed to the person’s subjective experience of their illness (Kleinman 1987). Humoral theory is based on the understanding that health and wellbeing is achieved when the ‘humours’ of the body are in balance. I elaborate on these concepts in Chapter Three.

Central to the principles of naturopathic philosophy is the emphasis given to maintenance of health and self-healing through balancing the body’s vital force (Bradley 1999; Coulter & Willis 2007; Di Stefano 2006). Underpinning the concept of vitalism is the tenet vis medicatrix naturae, the healing power of nature, a fundamental principle informing naturopathy (Di Stefano 2006). The concept of vitalism suggests that ‘the body possess[es] an inherent intelligence or wisdom, and has an innate capacity to heal itself … ’ (Jagtenberg & Evans 2003:325). This is similar to the notion of ‘qi’ in traditional Chinese medicine, or ‘prana’ in Ayurvedic medicine (Kleinman 1995a).

A key factor defining naturopathy in this framework is the recognised paradigmatic discord between the reductionism of biomedicine and the vitalistic underpinnings of naturopathy. This perspective is exemplified by authors such as Coulter and Willis (2004:584) who maintain that inherent in naturopathy is:
... the principle of ‘vitalism’ – that all living organisms are sustained by a vital force that is both different from and greater than physical and chemical forces ... [and this] contrasts with materialism, which holds that disease can be explained entirely in terms of materialistic factors.

Di Stefano (2006:xxv) takes a similar position:

Naturopathic philosophy leans strongly towards a vitalistic perspective of health and disease. Naturopathic treatment aims to enhance the life force or vitality of the patient through supportive medication and treatment, and through the activation and support of the body’s detoxifying capacities. Most practitioners of naturopathy are comfortable with the notion that physical reality is conditioned by an energetic reality that can be utilised for the purposes of healing.

Within a naturopathic framework the notion of vitalism is epistemologically different from the pathogenic focus of biomedicine. Naturopathy is health orientated as opposed to disease focused. It looks to the inherent physiological strengths and weaknesses of the individual to understand how they are coping with life circumstances rather than trying to simply remove the symptoms. Emphasis is given to the prevention of illness and the maintenance of health, rather than to treating named diseases states. Illness is understood to be an imbalance and treatments aim to restore balance, rather than cure diseases. Through restoring balance, naturopathic approaches aim to assist the body to heal itself. Health is achieved through supporting the body’s vital force or innate healing capacity so that the person has the resources for attaining and maintaining health and wellbeing. Treatment is individually based, in that each person is seen to have a unique response to illness, irrespective of their named disease state. Similarly, naturopathic medicines are understood to assist the body’s innate healing potential by supporting physiological processes, whereas pharmaceuticals are employed to direct change at a pathological level. The interaction between body, mind and social and physical environments are understood as fundamental to healing (Di Stefano 2006; Myers et al. 2003)

The notion of vitalism was also found in sectors of biomedicine up until the middle of the 20th century. For example, it was strongly endorsed within areas of biomedical culture in France during the early part of the 20th century. Weisz (1998) suggests that the work of
the French philosopher Georges Canguilhem contributed to a deeper conceptualisation of vitalism at this time. According to Weisz (1998:71), Canguilhem believed that vitalism was ‘also an attitude, a sense of identification with nature’ that was a reflective rather than aggressive relationship in which the place of humans was to ‘adapt to rather than conquer’ nature. This view is in line with the philosophical tenets of naturopathy. The notion of vitalism has become one of the most distinctive factors that now separate naturopathy and other traditional medicines from that of biomedicine (Kleinman 1995a).

While naturopathy is premised on a holistic epistemology that favours a vitalistic tradition, contemporary practice is heavily influenced by Western cultural assumptions (including biomedical knowledge), values and rules of conduct. For example, within a naturopathic framework the site of healing is predominantly with the individual, rather than the broader society as is the case with many non-Western ethno-medicines (Csordas & Kleinman 1996; Macintyre 2003). Although naturopathy does not originate from indigenous peoples, it adheres to many of the qualities and world views of a traditional paradigm.

Currently in Australia the naturopathic profession does not have statutory registration. This unregulated status has implications for the education, training and professional standing of practitioners. Naturopathic courses are taught predominantly in private naturopathic colleges, and in recent years have become available in a few public universities. The curriculum varies considerably across these different institutions (Evans 2000).

Naturopaths are represented by various professional associations and these associations have differing educational standards for membership and variable codes of ethics. Although naturopathy is not covered by the national health care insurance scheme in Australia, Medicare, some private health insurance policies will provide a rebate on the consultation if the practitioner is a member of a particular professional association. Membership of such associations also enables practitioners to obtain professional indemnity insurance. The history of naturopathy and details of the broader issues pertaining to the profession are not the focus of this thesis. However, I point the interested reader to the Naturopathic Reference List.

Significantly, there is considerable diversity in the contemporary practice of naturopathy with varying degrees of emphasis given to vitalistic principles and scientific knowledge. At one end of the spectrum practitioners are strongly influenced by a holistic world view and vitalistic
principles; at the other end, ‘the [more] scientifically-orientated practitioner thinks in terms of the medical classifications of disease and symptom relief ... [and] products for which there is scientific evidence of safety and efficacy are prescribed to target symptoms rather than to restore balance by improving vitality’ (Singer & Fisher 2007:24).

It is my understanding that the naturopaths at Foundation House are highly skilled in blending an appropriate mix of vitalistic and biomedical knowledge in their clinical practice. The main modalities employed at Foundation House are Western herbal medicine, various massage therapies and nutritional and dietary advice (Chapter Five describes the naturopathic program at Foundation House).

Naturopathy has been available as a treatment option for clients at Foundation House since 1989, two years after the organisation’s inception.

**Medical pluralism**

Medical pluralism refers to many different systems existing within the one society (Brown, Barrett & Padilla 1998). It is not about forcing the adoption of one health system rather than another, but rather allows a situation where a person can seek out a range of different health care approaches according to their beliefs and preferences (Belliard & Ramirez-Johnson 2005:271).

Most Western societies demonstrate an active, yet not necessarily equitable, pluralistic health care approach (Belliard & Ramirez-Johnson 2005; Janes 1999). Particularly in Western societies, pluralism is predominantly driven by consumer demand for alternative approaches. For example, the advent of the holistic health movement (HHM) in the West indicates that the interest in ‘other’ health care practices was strongly driven by consumer dissatisfaction with the dominant biomedical system, rather than by biomedicine sanctioning the value of other approaches (Cant & Sharma 1996). Despite the overwhelming popularity of these other ethno-medicines, within Western society biomedicine is still legally considered the ‘real medicine’ (Amarasingham Rhodes 1996:172) and is a financially more viable option for most people who also have access to universal health insurance that predominantly covers biomedicine and not other health-care practices.
Medical pluralism, incorporating traditional medicine and biomedicine exists within many non-Western societies (Tribe 2007; Whittaker 2000) and in multicultural contexts (Dossa 2006; Dyck 2003; Reed 2002). Essentially pragmatic, many indigenous peoples are skilled in navigating plural health care systems (Edgerton 1977; Geertz 1977; Gould 1977; Harwood 1977). A practical understanding, informed by local cultural norms, experience and availability or access to particular practitioners and medicines informs their health care choices. Gould (1977:502) terms this approach ‘rustic pragmatism’ – using the most effective treatment for the given problem. For example, within the Modjokuto community in Java (Geertz 1977) and the Hehe of Tanzania (Edgerton 1977), it is understood that when the cause of an illness is ‘natural’, or having a discoverable physical cause, then treatment by Western medicine is seen to be effective. However, it is also understood that if there is no perceivable physical cause for the illness, then seeking out Western medicine will not be helpful. In such cases, the traditional healer is the practitioner of choice.

Variations of medical pluralism exist in numerous contexts. Greenfield et al (2005) note that a high degree of medical pluralism exists in Belize where traditional herbal medicine is used effectively alongside biomedicine. Quah (2003) cites a similar approach through most of Asia, and in particular, Kleinman (1995a:23) observes that in China and Taiwan ‘both high-technology biomedicine and folk healing practices are flourishing for a variety of reasons’. Last (1996:385) has described pluralism in India, under British imperial law, where ‘practitioners of Ayurvedic, Siddha, and Unani medicine were at liberty not only to practice but to develop associations and schools of medicine’ alongside biomedicine.

However, Bodeker (2001:165) argues that in recent times in China, as well as in India, biomedical appropriation of traditional knowledge has diminished these traditional practices, stating that ‘modern medical control over the terms and process of integration has resulted in the loss of important aspects of traditional theory and practice’. Similarly, in Western society as non-biomedical practices are under pressure to conform to a scientific model they risk weakening their own knowledge base. I elaborate on these concerns below.
The annotated chronology by York (2003) provides a detailed history.
2004/2005, sixty-six per cent of refugees were coming from African countries. As York (2003) states, the period from 1992 until the publication of his report in 2002 represents another highly complex and contentious phase in Australia’s refugee history.

Australia has been a signatory to the Refugee Convention since 1954 and more than 675 000 refugees and their families settled in Australia between 1951 and 2006 (FASSTT 2006). The Federal ‘Department of Immigration and Citizenship’ (DIAC) is responsible for the management of Australia’s refugee intake through the humanitarian program. The annual quota of 13 000 humanitarian places is divided into two main categories. Approximately 6000 places are reserved for people who meet the legal definition of a ‘refugee’ set by the United Nations High Commission for Refugees (UNHCR), and 7000 places are held for people who come from a ‘refugee-like’ background and are sponsored by someone living in Australia.

**Psycho-social services for refugees in Australia**

Specific psycho-social health care for refugees in Australia has only been made available since the late 1980s. This occurred after research documenting the prevalence of torture and trauma within refugee communities could no longer be ignored (Reid & Strong 1987). Centres providing comprehensive care for survivors of torture were then established in all states and territories, including Foundation House which opened in 1987. It is estimated that in 2004/5 11 000 survivors of torture received help from torture and trauma rehabilitation services (FASSTT 2006:11).

The necessity for multidisciplinary approaches within Western settings that provide health care for refugees is now well established:

> The torture rehabilitation movement has been in existence more than twenty years and it has now been universally accepted that a multidisciplinary approach is the best treatment for torture survivors (Quiroga & Jaranson 2005:70).

Equally important, but generally not readily applied within multidisciplinary settings, is the need to include different sociocultural understandings and health care practices. I suggest that it is the inclusion of specific culturally relevant healing practices that improves the meaningfulness and efficacy of these multidisciplinary settings. In this thesis I argue that the inclusion of health care practices such as naturopathy augments the biomedically...
Chapter 2: Refugee health care and naturopathy: Terminology and context

A base multidisciplinary approach that currently dominates Western torture and trauma rehabilitation services. It adds an approach to treatment which enables a less pathologically orientated view of the person's symptoms and which also reconnects the person to a form of treatment which is culturally familiar and may carry considerable psychological and spiritual weight. With this understanding Foundation House implemented its natural therapies program.

The role of Foundation House

Formally known as the Victorian Foundation for Survivors of Torture (VFST), Foundation House (FH) provides a range of psycho-social services for asylum seekers and refugees, including counselling, naturopathy, extensive advocacy and social support. Clients are referred to Foundation House from a range of governmental departments and community sources including community health centres, hospitals, English language centres and public schools. Clients may self refer and are often referred by family members already attending the organisation.

Within the organisation, counselling and naturopathy are practised concurrently, with the aim to provide a culturally relevant approach to health care (Adams 2006). Although doctors are not employed by Foundation House, the counsellors and naturopaths work closely with a range of doctors and medical specialists in the community. In the international context, an integrated approach that includes non-biomedical practices is uncommon. In Chapter Five I provide a comprehensive overview of the organisation's approach to refugee health care.

Refugees attending Foundation House come from a wide range of countries, ethnic backgrounds and religious affiliations. The cultural diversity of these clients reflects both the national and international landscape of refugee politics and policies.

Refugee health care and cultural relevance

Global recognition of the plight of refugees has existed since the end of the Second World War. However, interest in the complexities of refugee trauma, and specifically the provision of culturally meaningful health care, is a contemporary issue and exemplifies many of the tensions that exist between biomedical and traditional knowledges (Coker 2004a, 2004b; Gronseth 2001; Malkki 1995a; Tribe 2007).
Over the past decade, the national and international debate on treatment strategies for refugees has included an emerging body of research advocating the need for holistic interventions (Bracken, Giller & Summerfield 1995; Chung & Kagawa-Singer 1995; Hollifield et al. 2002; Silove 1999; Tribe 2007; Turner & Gorst-Unsworth 1990; Watters 2001). This interest has developed predominantly in response to concerns of ethnocentric bias in current Western treatment models, and the consequent need to establish relevant cross-cultural strategies within existing models (Bernstein-Carlson & Rosser-Hogan 1994; Bracken, Giller & Summerfield 1995; Kleinman 1987; Marsella et al. 2001).

A case in point is the current debate about the ethno-cultural validity of the Western biomedical trauma model exemplified by Posttraumatic Stress Disorder (PTSD). This debate has generated significant inter-disciplinary concern about its suitability as a framework for addressing refugee trauma. In this way the biomedical diagnostic category, PTSD, can be understood as an exemplar, or site for the paradigmatic tensions between reductive/disease and holistic/illness positions on refugee health care (Tribe 2007). Contentions that there is a lack of cultural validity in the biomedical approach and the consequent ‘medicalisation of distress’ underpin these concerns and demonstrate the necessity to redefine refugee trauma within a culturally and sociopolitically more appropriate context (Eastmond 2000; Jenkins 2001; Silove 1999; Summerfield 1999; Tribe 2007; Watters 2001; Young 1995). Summerfield’s (1999) stance on the application of PTSD to culturally diverse refugees provides an example of this position. He argues ‘PTSD has been given the status of a scientific truth that has come to represent a universal response to trauma, irrespective of cultural context’ (Summerfield 1999:1450).

Marsella et al. (2001) suggest that the ethno-cultural aspects of refugee health care are now a fundamental concern and are increasingly gaining attention within biomedical discourse. For example, the critical review of trauma and health status by Hollifield et al. (2002) acknowledges the lack of cross-cultural applicability of the conventional biomedical model for non-Western refugees. The authors conclude that a broader model of health care, incorporating non-biomedical interventions, is required. They suggest that the need to provide meaningful cross-cultural health care for refugees is based on the understanding that most refugees come from non-Western cultures, where concepts of health, illness and the
body are framed within different world views to that of the biomedical paradigm. An example is the research by Chung and Kagawa-Singer (1995), which shows that many South-East Asian refugees living in the USA express their symptoms within a traditional Asian or holistic paradigm where psychological and somatic symptoms are recognised as coexisting on a continuum.

Endorsing the value of a holistic approach, some scholars argue that in many cultures an explicit relationship between mind and body is central to notions of health and illness (Chung & Kagawa-Singer 1995; Watters 2001). Similarly, Turner et al. (1990) contextualise refugee trauma as a ‘whole person phenomenon’ in which the aftermath of refugee trauma cannot be reduced to wholly physical or psychological symptoms. As the response to trauma is mediated by cultural context, effective health care for refugees requires awareness of differences in the meaning attributed to symptom expression (Kleinman 1987). Researchers have argued that establishing a range of treatment approaches that includes holistic strategies better accommodates cultural difference and minimises the tendency towards medicalising refugee trauma (Bernstein-Carlson & Rosser-Hogan 1994; Cunningham & Cunningham 1997; Morris et al. 1993; Phan & Silove 1999; Silove 1999).

**Studies in cross cultural refugee health care**

The study conducted by Macintyre (1994), examining migrant women’s access to hospital services, emphasises the significant disparity in expression of cross-cultural health concepts. Macintyre (1994) gives a classic example of a young Vietnamese woman who described feelings of being ‘cold’ postpartum. The term ‘cold’ in a Vietnamese context describes the experience of debility and weakness and is an expression of a humoral perspective. But to the biomedically trained practitioner, ‘cold’ only relates to the sensation of temperature. In this case example, the Vietnamese woman’s concerns were dismissed by the doctor who told her that the hospital room was already very warm. Within traditional Vietnamese medicine, and many other non-biomedical systems, humoral conceptions are central to the process of bringing the body back into balance.

The research by Chung and Kagawa-Singer (1995) further demonstrates these points. They argue that because meaning and symbolic values attributed to symptoms are culture specific, diagnostic measures must account for these differences in order to be useful for
refugee populations. Their research into a community sample of South-East Asian refugees living in the USA showed that members of this population express their ‘psychological distress in patterns of symptom clusters more culturally consistent with Asian nosology’, rather than biomedical categories (Chung & Kagawa-Singer 1995:640). Within a traditional Asian medical paradigm, psychological and somatic symptoms are recognised as coexisting, rather than being categorised as either physical or psychological (Macintyre 2003). From their research, Chung and Kagawa-Singer (1995) demonstrate the imperative of providing culturally sensitive health care. They argue that in the absence of culturally appropriate care, South-East Asian refugees are at risk of developing mental health pathologies because the existing biomedical services are unable to accommodate the culturally different needs of this group of refugees. In particular, the stigmatisation associated with mental ill health for this group further inhibits access to psychiatric services. For these reasons, it is argued that it is unlikely that refugees from this region will seek help. Tribe (2007) notes similar issues in Sri Lanka where people are reluctant to seek out Western mental health services for fear of stigmatisation within the community which may have long-lasting detrimental repercussions for marriage prospects for the family implicated with mental illness.

The Australian study by Morris et al. (1993) compares the emphasis Cambodian and Chilean refugees place on the significance of disclosing past traumatic experiences as part of the therapeutic processes. Their results showed that for Chilean clients disclosure was far more important than for the Cambodian clients. Thus, the authors of this study emphasise the need to provide a range of different approaches for refugees in order to accommodate the diversity of cultural needs in regards to addressing health and well-being.

Studies such as those described above suggest that when non-Western beliefs and concepts about health and illness are not taken into consideration, refugees are unlikely to receive meaningful and effective health care. To highlight such cultural differences, Julian (2004) describes how many Vietnamese refugees in Australia express feelings of depression as physical symptoms rather than as psychological concerns. She states ‘[t]hey therefore have different symptoms for the same disease from Anglo-Australians [and] furthermore, given
different symptoms, they seek different treatment: massage rather than counselling’ (Julian 2004:102). The stigma and shame attached to mental ill health means that people will more readily seek help for the physical expression of their distress.

Bracken (1993) suggests that there is now growing acceptance of a cultural relativist position within the discipline of the ‘new cross-cultural psychiatry’ which is strongly influenced by medical anthropological discourse. As the cultural relativist position acknowledges and respects the importance of differences in beliefs, traditions and concepts of health and illness and encourages cultural diversity (Littlewood 1990), it would seem to offer a stronger framework for addressing refugee health and wellbeing. I argue that it offers a meaningful and intelligent breakthrough that favours validation of traditional ethno-medicines and positions biomedicine as just one of the many ethno-medicines that address refugee health and wellbeing.

The need to provide holistic approaches within refugee health care settings has been substantiated by research from clinicians, sociologists and anthropologists who advocate the need for holistic models of refugee health care that are culturally relevant (Bernstein-Carlson & Rosser-Hogan 1994; Bodeker, G. et al. 2005; Chung & Kagawa-Singer 1995; Friedman & Jaranson 1994; Hiegel 1994; Higginbotham & Marsella 1988; Hollifield et al. 2002; Jablensky et al. 1994; Jenkins 2001; Julian 2004; Kneebone & Allotey 2003; Morris et al. 1993; Silove 1999; Watters 2001; Westermeyer & Janca 1997). Although what constitutes ‘holistic health care’ in settings that provide services to refugees will depend on the cultural definitions within particular contexts, the need to move beyond singular biomedical structures is clear. In order for this view to progress further than ‘multi-cultural rhetoric’, I agree with Julian (2004:121) that a paradigm shift in health care values is required.

The case for medical pluralism in culturally meaningful refugee health care

Some scholars advocate that holistic health care for refugees requires the inclusion of medically pluralistic approaches that extend beyond the limitations of the biomedically based mono-cultural health system of most Western countries (Julian 2004; Neumann & Bodeker 2008). Many refugees are familiar with a medically pluralist approach in their home countries, and they often seek out their own traditional healers in their new country of resettlement ‘whilst selectively using available cosmopolitan [biomedical] health services’ (Sargent &
Chapter 2: Refugee health care and naturopathy: Terminology and context

Marcucci 1984:9). For instance, since the arrival of Vietnamese and Cambodian refugees in the 1970s in Australia there is greater visibility and availability of South-East Asian medical practices, such as acupuncture and herbalism.

Examples of effective medical pluralism have been documented within refugee camps, particularly in Asia. In their work on the Thai-Burma border Neumann and Bodeker’s (2008) findings demonstrate that a large proportion of refugees prefer to use traditional medicines alongside Western medical services. Similarly, Hiegel, (1994:294), who worked for seventeen years as a psychiatrist in South-East Asian refugee camps where he encouraged a pluralistic approach between traditional medicine and biomedicine, concludes that ‘Western and indigenous care systems could exist side by side, supplementing and complementing one another’, thereby providing far more efficacious health care.

In a migrant context Reed (2002) discusses the pragmatic pluralism of British South Asian women in navigating a range of health care practices and commodities in Leicester. Tribe (2007) finds that in medically pluralist Sri Lanka, it is common for people to seek out allopathic and Ayurvedic medicine concurrently. In research exploring health pluralism in relation to treatment for trauma in Sri Lanka, Tribe (2007:23) quotes one participant’s rationale for a pluralistic approach: ‘I am receiving some treatment from the people at the government hospital, but it is not strong enough, so I am seeing an Ayurvedic doctor also’. Similarly, in Thailand Whittaker (2000:49) explains that the practices of traditional medicine and biomedicine coexist and patients are adept at blending the two systems:

> In theory the forms of knowledge of biomedicine and traditional healers seem incommensurable, yet the differences are transcended everyday in practice as people seek care and healing from various practitioners.

Based on the literature cited above, in Western refugee resettlement contexts providing a medically plural health care approach that incorporates culturally meaningful practices would seem to make good cultural sense.
History of Western health care practice

In this section I present an historical and sociological overview of the development of naturopathy. Contextualised to the evolution of Western medicine(s) from the nineteenth century, this discussion locates the development of naturopathy to these particular circumstances. The purpose of this discussion is to elucidate the underlying tensions between biomedical and traditional knowledges and practice, which is further elaborated in Chapter Three.

Health care before the 19th century: The age of holism

Until the nineteenth century the orthodox practitioners were a well-established and distinct group who still maintained significant notions of ‘whole person’ health care (Hahn 1995). However, with the ascendency of the scientific world view, and particularly with the advent of germ theory and its fundamental influence on allopathy, ‘other’ forms of medicine were dismissed as unscientific and thus inferior (Cunningham & Andrews 1997; Hahn 1995; Illich 1977). Berliner (1975; 1980) suggests that although whole person medicine had been challenged within orthodoxy since the early seventeenth century, it was still an integral component of allopathic practice in the USA until the advent of the Flexner report in 1910. However, with the historical events of the 19th century, particularly, the augmentation of the scientific paradigm, notions of holism became outmoded within the practice of biomedicine. Conversely, Weisz (1998) points out that during this era, in certain clinical contexts in which scientific developments were not readily accessible to the clinician, holistic medical practice was still integral to practice. However, the rise of scientific medicine did eventually split conceptions of holism from medical orthodoxy, relegating holism to being synonymous with unscientific, non-orthodox practices (Kleinman 1995a).

5 The overview of the historical and sociological development of naturopathy and the analysis of current challenges confronting this field are based on analysis that first appeared in Singer and Fisher (2007).
Professionalisation of biomedicine

The distinction between ‘orthodox’ and ‘non-orthodox’ health care practice only came into existence around the mid-nineteenth century in Britain, Australia and the USA. This division was created as a result of the professionalisation of allopathic medicine which established licensing requirements for the practice of medicine in all three countries. While there are differences in the situations of non-orthodox medical practitioners in the three countries, state-sanctioned medicine has since this time become the dominant form of medical practice, with other approaches to medicine being significantly marginalised. Prior to the Medical Registration Act 1858 in Britain and the Flexner report in 1910 in the USA, a fluid and pluralistic approach to health care existed in which allopaths did not have privileged status (Berliner 1975; Hahn 1995; Saks 1998). Theirs was one among many approaches to medicine, including herbal medicine and homoeopathy, with each group competing for business on what could be considered a ‘level playing field’ in health care services (Hahn 1995).

The influence of the Flexner report in the USA provides a case in point that highlights the intimate relationship between medical science, economic power and the political climate of the day. On request from the American Medical Association (AMA), Abraham Flexner was commissioned by the Carnegie Foundation to evaluate medical training in the USA and Canada. While many medical historians see the implementation of the recommendations of the Flexner report as heralding dramatic improvements in medical education in North America, Berliner suggests that the subtext of Flexner’s commission by the AMA can be understood sociologically to be a highly political strategy to ensure allopathic hegemony (Berliner 1975). The outcomes of the Flexner report heralded the introduction of the scientific paradigm into medical theory and practice by redirecting medical education away from individual practitioners to academic institutions. It also focused the acquisition of knowledge on laboratory experimentation rather than clinical practice to the extent that the only medical universities that received funding had a laboratory base (Cunningham & Andrews 1997). In summary, the recommendations implemented by the Flexner report

---

6 A history of hydrotherapy in Britain in the mid-nineteenth century provides a case study of the interactions between orthodox and non-orthodox practices of this era. See Bradley (2002).
saw the replacement of the pluralistic medical model of the era by a biomedical model that discriminated against ‘other’ forms of health care, as eventually only graduates from these colleges were able to obtain licences to practice medicine (Berliner 1975; Hahn 1995).

Thus, allopathic medicine become known as ‘scientific medicine’, with its base in a positivist epistemology that argued science was objective, neutral and value free and hence preferable to any other basis for assessing knowledge (Berliner 1975; Cunningham & Andrews 1997; Illich 1977).

The establishment of biomedical hegemony

This ascendancy of the biomedical profession, via its legislative status and the institutionalisation of the production of medical knowledge, thus marginalised ‘other’ forms of medicine which collectively became known as ‘non-biomedical’ in comparison to biomedicine, which was taken to be scientifically based knowledge. With this status, biomedicine was able to establish its own knowledge base as the validated and accepted standard, thereby gaining hegemonic power and legitimacy in the sphere of health care (Willis 1989). The sociopolitical background to these historical events contextualises the development and pre-eminence of biomedicine (White 1994). The successes of medical interventions, for example immunisation and antibiotic treatments, also promoted this hegemony. The rise of modernity accompanying industrialism, the adherence to scientific knowledge and the meta-narrative of positivism allowed the development of biomedicine’s dominant position within society (Baer et al. 1998; Kleinman 1995a; White 2004).

However, the practice of biomedicine, like any other ethno-medicine, cannot be separated from its historical, cultural or sociopolitical context (Cunningham & Andrews 1997). Although originating within Western nations, the practice of biomedicine in a globalised world undergoes what Kleinman (1995a:23) calls ‘indigenization’, the process of incorporating the cultural nuances of the society in which it is practised. Across diverse cultures and even within the same society, the practice of biomedicine is not homogenous (Kleinman 1995a; Last 1996; Payer 1990). While the practice of biomedicine cannot therefore be seen as uniformly applied, the underlying world view and epistemology that privileges the scientific/reductionist paradigm is, according to Kleinman (1995a), what separates it from all other ethno-medicines.
The countercultural response to biomedical hegemony

With the hegemony of scientific knowledge, biomedicine’s ‘golden age’ is said to have occurred through the first half of the twentieth century (Turner 2004). By the 1960s the voice of the emerging counterculture, critical of the dominance of biomedical science, was intensifying its volume. The shifting relationship between biomedicine and other forms of medicine has been analysed within the complex sociological discourse on post-modernity (Bakx 1991; Coulter & Willis 2007; Easthope 2004; Riches 2000; Saks 1998; Siahpush 1999). One line of argument suggests that the upsurge of interest in holistic health care practice, initiated in the 1960s, reflected the changing values of Western industrialised society at that time (Baer et al. 1998; Williams 1998). This literature argues that it was specifically the increased dissatisfaction with a scientific world view, and especially biomedicine, which led to a resurgence of interest in contemporary folk medicines such as herbalism and homeopathy (Bakx 1991). The move towards what Bakx (1991:31) calls ‘green’ culture, by the holistic health movement of this era, in preference to the scientism of modernity has been interpreted as ‘representing a positive protest against certain aspects of biomedical knowledge and practice’ (Cant & Sharma 1996:11).

A combination of factors added significant momentum to the countercultural influences of this era. According to Griggs (1997), iatrogenic disease and in particular, the tragedy of Thalidomide, proved to be critical factors in diminishing biomedicine’s privileged status. At the same time, several other key developments considerably enhanced the move towards alternative health practices: the disillusionment with biomedicine’s limited success in the treatment of chronic diseases, such as heart disease and arthritis; and the growing ‘self-help’ movement in which patients were encouraged to participate in their healing process in a partnership between patient and practitioner (Bodeker 2000; Coulter & Willis 2007; Janes 1999; Turner 2004). The advent of the holistic health movement posed a challenge to biomedical hegemony, consequently weakening the hitherto impermeable boundaries between these two health care paradigms (Baer et al. 1998; McKee 1988).

Biomedicine’s response to these changes is evidenced in what has come to be known as the ‘mainstreaming’ of non-biomedical practices.
Chapter 2: Refugee health care and naturopathy: Terminology and context

**Biomedicine’s response: Mainstreaming non-biomedical practices**

‘Mainstreaming’, in this context, is an expression used by sociologists and medical scholars to describe the selective incorporation of non-biomedical practices into the biomedical domain. In some literature, the term ‘mainstreaming’ suggests a benign, beneficial and consensual arrangement, occurring in response to the increasing popularity of non-orthodox practices (Ruggie 2005). An example of this type of mainstreaming is the general practitioner, who, having completed a short course in the use of herbs for which there is ‘evidence’ of safety and efficacy, then prescribes herbal tablets to treat specific conditions, such as St. John’s wort to treat depression. Alternatively, the general practitioners wanting to be seen as ‘holistic’ may engage a naturopath to consult from within their practice without necessarily engaging in a collaborative referral system.

In contrast to the benign critique of mainstreaming, some scholars argue that mainstreaming is the reaction of biomedicine to its loss of power and control. Driven entirely by profit, it equates to co-option rather than to acceptance of the coexistence of different knowledges (Baer 2004; Barry 2006; Bodeker & Kronenberg 2002; Collyer 2004; Shuval & Mizrachi 2004). This argument suggests that co-option is understood as the explicit and coercive take over of traditional medicine by biomedicine and does not imply equality between the two systems (Baer 2004; Collyer 2004; Janes 1999; Root Wolpe 1990). The clearest manifestation of biomedical co-option is the commodification of non-orthodox products (for example St. John’s wort for depression), driven by increasing consumer demand and supported by corporate drive for profit. Marketing and sales of these products are big business. According to Collyer (2004:84), Australians spend twice as much on non-orthodox medicines as they do on orthodox pharmaceuticals. Such products have become corporatised, packaged and marketed like pharmaceuticals, and now present significant competition to orthodox products in the marketplace (Collyer 2004), especially as they have become readily available in supermarkets. In this context mainstreaming, ‘bears little relation to the enhancement of well-being, patient safety, altruism or the curing of disease’ (Collyer 2004:96).

Exemplifying biomedicine’s tactical position is the significant change in attitude of the British Medical Association (BMA) towards non-biomedical medicines. In 1983 the BMA described such practices as ‘residues from some pre-modern past’ (VanMarie 2002:23).
Within a mere ten years a far more favourable and inclusive stance had been taken in response to the increased public acceptance of non-biomedical practices, characterised by the BMA’s 1993 report titled *Complementary Medicine: New Approaches to Good Practice* (VanMarie 2002:23). Saks (1998) cautions against accepting this change as an indication of inclusivity and plurality, and suggests it is more likely an attempt by orthodoxy to maintain control. These changes reflect a substantive realignment of the biomedical/non-biomedical boundary and are more than semantic; they point to the complex tensions underpinning the power differential between the opposing health care systems.

**Traditional medicine – whose knowledge counts?**

Western medicine can be analysed as an ideology of domination which contributed to the destruction of indigenous peoples and their cultures of healing. At the very least medicine depoliticized the destruction of indigenous cultures by explaining their dissolution in biological terms (White 1994:207).

Problematising definitions of traditional medicine is the corollary of globalisation (Giddens 1994; Jagtenberg & Evans 2003; Janes 1999) and as White (1994) points out, the consequent universal hegemonic domination of biomedicine. Some scholars are concerned with how traditional knowledges can maintain their integrity and validity given the intense pressure to modernise (Higginbotham & Marsella 1988; Janes 1999). In this view, epistemological absorption into the scientific paradigm is seen as a tactical strategy by biomedicine to preserve dominance through control of the knowledge base of other ethnomedicines (Barry 2006) and thereby weaken traditional knowledges (Jagtenberg & Evans 2003; Janes 1999; Singer & Fisher 2007). The argument suggests that in the practice and philosophy of naturopathy, the increased demand by biomedicine for scientific, evidence-based knowledge to be applied to traditional naturopathic knowledge is indicative of this devaluation of traditional knowledge. This trend is even evident in early commentaries on the World Health Organisation’s (WHO) policy on the implementation and practice of traditional herbalism (Johnson 2001; Quick 1982).

Janes (1999:1805) points out that the essential issue is ‘that these alternative systems may become so much like biomedicine, so rationalized and “sanitized” [that they lose] their alternative epistemological tenets’. Bodeker and Burford (2007:3) also note that ‘the
indigenous sources of medical knowledge are disappearing. For example, Higginbotham et al. (1988) are concerned that the homogenisation of psychiatry in South-East Asia has negatively impacted on indigenous health beliefs and healing opportunities by imposing alien concepts of mental health onto vastly different non-Western communities. Thus, in a globalising world, the challenge for traditional healing systems is to find ways to sustain their epistemological bases.

In response to some of these concerns there has been a shift within some areas of medical anthropology regarding the notion of ‘integrating’ traditional medicine into biomedically based primary health care. Initially supportive of a more integrative approach, some medical anthropologists have moved away from an ‘uncritical integration of biomedicine with indigenous medical systems’ based on the concern for the integrity of traditional knowledges when they are integrated into biomedical systems (Janes 1999:1804). Given the ‘substantial conceptual and practical gulf that divides biomedicine from indigenous healing systems’ integrating such different knowledges is highly problematic (Janes 1999:1804). For example, Janes (1999:1815) is concerned about the tendency to redefine the humoral aspect of Tibetan medicine into ‘terms that can be easily reconciled with modern physiology’. Rather than subsuming traditional knowledge into the biomedical model, a genuinely pluralistic approach allows both knowledges/systems to coexist equally.

However, as Reed (2002:172) points out, in many plural health care settings the boundary between biomedicine and traditional medicine is increasingly blurred and she suggests that it is even questionable ‘whether Western and non-Western medical systems can be seen as completely distinct’. In Reed’s (2002:172) analysis, although medical systems should not be considered in isolation from each other, to syncretise systems ‘denies that systems have characteristics that are specific only to them’. I concur with Reed (2002) and Janes’ (1999) argument against the trend to subsume traditional systems into a biomedical framework. I argue that the ontological and epistemological differences between traditional medicine knowledges and biomedicine are important for encouraging ‘a recognition of the diversity of subjective positions and cultural identities’ (Sarup 1996:76), and this I suggest is essential for providing meaningful cross cultural refugee health care.
Impact on naturopathic knowledge

Expressing concern about the devaluing of traditional knowledge and the preference given to evidence-based approaches in herbal education and research in Australia, Hunter (2005) and Evans (2000) argue that scientific rationality has eclipsed traditional knowledge. Their views are echoed by scholars who are concerned about the perceived epistemological changes to traditional knowledges as a result of the increasing application of evidence-based methodologies to non-orthodox health care practices (Barry 2006; Coulter 2004; Grant 2004; Jagtenberg et al. 2006; O’Brien 2004). On this basis it is argued that the risk is that the integrity of traditional knowledge is eroded through epistemological incursion as these practices are decontextualised and manipulated in order to fit a scientific methodology (Baer 2004; Coulter 2004; Willis & White 2004).

In clinical practice, appropriately trained naturopaths are highly skilled in blending a mix of traditional and scientific knowledge and will use both methods for conceptualising and informing their clinical practice (Bradley 1999). While I am not advocating that scientific knowledge be abandoned, I nevertheless suggest that as a result of co-option by biomedicine, traditional knowledge is in danger of being subsumed within a reductionist methodology. Naturopathy is increasingly pressured to conform to a biomedical framework, for example through legitimation via randomised controlled trials, which delegitimizes the value and place of traditional knowledge (Evans 2000; Hunter 2005; Janes 1999; O’Brien 2004). Cautioning against the ‘mechanistic application’ of naturopathic medicines, Bradley (1999:49) summons practitioners to keep their ‘vitalistic roots’. At stake is the loss of a unique and paradigmatically different perspective on health and illness, one that genuinely complements rather than competes with biomedical knowledge.

Summary

In this chapter I have contextualised the need for a broader approach to refugee health care that includes non-biomedical practices such as naturopathy within a medical plural setting. I have argued that the global domination of the biomedical paradigm may negatively impact the sustainability of traditional healing practices (Bodeker & Burford 2007; Higginbotham & Marsella 1988; White 1994). For refugees in Western countries of resettlement, these
are significant issues which potentially affect the cultural identity and intactness of diverse minority groups. Furthermore, without culturally inclusive approaches, refugees’ inclinations to access mainstream health services is potentially restricted (Macintyre 1994).
CHAPTER 3
Conceptual frameworks and research literature in refugee health care

Having contextualised the fields of refugee health care and naturopathy in Chapter Two, I now introduce the anthropological and sociological concepts that underpin the conceptual framework of the thesis. I begin the chapter by extending the discussion on the concept of holism. Central to this discussion is the collision of two opposing world views, represented in the tension between holistic and reductionist perspectives on health, illness and the body. I explore this tension predominantly through the lens of medical anthropology and medical sociology, and focus on the differences between a biomedical/reductionist paradigm and a naturopathic/holistic paradigm.

To further develop this discussion I introduce the work of medical sociologist Aron Antonovsky (1987). I draw on his distinctions between holistic and reductionist perspectives, framed through the concepts ‘salutogenesis’ and ‘pathogenesis’. These concepts underpin the philosophical orientation I take up in this thesis and provide a useful sociological framework for explaining the philosophical and ontological underpinnings of naturopathy.

I draw on the anthropological conceptions of health, illness and the body described by Nancy Scheper-Hughes and Margaret Lock (1998) and employ their concept of the ‘three bodies’ to develop my framework. I introduce an interdisciplinary overview of theoretical positions on space and place in refugee health discourse. These links are important for locating my analysis
in Chapters Six and Seven within an embodied theoretical framework. I include a brief review of some of the significant concepts inherent in various traditional healing systems and relate this to naturopathic philosophy.

The interdisciplinary discussion presented in this chapter brings together the literature that argues for a holistic approach to refugee health care, an approach that endorses the way in which many refugees express their trauma symptomatology in terms of traditional models and metaphors. I link this literature to naturopathic philosophy and put forward my case for naturopathy as Western traditional medicine which is a meaningful treatment option in refugee health care.

**Anthropological and sociological concepts in refugee health studies**

**Holism**

Discussions on holism, even from within a medical anthropological framework, are complex. As Scheper-Hughes and Lock (1998) point out, Cartesian dualism has permeated Western thinking to such an extent that our conceptual understandings and consequently our language reflects this split. For example we speak of psychosomatic problems, or biosocial issues, or mind-body medicine, articulating these fundamental concepts from a dualistic position, rather than from an integrated perspective (Scheper-Hughes & Lock 1998).

The term ‘holism’ is a Western construct, originating in the 1920s, that articulates what Seymour-Smith (1986:138) defines as the tendency to understand and interpret phenomena ‘in terms of the total context which encompasses them’. The expression is currently applied to a wide range of contexts, both academic and popular. Within medical discourse, Rosenberg (1998:335) suggests that holism is an elusive term to define because it ‘has to be understood primarily in terms of what it is not’ – that is, in terms of the mechanistic reductionism underpinning biomedicine. Lawrence (1998:18) states that the emergence of holism in the West ‘expresses a protest against reductionism ... that has accompanied the rise of scientific medicine during the past two centuries’.
Definitions of holism are complex because what defines the parts that make up the whole will be mediated by cultural values, beliefs and interpretations. For example, comparing ‘Indigenous holism’ to Western and Asian holistic constructs, Macintyre (2003:34) states:

... holism is a very broad concept when applied to indigenous health, as it incorporates ideas about the person as a physical and spiritual entity into a landscape that encompasses land, food resources, sacred places and the social group or tribe who inhabit that space. Whereas Western and some ancient Asian healing traditions are holistic in the sense of integrating mental, physical and spiritual facets of the individual person, indigenous holism is more socially expansive.

Western culture locates the individual, incorporating body, mind and spirit, as the site of holistic healing. Coulter (2004:113) defines the Western notion of holism, within health care as:

... the balanced integration of the individual in all aspects and levels of being: body, mind and spirit, including interpersonal relationships and our relationship to the whole of nature and our physical environment. Holism therefore is contradictory to the notion of reductionism since it holds that the whole is different from, and greater than, the sum of the parts.

Although the term holism will hold different cultural meanings and the specificity of the various parts that make up the whole will differ within different cultural contexts, the unifying understanding is ‘of a fundamental interconnection among the diverse aspects of reality’ (Lawrence & Weisz 1998:3).

Whilst there is a body of sociological literature that critiques, to varying degrees, Western holistic models of health care (Baer 2004; Baer et al. 1998; Cant & Sharma 1996; Coulter & Willis 2004, 2007; Easthope 2004; Lyng 1990; McKee 1988; Riches 2000; Saks 1998; Willis & White 2004) there is also an analysis within medical sociology and anthropology that identifies specific ideological concerns inherent within holism and the holistic health movement (HHM) in particular (Baer 2004; Baer et al. 1998; Berliner 1975; Cant & Sharma 1996; McKee 1988). McKee (1988:775) summarises the main sociological concerns of Western holism as the tendency towards ‘individualistic, victim-blaming ideology that
Chapter 3: Conceptual frameworks and research literature in refugee health care

obscures the social origins of illness’. From a cultural studies framework, Johnston and Barcan’s (2006) critique of aspects of New Age discourse also demonstrates concerns of individualistic tendencies and the blatant lack of social or political agency.

Although the importance of social determinants of health has been taken up within the public health field, some commentators suggest this emphasis is lacking within areas of the HHM (McKee 1988). McKee (1988) suggests that the inclination within the HHM towards ignoring a social examination of health problems results in an imbalance of power and responsibility between the individual and the state. The emphasis is on the individual needing to change, rather than on the social structures which contribute to poor diet, lifestyle imbalance and increased stress levels. In this way, social problems become personal health issues to be socially and economically addressed by the individual and ‘health’ becomes a commodity purchasable from the health food store (McKee 1988). In this way, Johnston and Barcan (2006:32) argue that ‘alternative/New Age discourse meshes with a wider consumerist culture’. These are serious concerns which Baer et al. (1998) suggest are likely to worsen with the co-option of holistic health care practices. Given their current interpretation of holism, some areas of the HHM could be seen as limited and even reductionist in their overall focus (Baer et al. 1998).

Notwithstanding these concerns, the construct of holism provides a useful overarching conceptual framework to discuss the relevance of naturopathy to refugee health practice.

_Tensions between holism and reductionism_

In contrast to the holistic principles underlying most traditional ethno-medicines, the biomedical model is based on a reductionist paradigm (Kleinman 1995a), as discussed in Chapter Two. From this perspective, the functioning of the body is understood as quite separate from the mind and emotions (Coulter 2004; Kleinman 1995a; Samson 1999; Scheper-Hughes & Lock 1998). The theory of mind-body dualism dates back to Aristotle, but became a firmly entrenched characteristic of Western epistemology through the work of the philosopher Rene Descartes in the seventeenth century (Scheper-Hughes & Lock 1998).
Summarising the tensions between holistic and reductionist medical systems, Macintyre (2003:34) states that the biomedical system ‘fails to encompass the holistic view of health as a complex condition involving the person, the social group, the environment, spiritual or supernatural forces and morality’. As mentioned, some commentators have expressed similar concerns about the practice of non-orthodox medicines within particular contexts (Baer 2004).

The pervasiveness of the reductionist paradigm has been critiqued by many scholars who draw directly from Michel Foucault’s (1994) seminal work, *Birth of the Clinic*. The issue of knowledge and power within medical discourse is a central theme of Foucault’s work (1994). In *Birth of the Clinic*, Foucault (1994) argues that the development of scientific medicine in the 1800s was not so much about an actual improvement in how we understand the body, but rather it was about a shift towards a different way of knowing the body. Scientific medicine gave the doctor the power to determine the truth about a patient and the power to exert control over this knowledge (Cunningham & Andrews 1997; Illich 1977). According to White (2002), explicating the dynamic between power, knowledge and social control in the medical sciences is one of Foucault’s important contributions in this area. In this new way of knowing, the objectifying gaze of doctor became the crux of his power. Under this clinical gaze the patient’s knowledge about their body is rejected as ‘unscientific’ and hence irrelevant, and thus the subjective experience of illness is dismissed as untrustworthy (Cunningham & Andrews 1997; Kleinman 1995a). The value of the subjective experience and meanings of illness is a central theme in this thesis, and although I do not draw directly on Foucault in my analysis, the theorists I employ are significantly influenced by his work.

Further discussion of reductionism can be found in sociological and anthropological perspectives that divide ‘sickness’ from notions of ‘disease’ and ‘illness’ (Hahn 1995; Helman 2007). In this framework it is argued that a disease is a ‘specifically defined biological dysfunction, and illness, the condition of feeling unwell within distinctive cultural parameters’ (Macintyre 2003:34). Distinguishing the notion of illness from disease has enabled the cultural aspects of ill health to be investigated, focusing on the meanings and experience, rather than on the scientific ‘facts’ of the particular disease (Amarasingham Rhodes 1996).
The illness-disease distinction became widely acknowledged in the 1970s. Eisenberg et al. (1977) and Kleinman (1980), and numerous other commentators have critiqued this important concept (Amarasingham Rhodes 1996; Hahn 1995; Littlewood 1990). In particular, some scholars are concerned by the way in which biomedicine tends towards reinterpreting an illness as a disease, and the condition then becomes medicalised and located within the domain of biomedicine (Illich 1977; Kleinman 1995a; Scheper-Hughes & Lock 1998). In a refugee health context, Eastmond (2000:84) is concerned that a reductionist model tends to inappropriately shrink sociopolitically complex life experiences into ‘individual biology and psychology’, again creating disease states from complex life experiences.

In a reductionist model ‘(s)ickness is not something that happens to whole human beings but something that happens to their parts’ (White 2004:29). Using the experience of pain to exemplify this fragmentation, Scheper-Hughes and Lock (1998:210 original emphasis) argue that pain is inappropriately considered as ‘either physical or mental, biological or psycho-social – never both or something not-quite-either’. Similarly, Jackson (2005) takes up these dualistic concerns in her research on pain where she explores the experience of stigmatisation of chronic pain sufferers at a multidisciplinary pain centre. This ethnographic study involved eight months observing, interviewing and interacting with 173 resident patients. In her analysis, Jackson (2005) employs the concept of ‘liminality’, first proposed by van Geenep (1960) and further developed by Victor Turner (1964; 1974:232) and others, to theorise the ‘betwixt and between’ state of these chronic pain sufferers. I take up this concept in Chapter Seven.

Similarly, Moss and Dyck (2003:25), in the context of their research with women with chronic illnesses, argue that ‘pain’ is better considered non-dualistically as ‘a bodily sensation and as an emotional state of being, both with socially mediated meanings’.

They call for a broader conceptualisation of illness:

Body is both constituent and conveyor of social, political, and psychological meanings. As well, bodies constitute and are constituted by social relations imbued with power ... Rather than thinking of illness as the presence of disease, or concomitantly health as its absence, we think of illness as
simultaneously a category inscribing a body, a physiological process that hinders lust for and the vitality of life, a category constituted by bodily experience, and a process through which identities are shaped (Moss & Dyck 2003:15).

This distinction highlights a significant concern within refugee health discourse. For many refugees the cause of their symptoms cannot be reduced to a single problem or site, but rather, it is a combination of complex factors that manifest as health problems (Coker 2004b). One of the well-documented examples discussed in the literature is the condition nervios found within many Latin American refugee communities (Guarnaccia, DeLaCancela & Carrillo 1989; Jenkins 1996a; Low 1994). A central feature of nervios is the experience of pain which is understood to be neither solely physical nor emotional, but a blend of many factors.

Emphasising these concerns is the ethnographic work done by Jenkins (2001) with Salvadorean refugee women in the USA. The women Jenkins interviewed expressed their trauma symptoms in language and metaphors that are foreign to biomedical nosology. They spoke of conditions, such as nervios and calor that included a combination of bodily sensations and different emotional states that are often linked to external situations such as violence. These conditions, Jenkins (2001:171) argues, ‘do not make good cultural sense’ to the Western trained doctor. This study highlights the need for broader health care practices where conditions like those described by the Salvadorean women can be addressed within culturally familiar models.

I suggest that nervios and calor could be better understood in Moss and Dyck's (2003) theorising on the experience of pain in chronic illness where they suggest that:

Relocating pain at the intersection of mind, body, and culture ... loosens the hold of the dominant view of pain as a ‘controllable’ bodily sensation ... Once loosened, the notion of pain-free existence dissipates, paving the way to a more holistic understanding, explanation, and experience of pain (2003:25).

This understanding disrupts and challenges the entrenched reductionist epistemology of biomedicine and in doing so creates the space for different knowledges and theories of the body. Antonovsky’s (1987) notion of salutogenesis offers a sociological example of a paradigmatic shift away from a reductionist approach.
Salutogenesis

According to Antonovsky (1987), salutogenesis is a world view, a way of framing health and illness which is orientated towards investigating what creates health rather than focusing on risk factors and pathogenesis. This is a paradigmatic shift that challenges the existing disease/pathology orientation of health-related research and biomedical practice. A salutogenic orientation has a much closer philosophical resonance with most non-biomedical systems. As such, the salutogenic concept provides a succinct and comprehensible theoretical model differentiating the core tenets of biomedicine and naturopathy.

In this section I examine how Antonovsky’s work has been taken up in a refugee health research context. I draw on his seminal work, *Unraveling the Mystery of Health* (1987) in which he articulates his major theories, as well as many of his papers written on these themes (Antonovsky 1972, 1985, 1990, 1993b, 1993a, 1996). In the last few years there has been a resurgence of interest in Antonovsky’s theoretical work particularly in the area of health promotion and public health research. Pivotal in this endeavour is the work of Monica Eriksson and Bengt Lindstrom (Eriksson & Lindstrom 2005, 2006; Lindstrom & Eriksson 2005, 2006).

The development of Antonovsky’s salutogenic theory is contextualised within a sociological understanding of biomedical hegemony and the growing disenchantment with it during the 1970s and 1980s, discussed in Chapter Two. Antonovsky took particular issue with the biomedical assumptions that it was possible to control the environment (by eliminating germs/diseases) and that good health equated to a disease-free state. As it became evident that pathogens are uncontrollable in that they readily mutate into other forms and defy the latest treatments, Antonovsky (1987) argues that germ theory alone is not sufficient to explain the causes of disease. Other factors are involved. This understanding is fundamental to Antonovsky’s (1972:541) theorising that ‘medicine can never come close to closing the gap between demands and resistance resources by concentrating on specific diseases’.

Questioning biomedicine’s pathogenic orientation, Antonovsky (1987:89) is metaphorical when he suggests that biomedicine:
The salutogenic concept derived from Antonovsky’s (1987) research which investigated the experience of menopause for a cohort of Israeli women, some of whom had concentration camp experiences during the Holocaust. What intrigued Antonovsky was the fact that some of the women who had endured horrific life experiences were still able to maintain good health and seemed to have a healthy outlook on life. The ‘salutogenic question’ emerged when Antonovsky (1987:15) began to examine this phenomenon. ‘[T]here were survivors who were well-adapted. Somehow, by some miracle, they had managed to rebuild their lives’ (1990:75). He developed the premise that good health, irrespective of life traumas was determined by the way one views one’s life and one’s essence of existence. The resources that enable a person to maintain wellbeing in the face of significant life challenges are central to the salutogenic orientation (Antonovsky 1987).

**Health on a continuum**

Salutogenically, health is better understood as ‘a continuum conception’ (1990:77) in which the aim is to ‘see the entire person ... rather than the disease’ (Antonovsky 1996:18). Health is not simply the opposite of disease: both exist on a multi-dimensional continuum of ‘health ease/dis-ease’. This understanding fits well with naturopathic principles that conceptualise ill health as an imbalance rather than as a fixed disease state and where the aim of treatment is to strengthen the body’s innate healing capacity, rather than to target the pathogen.

In particular, Antonovsky (1990) suggests that chronic health problems are better understood as ‘a continuum conception’ (1990:77) as opposed to a bounded disease state in which the pathological diagnosis is dichotomous. Similarly, the complexities of trauma symptomatology, especially within a refugee context, fit well in this model where trauma symptoms, like chronic health problems, cannot neatly be classified dualistically, but exist on a dynamic continuum.
The significance of this conceptualisation of health is that it allows a fluid movement between ‘ease’ and ‘dis-ease’, understanding that this movement is influenced by broader sociocultural factors. Health/ill-health is seen as a process rather than a fixed state.

In this framework disease and stress are understood as natural parts of life. The main issue, argues Antonovsky (1987), is to explore how we survive, to focus on what causes health, instead of seeking only the reasons for disease. The intention is to strengthen a person’s capacity for salutogenesis – the creation of health. The focus is to understand ‘what underlies the movement toward health no matter how it [health] is defined’ (Antonovsky 1998:6).

Thus for Antonovsky, (1987:9) a person’s illness must be viewed holistically:

> By understanding the story of the person – note, not the patient, for salutogenesis constrains us to look at people on a continuum – rather than the germ or germs that caused a particular disease, I propose, we can arrive at a more adequate diagnosis…. When one searches for cures for particular diseases, one tends to stay within the confines of pathophysiology. When one searches for effective adaptation of the organism, one can move beyond post-Cartesian dualism and look to imagination, love, play, meaning, will, and the social structures that foster them.

**Salutogenesis and naturopathy**

Similarly naturopathy is based on the understanding that health exists on a multidimensional continuum; it is not a fixed state, and nor is it simply the opposite of disease. I was instantly drawn to Antonovsky’s salutogenic paradigm as its alignment with naturopathic principles seems to me to be a remarkable congruence. This discovery was particularly exciting as naturopathy has not been widely theorised within the academy, and hence there is a dearth of specific naturopathic theory to draw from. One important exception is the work by Johnston and Barcan (2006) on ‘subtle bodies’ in areas of alternative healing practice. This work develops and applies a cultural studies theoretical analysis to New Age discourse and this has the potential to further develop naturopathic theory.

Antonovsky’s salutogenic model provides a congruent theoretical framework for analysing naturopathy within a sociological context and it is curious that such a well-fitting model has not been adopted by the naturopathic field. This perhaps speaks to the lack of sociological
Chapter 3: Conceptual frameworks and research literature in refugee health care

scholarly work by naturopaths within the naturopathic field. I could find only a few scholars who have drawn on Antonovsky’s salutogenic model as a means to articulate and explain core elements of non-biomedical systems. For example, in her review of natural therapies in diabetic care, Dunning (2004) uses the concept of salutogenesis to explain the underlying holistic tenets of non-biomedical health care. Likewise, in their introductory chapter on alternative healing models, Jonas and Levin (1999:10) use the salutogenic concept to articulate the core tenets of alternative therapies.

Nonetheless, Antonovsky’s (1987) work is analogous philosophically with many of the core tenets of naturopathy, and his disenchantment with biomedicine and his consequent development of salutogenesis parallels the rise of the HHM, discussed in Chapter Two.

Antonovsky’s theories and health research

Research with a focus on health-causing factors is said to have a ‘salutogenic orientation’ (Antonovsky, 1987:12). To answer the ‘salutogenic question’ Antonovsky developed the ‘sense of coherence’ (SOC) concept and a measurement scale to determine where on the health ease/dis-ease continuum to locate the particular person (1987:15).

Fundamental to the SOC are three core factors: comprehensibility, manageability and meaningfulness (1987). According to Antonovsky (1987), this theory suggests that in order for people to maintain health, they require an understanding of what is happening to them and around them (comprehensibility), the ability to manage the situation either by themselves or by drawing on external resources such as others in their community (manageability), and to have the ability to find meaning in the situation (meaningfulness). This is reiterated by Eriksson and Lindstrom (2005, 2006), who argue that when a person believes the world is comprehensible, manageable, and meaningful they have a stronger sense of coherence and are more likely to stay healthy.

The SOC theory is operationalised for quantitative research in the Orientation to Life Questionnaire measurement scale and has been used across a wide range of disciplines and in diverse research contexts including psychology (Waysman, Schwarzwald & Solomon 2001), public health and health promotion (Lindstrom & Eriksson 2006; Suominen & Lindstrom 2008; Wikman, Marklund & Alexanderson 2005), medical sociology (Coe 1997; Levine
Chapter 3: Conceptual frameworks and research literature in refugee health care

1987), family studies (McCubbin et al. 1998), refugee health research (Suedfeld 1997; Ying & Akutsu 1997), nursing (England & Artinian 1996) and environmental stress research (Clark 2006).

Some qualitative researchers have taken up, as I do, a salutogenic orientation to frame their projects from a health-creating perspective (Backett 1992; Cowley 1999). These studies aim to explore positive rather than negative aspects of health and take up the philosophical aspects of SOC rather than applying it as a measurement scale.

Although I do not use the SOC scale in this research, I draw on the concept in my analysis of the women’s experiences of the naturopathic encounter in Chapter Seven.

Refugee research using a salutogenic approach

Absent is the study of refugee health or of healthy refugees. Yet refugees present perhaps the maximum example of the human capacity to survive despite the greatest of losses and assaults on human identity and dignity (Muecke 1992:520).

Muecke’s (1992) call for the study of ‘healthy refugees’ corresponds to Antonovsky’s (1987) salutogenic orientation where the focus is on resilience and agency rather than disease categories. Researchers, such as Jenkins (1996) are calling for more studies that specifically explore the remarkable ability of some refugees to survive trauma. Based on her research in the USA with El Salvadorian women survivors of political and domestic violence, Jenkins (1996b:288) concludes that more work is required on understanding women’s ability to survive such horrors ‘often with palpable grace and dignity’. She states:

... while refined understandings of the emotional distortion that occurs subsequent to traumatic experience are needed, it is also clear that accounts of the sustained emotional integrity and resilience of persons surviving extreme horrific human circumstances must equally compel our attention (Jenkins, 1996:288).

Furthermore:

... while the women discussed here certainly experienced pain and suffering in ways that are consonant with examination of their experience within an illness framework, my most striking
observation concerning this ethnographic case is that it can be analysed as a powerful example of the women’s considerable resilience and resistance in the face of extreme human circumstances. The sustained emotional integrity – as opposed to a fragmented (psycho) pathology – must equally compel our attention (1996:278).

Antonovsky was one of the first sociological researchers to look at what can be learnt from people who have been traumatised and who have been able to put their lives back together. His SOC concept and underlying salutogenic orientation provides an overarching model for exploring the ways in which many refugees are able to re-establish connections and rebuild their lives. This model focuses on the ways in which many refugees are able to draw on resilience, integrity and inner strengths in the numerous and difficult challenges they face through the refugee experience.

In this section I review some of the health-focused refugee and migrant health research that has drawn on Antonovsky’s theories.

In a study of Iranian and Afghani male refugees who have experienced war and now live in Australia, Hafshejani (2003) explores the relationship between having a sense of meaning in life and developing PTSD. Hafshejani (2003) defines ‘meaning of life’ as ‘the degree of commitment to having a framework from which to view one’s life’ (2003:239). Within the refugee communities from which this study was conducted many Iranian and Afghani men seek ‘some meaning to ascribe to their traumatic experiences in order to move on in life’ (2003:239). Within the Iranian community in Sydney some refugees have sought expression of meaningfulness through attending poetry nights. In this context poetry is the culturally relevant medium of meaning making and of bringing new meaning to past experiences. Hafshejani’s (2003) research concludes that having a sense of meaning in life is congruent with a lower PTSD symptomatology for this particular group. These findings inform the current discourse of health strategies for refugees by encouraging treatment approaches that assist refugees to explore this central issue of meaningfulness.

Ying and Akutsu (1997) examined the contribution of SOC to the psychological adjustment of five South-East Asian refugee groups in America. Their research suggests that SOC, through the experience of life as comprehensible, manageable and meaningful, ‘serves as a significant
and important predictor of psychological adjustment’ (Ying & Akutsu 1997:137). Although the mental health consequence of war, torture and trauma in South Eastern Asian refugees has been well documented, the authors argue that most early studies focus on pathological indicators and psychiatric symptoms. Using Antonovsky’s salutogenic orientation and the SOC scale, this research focuses on psychological adjustment of South-East Asian refugees through their experiences of happiness and demoralisation. The study demonstrates that a refugee’s ‘subjective sense of his or her world as comprehensive, manageable, and meaningful significantly impacted on his or her level of happiness’ (Ying & Akutsu 1997:135).

Sundquist et al’s (2002) research with migrants living in Sweden also used aspects of Antonovsky’s SOC scale. In this investigation into the link between migration status and psychological distress, 1980 migrants from Iran, Turkey and Poland now living in Sweden were surveyed. The research demonstrated that a high sense of coherence was linked with good mental health. The migrants with a high sense of coherence were less likely to succumb to mental stress during the process of migration and acculturation. In this research project three questions from Antonovsky’s questionnaire were used to measure the three dimensions of SOC: comprehensibility, manageability and meaningfulness. The researchers conclude that a low SOC is a ‘substantial explanatory variable for psychological distress’ (Sundquist et al. 2000:361). Furthermore, a low SOC along with other factors including exposure to violence and economic difficulties is understood as a strong predictor of psychological distress and psychosomatic complaint. The research also highlighted that poor social support was a greater predictor of depression than was a history of trauma. This has serious implications for migration health care policy, indicating that health care services for these groups may be more effective when they include the social components of health and wellbeing.

The authors concluded by recommending their findings be applied to refugee populations as well as migrants. They suggest that ‘migrants and refugees who come to consult for psychosomatic problems may actually be suffering from psychological distress’ (2000:363) and that medical practitioners need to be aware that many of the physical complaints refugee patients present with in practice may be indicators of social distress.
Researchers who have used the SOC scales have found that SOC associates very strongly with subjective and objective health outcomes (Cheung & Spears 1995; Palinkas, Pickwell & Warnock 1999; Suedfeld 1997; Sundquist et al. 2000). Findings suggest that people who have been exposed to the same kind of traumatic events respond differently according to their ability to re-establish social connections. Those who are more able to re-build their lives have also been able to re-establish social connections. This has significant implications for health policy as it suggests a holistic approach is needed. I argue it provides the grounding for a multiplicity of different ways of thinking about healing and for not giving one particular medical system hegemony over others. The SOC concept can provide an overarching model for exploring the health enhancing ways in which many refugees are able to re-establish connections and re-build their lives.

Using the salutogenic model within a refugee health context shifts the focus to the resilience and strengths of survivors, questioning why some people who have endured trauma cope better than others. Applying Antonovsky’s concepts to people who have experienced torture/trauma suggests that ‘recovery’ might be better contextualised by attending to how people can live with their trauma. Echoing Jenkins’ (1996) views, this perspective emphasises the need to re-establish a sense of connection and coherence – linking past, present and future, and thereby being able to re-establish some meaning in the present. I take up these themes in my analysis in Chapters Six and Seven.

In sum, the salutogenic framework offers a paradigmatic shift from the biomedical orientation of pathogenesis and risk factors to a focus that emphasises strengths and determinants for health that includes interaction of body, mind and social influences. Antonovsky’s salutogenic model has a close philosophical resonance with many non-biomedical systems, in particular naturopathy. Importantly, salutogenic health research is more likely to address the broader social and cultural contexts of ill health, whereas pathogenically informed research focuses primarily on disease causation. In a refugee context the crux of Antonovsky’s work is the focus on developing the ability to move to the healthy end of the ease/dis-ease continuum by integrating past, present and future through bringing meaning into the present. By focusing on health-creating factors which draw on the person’s own resilience and strengths, this model is potentially empowering as it draws on the individual’s healing resources and agency.
Chapter 3: Conceptual frameworks and research literature in refugee health care

**The refugee body**

Demonstrated by the above-mentioned research findings, in a refugee health care context the experience of ill health cannot readily be reduced to a named pathology, or disease state. Distress is multidimensional and moves beyond the bounded notion of self to a complex interaction with the social and the political. Nancy Scheper-Hughes and Margaret Lock’s (1998:208) seminal work on the ‘three bodies’ conceptualises this understanding by emphasising:

… an assumption of the body as simultaneously a physical and symbolic artefact, as both naturally and culturally produced, and as securely anchored in a particular historical moment.

The concept of the three bodies offers an embodied understanding of the complexity of refugee trauma as signifying the interaction between the individual body – the lived experience of pain; the social body – a symbolic representation of extensive social trauma; and the body politic – reflecting the broader sociopolitical upheaval of war and violence.

Some academics have extrapolated Scheper-Hughes and Lock’s (1998) work to a refugee health context by taking up the notion of the ‘refugee body’ – the amalgamation of physical pain with the complex social, political and cultural factors that defines the refugee experience. For example, Coker’s (2004a) and Gronseth’s (2001) work take up the three bodies to express the interaction between the individual’s lived experiences of physical symptoms as they reflect the broader sociocultural influences of the refugee experience. Similar to Antonovsky’s (1990) continuum concept, in this model symptoms are not fixed, but rather, they can be understood as signifying multi-faceted interactions. Within a sociocultural paradigm, refugee trauma is contextualised to the lived experience of war, displacement, marginalisation, poverty, loss and upheaval. Interconnected on a continuum, the refugee body expresses what Kleinman argues is the ‘complex narrative of suffering’ (Kleinman & Kleinman 1991:284).

In this thesis the notion of the refugee body creates a framework for exploring the complexity of refugee health issues that is not limited by the Cartesian heritage of a mind/body dichotomy. In this model, healing can be conceived of as the simultaneous interaction between the individual and the society in which they inhabit socially and culturally. This perspective underpins medical anthropological studies on healing (Rubel & Hass 1996).
also contextualises the dialectical relationship within numerous traditional societies where the relationship between the individual and their society is fundamental, and develops the understanding that people and their illnesses may be symbolic of the culture in which they exist. The dialectic relationship between the individual and society is summarised by Scheper-Hughes and Lock (1998:209) as follows:

The body in health offers a model of organic wholeness; the body in sickness offers a model of social disharmony, conflict, and disintegration. Reciprocally, society in “sickness” and in “health” offers a model for understanding the body.

Drawing on Scheper-Hughes and Lock’s (1998) work, Coker (2004a:403) applies the three bodies to her work with Sudanese refugees in exile in Cairo, suggesting that the concept of embodiment enables the use of:

bodily metaphors or representations of the body ... to symbolise larger concerns ... of the refugee experience, namely the phenomenology of exile, or the way in which collective and individual experiences are felt in and by the body, not simply represented as such.

Coker (2004a:409) points out that it is often the individual body that experiences and expresses the social and cultural dislocation that epitomises the refugee experience. A wholly reductionist framework in which the social becomes set as individual pathology controlled by the clinical gaze of biomedicine cannot therefore adequately address the complexity of the refugee experience.

Adding to this discourse, Green (1994:246 my emphasis) suggests that some of the somatic representations of distress experienced by the Mayan women in her research became ‘a moral response, an emotional survival strategy, to the political repression they have experienced and in which they continue to live’. Through sickness the body thus gives voice to what cannot be literally spoken:

Their silenced voices speak poignantly through their bodies of their sadness, loneliness, and desolation … the body itself has become the site of social and political memory (Green 1994:247).
Chapter 3: Conceptual frameworks and research literature in refugee health care

Considering the body’s unrelenting pain as a ‘moral response’ to oppression seriously challenges the biomedical conceptions of disease causation and has critical implications for the provision of health care strategies for refugees.

At a broader level, the concept of the body politic, described by Scheper-Hughes and Lock (1998), allows the complexity of refugee trauma to be reconsidered from a culturally inclusive position in which the biomedical gaze is appropriately contextualised as representing only one of the many different understandings of the body. This is important as perceptions of what constitutes sickness and health will differ within different cultural and sociopolitical contexts. Furthermore, this concept elucidates the issues of power and control inherent in the state of being sick in a context where human suffering has increasingly become medicalised. As Coker (2004b:34) points out, the biomedical health system often struggles to make scientific sense of many of the symptoms refugees describe: ‘medical reality has no way to interpret such pain, and so it becomes reified as “somatization” or “depression”’. Often a refugee’s symptoms may not readily fit the disembodied biomedical categories such as those described by Frasa and Fahim in Chapter One, but rather are a representation of distress, and, for some, may even signal an act of resistance (Green 1994).

In Chapters Six and Seven, the women’s stories in this research describe the de-contextualising of their symptoms in the biomedical consultation and then the appropriate recontextualising in the naturopathic encounter. In the following section I take an interdisciplinary view by drawing on different theorists’ concepts of space, place and home. In Chapter Seven I take up these theories as I explore the recontextualising of the women’s symptoms in the naturopathic encounter and consider the notion of place-making.

**Place and space**

... space is imagined into being ... the biological, geological, material world around us is discursively imagined, understood and produced, and that even our bodily perception and experience of it does not occur outside of culture and history (Barcan & Buchanan 1999:9).
The universal concerns of place, space and notions of home have particular significance in the experiences of the world’s refugees (Malkki 1992, 1995a; Warner 1994). Dislocated from their homelands, refugees are frequently referred to as displaced peoples. In the growing body of literature concerned with theorising the refugee experience, and in particular displacement, Malkki (1995a) cautions against blindly taking up a functionalist model. Such an approach, she argues, tends to pathologise displacement by assuming that ‘to become uprooted and removed from a national community is automatically to lose one’s identity, traditions and culture’ (Malkki 1995a:508). In the current geopolitical environment where ‘people are chronically mobile and routinely displaced…’ (Malkki 1992:24), appreciating that it is possible for refugees to experience home beyond national borders disrupts the categorisation of the refugee as a helpless figure (Malkki 1995a; Warner 1994).

The concepts of place, space and home have been theorised across a wide range of disciplines (see Gupta & Ferguson 1992; Hubbard, Kitchin & Valentine 2005; Mallett 2004). Yet, as Dovey (2008:76) suggests, the notion of place remains ‘tantalizingly difficult to define’; its numerous meanings reflect the diversity of positions within and between disciplines and contexts. In anthropological literature, for example, some scholars contend that theorising place, beyond simply a description of the field work setting, is a recent development (Gupta & Ferguson 1992; Rodman 2003). Rodman (2003:205–207) asserts that place holds far greater significance and must be conceptualised as more than locales; places ‘are politicized, culturally relative, historically specific, local and multiple constructions [which] come into being through praxis, not just through narratives’.

The concept of ‘inscribed spaces’ is defined by Low and Lawrence-Zuniga (2003:13) as ‘the fundamental relationship between humans and the environments they occupy’. This concept takes up the ways in which ‘experience is embedded in place and how space holds memories that implicate people and events’ (Low & Lawrence-Zuniga 2003:13). Through the meaning people give to space, Low and Lawrence-Zuniga (2003) suggest space is then transformed into place. However, qualifying this understanding, they state that the complex relationship between people and their locales ‘encompasses more than attaching meaning to space’ (2003:14). Developing this argument, Dovey (2008:76) cautions against the tendency to restrict descriptions of ‘place’ to only ‘an experiential phenomenon defined in
opposition to “space”. Thus, he suggests a broader vision in which ‘place is aligned with a group of terms, such as “identity”, “community”, “character” and “home”, that perform key roles in our everyday lives...’ (2007:76). Perhaps, in a manner similar to Antonovsky’s (1987) health ease/dis-ease continuum, the complex interaction between space and place can be conceptualised as actively coexisting on a multidimensional continuum.

Similar to Dovey’s (2008) critique, the philosopher Madan Sarup (1996; 1998), through his personal experiences of being a migrant, has much to offer in this enquiry into place, identity and home. He brings a sense of the everyday to notions of home and place:

> It is usually assumed that a sense of place or belonging gives a person stability. But what makes a place home? Is it wherever your family is, where you have been brought up? The children of many migrants are not sure where they belong. Where is home? Is it where your parents are buried? Is home the place from where you have been displaced, or where you are right now? (Sarup 1998:94)

Reflecting Sarup’s musing on the multiplicity of meanings for what constitutes home at any given moment, Warner’s (1994:168–9) critique of the issue of refugee repatriation makes the distinction that ‘home and the country of origin do not have to be the same’. This distinction challenges nostalgic notions of home where the return implies not only going back to a place unchanged by time, but also that the person is unchanged by their exile experience (Kibreab 2004). It is impossible to go back in time to recreate what was the pre-flight home. In fact, Warner (1994) argues that for some returnees the return home can be just as distressing as their flight (See also Corlett 2005; Gupta & Ferguson 1992). Warner’s distinction also alludes to the understanding that the notion of ‘home’, as place imbued with meanings, is not simply the fixed place of birth, but it is transportable and re-imagined into other meaningful locales. Likewise, Kibreab’s (2004:11) research with Eritrean refugees returning home after exile in Sudan showed that the majority of these returnees chose not to resettle in their original villages because the ‘profound social change they [had] undergone in exile in Sudan’ significantly altered their conceptions of home. Home can thus be understood as ‘an ideological construct and/or an experience of being in the world’ (Mallett 2004:84).
Sarup (1998:94–95) defines home as:

\[
\ldots \text{(often) associated with pleasant memories, intimate situations, a place of warmth and protective security amongst parents, brother and sister, loved people \ldots} \text{ Of course, I realize that the notion of home is not the same in every culture \ldots} \text{ Nevertheless, I want to suggest that the concept of home seems to be tied in some way with the notion of identity – the story we tell of ourselves and which is also the story others tell of us. But identities are not free-floating, they are limited by borders and boundaries.}
\]

The understanding that people invest places with meaning is clearly articulated in the literature (Barcan & Buchanan 1999; Dovey 2008; Gupta & Ferguson 1992; Low & Lawrence-Zuniga 2003; Malkki 1992; Probyn 2003; Rodman 2003; Sarup 1998). The essence of a place is subjective and in part is defined by what the person brings to it. As embodiment scholar, Elspeth Probyn (2003:294) suggests ‘... the space and place we inhabit produce us ... [and] how we inhabit those spaces is an interactive affair’. There are usually strong emotional bonds attached to places, both positive and negative. Places associated with positive memories may evoke a sense of belonging which is often connected to developing a sense of self and identity (Probyn 1996). Thus place and identity are often entwined. Furthermore, in Dovey’s (2008:84) analysis:

\[
\text{Constructions of place are equally a product of difference ... if place embodies ‘identity’ then it also embodies ‘difference’; and a rejection of ‘place’ is a rejection of ‘difference’ ... The mistake is often to identify place with form rather than social process ...}
\]

Humanistic geographer Isabel Dyck (2003:3) suggests that ‘place [is] understood as constantly in process, with a place’s inhabitants as co-creators of its material, social and cultural transformations over time.’

The fluidity of place and home is further explained by Sarup (1998:96–97): ‘home is (in) a place ... [and] places are not static, they are always changing...’. Cooper-Marcus (1992) suggests that environmental memories are significant factors in providing a sense of continuity with the past which is fundamental to making sense of who we are and where we come from. Memories of past places are often the significant markers used to compare
and frame current experiences. Developing this theme, Malkki (1992:38) calls for the understanding that the ‘multiplicity of attachments that people form to places through living in, remembering, and imagining them’ are equally significant. Linking this understanding to conceptions of wellbeing, Antonovsky (1987) emphasises the importance of connecting the past with the present in order to create the possibility for a future, essential for health and wellbeing.

Similarly, Dyck (1995; 2003; 2004; 2006) notes the increasing contribution of humanistic geographical studies, with their emphasis on space and place, in understanding women’s experiences of health and health care behaviour. She suggests that ‘how illness is interpreted and responded to within the lived experience of place’ (1995:252) is significant for immigrant women. In particular, Dyck (2003:8) explores the ways in which women set about the process of place-making through a range of social and cultural activities.

Further contextualising the relationship between refugees and notions of place, home and identity, Malkki (1992) makes the case for a fluid analysis in which a multiplicity of expressions can exist. Similarly, Rodman (2003:211–12) uses the term ‘multilocality’ in order to ‘understand the construction of places from multiple, non-Western as well as Eurocentric viewpoints’. This analysis encourages a reflective comparative understanding of place. In contrast, a static interpretation of these concepts implies that the notion of ‘home’ is bound by territory, restricting a person from experiencing home outside of their country of origin (Gupta & Ferguson 1992; Malkki 1992). This implied nationalistic agenda imposes a constrictive position which dismisses the understanding that people can take on (and do take on) new identities in exile or their country of resettlement. For example, based on her ethnographic research with two separate groups of Burundi Hutu refugees – one living inside and one living outside a refugee camp in Western Tanzania, Malkki (1992:37) concludes that identity is ‘mobile and processual’, thus disrupting the territorialised image of the generic, monolithic refugee figure.

Malkki (1995a) makes a strong argument against the assumption that displacement automatically results in loss of culture and identity. Although I agree with Malkki’s analysis, I would further add that the task of maintaining certain cultural practices and traditions in Western countries of resettlement is not necessarily easy to accomplish for many refugees.
This concern is exemplified in Gronseth’s (2001) work with Tamil refugees in northern Norway. Within a health context, the disparity between the Norwegian doctors’ biomedical conceptions and the Tamil refugees’ Ayurvedic beliefs left the refugees feeling ‘not understood … and not treated as whole persons … but rather “as organs”’ (2001:505–7). According to Gronseth (2001), these Tamil refugees are strongly connected to their culture, identity and traditions. The problem however is that it became increasingly difficult for them to maintain certain health care practices when these beliefs were overtly delegitimised in their new country of resettlement. In order to fit into their new home, many refugees are quick to suppress practices and beliefs that do not conform to the dominant culture.

In contrast to Gronseth’s (2001) research, Dyck (2003) demonstrates that in settings where people feel safe to practise their traditional approaches to health care, and have the opportunity to do so, their sense of wellbeing is enhanced. Dyck’s (2003) research with South Asian women migrants now living in Canada demonstrated the importance for these migrant women of access to ‘Desi’ or home remedies for keeping healthy. In Dyck’s (2003) study the women spoke knowledgeably of their practice of using certain herbs and spices to treat a range of ailments. Everyday use of these herbal remedies enabled the process of place making; it connected these women to important social and cultural activities.

**Healing principles in traditional societies**

Ethnographic investigations into traditional communities and their healing practices sheds light on key aspects of traditional knowledge and concepts of healing. Although the contexts are different, many of the underlying concepts and principles of practice in naturopathy and non-Western traditional systems share some notable similarities.

**Congruence/rapport**

One such quality, described by Geertz (1977:148) in his study within a Javanese community, is the concept of ‘tjotjog’, meaning ‘fittingness’ between the dukun (healer) and the patient. If there is ‘tjotjog’ between the healer and the patient then the potential for healing is activated. If ‘tjotjog’ is lacking, then the patient should seek out a different healer. This could be translated into the notion of ‘rapport’ (or resonance) within a Western context. When
there is rapport or congruence between practitioner and patient, the potential for healing is much greater. Resonance is often generated through a sense of shared values and cosmological understandings.

Inherent in traditional societies and related to the concept of ‘tjotjog’ is the understanding that the traditional healer ‘must live within the belief system of his culture’ (Edgerton 1977:444). Belief in the use of herbal medicines for treating a range of illnesses, originating from both natural (physical) and psychological or spiritual causes is common to most traditional societies (Edgerton 1977). Central to naturopathic philosophy is the understanding of the ‘vital force’ as the central component determining health. Imbalance of physical, environmental, emotional or mental factors in the client or the practitioner can cause an imbalance in the vital force, resulting in ill health. The naturopathic training of the practitioners at Foundation House included knowledge about the interconnection of mind-body-spirit in health and dis-ease, and faith in herbal medicines as effective and safe. These are some examples of the shared understandings that generated feelings of connection and resonance in the naturopathic encounter. This theme is taken up in detail in Chapters Six and Seven.

**Balance**

The notion of balance is another principle central to most traditional healing systems and is often used as a metaphor for health (Eastmond 2000). Individual health will often depend on the balance of internal (for example, humours and vital force) and external (land and environment) factors, and on the equilibrium between the individual and their community. For Australian Aborigines ‘living a life out of balance, a life of lost or severed connections with land and kin…’ is understood as the cause of all disease (Thompson & Gifford 2000:1457). The ability to maintain balance is directly related to the experience of ‘meaningful connections to family, the land, the past and future, all of which are important for health and well being’ (Thompson & Gifford 2000:1458).

In Probyn’s (2005) terms, balance can be understood as the experience of feeling at ease or in place. The notion of balance is relevant to refugee models of health care, ‘in particular the idea of health as restoring significant relationships, healing in the sense of “making whole” that which has been ruptured’ (Eastmond 2000:70).
For the people of Modjokuto, ‘the psychological cause of physical illness is [a] commonplace’ understanding (Geertz 1977:150). The connection between emotional and physical wellbeing is well integrated into society. For example, it is understood that fear, anxiety and depression are causes of a lack of blood. Experiencing such emotions can lead to the blood becoming thinner, resulting in pallor, tiredness and weakness. For the Hehe, headaches and stomach pain are usually associated with excessive worrying (Edgerton 1977). Herbal medicines as well as removing the cause of the worry are effective treatments (Edgerton 1977).

**Interconnectedness: ‘Return to one heart’**

Embedded in many traditional medical systems is the notion that healing is implicitly connected to the relationships with the broader community. Within the Safwa community in Tanzania, illness is usually seen as being caused by conflict within a human relationship which then causes a weakened life force (Harwood 1977). Once a diviner has made the appropriate diagnosis, a process is set in place to heal this rift in order to re-establish a ‘return to one heart’ (Harwood 1977:171).

The social context for healing is a strong feature for the Hehe people of Tanzania where consulting the *mbombue*, or traditional healer occurs within the context of the broader community (Edgerton 1977). The *mbombue* is ‘concerned with the entire social context of the patient and his illness’ (Edgerton 1977:439). Distress or ‘heart ache’ can deregulate the vital force, depleting the person and causing ill health. Naturopathic treatment includes the use of herbs, diet, and massage within a therapeutic relationship (which also includes active listening) and aims to balance the vital force and re-establish harmony. Antonovsky’s (1987) salutogenic orientation is another expression of this understanding. Through focused discussion with the patient and family members, the *mbombue* is searching for ‘an understanding of the social context of the illness’ (Edgerton 1977:440).
Humoral principles: Hot/cold theories

While the term ‘humoral’ is derived from the Graeco-Arabic tradition, other medical systems have similar theories, for example, the elements system in Traditional Chinese Medicine and the tri-dosha theory of Ayurveda. Although the term of humoral theory is not completely adequate, it is the best available term to broadly describe the system of hot/cold theory that exists in many non-biomedical healing systems.

As stated earlier, some naturopaths draw from humoral theory in their practice of Western herbal medicine. Humoral theory is found in most naturalistic ethno-medical systems (Foster 1998). Applications of humoral theory originating from Hippocratic or Gallenic medicine became widespread throughout numerous healing systems (Hopwood 1997). This theory is premised on the understanding that health and wellbeing is maintained by balancing the four different humours: blood, phlegm, black bile and yellow bile (Harwood 1998). In particular, understanding the influence of ‘temperature’ and ‘moisture’ on the four humours is a central guiding principle. Imbalance of the humours will result in an excess of dryness, heat, cold or moisture, or a mixture of these qualities (Harwood 1998). Illnesses are treated by providing the appropriate counteracting medicines in the form of foods, herbs or other culturally specific remedies.

Historically, humoral theory spread globally via trade routes, colonisation and through the influence of missionaries (Harwood 1998; Hopwood 1997; Manderson 1986). For example, Manderson (1986) writes that although a hot/cold system was already in existence in the Malayo-Indonesian region, the arrival in the seventh century AD of Muslim traders and missionaries who brought Arabic medical texts that detailed Islamic humoral medicine further strengthened the hot/cold theory of this region. In another example, Rubel (1996) and Harwood (1998) explain the spread of humoral theory to Indigenous America by the conquering Spanish in the 17th century. According to Harwood (1998), during this era, humoral medicine was taught in medical schools in Mexico and Peru and incorporated into household medical texts that were also used by priests to treat the Indigenous populations throughout Spanish America. Although biomedicine has severed any links to humoral theory, as Hopwood (1997) points out the British aphorism ‘feed a cold, starve a fever’ highlights the presence of humoral principles currently in the English language and folk knowledge.
Although permutations of humoral principles are common to many ethno-medicines (Harwood 1998; Hopwood 1997; Macintyre 1994; Rubel & Hass 1996; Sargent & Marcucci 1984), specifically, the hot/cold theory of illness has come to be the most commonly practised humoral concept worldwide (Harwood 1998; Manderson 1986). Significantly, the hot/cold theory exists within diverse cultural contexts. For example, it is found throughout Latin America (Harwood 1998; Rubel & Hass 1996), South Asia and East Asia (Chung & Kagawa-Singer 1995; Sargent & Marcucci 1984) and the Middle East (El-Gendy 2005). For some naturopaths in Australia, humoral theory informs their approach to diagnosis and treatment (Trickey 2003).

Given the extent to which hot/cold theory exists globally, across numerous and varied cultures, it is not surprising that no universal classification system has been developed (Harwood 1998). Also significant is how the hot/cold theory is able to continually change and adapt (Harwood 1998). It is not a static or fixed theory and it seems to adapt to culturally specific circumstances.

Classification is usually culturally relative and ethno-specific and may also vary according to the individual’s experience of certain foods or medicines. To the ‘Western mind’ that seeks a single truth, the lack of consistency in hot/cold classification can be difficult to accept. For instance, how can a certain food or spice be considered ‘cold’ by one group and ‘warm’ by another group? Such inconsistencies are common and usually reflect differences in environmental factors or cultural practices. However, Manderson (1986:132–3) points out in relation to her field work in Peninsular Malaysia, ‘the variations and inconsistencies simply underscore the dynamic nature of the system and are not problematic for members of the society’. This ‘inconsistency’ in many ways is comparable to the very diverse ways in which biomedicine is practised within different European and other Western countries. As Payer (1990) points out in her book Medicine and Culture, the practice of biomedicine is far from universally applied or even conceptualised in Britain, the US, France and Germany.

According to the principles of humoral theory, health occurs when there is an appropriate balance of hot/cold within the individual (Sargent & Marcucci 1984). Illnesses or symptoms are similarly diagnosed and treated by countering the imbalance. Thus a hot illness is treated with cooling medicines or foods (Harwood 1998). This classification describes the qualities or
character of the particular illness and the medicines, foods and other substances that are used to treat the illness. Embodied in the example of Vietnamese women’s experiences postpartum that was described in Chapter Two, this concept is distinguished from the biomedical understanding of temperature that literally describes a thermal measurement (Macintyre 1994).

It is argued that humoral medicine was the ‘universal’ medical system before scientific knowledge became the basis of biomedicine (Last 1996). Humoral theory, far from homogenous in its application, continues to underpin most of the traditionally based medical systems worldwide, including naturopathy.

**Conclusion: Making the case for naturopathic treatment in refugee health care**

At present the norm stresses similarity, but what would happen if the norm changed and stressed difference? (Sarup 1996:12).

Demonstrated in this and the previous chapter, the growing interest in holistic approaches within refugee health discourse reflects the need to address refugee health issues from a significantly broader perspective that takes into account diverse cultural concepts of health and illness, as well as sociopolitical factors (Coker 2004a; Eastmond 2000). The aim, as Sarup (1996) points out, is to promote culturally different world views of health and illness to coexist, thus providing refugees with health care approaches that make cultural sense.

As noted in the literature, many refugees bring with them to the country of resettlement a strong affiliation to their own traditional healing knowledges and practices (Julian 2004; Macintyre 1994). Traditional approaches to health care often hold a strong place in the cultural identity of the particular community (Fadiman 1997), and serve to legitimate socially accepted notions of health and illness (Julian 2004). For some refugees the socially accepted definitions of health and illness existing in their own culture may not match the health care system in their new country of resettlement, thus limiting access to appropriate health care
(Chung & Kagawa-Singer 1995; Julian 2004; Macintyre 1994). And others may ‘find that their health care practices are in direct conflict with the [Western] health care system’ (Julian 2004:102).

For many refugees their sense of health and wellbeing is often improved when they have access to their own or similar healing practices (Englund 1998; Malkki 1992). Neumann and Bodeker (2007:187) note that it is in the ‘medical non-emergency’ phase when a refugee arrives in the country of resettlement that ‘issues of culture, identity and traditional practice emerge’. Thus the purpose of including conceptually familiar non-biomedical practices within a plural health care setting is important in order to establish an inclusive approach which is meaningful and efficacious (Englund 1998).

In advocating for the inclusion of non-biomedical practices, Watters (2001) emphasises the value of such approaches by arguing that biomedicine alone is unlikely to address the complexity of refugee trauma. Friedman et al. (1994: 218) suggest that the:

\[
\text{[U]se of more traditional approaches familiar to the indigenous culture such as acupuncture, herbal medicines, religious beliefs and native healers, when used in conjunction with Western approaches, can be helpful in treating refugees [in Western countries of resettlement].}\]

Kaplan and Webster (2003:118) suggest the inclusion of ‘natural therapies’ and ‘linking [refugee] women to traditional healers’ may form part of a holistic strategy ensuring appropriate health care for culturally diverse women.

As previously stated, research demonstrates that many refugees report trauma symptomatology in terms of traditional models and metaphors that do not fit the existing biomedical categories and underlying biomedical assumptions of health and illness concepts (Coker 2004a; Jablensky et al. 1994; Jenkins 2001). A major theme of this thesis explores how many refugees experience a combination of physical and psychological symptoms that often do not fit into biomedical categories.

From a sociological and anthropological perspective, dividing healthy people from unhealthy people based on a biomedical category marginalises the experience of many people who feel unhealthy, yet a disease cannot be identified in their body (Illich 1977; Jackson 2005). This
Chapter 3: Conceptual frameworks and research literature in refugee health care

is exemplified in the experience of refugee trauma and chronic illness. Particularly relevant in these situations, the naturopathic approach does not give primacy to ‘the doctrine of specific aetiology or germ theory’ (McKee 1988:777), but aims to understand and treat illness by encouraging the person’s vital force, rather than the uniform treatment of named disease states (Jagtenberg & Evans 2003). In this way, naturopathic treatment can make more sense for people whose symptoms do not fit biomedical classifications such as those described by Frasa and Fahim in Chapter One, or for people for whom the biomedical classifications are of far less importance.

In contrast to the biomedical gaze, the starting point for naturopathy is with the patient’s subjective understanding of their body, symptoms and circumstances (Cant & Sharma 1996:15). This is a core site, where differences between holism and reductionism are highlighted, and become magnified by cross-cultural differences of meaning in regards to concepts of health and illness (Coker 2004b; Kleinman 1995a). An equally important distinction between these two systems is in the relationship between practitioner and patient. Under the biomedical gaze, the doctor exerts authority over the patient, whilst the relationship between naturopath and patient is seen more as collaborative (Williams 1998).

Most refugees who are being resettled in developed countries like Australia come from vastly different sociocultural backgrounds. Within a Western refugee health context the opportunity to receive non-biomedical treatments can create common ground in what may otherwise be an alienating medical experience. The commonality of understanding generated by a similar world view of health concepts then facilitates positive feelings of what the philosopher Madan Sarup (1998:95) calls being ‘at home’ within a new and unfamiliar country. This understanding was one of the major themes that emerged from the data and is elaborated in later chapters.

Refugees and their health problems are often objectified into medical conditions and complex sociocultural health issues are reduced to medical pathologies emphasising risk factors and disease states (Coker 2004a; Watters 2001). However, recent advances within the literature on refugee health care mean that some scholars and clinicians are now specifically calling for the development of health care programs that include appropriate non-biomedical approaches (Dyck 2003; Englund 1998; Watters 2001). These developments are in response
Chapter 3: Conceptual frameworks and research literature in refugee health care

to extensive documentation that demonstrates how, in isolation, the biomedical model is problematically limited. It lacks the scope to address the complexity of the refugee experience and in particular the social, political and cultural contributors to ill health, as well as the individual’s lived experience of distress.

In the following chapter I draw on concepts outlined in Chapters Two and Three to inform the approach I take to researching the meanings and experience of naturopathic treatment for refugee women survivors of torture.
CHAPTER 4
Methodology

On a hot summer morning I meet our interpreter, Roshan on the pavement in front of a block of flats in an ethnically diverse Melbourne neighbourhood. We are here to see Lani, an elderly Afghani woman, my first interviewee. At the door I hold out my hand to Lani who grips it vigorously and we greet each other warmly. Roshan is interpreting as Lani and I continue the greeting. Smiling and making eye contact, we make our way into her neat and spotless lounge room. I begin by thanking Lani for participating in my research and she is quick to tell me that she wants to talk to me; she has been looking forward to this interview as she wants to tell me how important it has been to have the massage treatment at Foundation House. I feel the urgency in her voice before I understand the words. I am already moved by her conviction and determination. And I haven’t even got the tape recorder out of my bag yet.

In this chapter I explain the methodology used to investigate the research topic: the meanings and experience of naturopathic treatment for refugee women survivors of torture. Consistent with the interdisciplinary focus outlined in Chapters Two and Three, the discussion on methodology is orientated to the sense of meanings and value people give to their own experiences of ill health and the healing traditions within their particular cultural setting. This chapter begins with an outline of the methods of sampling and data collection. Issues relevant to the refugee experience and how such issues are vital in informing the choice and application of appropriate methodologies for research with refugee populations are

---

7 The terms naturopathy, natural therapies and complementary therapies are used interchangeably at Foundation House.
Chapter 4: Methodology

then discussed. The chapter proceeds with detailing the recruitment process, including the preparation I undertook as the researcher before conducting the interviews, and then describes the distinctive process of interviewing refugee participants from non-English speaking backgrounds. I emphasise the importance of developing trust with vulnerable and marginalised participants, and outline the complex set of factors involved in conducting cross-cultural research reliant on interpreters. The chapter concludes with my reflections on the interview encounters and data analysis process.

Overview of methods of sampling and data collection

The research participants for the study were recruited from Foundation House following approval from Southern Cross University’s Human Research Ethics Committee (HREC) (see Appendix 1a) and the Victorian Foundation for Survivors of Torture Institutional Ethics Committee (VFST–IEC) (see Appendix 1b). The rationale for recruiting participants from Foundation House was based on my previous work as a naturopath in this organisation, my extensive professional connections with the staff and a personal long-standing goal to document the unique contribution of the natural therapies program.

The method of data collection was in-depth interviews. I contacted the women by phone several times during the recruitment phase and interviewed each woman once and in one case, twice. The women were interviewed in their own homes or at Foundation House. The interviews were guided by a theme list (see Appendix 7) and purposeful sampling was used to select the participants. As this project originally began as a research Masters degree, purposeful sampling was employed in order to achieve a purposeful sample of ten women that was homogenous. It was during the data analysis phase when the richness of the emerging data, and my supervisors’ endorsement, encouraged me to upgrade the project to a PhD.

I conducted all of the interviews which were taped and then transcribed by me. Pseudonyms were used for the participants, and, where they are cited in the data, for the naturopaths and the interpreters. A coding framework, based on the principles set out by Gifford (1998a) and Patton (2002) was developed and I coded the data for dominant categories and themes. The data was then analysed using thematic analysis. The focus of the research questions was to
explore the participants’ experiences of the natural therapies program at Foundation House. The purpose of the research was not to evaluate the effectiveness of the natural therapies program.

**Appropriate research methodologies for refugee research**

**Refugee-specific issues**

Because refugees experience upheaval, uprooting, loss, and adjustment to new and alien cultures of resettlement, studies of refugees often require different methods ... (Krulfeld 1994:147).

Conducting research with refugee populations needs to take into account complex cross-cultural factors, combined with the devastating consequences of torture and trauma on individuals, families, and communities (Ahearn 2000a; Black 2001; Gifford et al. 2007). A significant challenge for researchers in this field is to develop research methods that are culturally appropriate and that do not simulate prior traumatic experiences (Mackenzie, McDowell & Pittaway 2007). This project is informed by the understanding that conducting research with refugees cannot be separated from the cultural and sociopolitical factors that generate the refugee experience. It is contextualised within a framework that makes explicit the effects of torture and trauma on the whole person and how these issues must be addressed at every stage of the research design and process.

Meaningful refugee research takes seriously the effects of extreme and devastating life events that are inherent in the refugee experience (Ahearn 2000a; Eastmond 2007). At the core of most refugees’ experiences is exposure to trauma. Most refugees have fled countries overrun by political violence and corruption. Many have lived with overwhelming fear, under siege by police states, dictatorships or war. Because of these experiences many refugees embody a deep-seated terror of being formally questioned or interviewed, fearing any information they give could be turned against them or their families (Omidian 1994; Sue, Kuraski & Srinivasan 1999).

---

When seeking asylum, refugees are obligated to disclose their experiences under the rigorous scrutiny of numerous immigration officials. Typically, deeply personal and painful details are required by the authorities in order for the refugee to demonstrate their humanitarian case for asylum. For most people telling a stranger such private and often shame-evoking details causes enormous distress. In the context of the refugee experience this kind of interviewing is laden with complexities. Always at stake is the person’s fate: life in a refugee camp or worse, contrasted with a chance of gaining a humanitarian visa and longed-for freedom. Thus it is not surprising that for many refugees the very act of being interviewed, irrespective of the research context, may evoke feelings of apprehension or fear (Krulfeld 1994).

In order to protect marginalised and vulnerable participants, research protocols must address several key concerns, in particular the numerous disparities that exist between the researcher and the researched (Allotey & Manderson 2003). Hynes summarises some of the critical factors requiring explication as ‘inequalities of political rights, economic positions, psychosocial positions, gender and other social and cultural factors’ (Hynes 2003 13). Sue et al. (1999:63) argue that the ‘commitment to conduct research should involve the reduction of this unequal power relationship between the two parties’. They suggest that strategies such as reframing or rewording the interview questions to suit the range of cognitive and language skills of the participants may balance unequal power relations. Developing language and conceptual equivalence, discussed below, ensures culturally sensitive research practices (Ahearn 2000a). By giving careful consideration to these issues, the research process is less likely to inadvertently exacerbate the divide between ‘us’ and ‘them’ and thereby encourages ethically sound research (Allotey & Manderson 2003; Rodgers 2004).

As mentioned above, there is a serious risk in refugee research that the researcher or research process could unintentionally cause further distress to the participants. Ethical research practices actively seek to minimise risks whilst aiming to benefit the refugee population through the outcomes of the research (Omidian 2000). By definition, refugees are people who have endured horrific suffering. At the core of their experiences is often a profound loss of trust in the humanity of others (Allotey 1998). Significantly, when applied skilfully and with the emphasis on respectful and meaningful interpersonal connections, qualitative inquiry has the potential to alleviate these concerns to some extent. By engendering a safe
atmosphere in which a vulnerable and marginalised person may feel safe to speak freely, it is possible that some refugees may rediscover their ability to trust in others and may feel some relief through the process of telling their stories (Hynes 2003).

In this project my aim was to ensure that the research process at the very least did not detrimentally affect the participants. My intention in the interviews was that in the process of telling me their stories and sharing their knowledge of traditional medicine in their home countries, the participants would re-experience positive memories of home and rediscover personal strengths that would empower them in their current lives (Eastmond 2007). It was therefore essential that I was knowledgeable about the refugee experience and maintained an ethical position. Demonstrating empathy and being explicit about the purpose of my research with the women I interviewed was critical.

**Linguistic and conceptual communication issues and strategies**

Language can be a significant barrier to research with people who are not like the researcher in various ways. To assume that there is no problem in interpreting concepts across languages is to assume that there is only one baseline, and that is the researcher’s own (Temple & Edwards 2002:7).

A major challenge in cross-cultural research exists where there are differences in language and conceptual understandings between the researcher and the participants. This is one of the most significant factors that must be addressed in order to ensure linguistic and conceptual equivalence in both the written material given to the participants and throughout the interview process (Andary, Stolk & Klimidis 2003; Westermeyer & Janca 1997). Often the literal translation of a word or phrase has a very different meaning to the one intended and clarification is required around concepts to ensure appropriate translation (Andary, Stolk & Klimidis 2003; Temple 1997). In some situations words, phrases or concepts may need to be changed or modified to ensure compatibility of meaning across different languages (Andary, Stolk & Klimidis 2003; Bloch 1999). For example, translating a culture-specific term such as ‘naturopathy’, where the literal translation is open to a wide range of interpretations, requires conceptual input in order to provide an accurate and meaningful translation. As noted in Chapter Two, even within different English-speaking cultures this term has various connotations and meanings.
Translation issues – preparing background material

I became more aware of these issues when I received feedback from one of the translators working on my written material. I had organised through a professional translating service for my ‘Subject Information Sheet and Consent Form’ to be translated into the different languages spoken by the participants (see Appendixes 4b, 4c, 4d & 4e). One of the professional translators required further explanation and clarification of the sections detailing the technical aspects of informed consent and confidentiality in order to accurately translate these concepts. Based on the professionalism of the translating and interpreting organisation, I trusted that they had translated my material correctly.

Interpreting cross-culturally

There is increasing awareness of the vital yet complex role of the interpreter within the medical and psychological context (Dysart-Gale 2005; Freed 1988; Hsieh 2006; Kaufert & Putsch 1997). However, according to Temple and Edwards (2002:1) little has been written about the involvement of interpreters and translators in the research process, even though qualitative approaches are ‘steeped in a tradition that acknowledges the importance of reflexivity and context’ (See also Edwards 1998; Temple 1997). There is a significant difference between interpreting and translating. What is critical here is that in the process of interpreting the interpreter is constantly making decisions regarding the meaning of what is being said. They are ‘interpreting’ or bringing meaning as opposed to a literal translation. Temple and Edwards (2002) suggest that qualitative researchers, relying on interpreters in order to conduct their research, have not given enough recognition to the influence of the interpreter on the actual research process. They argue that the interpreter’s ‘voice’ is central to the entire interview process as the interpreter directly influences every aspect of the interaction between interviewer and interviewee. It is thus not possible to dismiss this third party as neutral or value free. For instance, if there is ethnic, gender, social class, age or personality tension between participant and interpreter or researcher and interpreter this will have a significant bearing on the quality of the interview and this needs to be recognised and acknowledged (Edwards 1998).
Chapter 4: Methodology

Linguistic and conceptual equivalence are paramount in cross-cultural research (Sue 1999). Temple and Edwards (2002:2) suggest that ‘communication across languages involves more than just a literal transfer of information’ and the interpreter, if seen as more than a neutral mouthpiece, is central to the development of both linguistic and conceptual equivalence through discussing concepts rather than simply translating words. This approach allows a much greater level of conceptual equivalence to be reached, as the researcher, with the assistance of the interpreter, can determine ‘whether the construct being measured exists in the thinking of the target culture and is understood the same way’ (Sue, Kuraski & Srinivasan 1999:59).

The visibility of the interpreter is also essential in order to achieve data validity. Ryen (2002:344) states that ‘[i]t is of vital importance that words and concepts be interpreted in the same ways by interviewers, interpreters, and respondents to avoid violating validity’. The active role of the interpreter thus offers a greater likelihood of the researcher not superimposing their own world views onto participants who may hold different belief systems. Temple and Edwards (2002:3) ask ‘[w]ithout talking to people who are communicating directly to others for us, how can we even begin to know if we are imposing our framework of understanding?’ Thus, when the interpreter has an active role in the research rather than being an irrelevant, neutral transmitter of information, a greater level of cross-cultural equivalence can occur.

The active role of the interpreter has further significant benefits, particularly when working cross-culturally and with traumatised participants (examples specific to this research are described in a later section of this chapter). In particular, idiosyncratic language differences and culturally specific nuances are more likely to be exposed and then appropriately interpreted. Based on their own research projects that involved working with interpreters, Temple and Edwards (2002:1) conclude:

[T]hat to conduct meaningful research with people who speak little or no English, English speaking researchers need to talk to the interpreters and translators they are working with about their perspectives on issues being discussed.
Conversely, when the interpreter has an active role as opposed to a neutral transmitter role, marginalised and vulnerable participants are able to feel comfortable enough to clarify with the interpreter any culturally confusing issues which they would feel shy or embarrassed to ask the researcher about directly.

Within a medical context Hsieh’s (2006:721) research investigating the complex role of the medical interpreter highlights the inappropriateness of the interpreter being seen as a ‘machine-like’ conduit. While much of the literature on interpreting is based on the notion that the interpreter is ‘posed as a neutral mouthpiece’ (Temple & Edwards 2002:4), this approach is particularly inappropriate when interpreting for traumatised refugees from minority ethnic groups. As Hsieh (2006:727) explains:

[A]lthough a conduit role may carry the image of an emotionless professional that is valued in the western biomedical culture, it may be problematic to people who do not share the same appreciation for that role expectation.

If the interpreter is confined within a conduit role, Hsieh (2006) argues they are powerless to provide the appropriate culturally specific information necessary for the efficacious treatment of the patient.

A transparent and open research framework therefore enables the interpreter to become visible rather than hidden. In this context the interview takes place with the interpreter, rather than through the interpreter (Edwards 1998). Or, as McMichael (2002:176) states: ‘I did not use an interpreter, but worked with an interpreter’. Just as the researcher in qualitative work acknowledges that they are part of the research, the interpreter also is located in the social world of the interview.

For the researcher, interviewing with interpreters requires specific skills and awareness. In a bilingual interview setting when communication occurs with an interpreter, it is important for both the researcher and participant to be familiar with the nuances of this unusual three-way dynamic. Common problems include the excessive use of jargon that is difficult to interpret or the use of long and complex sentences. People unaccustomed to working with interpreters often direct the questions or responses to the interpreter, rather than to each other (Andary, Stolk & Klimidis 2003). Also, if a researcher is not accustomed to having a third person
observe them while they work, they may feel threatened by the presence of the interpreter, perhaps experiencing them as a critical observer. Inevitably, the presence of the interpreter changes the dynamic in an interview setting. Although there are perceivable benefits of this dynamic (discussed below), communication can often be difficult and stilted. In particular, the transmission of difficult concepts can be hindered by the constant interruption to the flow of speech and thought as there is only so much information that can be interpreted at a time (Andary, Stolk & Klimidis 2003).

As confidentiality is a significant issue for many refugees, an unprofessional interpreter can cause serious trauma through breaching confidentiality within the client’s community. From my previous work at Foundation House I was aware that many refugees have experienced such traumas at interviews with immigration officials, at Centrelink appointments and during medical appointments and are therefore rightly wary of working with new or unfamiliar interpreters. It can take several sessions with a new interpreter before a person will feel safe enough to open up and talk about personal and traumatic events.

It is imperative that the interpreter is professional, ensuring confidentiality, holding proficient language skills and working under ethical interpreting protocols, for example, not adding or subtracting dialogue or behaving inappropriately (Turner & Ozolins 2007). In this project I formally employed interpreters from a professional interpreting agency and therefore it was not necessary for the interpreters that I worked with to sign additional confidentiality forms. Within small ethnic communities in particular, where most interpreters will be known and often active within the community, they will not be regarded as neutral bystanders. Most important when interviewing with an interpreter is the understanding of the complexities that arise in a three-way conversation. These dynamics will be discussed in relation to my interviews below.
Justification for using in-depth interviews

In-depth interviews open up what is inside people (Patton 2002:406)

Investigating the magnitude and complexities of the refugee experience does require multiple levels of inquiry and perspective (Eastmond 2000). As demonstrated in the literature, both qualitative and quantitative research methodologies are useful approaches in refugee research (Ahearn 2000b; Castles 2003; Hollifield et al. 2002; Jacobsen & Landau 2003; Mackenzie, McDowell & Pittaway 2007; Powles 2004; Rodgers 2004). The decisive factor, however, is to select the methodology that will best address the research question under investigation (Johnson 2002). In-depth interviewing was chosen for this research project as the most meaningful and effective qualitative method to explore and describe refugees’ experiences of naturopathy at Foundation House. In the process of interviewing, stories often emerge which provide deeper meaning and help to facilitate insights (Powles 2004). Validating this approach, Omidian (2000:49) argues that ‘in refugee research on psychosocial health [in-depth interviewing] is irreplaceable’. The in-depth interview is a guided conversation.

In-depth interviews are understood as a particularly appropriate methodology for health-related research amongst culturally and linguistically diverse groups (de Laine 1997; Rice-Liamputtong & Ezzy 2001; Sue, Kuraski & Srinivasan 1999). When values about health and illness differ from those of mainstream Western society, an approach that seeks to explore the meanings people give to certain phenomena facilitates this process (Sue et al 1999). An essential feature of qualitative data is that it is descriptive, capturing and communicating another’s experience through telling their story in their own words (Patton 2002:47). Patton (2002:48) describes this approach as ‘getting close to the people and situations being studied to personally understand the realities and minutiae of daily life’. This is important as it enables the lived experience of the person to be revealed (Hollifield et al. 2002; Rodgers 2004). Sue et al. (1999:66) suggest that the ‘emic’ or culture-specific nature of in-depth interviewing enables the researcher to access ‘new or indigenous concepts’ which, in the area of refugee research, are highly relevant as refugees come from diverse and predominantly non-Western cultures.
A distinguishing advantage of the qualitative interview is that it allows an array of different views, experiences and beliefs to be expressed whilst enabling a detailed picture of the person’s perspectives to emerge (Kvale 1996). Johnson (2002) suggests that if the focus of the research is on deep understandings and drawing out meaning of certain phenomena, then in-depth interviewing is the best approach. Hollifield et al. (2002) argue that in-depth interviews are able to reflect cultural specificity, sensitivity and the social context of the refugee population under examination and are therefore a highly relevant research method for this group. Within many refugee communities, story telling is one of the most significant means by which women communicate important information (Dossa 2006; Manderson & Allotey 2003). In this research project, the aim of the interview context was to provide a safe environment for women to tell their stories of traditional medicine practices in their home countries and their experiences of naturopathy at Foundation House.

The level of interaction encouraged in a qualitative approach enables rapport to develop between the researchers and researched. This allows confidence and trust to grow, thereby creating a favourable environment for deep conversation (Kvale 1996). The flexibility of in-depth interviews allows the interview to be more like an intentional conversation in which ‘[t]he interviewer wanders along with the local inhabitants, asks questions that lead the subjects to tell their own stories of the lived world’ (Kvale 1996:4). In the context of my research, conversation-style interviewing enabled the participants to tell their stories in a relaxed manner that encouraged spontaneous dialogue. As one participant said during her interview:

*Please take your time, this is so important, I want to tell you another story.*

Flexibility is a basic tenet of qualitative interviewing (Rubin & Rubin 1995). Modifying aspects of the research design as required allows the project to develop in accord with what is actually happening during the field work. ‘Adjusting the design as you go along is a normal, expected part of the qualitative research process’ (Rubin & Rubin 1995:44). I was required to make adjustments continually throughout the recruitment phase. Research with refugee populations exemplifies the need for flexibility at all stages of a research project. Many refugees live with enormous irregularity and dislocation in their everyday lives. Many live within the shadow of traumatic memory and acute grief. The effects of upheaval, loss,
poor health and cultural dislocation cause significant instability in their lives. These factors can make recruitment a complex and often difficult task. For example, due to family crises several women who had given oral consent to be interviewed had to withdraw. One potential participant, an asylum seeker, was suddenly deported before her interview. This situation reinforced the unrelenting fear associated with seeking asylum and the vulnerability of this group of people in our society. It also highlighted the generosity of spirit of many asylum seekers who even in their vulnerability choose to contribute to the society in which they are living.

**Research context**

**The role of Foundation House in the research process**

Because of my previous work at Foundation House, I was well known and trusted by the naturopaths and counsellors (the practitioners) at Foundation House. The staff were extremely positive about my research project and they had confidence in my ability to work with refugee survivors of torture in a respectful, culturally appropriate and meaningful way.

The practitioners played a pivotal role in my research project. As described later in the section on recruitment, the counsellors and naturopaths were instrumental in referring to me appropriate participants as well as providing me with critical background information that made the recruitment phase significantly smoother than it might otherwise have been. For example, when referring participants the practitioners gave me the details of the participants’ preferred interpreters so that I was able to employ the interpreters that the participants were comfortable with. This meant that ethnic and language-specific issues had been previously resolved and a relationship of trust already existed between interpreter and participant. The interpreters were professional and accustomed to working with Foundation House clients and they were familiar with the concept of naturopathy as they had often interpreted for the practitioners. Equally, the participants were also familiar with the nuances of working with interpreters and through my previous work at Foundation House, I also had significant experience of this three-way interaction.
Another enabling factor in this context was my prior professional relationships with some of the interpreters from my previous work. These interpreters had spoken warmly of me to the participants who therefore readily trusted me.

Although I had pre-existing professional connections with Foundation House staff and many of the interpreters, I had no prior connection with any of the participants I interviewed. Clearly, it would be ethically inappropriate to interview people with whom I had a previous therapeutic relationship.

Also, my field work took place two years after I finished work at Foundation House which I believe was enough time to have lapsed for me to have established appropriate distance from my previous role.

**Background of researcher: The insider/outsider tension**

In qualitative research, in-depth interviews are often ‘used in conjunction with data gathered through such avenues as [the] lived experience of the interviewer as a member or participant in what is being studied’ (Johnson 2002:104). This is a significant shift away from the idea of a detached and neutral researcher, preferably one with no prior lived experience in the particular field under inquiry (Rubin & Rubin 1995). Significantly, qualitative approaches are increasingly validated because of their emphasis on the subjective interpersonal interaction between interviewer and interviewee (Kvale 1996). Some researchers go so far as to argue that the actual relationship between researcher and participant in qualitative interviewing is the optimum site of data gathering (Patton 2002).

My years of work at Foundation House were central to my research design and data collection. My detailed understanding of the complexity of the refugee experience and my knowledge of the natural therapies program at Foundation House gave me another layer of understanding which was beneficial in the process of recruiting participants and conducting the interviews. Furthermore, I had existing therapeutic skills in working with traumatised people. Sue et al. (1999) argue that research with different ethnic groups should include investigators who have training in ethnic and cross-cultural issues. My background enabled me to implement and develop cultural sensitivity and awareness through each phase of the research project (Rogler 1989).
My background also enhanced my ability to hear the nuances within participants’ stories. I was sensitive to the textured meanings and fine distinctions in the conversations with the participants. For example, because I was knowledgeable about traditional herbal medicine I was familiar with many of the non-Western concepts such as the ‘hot/cold’ qualities of herbs and spices that some of the women referred to in their interviews. These concepts are discussed in detail in Chapters Six and Seven. This enabled a deeper and more meaningful conversation. At the same time I had to continually be alert to what Johnson (2002) argues is a common disadvantage of this insider position: the danger of assumed knowledge and unconscious assumptions.

The tensions associated with the ‘insider-outsider’ positions presented in several specific ways. From an organisational perspective I could be considered inside because of my previous work at Foundation House. I was extremely familiar with the underlying cultural complexities of the organisation; I held established professional relationships with most of the staff and my research project was strongly endorsed by the organisation. Despite the possible pitfalls, Johnson (2002:106) validates the notion that being a ‘current or former member or participant’ of the field being researched is predominantly advantageous as their prior experience in that field brings depth to the interactive process of the interview. Similarly, Sharpe’s (1996) research with newly arrived Iraqi male refugees supports this position. Sharpe (1996:43) argues that ‘valuing the subjective experiences of both the researcher and the research participants underpins the naturalistic paradigm of inquiry’. However, there were also disadvantages in this position. I may have missed particular nuances during the interviews because of my inevitable entrenched preconceptions.

Although I had a strong insider position, I was an ‘outsider’ in that I was not employed by Foundation House as I conducted the research two years after I had resigned.

In relation to this study, I argue that my history at Foundation House worked to my advantage. According to Ellis and Berger (2002:851), the interview situation is ‘an active relationship [and they urge] researchers to acknowledge their personal, political, and professional interests’. Particularly in the context of refugee research, this level of disclosure on the part of the researcher is critical in order to establish a relationship of trust. In this way, the interview can be seen more as a collaboration between researcher and participant, rather
Chapter 4: Methodology

than as an information-seeking pursuit (Sue et al 1999). When telling the participants about my previous involvement at Foundation House during the briefing phase of the interview, I noticed that they visibly relaxed and I experienced renewed warmth towards me. Perhaps I was now seen as part of the Foundation House family and therefore could be really trusted. I observed these nuances as the interpreter translated my words that described my history. At that point, the participant would often make eye contact with me, acknowledging me directly with a nod and a smile; it seemed to me that my standing as an ex-worker at Foundation House put me in a certain context and perhaps gave me greater credibility in the eyes of the participants.

What Johnson (2002:107) calls my ‘member knowledge and lived experience’ meant that I was more able to ‘hear ... about the important matters of lived experience’. I perceived that my background was clearly advantageous in building rapport and trust. If it was problematic for a participant, they certainly did not make these feelings overt. Given the extensive recruitment process, discussed in the next section, perhaps potential participants who would have had issue with my background or any other aspect of the research declined to participate. In this way the participants may have self-selected to be interviewed because they were interested in having their views heard.

On another level, I held insider status with the participants as I am a naturopath and familiar with traditional healing knowledge. A significant part of the interviews was centred on exploring the participants’ knowledge of their own traditional medicine practices. As components of contemporary naturopathic practice stem from the same lineage of healing as the participants’ traditional medicine, we shared a common understanding and world view. For instance, one Iranian woman, Rosa, spoke about the great Persian healer Avicenna and his role in Iranian culture. I had learnt about Avicenna in my training, as his work informs much of traditional Western herbal knowledge. Rosa’s eyes filled with tears as she recognised our connection and she delighted in my knowledge and admiration of her hero. It was a significant moment of connection between us. In my interview with Soula, a participant from Afghanistan, we shared stories about how we use the herb dandelion. We connected through our shared knowledge and respect for the plant world. Although these women come from non-Western cultures, speak a different language, hold different religious beliefs and have
different cultural practices, what became apparent through the interviews was our shared knowledge and belief in traditional medicine. My lineage of herbal medicine was a direct link with most of the women I interviewed. I was on the inside.

**Recruitment process**

Good qualitative research, according to Jacobsen and Landau (2003) requires the explication of the methods used. Revealing participant numbers, sampling strategies, the place where the interviews occurred, who conducted the interviews and interpreting/translating issues increases the rigour of the research. Research practices become ‘culturally sensitive’ through the ‘incessant and continuing finely calibrated interweaving of cultural components and cultural awareness into all phases of the research process’ (Rogler 1989:302).

**Recruiting participants**

The approach taken to recruiting participants was primarily informed by understanding the traumatic and depersonalising experiences that make a person a refugee. To ask a person to participate in research when they had previously endured numerous formal interviews, from stringent immigration processes to ongoing social security interviews, let alone any history of interrogation in their home countries, required a respectful and culturally sensitive approach (Hynes 2003). Given the participants’ backgrounds, it was therefore inappropriate to recruit the women through impersonal methods such as random sampling techniques.

The sampling strategy was chosen to best suit the aims of the research, which were to explore meaning and experience rather than to make generalisations (Ahearn 2000a; Gifford 1998b; Patton 2002). Selection of participants was based on a ‘purposeful sampling’ approach (Patton 2002:230). As the underlying principle of purposeful sampling is to intentionally select a smaller number of ‘information rich cases’ for in-depth study, this provided an appropriate strategy for this research (Patton 2002:230). Significantly, the central tenet of purposeful sampling directly opposes the logic inherent in statistical sampling methods (Patton 2002). In this project participants were selected based on a certain set of criteria, the main factor being the experience of naturopathy at Foundation House (criterion sampling) (Patton 2002:238). Participants selected had to have had, or were currently undergoing,
either short- or long-term naturopathic treatment by a practitioner at Foundation House. Experience of traditional medicine in the home country was not a named criterion (see Appendix 1a & 1b). However, it was significant that all but one of the participants interviewed had some experience of traditional medicine in their home countries.

Some researchers emphasise the importance of accessing several different channels through which potential participants may be recruited (Bloch 1999). Underpinning the view that participants should be recruited from a broad base is the understanding that ‘refugees are not a homogenous group’ (Hynes 2003:15) and therefore effective recruitment should include participants from a range of sources (Bloch 1999). As this research project focused specifically on exploring refugees’ experiences of naturopathy at Foundation House, it was inappropriate to recruit participants from outside the organisation. However, all of the practitioners at Foundation House were enlisted in the recruitment phase. Thus, participants were potentially referred from the entire practitioner pool rather than a select few.

Selecting participants: Negotiating with Foundation House

The inclusion criteria outlined in my research proposal (see Appendices 1a & 1b) stated that participants must be women over the age of 18 years, psychologically stable as determined by their practitioner (a counsellor or naturopath at Foundation House), have received naturopathic treatment at Foundation House, and have not been previous clients of mine when I worked at the organisation.

The process of selecting participants for this project required extensive negotiations with the research subcommittee of the VFST–IEC. In particular they determined the gender and ethnic backgrounds of participants for this project. Initially, the VFST–IEC recommended that only women be interviewed, and specifically women from Middle-Eastern backgrounds. These two criteria were suggested in order to decrease the number of variables in the cohort with the aim of providing a deeper insight into the research topic. At the time of designing this research project, a significant group receiving services from Foundation House came from Middle Eastern countries and therefore it was assumed that enough appropriate participants could be recruited from this group.
Chapter 4: Methodology

With qualitative research, the best laid plans often veer in unexpected directions and the researcher must be able to modify the design accordingly without compromising the integrity of the project (Rubin & Rubin 1995). During the recruitment phase it initially seemed that it would not be possible to recruit enough Middle Eastern women and after discussion with the VFST–IEC research sub-committee, the ethnic criterion had to be adjusted several times in order to recruit enough appropriate interviewees.

Due to the mercurial nature of recruiting, and also the involvement of my key informants (the practitioners at Foundation House), I ended up with a different mix of participants than the VFST–IEC had originally suggested. However, the different ethnic backgrounds of the women provided a diverse range of experiences, views and opinions which, I argue, further enriched the data.

**Number of participants**

Given the detailed nature of in-depth interviews and the amount of rich data that would potentially be generated through the interview process, in consultation with the VFST–IEC research sub-committee it was decided that around 10 interviews was appropriate for the research project. Many scholars with expertise in qualitative in-depth interviewing assert that it is impossible to state the ideal number of interviews to be conducted for any given research project (Gifford 1998b; Johnson 2002; Kvale 1996; Patton 2002). The appropriate number of participants is reached once saturation has occurred – that is, enough participants have been interviewed once no more new themes emerge from the interviews (Strauss & Corbin 1996:143).

At the end of the field work, 12 women had been interviewed. I found that the extra two interviews I conducted were necessary in order to achieve saturation. These interviewees were also significant because these particular women came from different ethnic backgrounds to those I had initially set out to interview, yet the data from their interviews paralleled the underlying themes that had emerged in the earlier interviews. Although there were discernable cultural differences amongst the women, most of the themes were consistent across all interviews. In all, I had contact with fifteen women during recruitment. One woman who had initially agreed to be interviewed decided not to go ahead when I rang her to make an appointment. Another woman had to pull out at the last minute because of a death in her
family, and one other was deported before we were able to meet. Significantly none of the women who had agreed to be interviewed after making an interview appointment cancelled or did not turn up. Prior to each interview I had approximately two to three phone conversations with each woman.

**Introducing the women**

The women in this study represent a typical mix of the clients who attend Foundation House. Their ages range from mid twenties to mid sixties. The following table provides a demographic overview (see Appendix 11 for more details).

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Country of origin</th>
<th>City/rural</th>
<th>Religion</th>
<th>Marital status</th>
<th>Children Australia</th>
<th>Occupation in home country</th>
<th>Years in Australia</th>
<th>Interpreter in interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lani</td>
<td>Afghanistan</td>
<td>Married in city</td>
<td>Muslim</td>
<td>Widow</td>
<td>2</td>
<td>Home duties</td>
<td>1½</td>
<td>Yes</td>
</tr>
<tr>
<td>Frasa</td>
<td>Afghanistan</td>
<td>City</td>
<td>Muslim</td>
<td>Married</td>
<td>5</td>
<td>School teacher</td>
<td>2½</td>
<td>Yes</td>
</tr>
<tr>
<td>Mary</td>
<td>Iraq</td>
<td>City</td>
<td>Catholic</td>
<td>Single</td>
<td>None</td>
<td>Mechanical engineer</td>
<td>2½</td>
<td>No</td>
</tr>
<tr>
<td>Rosa</td>
<td>Iran</td>
<td>City</td>
<td>Muslim</td>
<td>Separated in Australia</td>
<td>2</td>
<td>Social worker</td>
<td>2</td>
<td>Yes</td>
</tr>
<tr>
<td>Soula</td>
<td>Afghanistan</td>
<td>Mountains near Kabul</td>
<td>Muslim</td>
<td>Married</td>
<td>4</td>
<td>University student</td>
<td>3</td>
<td>Yes</td>
</tr>
<tr>
<td>Hati</td>
<td>Yemen</td>
<td>City</td>
<td>Muslim</td>
<td>Married</td>
<td>3</td>
<td>Accountant</td>
<td>2</td>
<td>Yes</td>
</tr>
<tr>
<td>Amar</td>
<td>Iraq</td>
<td>City</td>
<td>Muslim</td>
<td>Single</td>
<td>1</td>
<td>Belly dancer and teacher</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>Raza</td>
<td>Iran</td>
<td>City</td>
<td>Baha’i</td>
<td>Married</td>
<td>1 Australia 1 Iran</td>
<td>Dressmaker</td>
<td>1½</td>
<td>Yes</td>
</tr>
<tr>
<td>Sally</td>
<td>Burma</td>
<td>Rural</td>
<td>Buddhist</td>
<td>Single</td>
<td>None</td>
<td>Student</td>
<td>7</td>
<td>No</td>
</tr>
<tr>
<td>Sita</td>
<td>Iran</td>
<td>City</td>
<td>Muslim</td>
<td>Separated in Australia</td>
<td>2</td>
<td>Hairdresser, receptionist, child care worker</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Faduma</td>
<td>Somalia</td>
<td>Rural</td>
<td>Muslim</td>
<td>Married</td>
<td>3</td>
<td>Student</td>
<td>9</td>
<td>No</td>
</tr>
<tr>
<td>Vesna</td>
<td>Former Yugoslavia</td>
<td>Rural</td>
<td>Christian</td>
<td>Married</td>
<td>2</td>
<td>Home duties &amp; part-time work</td>
<td>3</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The process of recruitment at Foundation House

I liaised with all of the practitioners to conduct the initial recruiting phase. Refugee clients fitting the selection criteria were invited to participate at the discretion of their practitioners and the Clinical Director of Foundation House and on the basis of the clients’ expressed
interest in the study. I sought permission from the VFST Ethics Committee to write to all practitioners at Foundation House providing details of the project (see Appendixes 1a & 1b). On the basis of this request, practitioners could identify appropriate client participants for the study. They then made the initial contact with the client. The rationale for this method of client selection was primarily to ensure the psychological safety and wellbeing of the clients participating in the project. Bloch (1999) refers to this role as that of a gatekeeper, an intermediary providing an essential link between researcher and possible participant. In this way, the practitioners at Foundation House played a critical role in this research project. They determined appropriate referrals, provided crucial demographic and culture-specific details and made themselves available if debriefing was required by the participant after their interview.

The pre-fieldwork period involved a lengthy and intensive process of liaison with over 20 practitioners at Foundation House. Initially each practitioner received an email introducing the project and I requested a phone appointment to discuss the project in more detail. If the practitioner expressed interest to further discuss the project, I made a phone appointment and then sent written material (see Appendix 2). If the practitioner then agreed to review their case load and refer potential participants, we had ongoing communication. This phase of the recruitment process required constant and clear communication between the practitioners and me. I relied on each practitioner’s professional assessment of their clients and was impressed by their sensitivity and respect for their clients and the ways in which they always made their clients’ wellbeing a priority.

As the practitioners had an in-depth understanding of the psychological and overall health status of their clients, they were well positioned to inform appropriate clients about the study. The practitioners were thoroughly briefed on the research project and in order to assist them in describing the important details of the research, I developed a ‘script’ for them to use when speaking to the prospective participants (see Appendix 3). This also provided some degree of consistency in the recruitment process. My overall aim was to minimise the prospective participants’ sense of obligation to participate and to ensure they were clear about the purpose of the research before agreeing to participate (Patton 2002). This approach provided the
necessary screening to ensure that only clients who were psychologically stable were invited to participate. As the researcher, I recognised that the actual process of being interviewed could trigger traumatic memories in vulnerable clients.

Only after the practitioner had spoken to the prospective participant about the research and they had shown keen interest to participate did I make contact. This selection process enabled the practitioners to have an initial discussion about the research project with their clients (prospective participants) without my presence, making it easier for them to decline participation at this initial stage. These conversations took place with an interpreter when necessary. If the prospective participant was interested in participating, the practitioner gave them a copy of the subject information sheet (see Appendix 4a) in English, and passed on their contact/phone details to me and I then phoned the prospective participant. This was the first personal contact I had with prospective participants and I was aware of the importance of building rapport at this initial stage. I offered to call them back with a telephone interpreter if they preferred. I then explained that the purpose of my phone call was to provide further details of the research project (see Appendix 5), and reiterated that speaking to me did not commit them to participate in the study. If they were interested in participating, we then set up an interview time with their preferred professional interpreter, if they requested it. At the interview I gave the participants a professionally translated subject information sheet/consent form (see Appendixes 4b, 4c, 4d & 4e).

To further assist with the recruitment process I developed a simple form that contained appropriate details of the prospective participants from the referring practitioner (see Appendix 6) with details such as ethnicity, preferred language, contact details, preferred interpreter, and the names of any inappropriate interpreters. This ensured that I had the correct and critical information that would assist in ensuring a smooth first contact. For example, although a particular Iranian woman I interviewed was Muslim, she preferred to work with an Iranian Baha’i interpreter as she was very fearful that information could be leaked. She felt safer working with an interpreter from outside her religious community. This simple yet critical detail made the difference in creating the opportunity for an interview in which the participant felt safe to speak freely and openly, access that otherwise would not have been available.
A significant advantage of this approach to recruitment was that the offer to participate in the research was introduced to the prospective participants by someone they trusted and who was not involved in the actual research project. This process was important in several ways: it legitimised the project and also enabled the prospective participant to be in a position to clearly choose whether they wanted to participate or not by making refusal easier and minimising the risk of coercion. This aspect was particularly important because, as a vulnerable minority group in a disempowered position, it may have been difficult to say ‘no’ when a person with power and privilege made a request (Sue et al. 1999). For some, this difficulty can be about fear of losing favour. For others it may be seen as socially or culturally impolite to say ‘no’, and for others the desire to please overrides personal needs.

Another important factor was the opportunity to be ‘introduced’. Within many non-Western cultures, it is inappropriate and often seen as disrespectful to make contact with a person without going through a mutual friend or acquaintance (Omidian 1994; Sue, Kuraski & Srinivasan 1999).

Limitations of this approach could be that there was a lack of consistency in how the project was presented and explained to participants and that the participants’ responses may have been influenced by their relationship with the practitioner. However, the participants did have a good understanding of the aims of the project when we first met, thus indicating that the practitioners were able to communicate clearly to the potential participants.

Because of the particular recruitment process I undertook, the interviewees did not appear to be suspicious of me or the project. In fact most of the women were eager to speak to me about their experiences. No one requested that I not use the tape recorder or not take notes. Only one woman asked that I refer to her by her pseudonym during the actual interview, for fear of being identified by those of a different ethnicity in her local community in Australia. At the other extreme, one woman offered to come with me to speak to government officials about my research in order to gain more funding for the natural therapies program.

In summary, the recruitment processes I followed, setting up debriefing for participants if requested, allowing the participants to choose the location for the interviews and their preferred interpreters, as well as the translated subject information sheets all contributed to
trust building. The factors that gave depth to the process and ensured ethical and efficacious research were my deep understanding of the complexities of the refugee experience and my professional experience of naturopathy, as well as my ability to ‘sit with’ people in pain.

**Preparing for the interview**

It is suggested that there is a boundless social universe of mistrust – much of which will remain unknown to the researcher – requiring consideration when conducting research on refugees (Hynes 2003:2).

A cornerstone of good qualitative research is trust and rapport between the researcher and the researched. Within a refugee context this has even greater importance, as a well-documented consequence of the refugee experience is a pronounced loss of trust in all areas of life (Colson 2003; VFST 1996a). From the experience of my previous work with refugee survivors of torture, I understood the intricacies inherent in building a trusting relationship as described above. I also understood that without developing trust between me and the participants, this research project would have lacked depth and meaning (Omidian 2000). Hynes (2003) suggests there are refugee-specific strategies for building trust within a research context. Confidentiality, ‘separation and independence from officialdom’, and making explicit the reasons for the research are some considerations (Hynes 2003:15). Providing the potential participant with written material that details the aims of the project and the ways the information will be used prior to seeking consent is also highly significant in building trust.

Kvale (1996:128) uses the term ‘briefing’ to describe the important phase at the onset of the interview. In order to develop a safe interview environment and to build rapport between myself and the participant, I spent time setting the scene, chatting in a relaxed way with the participant about the interview. I was actively building a connection with the participant before beginning the central questions of the interview. Defining the context and explaining the purpose of the interview, as well clarifying concerns or questions with the interviewee was essential for establishing a comfortable setting and clear communication. This is particularly important when interviewing cross-culturally and with an interpreter.
In my experience I found trust was more readily established and maintained when I was well prepared in my contacts with the participant, both on the phone and in the interview. In many ways the scene is set in the initial contact, whether that is face-to-face or on the telephone. Generally, traumatised people are highly sensitive (VFST 1996), instantly picking up underlying tensions and reacting to them instinctively. If the researcher is ill prepared and clumsy in the first interaction, developing rapport is likely to be impeded.

Additionally, in official or formal situations, most refugees will often demonstrate a very polite yet reserved persona, often hiding their true feelings behind the formalities of conventional conversation (Omidian 1994). In an interview situation, if the researcher is able to put the participant at ease by creating a relaxed and safe atmosphere, trust is more likely to develop. If this occurs, the researcher is then perceived as more than an ‘official visitor’ and the refugee participant is more likely to openly share her experiences, beliefs and feelings. Spending as much time as needed to establish rapport during the briefing part of the face-to-face interview gave me the opportunity to establish rapport and trust and to get beyond polite conversation. With some of the participants this occurred sooner than with others. What was important was that I did not move onto the interview questions until I felt that I had a good connection with the participant. I gauged this mainly through body language and a sense of ease in our conversation.

Trust is dependent on good communication. In a refugee context, clear communication is particularly relevant where the research is dependent on working with interpreters. I managed this by ensuring the participant’s preferred interpreter was booked for the appointment, by briefing the interpreter about the context of the appointment and by working with a telephone interpreter where appropriate. These measures increased the possibility for clear and respectful communication and enhanced my ability to develop trust. Understanding subtleties and cultural nuances as well as being conscious of assumptions was essential. For example, it would be reasonable to assume the Serbian woman I interviewed would naturally prefer a Serbian interpreter given the distressing history of conflict in the Former Yugoslavia. However for this woman this was not the case. Due to ‘community issues’ she chose to work with a particular Croatian interpreter.
Because of my prior work with refugees I was prepared for such situations and therefore I had developed a detailed checklist as part of my recruitment protocol to ensure I had the appropriate cultural details (see Appendix 6). An important strategy in building trust and rapport was to attend to detail and to maintain a respectful demeanour during the recruitment phase. My intention was that by the time I was sitting with the participant in the interview we had already established a connection and the participant was comfortable with who I was and why I was there to see them (Kvale 1996; Ryen 2002). At every stage of the research I was actively building a relationship based on trust and respect.

**Gaining informed consent**

Gaining informed consent from prospective refugee participants involves a detailed process in which cross-cultural issues and language barriers must be clearly addressed. The notion of informed consent means that the prospective participant is fully cognisant of every aspect of the research and what their participation involves (Sue et al 1999). Where there are cultural and language differences between the researcher and prospective participant as well as refugee-specific issues, the notion of consent being informed becomes even more salient. For example, the experience of signing an official document for some refugees may trigger traumatic memories or bring into question cross-cultural issues of how trust is demonstrated (Allotey & Manderson 2003; Omidian 2000).

In this project, gaining informed consent was integrated into the recruitment process. I reiterated to participants that they were able to discontinue their participation at any time without giving a reason and without prejudicing their ongoing treatment at Foundation House. The participant’s signed a consent form in their own language at the time of the interview (see Appendices 4b, 4c, 4d, 4e).

**Ensuring confidentiality**

Addressing the issues associated with confidentiality is particularly significant in research that involves vulnerable participants (Sue et al 1999). During the briefing stage of the interview, I explained to the participants (and when appropriate, with an interpreter), the processes that would be used to ensure their confidentiality (Patton 2002). This included information on how the original records of interviews, including notes, transcripts and audio tapes would
be stored (see Appendixes 1a & 1b). As participants would be referred to by their real name during the interview (unless they chose to be referred to by their pseudonym), only I would have access to the audio tapes. On the transcripts the participant would be referred to by their pseudonyms and therefore they would be unidentifiable. Only I and my academic supervisors would have access to the transcripts. The code detailing the participants’ names with allocated pseudonyms would be stored securely in a separate location from the audio tapes. Furthermore, I conducted the interviews in either a private room at Foundation House, or in the privacy of the participant’s home. Only professional interpreters, bound by a code of ethics that makes explicit issues of confidentiality, were employed for the project.

This information had been included in the subject information sheet (see Appendix 4a) that had been given to Foundation House staff and used during the initial discussion about the research with the prospective participants and had been translated into the participant’s preferred language and given to the participant at the time of the interview.

Preparing the interview guide

In this research project the in-depth interviews were guided by a theme list that covered five main areas (see Appendix 7). The first two areas covered background details and current life experiences in Australia. The next section explored the participant’s ‘home story’ and the final two sections looked at experiences of naturopathy at Foundation House. In this research it was appropriate to use an interview guide because it ensured a level of consistency across the range of interviewees while still allowing the interview to proceed with flexibility (Kvale 1996; Patton 2002). The guide served as a prompt, making sure that I covered all of the topics during the interview. This engendered a conversational tone that allowed me to be spontaneous and to probe the predetermined topics at appropriate points in the conversation (Patton 2002). In this way the interview guide acted as a carefully constructed framework which kept me focused but allowed the interviewee’s experiences and views to emerge through our conversation (Patton 2002). Thus, my interview guide worked to ‘contribute thematically to knowledge production and dynamically to promoting a good interview interaction’ (Kvale 1996:129).
During the course of the conversational interviews, as trust and rapport developed, some of the interviewees spoke about experiences that were outside the parameters set by the interview guide. In some situations it was important to listen respectfully and allow the participant to continue with their story as they seemed to be making important connections. However, when appropriate and with sensitivity, it was important that I brought the conversation back to the topics covered on the guide. It was ethically important that I held this boundary because the participants had agreed to the interview expressly on the basis of the research topic (naturopathy), and also because it was specifically these topics that had received approval from the appropriate ethics committees. Balancing this tension is difficult in the interview setting. Life experiences do not usually fit into neat disconnected compartments. For the interviewee a potential benefit of being interviewed is the opportunity for reconnecting and making meaning of their life experiences. In particular, the process of making connections is especially meaningful for refugees who are struggling to rethread and make sense of the fragmented nature of their lives. For example, women's experiences of healing at Foundation House were invariably linked to their experiences of trauma and dislocation, discussed in Chapters Six and Seven.

The issue of keeping to the interview guide surfaced when some of the women chose to speak in detail of their torture and/or trauma experiences. Although at times I was curious about their stories and would have liked to ask further probing questions, I refrained from opening up these areas unless they were directly relevant to my research topic. I had not been given ethics clearance to discuss these issues, and more importantly, the women had agreed to be interviewed on the understanding that we would be talking about traditional medicine, not their torture/trauma history. I had deliberately explained to the women during the briefing stage of the interview that I was not here to ask them about the reasons why they became refugees, but rather, to discuss their experiences of traditional medicine in their home country and at Foundation House. I explicitly framed the context of the interview in order to establish clear parameters for the interviewees. In fact, many of the women visibly relaxed on hearing this explanation and to break this confidence I felt would have been to act unethically. I argue that holding this boundary was paramount in order to establish and maintain trust between
us. When some of the women spoke of their torture/trauma experiences, I offered comforting words and gave the space for the women to speak and to be heard, but I did not actively probe or pursue these areas.

I quickly learnt that direct questions led to vague and narrow answers. Broader questions that enabled the woman to tell her story produced a rich and evocative narrative. However, at the time of interviewing I could not always make the relevant connection in the story. It was through the process of transcribing the interviews that I was able to immerse and experience the multi-layered and richly textured narrative. And then I found the gems.

**Process of interviewing**

In a research setting it is up to the interviewer to create in a short time a contact that allows the interaction to get beyond merely a polite conversation [and] establish an atmosphere in which the subject feels safe enough to talk freely about his or her experiences and feelings (Kvale 1996:125).

As Kvale (1996) explains, taking the time to build a connection during the early phase of the interview creates the necessary foundations from which to build a deeper connection. However, if intimate self disclosure occurs prematurely, that is, before a sense of trust is established, it may impede further important disclosures (Johnson 2002). In this early phase, I introduced myself, my background at Foundation House, why I wanted to do this research and how I would use the material from the interview (see Appendix 8). Good rapport between interviewer and interviewee is palpable and evidenced through body language and facial expression. However, in a cross-cultural setting the researcher cannot rely only on her own cultural indicators or signals. This is where prior work within cross-cultural contexts and the prior briefing with key informants/interpreters is of utmost importance. For example, as a Western woman, I rely on a certain level of eye contact to tell me that a harmonious exchange is taking place. For many Asian people, for example, making eye contact with an unknown person or someone in authority can be a sign of disrespect (Littlewood & Lipsedge 1993).
As I continued to cover background issues, I took the opportunity to test the tape recorder, which provided a way of familiarising the participant and interpreter with the machine. Given the vulnerability of this group, I was aware of the need to establish a certain level of rapport and trust before I turned on the tape recorder. As Warren (2002) suggests, recording the interview will hold different meanings for different people according to their past experiences and the researcher must be mindful of this impact on the quality of the interview. By the time I began the ‘formal’ part of the interview, rapport had been established and the participant and interpreter were comfortable with the tape recorder, hardly noticing its presence until the tape required changing.

I began the background phase by clarifying key terms and concepts with the interpreter and participant, thereby establishing linguistic equivalence (Rubin & Rubin 1995; Westermeyer & Janca 1997). I repeated the aim of my research and indicated that I would not ask about the reasons the participant became a refugee. Each time I went through this the participant noticeably relaxed. It became evident just how important it was for me to say these words. The participants knew I was not here to ask about their refugee experience, but rather to talk with them about traditional medicine. In every interview I noticed how my explicitness cleared the air and enabled the participants to relax further with me. As my words were interpreted, I saw the participant let out a deep breath of relief, or sit back in her chair making herself more comfortable and settled, or she might smile at me, her eyes softening, with what looked like appreciation and relief. As it happened, in some interviews the participant later went on to describe horrific experiences, but I did not ask probing questions.

The interviews took around two hours. Occasionally, if the interview ran over time, I asked both participant and interpreter if we could continue for a little longer. In this research project I interviewed each woman only once, with one exception, so it was important that I was able to establish rapport early on. The interviews took place either in the woman’s home or at Foundation House. Some women chose to meet me at Foundation House as for them it was a private and confidential place to talk. Others preferred the comfort of their own homes. It could be argued that Foundation House, as the site of the women’s current therapy, was a compromised location for my interviews, because the women would not be in a position
to make any negative comments about their treatment. However, giving preference to the women’s choice of interview location was significantly more important in order to establish trust and comfort than sticking to textbook methodology (Warren 2002).

A theme that emerged through most of the interviews was the women’s appreciation of being able to participate in the research. Many women felt a strong imperative to have their views and experiences of naturopathy at Foundation House formally documented. I describe this in detail in a later section of this chapter. Many felt that through participating they were able to ‘give back’ in a useful way.

*I wanted to attend this one [appointment] especially, because the Foundation offered me a lot so I need to give some back* (Hati).

**Working with interpreters: Challenges and benefits**

In the interview setting, the complexity of the three-way dynamic between me, the participant and interpreter inevitably created certain tensions as well as providing the opportunity for unexpected insights. In order to establish a friendly yet contained rapport, I made this three-way interaction explicit at the start of each interview. I began each interview with a discussion between the interpreter, participant and myself to clarify key words and concepts that were central to the interview questions, such as ‘traditional medicine’, ‘naturopath’, and ‘Western medicine’. By the time the formal interview was underway, I felt confident that the participant and the interpreter understood what I was asking about as we had established common ground, clarified meanings and established linguistic equivalence. This process also helped to establish rapport between myself and the interpreter and it enabled a spirit of inclusivity to be established. We were a team of three working together towards the same goal.

Inevitably in this dynamic complexities will arise. At times it seemed that the participant’s response to a question did not fit the question that I had asked. This could either be because the interpreter did not interpret properly or perhaps did not understand what I was asking, or that the participant was on a roll and just continued, ignoring my interpreted question, or that she suddenly thought of something important to say to me while the interpreter was speaking in English. Also, at times I found it difficult to keep the line of thought going because of the delayed responses. I would either clarify or re-ask the question or I let it go if I felt it wasn’t
helpful to push a point, and come back to that question a little later on. At other times I didn’t get a chance to respond or clarify or continue with my line of questioning as the participant had started speaking again and the conversation moved along another line.

A significant benefit that I experienced when working with the interpreters was the opportunity to observe the body language of the participant because of the time delay between when I spoke and when the participant received the interpretation. I was able to observe the effects of my words on the participant as the interpreter interpreted and could observe the facial expressions and body language without being preoccupied with speaking and thinking about what to say. The time delay thus provided a unique magnification of body language. Kvale (1996:129) describes this level of observation as having ‘empathetic access to the meanings communicated’ by the interviewee. The messages conveyed through body language became an important component of the data (Kvale 1996; Ryan 2002). This was evident throughout my interviews as I observed the women’s subtle as well as obvious physical changes. In one particular interview, I watched as my words were translated and the participant, Frasa, visibly relaxed in front of me. Her body shifted from a more upright and formal position into one in which she melted into the chair as she sighed with relief. I had responded with words of respect to a comment she had made about her mother’s herbal knowledge. When the interpretation came back to me, it became clear that because of my respect for her mother’s knowledge, Frasa now felt a deeper connection with me.

In the preliminary discussions and briefing I also had the opportunity to observe the relationship between the interpreter and participant before starting the formal interview. Were they very formal? Was the interpreter overly friendly with the participant? How involved was their relationship? Having a sense of these factors then helped me to contain and hold the boundary of the interview.

In one situation I was informed by the interpreting service just prior to an interview that the requested interpreter was not available due to illness and another interpreter was on the way. As the participant, Rosa, was early for her interview, I had a chance to explain the situation without the presence of the new interpreter. Rosa’s English was good enough for us to discuss the situation (otherwise I would have communicated through the telephone...
interpreting service) and I gave her the option of not going ahead with the interview if she felt uncomfortable with the change. I reassured her that she did not have to go ahead and it was no problem as we could reschedule the interview.

Although Rosa agreed to go ahead with a different interpreter, I sensed she was upset by this change. When I first met her in the waiting room at Foundation House she was very warm and open. But at the beginning of the interview she seemed reserved and I was not sure that the interview would work with the new interpreter. However, as we began the introductory part of the interview and Rosa got to know the new interpreter, she did begin to visibly relax. Because of the unexpected change, I spent more time in the introduction phase before moving on to the actual interview. I took particular care to explain to Rosa that the purpose of the interview was not to ask her about why she had become a refugee, but that I was interested in talking to her about the use of traditional medicine in her country and her experiences of naturopathy at Foundation House. I wanted Rosa to be very clear that she would not have to disclose any traumatic or refugee-specific details in front of an ‘unknown’ person. This seemed to alleviate any concerns and Rosa relaxed further, visibly settling into the chair and her facial expression softened and she appeared quite open again. She then seemed to relax with the interpreter and the interview proceeded well.

In another interview situation I observed that the interpreter and the participant, Amar, were on extremely friendly terms and that Amar was accustomed to clarifying and discussing issues with the interpreter. Because the interpreter was professional, she was able to interpret these side conversations and I was able to then reassure Amar that it was her responses to the questions that I was interested in and that there were no right or wrong answers.

Similarly, during the interviews when a participant couldn’t remember the name of a spice or herb, the participant would describe the plant and ask the interpreter if she remembered the name. This occurred on several occasions. Through this assistance from the interpreter the participants were then able to go on with the story they were telling me. At times this would result in a lengthy dialogue between participant and interpreter. As the interpreters that I worked with were professional, they were able to interpret the dialogue as it occurred and I was able to follow the conversation. If I had enlisted the interpreter merely as a ‘conduit’,
the participants’ ability to convey their stories would have been hampered. Further assisting
the interview process was the interpreter’s familiarity with how naturopathy was practised at
Foundation House.

Another important aspect of working with interpreters in a refugee context is the awareness
that many interpreters themselves come from refugee or migrant communities (Allotey &
Manderson 2003). They have their own stories and complex histories. Some would have
experienced traumatic events similar to those experienced by the people whose words they
are employed to interpret. In this research project the interpreters I worked with did not
reveal their own refugee experiences in the context of the interview, however some were so
enthusiastic about the research topic that at the end of the interview they often asked if they
could tell me of their own experiences with traditional medicine in their home countries.
They shared similar stories to those of the participants and appeared equally excited about the
topic.

Despite the various tensions and complexities, I was able to work effectively with the
interpreters in this research project. As most of the interpreters had worked with the
participants in their counselling and naturopathic appointments they had an already well
established relationship with the participants. The participant’s comfort with the interpreter
was critical to the quality of the interview and the extent of the participant’s familiarity with
the interpreter was on the whole markedly beneficial to my interview process. Pre-existing
rapport gave me a head start as a trusting relationship already existed between interpreter and
participant, demonstrated above in the situation with Amar.

The reflective researcher

Within the tradition of naturalistic inquiry the subjective experiences of both the researcher
and the participants are highly valued. Sociologist Michael Patton (2002:14) states that ‘in
qualitative inquiry, the researcher is the instrument’ (original emphasis). In this research, I took
my role seriously. Cognisant of the possible pitfalls of my insider position, I posit however
that the interweaving of my prior work at Foundation House within this research served to
fine tune this ‘instrument’ which enabled a deeper analysis.
Omidian (1994) suggests that the interviewing process involves at least three active voices in the recording and writing of each story: the interviewee’s story, the researcher’s voice, and the influence of the theoretical lens used by the researcher. She states, ‘my very presence and questions framed much of what was seen, heard, and recorded, distorting and shaping the search for the other’ (Omidian 1994:169).

The depth of engagement that is required for effective qualitative research means that it is unrealistic and even undesirable for the researcher to see themselves as emotionally neutral and unaffected by the experience (Rubin & Rubin 1995). The interview takes place in the context of a relationship which requires both parties to engage. Rubin (1995) suggests that if the interviewer is able to be open and to be themselves, the interviewee is more likely to reciprocate. A deeper level of interaction is then possible.

I had worked with refugees for ten years and had regularly engaged in debriefing and supervision sessions in which I developed skills in dealing with my own personal responses to the traumatic material. Emotionally, I found the role of researcher easier than my previous work as a naturopath at Foundation House. As the focus of my research was to explore women’s traditional healing knowledge, I was not actively seeking out their stories of torture and trauma. Of course, it is impossible to meaningfully connect with refugees without engaging with their suffering. However, in my research, I was purposefully connecting with the participants, not as refugee torture survivors, but as women knowledgeable and skilled in the area of traditional medicine. This gave me the opportunity to see a side of these women that, as the practitioner, was not as evident when my focus was treatment or outcomes based.

My personal response to the women I interviewed was one of deep gratitude for the generosity of spirit in which they gave to me by sharing their stories. All the participants answered my questions in an open and thoughtful manner. Many thanked me at the end of the interview for the opportunity to tell their stories. Along with great respect for their knowledge and wisdom, I felt humbled by the women’s understanding of herbal medicine. Often I felt that while I was talking to people extremely skilled in traditional medicine, they tended not to be aware of how significant and valuable their knowledge was.
In order to conduct in-depth interviewing … researchers must undertake considerable self-reflection to get to know themselves (Johnson 2002:109)

As preparation for my field work, my supervisor encouraged me to write my own family story in order to locate myself in the research. This was astute advice. I gave myself time to immerse in this journey and it became a deeply personal retreat. Through the writing process I opened doors into deeper understandings of myself, my family story and my relationship to my professional work with refugees. It helped me connect to the research in a deeper way that strengthened my sense of purpose in my project. The French ethnographer, Pierre Bourdieu (2005), describes the way one’s past intersects with the present as habitus, or embodied history. In the prologue my narrative of embodied trans-generational loss and displacement reveals aspects of my habitus and, I speculate, shows how my particular set of dispositions led to my work as a naturopath within a refugee context.

I found this reflective process gave me the confidence to conduct my field work in a way I had not previously felt. Because I had gone through my own ‘personal field work’, I felt more confident to conduct my interviews. Writing my story and then reading it to friends and colleagues helped me to find my authentic voice and thereby prepared me, at a deeper level, for my field work. Putting myself into an interview situation through writing my story helped to lessen the sense of the participant as ‘other’, as different and therefore separate from me. Thus, I argue, it enabled me to engage with my participants and ‘close the hierarchical gap … thus promoting dialogue rather than interrogation’ (Ellis & Berger 2002:851) during the interviews.

Distinct from the researcher/participant relationship that Ellis and Berger (2002) advocate, the dynamic between practitioner/patient is predictably hierarchical. In my practitioner role I had been the knowledgeable authority. Writing my personal story enabled me to consciously move from practitioner mode into empathetic interviewer engaged in a meaningful conversation. It assisted me to approach the interview ‘more as a conversation between two equals than as a distinctly hierarchical, question-and-answer exchange’ (Ellis & Berger 2002:854).
Chapter 4: Methodology

Warren (2002:97), drawing on the work of Kvale (1996) and Rubin (1976) suggests the qualitative interview is ‘about self as well as other’. I would suggest therefore that it is of great benefit to the qualitative researcher working with deeply sensitive and personal material to have developed some level of awareness and understanding of their own personal story in order to conduct authentic and meaningful research. Significantly, Rubin (1976:13) states ‘[n]o matter how far we travel, we can never leave our roots behind. I found they claimed me at unexpected times, in unexpected places’.

The interview encounter: A place of listening and sharing

Interviewing was not a tool to produce an account of the truth of women’s experience; rather, it provided a context to explore how women ascribe meaning and order to their lives (McMichael & Manderson 2004:91).

In order to generate a reflective atmosphere in the interviews I intentionally began by asking the women: ‘In your country, when you were sick, who did you go to for treatment and what kinds of medicines did you take?’ The question was framed to prompt the women to instinctively describe their experiences (Kopinak 1999). Lively conversation then occurred about the types of doctors and medicines available in home countries and many of the women told vividly descriptive and personal stories of healing. The many fascinating stories that emerged are woven through the thesis. However, what was just as compelling as their stories of various traditional practices were the unexpected experiences that emerged from our dynamic engagement in the interviews. The interview space became a meeting place as the women and I created space for sharing old and new worlds.

Through their stories and anecdotes about the practice of traditional and biomedicine in their home countries, the women’s practical wisdom and confidence in dealing with everyday health issues was apparent. Their stories stimulated my own reflections about the interface between biomedicine and naturopathy in the Australian context, and reflections on my own practice as a naturopath. ‘Self conscious reflection’ is, according to Ellis and Berger, (2002:852) part of the interactive interview. I gained insight into the women’s depth of knowledge and their experience in using traditional medicine, and came to see just how significant this knowledge was in terms of their identity as women. It prompted
me to think about my own background in traditional medicine. I felt an allegiance with the women through our shared knowledge and connection with herbal medicine. I revisit these experiences in Chapter Eight.

In my role as a researcher exploring the women’s encounters with naturopathy, I was not setting out to question the women about their reasons for becoming refugees, or even to inquire about their current health issues. My focus was on their knowledge, not their so-called pathology, and this created a different kind of space: one of sharing, where each was in the role of knowledgeable woman, not refugee victim.

The women’s enthusiasm to share their knowledge and their appreciation for the opportunity to talk with another person also knowledgeable in traditional medicine was a defining experience of the fieldwork.

**Analysis of the data**

Refugees are often regarded as generic figures, represented as floods, waves and streams rather than as individuals with different lives. This leads to generalisations that mask the humanity and varying experiences of individuals, and depict an image of refugees as an amorphous other (McMichael 2003:192 original emphasis).

In qualitative research, in-depth interviews apply interpretive theoretical perspectives that allow meanings to be co-constructed through the interaction between researcher and participant (Rice-Liamputtong & Ezzy 2001). In a refugee setting, qualitative research has the opportunity to counter what McMichael (2003) argues are the dehumanising effects of categorising refugees through gross generalisations. By giving voice to the research participants, understandings are developed through the interview process (Kvale 1996; Patton 2002; Rice-Liamputtong & Ezzy 2001; Strauss & Corbin 1996).

In this study I take up the principles of grounded theory in my approach to data analysis. A key component of grounded theory is the potential for theory to develop through the process of the research, rather than starting out with a theory and then attempting to test its accuracy (Gifford 1998a; Minichiello et al. 1999; Patton 1990; Strauss & Corbin 1996). Thus the
process of data analysis in qualitative studies occurs as part of the research practice during the data collection phase, rather than exclusively occurring at the end of the field work (Gifford 1998a).

It is important to note that multiple approaches to grounded theory exist (Charmaz 2003; Glasser & Strauss 1967; Strauss & Corbin 1996) and there is an increasingly contentious scholarly debate on the validity of its different versions (Patton 2002). In this project I draw on a range of approaches, including the work of Strauss and Corbin (1996). In particular I take up Patton’s (2002) interpretations and applications of their work and I employ Gifford’s (1998a; 1998b) guidelines for analysis of qualitative data.

During my field work, the themes I noted in the first few interviews informed the emphasis I gave to questions in subsequent interviews. One example of this was with Frasa, the second interviewee. I had not anticipated the extent of her personal knowledge. The depth of Frasa’s knowledge of herbal medicine prompted me to ask the women in the subsequent interviews more directly about their practical experiences of using herbs in their home countries. This encouraged the women to share detailed descriptions of their experiences. In another example, and in contrast to Frasa’s experiences, Mary, my third interviewee had absolutely no experience of using traditional medicine in her home country. This revelation then stimulated my thinking into new directions during the following interviews and I probed deeper about the women’s diverse experiences of biomedicine in their home countries.

Using an inductive methodology (Patton 2002) was essential in order to reveal the women’s accounts of their experiences and understandings of traditional medicine and naturopathy from their point of view. The aim was to produce in-depth or ‘thick descriptions’ of the phenomena being researched (Gifford 1998a:543). This interactive and interpretive approach enabled me to engage with the complexities of meanings and interpretations of the women’s stories and particularly their concepts of health and healing (Rice-Liamputtong & Ezzy 2001). In this process my own preconceived ideas and beliefs were expanded.
The transcription process

Transcribing each interview formed an important component of my analysis process as it provided a direct way of fully immersing in the data. Listening closely to the interviews created the space to pick up nuances that I had not previously heard; it reinforced ideas and themes that were percolating, and conversely, challenged my existing ideas. It gave me the time and space to sit with the women's stories and replay their voices to gain deeper understandings. The transcribing process allowed me to think with the data (Patton 2002) and to allow questions to arise. I transcribed the interviews in the days following the actual interview, while it was still fresh in my mind. This allowed me to use insights or questions from the preceding interview to inform the following one which was essential in order to uncover the emerging themes. On a practical level, transcribing as I went also enabled me to check for possible technical problems with the tapes. As it happened, when I was transcribing Rosa’s interview, I was devastated to discover that a section of the interview did not come through on the tape. Fortunately I was able to reschedule another interview with Rosa. At the end of our first interview Rosa had very explicitly said to me that she would be happy to meet again if I had any more questions. I explained the problem to her and we met again.

Thematic analysis

Thematic analysis is based on the principle of revealing common patterns throughout an entire set of data (Gifford 1998a:546). Gifford (1998a:546–7) notes that:

[I]t is often difficult to code for specific themes – themes are most commonly identified through numerous readings of the dataset [and] will be identified more through the common stories that emerge rather than through specific words.

In this project, I employed the thematic analysis framework set out by Gifford (1998a:544) which articulates three critical steps in qualitative data analysis: ‘description, classification and connection’. Beginning with a comprehensive description of the data collected allows the researcher to then classify the data into meaningful categories (developing a conceptual framework) and finally, to make connections between and within the categories and importantly, to note the variations (Gifford 1998a:544).
Chapter 4: Methodology

Strauss and Corbin (1996:3) state that coding enables ‘the analytic processes through which data are fractured, conceptualized, and integrated to form theory’. It forms a critical step in qualitative analysis. After transcribing all of the interviews I read and re-read the transcripts, identifying the broad concepts and categories that arose in each one. From this initial and extensive list I organised the categories into three layers of subcategories. I used alpha codes to represent the main categories and numerical and lower case alpha codes to delineate the subcategories (Gifford 1998a) (see Appendix 9).

In order to systematically code the data I formatted each transcript into a table. The text was divided into separate sentences with a column at the right margin for noting the ascribed code. I then methodically coded each sentence. Although this strategy was a slow and labour intensive exercise it enabled me to break down the data into small sections which I could individually code (see Appendix 10 for an example of a part of one coded transcript). This seemingly reductionist stage of the analysis is essential as ‘making sense of the whole requires breaking it down into its parts and looking at the patterns that connect these parts to each other’ (Gifford 1998a:544).

Strauss and Corbin explain:

Doing line-by-line coding through which categories, their properties, and relationships emerge automatically takes us beyond description and puts us into a conceptual mode of analysis (1996:66 original emphasis).

In the process of coding I kept handwritten notes documenting the emerging themes, my thoughts and ideas, and particularly the aspects that stood out as unusual or different. Gifford (1998a:544) refers to this process as ‘concurrent data collection’ which she states is important for ‘maintaining theoretical rigor’. At the end of coding each interview I wrote brief story-like summaries of the women which helped to keep a personal connection to the data. I included my field notes as well as emerging themes and anomalies (Willms & Johnson 1993).

In the next stage, using highlighter pens I went back through the coded data using a different colour pen to highlight the broad themes (Gifford 1998a; Patton 2002). During this stage I noted that some of the subcategories became redundant and I collapsed several into one, at the same time recognising new patterns emerging.
My field notes formed an important component for my theme development. During the field work I noted thoughts, ideas and patterns as they emerged from the interviews. During this stage supervision was helpful as I could discuss the interesting observations that I was making which helped clarify my thoughts. I further interrogated my data by making links to the existing literature and, by comparing and contrasting the themes with the literature, I further elaborated on my analysis. In Chapter Six I detail the emergent themes and theorise them in Chapter Seven.

Gifford (1998:553) identifies several critical steps essential to ensuring the credibility and rigour of qualitative research. Applied in this project and described throughout this chapter they include: making data collection methods explicit, actively seeking and interrogating examples of negative findings, making explicit analysis strategies, documenting any changes to the research strategies, making data available for reanalysis, employing methods for checking data quality, and connecting the study to the broader literature. It is also important to note the potential biases. In this project it is important to consider that the referring practitioners only referred participants who would make good case studies or participants who were more likely to be able to reflect and articulate their experiences. Also, the participants were aware that I was a naturopath and a prior employee of Foundation House and thus it is possible that they would not have made negative comments about the natural therapies program.

The following chapter describes the research site, Foundation House and details the natural therapies program.
Refugee health [is] one of the fastest growing areas of public health practice and research. With this growth come some major challenges that require innovation and lateral thinking (Allotey & Manderson 2003:210).

This chapter locates and describes Foundation House, the site of this research project. It begins with a brief overview of the establishment of torture trauma services in Australia, and specifically provides an historical account of the factors that led to the development of Foundation House. In particular, the chapter explains the circumstances and underlying philosophical influences which led to the inclusion of the natural therapies program within Foundation House’s service delivery. To this end I draw on an in-depth interview with Paris Aristotle, the Director of Foundation House. Significantly, Aristotle has held this position since the organisation’s inception 20 years ago, and as a key informant for my research his observations provide invaluable historical context for explaining the development of Foundation House and particularly the inclusion of naturopathy. The annual reports produced by the organisation give further historical context (VFST 1990, 1991, 1993, 1996b, 1997). I describe the physical landscape of Foundation House and note its relationship to the overall philosophical stance of the agency. I then outline the organisational structure of the

---

9 In accordance with the requirements of the ethics committees involved in this project, Aristotle read and accepted the transcript of our interview and this chapter of the thesis in which he is extensively quoted. In this chapter Aristotle’s verbatim quotes appear in italics.
natural therapies program within the agency and detail the strategies employed to facilitate its collaborative engagement with the counsellor-advocate role. I conclude the chapter with a postscript of the ongoing issues facing the natural therapies program.

**Background context: Establishing torture trauma services in Australia**

Australia has accepted refugees since the Second World War. However, specific psychosocial health care for refugees has only been available since the late 1980s. The impetus to establish such services in Australia was the result of several interconnected factors both nationally and internationally. Explained by Aristotle, it was the recent development of torture and trauma services in several European and Latin American countries and the emerging published literature based on this work which facilitated a global change in the awareness of the psychosocial plight of refugees. Equally significant suggests Aristotle was the gradual shift in perceptions of mental health in the Australian context:

> [M]ental health was a big taboo for a long time and ... the broader community attitude was, well just get on with it and within those communities too there was a strong sentiment about we have to forget and move on ... [and then] a whole movement developed saying we shouldn’t forget or that we can’t forget ... and at the same time the discussion ... that mental health issues were not about people being crazy and I think all of that started to broaden people’s thinking and I think there was more opportunity to talk about these issues in a different way ... and people were more ready in terms of social policy to tackle it in a different way.

In Australia, the first comprehensive investigation into the prevalence of torture and trauma within refugee communities was commissioned by the Western Metropolitan Health Region of the New South Wales (NSW) Department of Health (Reid & Strong 1987). As a result of this report, funding was secured through the NSW State Health Department to establish and administer the first Australian torture trauma service. Around the same time, but under different circumstances, the second service was established in Victoria. Over the following years torture trauma agencies were developed in all states and territories. Instigated by Aristotle in 1992, the National Forum of Services for Survivors of Torture and Trauma,
subsequently renamed the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) was established. This organisation provides the infrastructure required to maintain a comprehensive network for the eight Australian torture/trauma rehabilitation services (FASSTT 2006; VFST 1993, 1996b).

**Foundation House**

Foundation House is an incorporated non-government organisation (NGO) that receives funding from both federal and state governments and from philanthropic sources. Unlike the NSW torture trauma agency, Foundation House is not a service of a state health department and thus has greater self governance. This distinction has significant implications for determining the scope of interventions endorsed within the agencies. Foundation House has had greater latitude because of this independence. Management of the organisation is overseen by an elected volunteer committee of management made up of a wide range of professionals. Responsibility for the overall operation, financial accountability, relationship with government and overseeing the in-house management team is held by the director. Initially employed by the original working group in 1987 to set up the agency, Aristotle has been instrumental in Foundation House’s development and expansion and is actively engaged in the on-going sociopolitical arena of refugee health policy development in the national and international arena (VFST 1997).

According to Aristotle, the impetus for the Victorian service grew specifically out of the increasing groundswell of welfare, health and legal professionals and refugee community-based activists who were working within the Latin American and Cambodian refugee communities at that time: *they established a working group which got the organisation incorporated and then set about the process of finding money.* It was this level of community-based collaboration that generated a movement to develop a specialised health care service for refugees in Melbourne (VFST 1997:5). Thus the Victorian torture trauma service grew out of a strong community-development model and this approach directly influenced the initial orientation and philosophical mandate of the agency. According to Aristotle, the directive to take up a community-development model as opposed to a medically orientated model was intentional and the decision was led by staff and committee of management:
Very early on when we developed our philosophy our view was that the value of interventions needed to predominantly be determined by what clients expressed they needed, not what particular professional paradigms said they should get and that’s a strong philosophical point for me.

The primary function of Foundation House is to provide a mental health service for refugee survivors of torture and trauma and so the majority of the direct service staff are either social workers or psychologists. However, as Foundation House was committed to providing a de-medicalised, community-based model of health care, these professionals are employed in the specific role of ‘counsellor-advocates’ (Aristotle 1990). This model is important because it recognises the need to provide counselling alongside the relevant advocacy needs of refugees, such as assistance with housing. Explaining the rationale to take up the counsellor-advocate role, Aristotle (VFST 1990:4–5) states in the 1990 Annual Report:

[I]t is obvious that the psychological needs of our service users cannot be addressed whilst their day to day lives are in turmoil. In order to address the broadest possible range of social and clinical needs, we have appointed casework staff as Counsellor Advocates … combining the roles of counselling and advocacy, we are able to work more effectively with service users, assisting them to assert more control over their lives.

Within the agency the counsellor-advocates work in a range of different programs that include: long and short term counselling/psychotherapy, on-arrival advocacy and counselling, school-based programs, work with families and networking and community development projects in the wider community. The process is explained by Quentin Buckle (VFST 1997:9), one of the founding Committee members:

The refugee experience is a complex social and political phenomena with past exposure to torture, trauma and organised violence being overlaid with the present day challenges of settlement … People may not present to our service on the basis of needing counselling – they might come with a housing problem and in the course of talking about that may mention that they also have nightmares.
By taking up the counsellor-advocate role and by including naturopathy, Foundation House had operationalised a service with a strong philosophical commitment to working in a broadly integrative way (VFST 1997:10). This is further articulated in Aristotle’s explanation of the underlying principle on which service delivery is based:

\[
\text{[T]he most significant thing we can help people do is integrate their experiences into their lives in a way where it doesn’t dominate them anymore … it’s that ability to reclaim a little of the power over their own lives that was taken … and the big thing for our clients is that we believe them … and that enables people to feel embraced as a valuable decent human being.}
\]

**Introducing naturopathy**

The complexity of working with people from such diverse backgrounds, our desire to be culturally sensitive and the need to explore approaches that would complement our counselling and advocacy work led us to focus attention on this area of work (VFST 1991:10).

In keeping with its philosophical mandate, the organisation’s interest in employing non-biomedical approaches to health care for refugees is not surprising. By the end of the first year of direct service, ‘the need to offer natural therapies [was] foreshadowed’ and the following year ‘the natural therapies project commence[d] with the appointment of a naturopath, Heather Fraser, and the development of a network of volunteer therapists’ (VFST 1997:10) to work alongside the counsellor-advocates. Since that time the two components of direct service are counselling-advocacy and naturopathy. According to Aristotle, this unique combination of care reflected the agency’s orientation:

\[
\text{[T]here was a tension in the organisation about not wanting to be a medically orientated program, wanting to have a far broader base of intervention than just those grown out of a medical orientation … that services had to have a strong cultural relevance … was something that had been part of the very early thinking in the organisation.}
\]
Thus the organisation intentionally created the space within its philosophy and therapeutic approach for non-biomedical health care practices. In the context of Australia’s biomedically dominant health system, this development must be acknowledged as a radically innovative and progressive stance. According to Aristotle the driving force behind implementing a natural therapies program came from members of the Committee of Management and the counsellor-advocates who deemed it as an important facet of service delivery:

[\text{T]hat a number of communities used herbs in their own cultural practices ... [which influenced our] discussions about culturally aware and sensitive models of intervention [and] traditional or indigenous modes of intervention ... some people on the committee felt very strongly about it [naturopathy] ... and on the staff team, most people were quite keen as well.]

As stated, the rationale for pursuing a natural therapies program was centred on several factors. In Aristotle’s view it was the understanding that naturopathy was perceived as providing strong cultural relevance within a broader approach to health care that was not:

[\text{C]onfined by a Western medical model of intervention solely ... [and] the general ethos of the place was to operate in a way where people would claim control over what their interventions were.]

Providing the opportunity for choice was a significant reason for implementing the natural therapies program. According to Aristotle: ‘we wanted the medical elements of the service provision, that we were very committed to as well, to not be the only avenue that people had’. The rationale was that by providing clients with greater choice in their health care, the agency was better able to ‘promote a sense of safety and control’.

The ramifications of torture for some clients was another important factor for developing a non-biomedical health care model. Aristotle explains:

[\text{T]he use of psychotropic medications in torture and people’s suspicion of doctors because doctors have participated in torture, so some people were very concerned about chemical interventions.]

Another important factor is that naturopathy is seen as:
Chapter 5: Foundation House

not as intrusive as other forms of intervention and … there is an easier sense of relationship with non-medical practitioners.

Furthermore, Aristotle suggests that naturopaths are understood to work holistically in that they assist people to make the link between mind and body. The clients who come to Foundation House often store an inordinate amount of pain in their bodies and naturopathy is seen to assist in dealing with both the physical and the psychological ramifications of trauma, like sleep problems and pain in the joints.

Significantly, in the early stages of its implementation, perceptions about naturopathy were also closely linked to the notion of spirituality. It was understood by some Committee members and staff that for many clients spiritual beliefs were an important part of their lives and influenced their experience of torture and trauma. Within the agency’s thinking, access to naturopathy was believed to provide a form of health care that was compatible with notions of spirituality. This link was based on the understanding that naturopathy is seen as holistic and positioned outside the biomedical model:

Discussion about culturally responsive services coupled with the discussion about the relevance of spirituality and religion again was just moving people’s thought processes around into more lateral ways of thinking … you couldn’t go into the work and think oh well spirituality and faith didn’t have anything to do with it.

Thus the rationale for including the natural therapies program was clearly to broaden the therapeutic choices for clients through access to non-biomedical care. These therapies were perceived to have a strong cultural resonance with the beliefs and practices of the culturally diverse client group. This familiarity is understood to generate a safe healing space. I take up this theme in Chapters Six and Seven.

Significantly for Aristotle, the notion of a holistic service delivery has a much broader definition that is not limited by a particular discipline, but rather is:

about being open to the possibilities we think exist around different kinds of interventions … [that enable people] to feel whole … they have to feel that they are not crazy, that their body is ok, they have to feel believed, to feel confident that there is a future for them … the sense of social well-being and connection are all crucial and there is
no one discipline that accounts for all of that so our challenge is to find an ability to deliver again what the person needs in the most sensitive and most culturally appropriate, supportive and effective way possible that leads them as much as is practical to feel in control of the process.

Thus, including naturopathy is seen to be in line with the agency’s intention to provide a holistic, culturally appropriate approach to service delivery:

The value is that we can say to someone ‘we can deal with you as a whole person and we can do it through these different kinds of interventions and we will work together and with you to do that’.

Implementing and managing the natural therapies program

Despite the overall organisational support for including naturopathy, Aristotle contended that implementing the program would require a strategy to offset any potential concerns from conservative stakeholders. From Aristotle’s perspective, publicly emphasising the tactile work was an important tactic for developing legitimation for the program and enabling it to be sustainable: The fact that we kept emphasising the tactile work was strategic in terms of building acceptance. At this time some of the European torture trauma services were employing physiotherapy which had been well documented in the literature, and this, suggests Aristotle, gave legitimacy to the tactile component of Foundation House’s natural therapies program:

[T]here needed to be a cultural shift in people’s minds … and the fact that we maintained a very strong emphasis on the tactile side of it always made people comfortable enough to allow the development of the herbal side of it to occur as well and then eventually they became more comfortable with that.

In Aristotle’s view, the other significant factor that worked in the agency’s favour was ironically the extreme nature of the work:

[T]he fact that we were working with survivors of torture and trauma [and] that freaked everyone [government] out so much that they were quite happy to leave us alone and try whatever we wanted to and we were prepared to do the work and I mean that quite literally so we were given a phenomenal degree of latitude
I argue that since the program was introduced in 1989 there has been a cultural shift within the mainstream attitude to naturopathy (Singer & Fisher 2007). However, naturopathy is still considered outside the dominant biomedical system as it does not hold legislative status, and natural therapists are rarely, if ever, employed in government-funded health services, as discussed in Chapter Two. Given this context it is remarkable that the organisation was able to implement and then maintain and develop the program without having to compromise the non-biomedical/holistic philosophical basis of the program, that is, without mainstreaming its alterntiveness. In fact, I argue it is precisely the explicit non-biomedical basis of the natural therapies program at Foundation House that underlies its popularity and appeal with clients and hence its success within the organisation. By contrast, in most multidisciplinary settings where naturopathy is included alongside biomedicine, the non-biomedical practitioners must often epistemologically and ontologically adapt to the dominant biomedical paradigm, thereby losing their difference (Shuval, Nissim & Smetammikov 2002).

Responsible for the financial management of the organisation, the director has had to sustain the funding source for the natural therapies program. In this way Aristotle takes on a gatekeeper role for the natural therapies program. Balancing the tensions between the agency’s ongoing need for increased natural therapies services within a governmental context that de-legitimises non-biomedical health care practices has not been straightforward. Pragmatically orientated, Aristotle has managed these tensions strategically and objectively in my observation.

As he described in our interview, Aristotle is certainly aware of the value of naturopathy for survivors of torture. Significantly however, he claims his motivation for sustaining the program is driven by an ethical imperative to provide holistic and culturally appropriate care for refugees, rather than a personal belief or interest in naturopathy:

[It] wasn’t out of this deep seated belief that ... all forms of natural therapies worked ... it was more driven out of that sense that there was a strong cultural relationship between offering these forms of interventions alongside of others, not that they were more
important or less important ... but we were operating with the view that any possible form of medical intervention that had some cultural relevance or level of acceptance that would yield tangible benefits we had a responsibility to embrace.

Aristotle’s ethical imperative to provide a broader approach to service delivery does not favour one discipline over another:

I didn’t think much of psychologists either ... and I was even more suspicious of psychiatry ... so I think it was probably healthy for the organisation to have a sceptic running it ... [as] I wasn’t prepared to think one kind of intervention was the be all and end all.

In his view, if herbal remedies were:

meaningful and [if clients] could connect to that they would feel safe ... it meant they felt accepted and affirmed at a cultural level ... and that was enough for me.

As the director of the organisation since its inception, the importance of Aristotle’s role in the development of the natural therapies program, and in particular, in ensuring its financial viability and therefore longevity cannot be underestimated.

Creating the Foundation House space

As I discussed in Chapter Three, concepts of space and place inform one’s sense of feeling home in unfamiliar settings. This understanding has played an important role in the ways Foundation House has established its physical environment. From its inception, the organisation has intentionally created a physical environment that is welcoming, non-bureaucratic and homely. For the first 17 years, Foundation House was housed in the parklands adjoining the Melbourne Zoo, where the ‘tranquillity offered by these surroundings provided sanctuary for clients recovering from traumatic experiences’ (VFST 1999:3). These positive qualities were easy to achieve in the original site, where ‘Foundation House’ was literally that – a house, originally used by the local hospital to provide accommodation for doctors. Because the building was a residential house, it felt like a home. Bedrooms were turned into offices, the kitchen had a conspicuously domestic ambience, and even the bathroom was a reminder of home with its 1960s tiles and bathtub. Over the years, as
Foundation House grew from its original team of about eight employees, the house next
door was incorporated and the dividing fence pulled down. Attention was always given to
maintaining the gardens. At times different clients were in paid work attending to the gardens.
With time and organisational expansion, funds were sought to install a couple of pre-built
offices, designed in a ‘ranch-like style’ in order to fit in with the existing homely atmosphere
(VFST 1994).

The houses were surrounded by magnificent gardens. There was a rich display of bird life,
majestic large old gum trees, places to take a stroll, a vegetable patch and plenty of spots
for sitting and enjoying nature. In good weather some counsellors even held their sessions
outside, which for some clients was a great relief as they could freely smoke. Centrally located
in the front garden, close to the front door, was a weeping blossom tree. This tree was planted
in memory of a Guatemalan man, one of the first clients to come to Foundation House, who
‘through his gentleness and generosity of spirit taught us a great deal about our work and
about our common humanity’ (VFST 1998:5). Eliseo Balcazar treated the organisation like it
was his second home, and we were his extended family. His revolutionary spirit and heartfelt
presence kept us connected to the reasons we chose to work at Foundation House. He was my
first client.

From its inception, the organisation had purposely created a de-medicalised space,
emphasising an informal ambience that eschewed a Western clinical model. As described
earlier, this attitude is also evident in the counsellor-advocate role. It is also the reason many
clients felt ‘at home’ at Foundation House.

In 2005 Foundation House was required to move premises and management acknowledged
the importance of ‘capturing in the new Foundation House the very positive qualities of the
old’ (VFST 1999:3). The state government was responsible for relocating and rehousing
Foundation House. A new site was found and a standard government-design building was
constructed. Put simply, the new building is the extreme opposite of the old. A concrete,
treeless, desolate car park dominates the entrance to the site. The actual building is purpose
built to house public servants. It is located in the middle of an inner city industrialised area.
Factories now surround Foundation House, whereas the old site was a set of small houses
located in parkland. However, in true Foundation House style, the inside of the building
has been softened by lighting, homely furnishings, and photos and prints that reflect the cultural diversity of the clients. Once you get past the exterior and enter the building, you are surrounded by colour, warmth and a welcoming atmosphere.

As the previous natural therapies coordinator, I was involved with designing and planning the naturopathic rooms for the new building. A team was gathered to work with the architects to ensure the spirit of the organisation would be transferred to the new building. I was given plenty of scope to create the best possible naturopathic space. In the new building the naturopathic rooms are centrally located and ambient. They are spacious and purpose built and now also include the space for a large herbal dispensary. The rooms have natural light, but unfortunately do not look out onto the lush gardens of the old site. However they are fresh, spacious and warm and the décor has been thoughtfully crafted to create an informal and inviting space. As was the case in the naturopathic rooms at the previous site, the pictures on the walls of herbs, the comfortable chairs, soft lighting, gentle music, the smells of essential oils like lavender and orange, create a relaxing space. Centrally located, the naturopathic rooms have become a feature in the new building. When showing visitors around, it is often the naturopathic rooms and what they represent that attract interest. For staff too, these rooms often provide a place for respite.

Despite the unavoidable industrial feel of the new building, the atmosphere within Foundation House and particularly within the naturopathic rooms is transformative; the space is created for healing. It becomes a healing place.

**Integrating the natural therapies program**

Foundation House’s model of service delivery that combines the practices of counselling and naturopathy is unusual within the public health sector (Adams 2006). Although most torture trauma services in Australia now include aspects of natural therapies, these modalities tend not to be integrated into the core clinical services structure. Naturopathy, although valued, is positioned within these agencies as an adjunctive health care strategy. By contrast, in Foundation House’s model, there is a greater degree of integration for the natural therapists which in turn allows counselling and naturopathy to be practised collaboratively and within
a highly developed integrative structure. It is my view that Foundation House's sophisticated integrative model is a result of the early community-development philosophy on which the agency was originally based.

Before describing this model, a brief overview of the current issues inherent within multidisciplinary health care settings will provide some background context. Notably, there is a dearth of research investigating models of health care that combine naturopathy with other non-biomedical approaches. The one exception is a research project conducted at Foundation House that investigated the patterns of referral from counsellors to natural therapists (Adams 2006). In this significant project Adams (2006:43) explores ‘a different example of multidisciplinary practice in which counsellors and natural therapists work collaboratively.’ Examining how counsellors’ understanding of naturopathy shapes their referral practices, Adams (2006:43) notes ‘at the practice level as well as conceptually, there is not the assertive power imbalance that is problematised in much of the literature about natural therapies’ relationship to biomedicine.’

The development of multidisciplinary settings where naturopathy interacts with biomedicine is a recent phenomenon (Hollenberg 2006). Multidisciplinarity in this context is defined as various disciplines working under the same roof without true interaction (Correa-Velez 2006). Significantly, the overwhelming majority of multidisciplinary research has been conducted within biomedically dominant settings where naturopathy is positioned in opposition to biomedicine and is generally perceived antagonistically by the biomedical practitioners (Hollenberg 2006; Shuval & Mizrachi 2004). Although the natural therapies program at Foundation House is not comparable to the biomedically based multidisciplinary settings documented in the literature, a brief comparison between these different approaches is useful for demonstrating the level of ‘integrative’ sophistication of Foundation House’s model. Here I take Hollenberg’s (2006:732) definition that integrative health care (IHC):

[C]onveys different meanings and implications to different people and groups [however] the most basic definition of IHC refers to health practitioners of different backgrounds and training working together for the benefit of the patient.
Based on Hollenberg’s definition, I posit that Foundation House is more an example of integrative health care than a multidisciplinary setting.

Disparity between disciplines within biomedically dominant settings is largely created by ontological differences and this is reinforced by organisational infrastructures which privilege the biomedical practitioners. Typically, the non-biomedical practitioners are not salaried and this directly impedes attempts to generate an integrative model. Without a salary to remunerate non-clinical time, participating in agency-wide meetings such as clinical reviews or staff meetings is prohibitive; without a salary practitioners must operate from a private practice model and rent consultancy rooms; unlike the biomedical salaried staff, the non-biomedical practitioners operate on a fee-for-service basis and are financially dependent on receiving referrals from the biomedical staff who thus act as referral gatekeepers. Furthermore, the non-biomedical practitioners are often geographically marginalised in smaller less conspicuous consulting rooms (Hollenberg 2006; Shuval & Mizrachi 2004; Shuval, Nissim & Smetammikov 2002).

In stark contrast to the multidisciplinary settings documented in the literature, the model at Foundation House demonstrates a highly developed and functional level of equality between the practices of naturopathy and counselling employed within the organisation. I argue that the success of Foundation House’s model is based on several critical factors. Counsellor-advocates continually witness the beneficial effects of naturopathy on their clients and thus keep referring new clients. The organisational infrastructure generates genuine integration. Equally significant is the perceived paradigmatic congruence between naturopathy and counselling (Adams 2006). At the organisational level perhaps the most distinctive factor is that the naturopathic positions are salaried. Formal employment arrangements mean that natural therapy practitioners are seen as regular staff members and this has far reaching implications in terms of generating professional self esteem and equity between the two disciplines.

As salaried staff, the naturopaths have the capacity to participate equally in the range of in-house meetings. On equal terms with the full and part time counsellor-advocate staff, the naturopaths attend proportional levels of organisation-wide meetings including staff meetings, debriefings, regional team meetings, professional development courses and
joint supervision with counsellors. They also access discipline-specific supervision when necessary. Participating in these meetings is critical to enabling a genuinely integrative and collaborative environment of inclusion. In this organisational structure the naturopathic staff are seen as core practitioners with the same professional responsibilities as counselling staff. Foundation House is a free service and the fact that clients do not pay for either counselling or naturopathy also contributes to enhancing a genuinely integrative approach.

The decision to integrate naturopathy into the service delivery of the agency rather than introduce it as an add on, or adjunctive program is seen by many as part of the reason for the program’s longevity.

Integration brought legitimation for naturopathy within the agency, making it sustainable and enabling the practitioners to develop practice skills and to build a solid body of knowledge and expertise. Without this level of legitimacy the program may have had a physical space, a room where it was practised, but it would not have had status as a core component of service delivery. In Aristotle’s view:

\[
[\text{You}] \text{ can’t appreciate the value and potential if it’s an add on, it has to be integral ... if it is not integrated the full force of the other interventions can’t be realised as well.}
\]

Integrating the natural therapies program is also understood to be important for legitimising the naturopathic practitioners: \text{I don’t think anyone here thinks that the naturopaths are anything but equal partners in the way in which they work.}

The natural therapies team at Foundation House comprises one full-time naturopath (program coordinator) and three part-time practitioners. In addition there is a small group of volunteer practitioners who are supervised by the natural therapies coordinator. Although the natural therapies program makes up only a small component of the direct service delivery (the ratio of counsellors to naturopaths is about twenty to one), it is well integrated within the agency. Adams’ (2006) research demonstrates that counsellors and naturopaths value the opportunity to work collaboratively and both have clear understandings and respect for each others’ disciplinary role. Counsellor-advocates do not incorporate naturopathy into their counselling work, and naturopaths do not take up a counselling role. Moreover, the agency’s internal infrastructure has generated a culture of communication which provides the context
for regular case discussion between counsellors and naturopaths. Unlike other settings documented in the literature, the relationship between counsellor-advocates at Foundation House and naturopaths demonstrates highly functional integrative attitudes (Adams 2006).

**Structure of the natural therapies program**

Within the overall structure of the organisation there is a clear referral process for clients accessing the service. Based on the primarily psychosocial function of the agency, all clients are initially assessed and then allocated a counsellor-advocate who acts as a case manager. Significantly, clients' access to naturopathy is only possible on referral from a counsellor-advocate. In this way the counsellor-advocates have full control over which clients are referred. In effect, they are the gatekeepers of the natural therapies program. The natural therapists, however, determine which referrals they will take up, and they can reject referrals if they deem them to be inappropriate. Clients also have some degree of influence in this process. If they have prior knowledge about the program (for example another family member may already be accessing the natural therapies program) and they wish to have naturopathic treatment, they can request to be referred by their counsellor.

Within the agency the gatekeeper role of the counsellor-advocates tends to be unspoken, yet it must be acknowledged as having a particular influence on the overall positioning of the natural therapies program. Hierarchically, the balance of power is with the counsellors. In practice however this difference does not seem to generate overt problems between counsellors and naturopaths, and in the entire history of the program there has never been a lack of referrals, and nor have counsellors voiced any opposition to the natural therapies program. In fact, the main concern continues to be the lack of access due to minimal resources and the excessive waiting list which at times causes frustration for counsellors who are keen to refer their clients (Adams 2007).

Because clients have to be referred to naturopathy by a counsellor, it is the counsellor who holds the balance of power. The potentially detrimental side of this arrangement means that a counsellor's personal views on naturopathy can significantly influence whether or not they will refer their clients. Thus, if a counsellor has a negative opinion of naturopathy, they may be less likely to make it available to their clients. This imbalance of power creates some
vulnerability for the natural therapies program, but more significantly, it highlights an area of possible inequity for clients. In effect, clients do not have free choice in regards to accessing the natural therapies program.

In response to some of these concerns the natural therapies team has developed strategies to ensure the visibility of the program. In particular, they take full responsibility for providing ongoing education about naturopathy for the counselling staff (Singer 2000). This happens in formal and informal contexts. New counselling staff (and administration staff) receive a natural therapies induction session that includes a detailed explanation of all aspects the program, including its philosophical stance, and information on how, when and why to refer clients. The natural therapies team provides regular educational in-service sessions for existing staff to ensure their continued understanding and education about the role of naturopathy within a torture and trauma agency. Combined group supervision with counsellors also provides a regular setting for naturopaths and counsellors to develop and enhance their collaborative practice. The referral process, described below, provides another important avenue for naturopaths to educate counsellors about the natural therapies program.

The referral process for naturopathy

A comprehensive natural therapies referral system is critical to the effectiveness of the collaborative practice between naturopaths and counsellors (Singer 2000). All counsellors are eligible to refer clients, however because the ratio of counsellors to naturopaths is disproportionate, clear referral guidelines and management of the referral process are essential. As documented in earlier work (Singer 2000, 2002), counsellors initiate the referral process by completing a referral form and engaging in a ‘pre-referral chat’. This conversation between counsellor and naturopath aims to clarify the appropriateness of the referral and to then assist the counsellors and naturopaths to implement a combined treatment plan.

The following flow chart (Singer 2000:11) tracks the referral process:
Figure 1  Referral process within the organisation

The natural therapies program has a set of criteria for determining appropriate referrals. This is documented in the ‘Natural Therapies Procedure Manual’ (Singer 2002).

Counsellors’ reasons for referring their clients to naturopathy are varied. Research by Adams (2006:2) shows that the counsellors at Foundation House:

> [H]old multiple understandings of complementary therapies: some of these are shaped by their own professional ideology, rather than an understanding of the complementary therapies
paradigm. Decisions about referral are made in part by differentiating their role from that of complementary therapists. Differentiation occurs along the line of constructions of the body and what they perceive complementary therapies to provide that is outside their sphere of professional competence.

Adams (2006) identifies four main themes that underpin the counsellors’ understanding of how naturopathy works and their reasons for referral:

- **Relationship** – counsellors understand the therapeutic relationship between natural therapist and client to be ‘central to how natural therapies work’ (2006:19) and refer clients based on the perception that engaging in a safe relationship facilitates the healing process.

- **Somatic presentations** – counsellors understand naturopathy to ‘work on and through the body because they engage with clients’ physical symptoms expression … and provide a model which fosters integration of the physical body and the psychological’ (2006:22).

- **Cultural familiarity** – naturopathy is seen by counsellors to ‘create a link to a client’s past, by offering medicines or therapies that are familiar, trusted and congruent with many refugee clients’ beliefs about healing’ (2006:24)

- **Break in symptoms** – counsellors perceived naturopathy and in particular massage, to provide clients literally with a break from the chronic experience of pain. Massage treatment has the effect of creating ‘a state of relaxation [which] is in direct contrast to their usual state of chronic tension and anxiety, and this may produce embodied learning by reframing their understanding of, or relationship to, their symptoms and their experience of self’ (2006:25).

In sum, the counsellors instigate the referral to natural therapies on behalf of their clients. Predominantly, clients continue to engage in counselling whilst also receiving naturopathic treatment. Commonly, clients will finish their counselling process yet continue with natural therapies. Thus there will be times when the naturopath may re-refer a client for further counselling.
**Conclusion**

As I understand it, the inclusion of naturopathy as a core component of the service delivery positioned Foundation House as the first Western-based torture trauma service in the world to include non-biomedical health care practices. This approach heralded an innovative health care model (VFST 1997:10). The natural therapies program has continued for the last nineteen of the twenty-one years since Foundation House's inception. The role of the natural therapies program in the organisation's development is significant to the overall context of this thesis. It is also an important case study that challenges existing multidisciplinary models of health care practice and specifically challenges Western dualistic approaches to refugee health care.

**Postscript: Current challenges**

Notwithstanding its respected position within Foundation House and in the broader community, the natural therapies program is a marginal component of the organisation's direct services. The ratio of counsellors to naturopaths is approximately 20:1. This position brings certain challenges and vulnerabilities. This research project explores a particular case study, Foundation House, yet it has relevance for other torture trauma organisations that incorporate naturopathy as well as other health care agencies.

As described, Foundation House was established on an explicitly community-development model, evidenced by the counsellor-advocate role and the rationale for including non-biomedical therapies. The agency actively endorsed a de-medicalised approach which originally positioned it outside mainstream mental health services. However, in 2008, Foundation House is working within a very different context and there have been a number of issues that have had a significant effect: the continual growth and expansion of the agency (in 1990 there were 8 staff; in 2008 there are 100 staff); a shift to a more hierarchical management structure; the adjustment needed to collaborate with changing federal governments and a different political climate as well as a changing international political climate; varying refugee populations; competing in an arena where the agency now must tender out for its services as it is not the only player; and the increasing pressure to develop an evidence-base in direct services to justify what it does. Furthermore, the agency has expanded its operation
to encompass far more than just direct service and community development. Foundation House now has several significant non-clinical streams including a research unit, schools-based programs and an extensive education and training program which delivers training on torture/trauma rehabilitation nationally and internationally.

With this welcome and necessary expansion has come a change in the agency’s initial grassroots characteristics. Arguably, this has meant the organisation has shifted ground, becoming increasingly accepted as a mainstream refugee mental health service. Undoubtedly, this change has brought with it tremendous benefits. In particular it has enabled greater awareness of the plight of refugees and has ensured increased mainstream service provision of refugee-specific health care. These changes, I argue, have also had a particular effect on the natural therapies program and also on the philosophical underpinnings of the counsellor-advocate role.

Although the demand for naturopathy by the referring counsellor-advocates has continued to grow, the organisation has not matched this growth by increasing the number of natural therapy practitioners. The reasons for this are based on the primarily psychological focus of the agency, coupled with the bureaucratically complex issues of procuring philanthropic and government funding for health care practices considered outside the biomedical mainstream.

In the following chapter the client’s experiences of the natural therapies program are revealed through the stories of the twelve women I interviewed in this project.
CHAPTER 6
‘Myself and my body are very happy’: The refugee body in the naturopathic encounter

This chapter gives voice to the women’s experiences of their naturopathic treatment at Foundation House. Their stories are set against the prevailing discourse on refugee health care which has largely been dominated by the biomedical approach. As I identified in reviewing the literature in Chapters Two and Three, within the biomedical system there is a definite gap in the provision of effective health care strategies currently available for refugees in Western countries of resettlement. I argue in this chapter that the women’s narratives in this study demonstrate that naturopathic treatment was able to make a considerable contribution towards attending to this gap, specifically because it was able to effectively respond to their refugee bodies. As explained in Chapter Three, the refugee body is used as a representation of the metaphoric interconnection between the experiences of physical symptoms in the context of the broader sociocultural influences of the refugee experience (Coker 2004b).

In this chapter I describe the main themes that emerged from the thematic analysis of the participants’ narratives. The first theme, ‘biomedical inadequacy’, underlies the main reasons that the women were referred for naturopathic treatment at Foundation House. The other main themes emerge from what I term the ‘naturopathic encounter’ – the culturally mediated interactions between naturopathic practitioners and these particular refugee women. I argue
that the women brought their refugee bodies into the naturopathic encounter where they experienced respite and renewal, and for most, their embodied cultural knowledge, revealed through stories of connection to home, mother and herbal medicines, is validated.

**Biomedical inadequacy: The gap in health care for refugees**

As outlined in Chapter Five, all the women interviewed were referred to the naturopathic program at Foundation House by their counsellors and all experienced health problems that biomedical treatment had been unable to effectively address. Put plainly, the referral to naturopathy occurred in part as a consequence of biomedical inadequacy. These women had fallen through the gap. Some of these women would not have been referred for naturopathic care if their health concerns had been adequately attended to within the biomedical setting. Soula and Frasa’s experiences exemplify this:

*When they [doctors] give you the medicine it upsets the stomach and doesn’t seem to work. Whereas the massage has been helping to lessen the pain and even the worry (Soula).*

*I found herbal therapy of Kate much better because the medical treatment, the tablet that the doctor prescribed for me I found it very strong. I found it too strong. Because before with the doctor medication my sleep was very bad, I was very restless. Even when I went to the bed during the night, I heard all the noises, everything, I heard like people were talking, but it was night. And when I went to sleep, because of the nightmares, I was screaming and I would jump and be full of fear, very tense and restless. In here, the doctor treatment that I received, if you take the medication for your heart, the side effect will injure your lung, or injure your kidney, your liver. But that treatment [herbs] doesn't have side effects (Frasa).*

Importantly, it must also be acknowledged that the women were genuinely grateful for access to biomedicine in Australia and many also had positive experiences, for example:

*He [doctor] shows so much empathy with me ... I feel the sympathy in his eyes when I am telling him my condition (Amar).*
Although problematic experiences with biomedicine were prevalent throughout the women’s stories, such issues are not the primary focus of this research and they were not directly part of my interview schedule. However, in asking the women specifically about the experience of naturopathy, by default, any negative experiences of biomedicine were sometimes revealed. As the women described their health problems at the time of their referral to naturopathy, they inevitably spoke about their experiences of biomedicine in Australia, which for many included ineffective treatment and even detrimental experiences, for example:

-I went to the doctors and told them my symptoms and they thought I have asthma. So they gave me an inhaler ... which almost killed me. As soon as I used it, it just destroyed me completely. I almost passed out because it was too much (Lani).

-I go to Dr. Z., he doesn’t talk to me. All I get is a prescription. They don’t care so much (Mary).

-I've been to the doctor here [Australia] and he has given me medicine for nerves and stress and it caused me a lot of problems with my stomach (Soula).

In highlighting the women’s negative experiences of biomedicine, my intention is not to denounce biomedicine. Rather my purpose is to highlight the fact that there are health problems which cannot be treated effectively by biomedicine. I do so in order to move beyond that debate to emphasise the unique contribution of naturopathic treatment within a refugee health setting.

To contextualise the negative experiences that the women relayed about biomedicine in Australia, I refer to Coker’s (2004b:35) research with southern Sudanese refugees in exile in Cairo:

“This is sickness”, they are saying, “You have no sickness”, is what they are hearing from medical practitioners and others who reduce their physical complaints to organic processes or psychiatric entities like “depression” or “posttraumatic stress disorder”.

138
Similarly to Coker’s (2004b) research, for the women I interviewed, along with the broader social and political representations, the individual experiences of distress were largely seen as a collection of symptoms that had no pathological aetiology and were frequently delegitimised.

This was particularly evident in the stories told by women who sought biomedical treatment for illnesses that did not have a pathological aetiology. In these situations biomedicine was not equipped to deal with the broader sociocultural expression of their distress. As Mary stated:

> When I go to Western doctor, they don’t talk, they give you medicine to help, but if I say I have some problems in life past, and this problem affects on my life, they don’t confess [talk] about this.

This is a core site of difference between the naturopathic and biomedical models and is elaborated through the thesis. In the naturopathic encounter there was greater harmony between the women’s and the naturopath’s ways of conceptualising health and illness; it was possible therefore for the refugee body to be legitimised irrespective of a diagnosed Western disease state. There was greater understanding between the women’s and the naturopath’s ways of conceptualising health and illness than was possible in a biomedical context.

**Explanatory models**

Within medical anthropology the explanatory model proposed by Kleinman (1978) makes explicit the understanding that health and illness are culturally mediated. In this model illness is seen as ‘culturally shaped in the sense that how we perceive, experience and cope with disease is based on our explanations of sickness’ (Kleinman, Eisenberg & Good 1978:252). In recounting their experiences of sickness and healing in their home countries and in Australia, the women’s stories revealed the various models they used to explain their experiences:

> When my baby was born, she was really big and she starts crying and she wasn’t settling down. I thought probably that people invade her. We do believe in this. People said that probably you showed her when you were breast feeding and this is why she is no longer feeding from the breast [Hati is referring to the notion of ‘evil eye’ which she elaborates on later in the interview].
When they become paralysed like that, it is like the devil has come into the body and is causing this problem. I had this once in Afghanistan … they said that some foreign thing had come into the body … In Afghanistan what they did was to put me in a room, darken all the windows and left me in that room and put oil on my body and fed me with soup made from pigeons [Soula is referring to an episode of nervous exhaustion, which she calls ‘nerves’ in the interview].

I also complement healing with colours. Because I know that nice vivid colours are happy and if I have headache, or a lot of problem, I lie down with a pink cloth on my eyes and close my eyes and then I sleep. So colour therapy is also important for me (Rosa).

Explanatory models, such as humoral understandings discussed in Chapter Three and explored through the women’s stories in this chapter, were shared with the naturopaths:

We have two sorts of food: warm and cold. The warm food, for example, black pepper, olive, walnut, ginger, these foods are good for bones, good for mental problems. The cold foods, like milk, yoghurt, lemons oranges, salad. We are making a special salad from tomato, onion with other herbs (Frasa).

For refugees, much of their experience is imbued with loss and suffering, and this pain is what people bring with them into the present. However, as described in the interviews, most of the women also brought with them a strong faith in God. Their faith brought a sense of wellbeing and meaning to daily life and also underpinned understandings of health and illness, for example:

Well, just to go back to the issue of prayers and things, like in my town there is a church and each year on the 13th of June people from different religious beliefs and backgrounds they all go there and pray for health and wellbeing of all the people and so I must say, that it is a long tradition in my country … prayer is something that really works and I practise that myself as often as I can and occasionally I go to church … with the stress and tension, I think that prayer is the cure, especially with the people of my background. If you experience what we experienced, it is crushing you and having a terrible effect on all your body … I still believe in God … and I still have faith (Vesna).
Chapter 6: The refugee body in the naturopathic encounter

We pray for that sick person. We got a special part of the Holy Koran, we call it Sura, we read the Sura for them. I believe in that, it's my faith and I believe in the special shrines. Because the shrines are very important in my country, we go there and we pray. Just sort of a peace between God and human, we just talk to God and we just pray. There's got lots of benefit. This treats you emotionally, physically and it is my faith and my belief. Even I believe, once if I go back to my own country Afghanistan and if I find the shrine, a good shrine place and I go there and I give myself to there and have a good communication with me and my God and probably I get better. I get better very soon. This is my belief, my faith (Frasa).

If God wants to do something, we humans cannot do anything to stop that. I was always praying to God, so God answered my prayers (Lani).

The implications of differing explanatory models is particularly of interest within a refugee health context which involves diverse cultures, beliefs and world views, and where awareness of different conceptions of health and healing are paramount in establishing effective health care strategies. Within refugee health care contexts, ‘explanations of sickness’ (Kleinman, Eisenberg & Good 1978:252) become political when non-Western conceptions of the body collide with the dominant biomedical categories. As discussed in Chapter Three, the debate over the cultural relevance of PTSD for non-Western refugees exemplifies these concerns.

Grateful for access to biomedicine in Australia, the women I interviewed were pragmatic in their approach. The experiences they recounted to me in the interviews attest to the pervasive problems that occur when the ‘explanations of sickness’ (Kleinman, Eisenberg & Good 1978:252) of the biomedical doctor and the refugee patient are intrinsically dissonant. These concerns were particularly exemplified when the women sought biomedical treatment for health issues that were essentially linked to the complexity of their refugee experiences and inseparable from the broader sociocultural and emotional contexts. In contrast, the women's encounters with naturopathy were a more congruent experience.
Chapter 6: The refugee body in the naturopathic encounter

The naturopathic encounter

*It wasn’t just the massage that helped, I think it was the whole concept of seeing Anna, she seems to have healing hands, she had this lovely smell in the room, nice music and that was so congenial (Rosa).*

For the majority of the women I interviewed, herbal remedies and/or massage were a tangibly familiar experience, one that held deep significance as it linked the women directly to positive healing memories of home.

Equally important, the majority of women had strong cultural connections to the traditional medicine practices of their home countries, and many were knowledgeable and skilled in this field:

*Say if a child had diarrhoea, in the mountains there are some plants that have thorns on them, we would go and pick the leaves of these plants … then pound the leaves and then give the juice of that to the child for diarrhoea … I used to do that for my brother, I would go and pick the leaves myself … My grandmother showed me the different plants with different thorns, and you had to choose the right one (Soula).*

These women brought their embodied cultural knowledge into the naturopathic encounter and importantly, this knowledge was validated and respected by the naturopaths. Frasa, like many refugees, was accustomed to conceptualising ill health through humoral principles. Counter to the biomedical context, in the naturopathic encounter Frasa and her naturopath Kate shared this understanding of humoral principles and Kate was able to treat Frasa based on this knowledge:

*When the last baby was born, there was not my mum, there was nobody to tell me ‘don’t eat this, eat that’, I didn’t receive very good treatment during my first month after giving birth. It’s very important for a woman to keep herself warm [after giving birth] … and after the birth of this baby I was cold. After giving birth I got body aching … [But] because the medication that I [now] received from Kate is warm … and now when I am drinking the tea, I see there are some mint leaves, which are warm and my body aching is now very well (Frasa).*
Chapter 6: The refugee body in the naturopathic encounter

Not all of the women were familiar with traditional medicine however. Some had very little or no experience of using traditional medicines in their families or communities. For various reasons these women were taught primarily to use and trust Western biomedicine, and had very little knowledge about the use of traditional medicines in their home countries:

I don’t have any experience about the herbal medicine because we [her family] didn’t use it. But I think there is herbal medicine in my country. But I was far away from it (Mary).

Significantly, these same women described some of the most remarkable experiences of healing and renewal through their naturopathic treatments. Their stories are of particular interest because their responses were not based on the comfort of familiarity. These women’s responses to and engagement with naturopathy therefore speak to the broader issues of what determines meaningful health care for the refugee body, irrespective of cultural familiarity:

I can’t say much about using those herbs in the past but I am convinced now since taking these here that it really is working and is helpful … I notice that the tension I experienced before, I can’t say that it is removed totally, but you know, I feel so much more relaxed and also I had some sort of fear for the future and everything, so now I am much more prepared for whatever is coming … (Vesna).

Vesna had little experience of traditional medicine in her home country. Yet her encounter with naturopathy in the context of her refugee experience has been extremely positive.

The naturopaths at Foundation House adhere to appropriate professional boundaries and rules of conduct, yet for these women, their gaze is softer than that of biomedicine. The women spoke of the importance of this quality in the therapeutic relationship with their naturopath:

I talk with her like a friend because I feel comfortable with her (Mary).

I think Anna is an angel, and it was that her hands were healing because it was coming from her heart, it wasn’t just doing some techniques, there were her feelings, she had this human touch, wanting to help me and sort of like she wished that I’m well and I felt very relaxed and she would talk to me gently, she understood me, it was that connection … most people’s problems stem from
psychological, and not being happy and not getting enough love. And I think that what you get here [at Foundation House] is what you really need (Rosa).

Deep care

As described by Rosa, a fundamental component of the naturopathic encounter is the women’s descriptions of what I term ‘deep care’. I use this term to literally express the experiences described by the women of feeling deeply cared for by their naturopaths in the context of the naturopathic encounter. This concept is further developed in Chapter Seven. The term deep care conveys a particular kind of therapeutic relationship that includes the qualities of trust, safety and for many, the experience of feeling loved:

... there is compassion and you feel you are loved ... there is a feeling that another person, somebody cares whether I’m better or not ... it brings the value of the treatment a lot higher than if it was just a physical massage ... (Raza).

Well, I don’t know whether it was Kate who was really nice and really lovely as a person that helped me with that trust, but since I started, from the very first time when she started treating me I noticed so much improvement, so there was no doubt, there was no problem really and I find that she is an exceptional person which also important in this sort of treatment, it does help you feel safe and trusting in what she is doing (Vesna).

I feel that she is doing this work with all her heart, it is coming from her heart. She is not just doing a job to get paid, she is doing it genuinely because she cares. She feels with me, our feeling together get engaged with one another. She is like an angel that touches me ... I feel that there is someone who really loves me (Amar).

The level of care that I received from Kate, I never received from conventional doctor. Like she paid attention to my concerns ... It was extremely interesting for me. I actually enjoyed every single second of that and after the first massage I received, I just went into a deep, deep sleep. I felt so sleepy at that time, I experienced the sweetest sleep ... I want to emphasise that the treatment I received, the behaviour and the treatment and loving care that I received from Kate is affecting me directly and putting a positive effect on my
Chapter 6: The refugee body in the naturopathic encounter

health … People who haven’t seen me for a while they come and tell me ‘you have changed’; they can see the positive impact on my self and even on my face. You can see it (Sita).

As stated earlier, the notion of deep care in the therapeutic relationship is central to other Western practitioner-patient dyads such as the counselling relationship. Whilst many refugees respond positively to the counselling process, some do not access counselling services because counselling does not make sense to them, or it may be perceived as threatening because it is unfamiliar. As discussed in Chapter Two, the gap in health care for refugees is further evidenced in research demonstrating that in some refugee communities the low number of refugees seeking psychological intervention is a concerning phenomenon.

Attending to the body in the naturopathic encounter

Another quality distinctive to the naturopathic encounter emerged through the women’s stories. The experiences of bodily pain, both literal in-the-body and symbolic, understood in this context as an embodied expression of life-pain, were able to be legitimised and given attention:

After the first treatment I felt so much better I feel so relaxed, I feel that the pain has diminished, but also I feel that I could fall asleep and sometimes I do and she really has golden hands and it really is quite a dramatic improvement (Vesna).

In the naturopathic encounter the space is created that allows the body to be attended to and validated in ways that are quite distinct from both counselling (Adams 2006) and biomedicine:

I don’t sleep very well [but] the massage helps and I sleep so well that night. And the next day I feel a lot better and the herbs that I have as a tea help me with the headache, so it does really pick me up (Soula).

In the naturopathic therapeutic relationship, primacy is given to engaging with the everyday lived experience of the body and this may also include literal ‘touch’ in the form of massage treatment:
Chapter 6: The refugee body in the naturopathic encounter

It is a feeling that I have when I leave there something very pleasant. I’ll tell you, I’m lost for words to describe the feeling, but in a way she is telling me ‘go live, take away the pain, you know, don’t think about anything painful’. She says that in her hands without words while she is massaging me … she renews my life … I feel alive when I leave the room after massage (Amar).

The non-discursive methods of naturopathic treatment, with their emphasis on massage, diet and herbal medicines are grounded in and through the body. Although some forms of Western psychotherapy will use the body as the site of therapeutic engagement, this occurs discursively in a psychodynamic exploration of bodily sensation and bodily memory (Young 2002). The multifaceted field of body-centred psychotherapies is not the focus of this discussion, yet it is important to note this critical point of difference. As described in Chapter Five, Adams’ (2006) work takes up these issues and provides an analysis of the interaction between counselling and naturopathy in the context of Foundation House.

The potential for the ‘refugee body’ (defined in Chapter Three) to experience healing was there irrespective of prior experiences of traditional medicine. The physical space of the naturopathic consulting room and the qualities inherent in the naturopathic encounter created the opportunity for the women to bring their refugee bodies and experience respite and renewal. The naturopathic encounter, with emphasis on the subjective bodily experience, provided the setting for the women to attend to their physical symptoms in ways that legitimised their experiences. Attending to the body in this way was crucial in creating a healing space, literally and metaphorically. In this space there was a shared understanding between the naturopaths and the women that recognised that the body contains both the literal and symbolic pain of the refugee experience, and that the body itself requires particular care.

The women’s narratives show that a central factor in their experiences of naturopathy is the potential for attending to the refugee body, which I argue, because of ontological difference, biomedicine is simply unable to provide.
The refugee body

In the naturopathic encounter the focus was not so much to eliminate the symptoms or ‘cure the trauma’, but to offer a space and also a time in which the women could allow their bodies to speak to the complexity of their circumstances. Implicit in this space is the understanding that the body tells a story; it often holds the unspeakable. In this setting the naturopathic treatment started out by implicitly legitimising the physicality of the women’s symptoms, acknowledging their lived bodily experiences. In this way attention to the body is not passive, but rather encourages exploration of the women’s subjective experiences. The women’s stories illustrate how the combination of a safe space and, for many, the familiarity of traditional medicines, created an environment of deep care based on the validation and acknowledgement of their bodies. Their physical symptoms were understood as real and their bodily experiences were trusted.

The women’s physical symptoms were often deeply entwined with painful memories of past trauma and torture, of severed connections with loved ones and were often entrenched in the turmoil of upheaval and dislocation. To try to separate the physical from the emotional or social context would therefore be meaningless. This is plainly explained by Frasa:

The first time that I found myself as a sick person I was in Afghanistan and it was during the Taliban, the time of the war and my family flee the country, my mum, my sisters, I was isolated from my family for the first time and I found myself different. I found myself very nervous, agitated, I am getting provoked for every simple stuff. For example, I was impatient against my husband, my cousin. I got very impatient, provoked, nervous, agitated, my heartbeat was beating raised up, my legs getting numb. I thought myself, that I’m getting fainting. I found this very hard. I found that I am sick.

For Lani, the irrevocable separation from most of her family members is a constant cause of profound distress and heartache. Equally compelling, her excruciating physical pain, originating from a horse riding accident many years ago in Afghanistan is now exacerbated by her painful life circumstances:
... as soon as I am tense and worried, the pain in the shoulder becomes stronger ... it’s just that I’ll picture all my children and grandchildren and I’ll miss them and that puts too much pressure on me and I can feel the level of the pain rising.

Although apparently causally unconnected, Lani’s body pain and ‘refugee pain’ have become inseparable. The physical pain symbolises her life pain; the body is a representation of the social dislocation. Lani responded dramatically to the massage treatment at Foundation House. Symbolically and literally, her naturopath’s ‘healing hands’ represented a meaningful interaction with her body-life pain and she experienced a dramatic and sustained decrease in physical pain:

I was always in pain ... I was always taking a lot of conventional medicine, sometimes 8 Panamax a day and that was not doing anything, nothing seemed to be helping. But when I came home [from the massage treatment] the old pain was a lie. It didn’t even exist, I was feeling so comfortable ... I still remember the experience of that first day that I received massage. From the time I came to Australia, I remember that was the happiest day I had ever had. I was extremely happy because I had no pain in my back and some herbal tea was given to me as well. I just boiled that and I had a cup of nice and warm tea before going to bed and that night I slept through the night very comfortably.

For Amar, excruciating physical symptoms were directly related to the torture inflicted on her whilst imprisoned in Iraq. The brutality of her experiences left her with severe physical debility and pain – it was a constant reminder of what she had endured:

They dragged me on the asphalt and skin came off [my knee] ... they scraped my knees with broken glass ... they broke my bones and my body ... you can say emotionally, I was dead.

Amar’s body was the repository for the physical and emotional abuse of the torture she endured. The physical pain became a living nightmare directly connecting her with the lived experience of torture. In radical contrast the experience of massage: made me feel that I am alive.

In this communication of care, Amar’s tortured body was given respite, an ‘angelic touch’. She felt safe to let her body be seen and to express the physicality of her pain:
I had been hung from my right arm and Anna said there are three spots that she can feel, I feel that she is very knowledgeable. When she is massaging these spots, when my eyes are closed, I feel her going into each spot one by one. She is aware of how I feel in these particular spots.

When I asked Amar how it was for her to receive massage after enduring such physical brutality, she responded by saying in a gentle and heartfelt voice:

Anna shows me affection; she shows me that she cares ... the effect she [Anna] has on me is like an angel that touches me.

Consistently the women explained the efficacy of their naturopathic treatment as being based in their experience of feeling deep care from their practitioner. Deep care was intrinsic to the actual physicality of the naturopathic treatment. In the context of their overwhelming loss, the women's readiness to make meaningful connections and to expose their refugee bodies to their naturopaths is, I argue, even more remarkable.

The following four stories clearly express the significance of the body's voice.

**Lani’s story**

When I was in Afghanistan I had all the facilities and my husband, may God bless his soul in peace, was very understanding and caring and he wanted me to go and seek medical, I mean Western doctors, because that was very popular there, because he didn’t want me to experience any pain. I personally didn’t experience lots of traditional medication because we had three doctors in the family. My cousins, three of them were doctors, one was specialist in bones, the other was a specialist of the ear and throat. So I was under their continuous care and treatment ... and I was always advised by family members that I should go and seek medical advice ... I still remember the American doctor who performed the operation on my back. His name was Doctor Roger.

Initially [in Australia] I was experiencing so much pain in my back, lower back and legs and knees and I did seek medical treatment, in that I was taking a lot of conventional medicine that was not doing anything. I was seeing my family doctor, who is really very nice and a very good doctor and he was prescribing different kinds of medications and nothing seemed to be helping. I even saw a specialist
and was advised by the specialist to do an operation, to take care of the spine. But he told me that I could end up being completely paralysed in the legs and I said what would be the point, I wouldn’t have any pain in my back, yet I don’t have the ability to walk. Now at least I can drag myself from one place to another. But if I don’t have my legs and my mobility I will never even think of doing that operation. That is why I decided not to go for the operation.

I can see the benefits of massage for me has been enormous. First of all it saves me from going under the knife, going for the surgery. I don’t have to do that anymore. Because they told me that the one and only way I can get rid of this pain is through surgery. While I’m going for massage now and I’m not experiencing that pain anymore. And I’m very mobile, I’m active, I can walk around. Of course it has definitely affected me and it is very positive. It is very interesting because when I saw the bone specialist he told me, the specialist told me very, very clearly that I can do an operation in your back that will get rid of the pain, but you could end up being completely paralysed. And look at me now! The pain is gone and I’m not paralysed and I can walk. So the massage has been extremely helpful and again I’m saying this is a personal experience. I’m talking from my own experience, I don’t know the effect of massage or natural therapy on other people but when it comes to myself, yes, I experienced it and for me it has been extremely helpful.

What I find particularly helpful, useful and different [about naturopathy], is the fact that when you have pain and you seek conventional advice and they give you these medications and you can’t feel the effect for quite a long time. The one that do help the pain to go away is by giving some strong injection or some strong medication. While in natural therapy, they are not doing anything. They are basically healing someone by using the power of their hands. That’s what I experienced myself. Without taking any injections or medication. By receiving massage the pain in my concerned areas are gone. So, I experienced it.

In Lani’s story, what is of particular interest is the dramatic difference between her experiences of biomedicine in Afghanistan and in Australia. In Afghanistan two noteworthy factors contextualise her story: Lani belonged to a ‘family of doctors’ and was totally comfortable with and accustomed to effective biomedical treatment. Having endured a serious horse riding accident in her youth, Lani’s spine had been saved by medical expertise at that time.
Although she was also educated in the use of herbal remedies by her aunty, *I was receiving this kind of [herbal] information from my aunty ... she was the one teaching me,* and she was reliant on using certain herbs *dosundiseina – which means boil for the chest* to treat her ongoing respiratory problems, Lani’s orientation was predominantly biomedical. However, in Australia Lani’s experiences of biomedicine were quite different. She described ineffective and even potentially damaging treatment. In contrast, Lani described how naturopathic treatment saved her from *going under the knife* and dramatically reduced her pain levels. It was almost miraculous in her experience. What I want to emphasise here is not a biomedicine versus non-biomedicine argument. My aim is to highlight a healing space where emphasis is not given to the search for a pathogen (Kirmayer 1992), but rather to a space in which the refugee body can be attended. In an embodied world view, symptoms can be explored as metaphors which express the ‘process of coping with the loss of society that is unique to the refugee experience’ (Coker 2004b:34). The significance of the naturopathic encounter is that it provides a practical and efficacious approach to caring for the physicality of symptoms without medicalising the person’s experience.

### Vesna’s story

Well the thing is that I experienced some back problems before the war and then it deteriorated and then we moved to Bosnia and life wasn’t good there … and finally when we came here [Australia], my back was in terrible condition and I couldn’t straighten my back. It’s not perfect now, but it is much better and I suppose if weren’t for this treatment [naturopathy] I may have ended up in a wheelchair. I had some physiotherapy before and I noticed some minor improvement, but the massage that I’ve been having here made such a difference.

Like before if I had any pain I would take pain killer and then two hours later or something I would have another one and that would cause a lot of stomach pain and discomfort and I’m taking this [herbal] without any side effects and it also works for a longer period of time. I’ve been on sleeping pills [from the doctor] for years as well and eventually I notice that they wouldn’t work and when taking one of those I would feel so tired and heavy and I would wake up. But with the ones that Kate [naturopath] is giving me I feel so light and when I wake up at night to check on my mother, but then I go back to sleep so easily which is really a major difference.
My personal experience is that it helped me like 100 per cent to recover and it’s definitely working 100 per cent and a major difference is that it is working [emphasised strongly] and it is not having any side effects. I’ve been having some teas which are really not invasive and not harmful for the stomach and also some herbal tablets that are working and yet they are not having any side effects. This sort of therapy gives me energy, gives me strength and I was really in a poor condition when I first started coming here and not just physically, but psychologically, mentally and as the time went on, I noticed that I had much more strength to deal with both emotional and physical components of my life and that really helped improve my life.

The combination of Kate’s ‘golden hands’ and the herbal remedies that had ‘no side effect’ were significant attributes of the naturopathic healing space and allowed Vesna to feel renewed and rejuvenated in ways that had not been possible through biomedicine.

Mary’s story

After the war everything is changed. All factories was making weapons in Iraq. After the war with America [1991, first Gulf war], everything is changed. I was working in a factory. At this time I wanted to go to Jordan with my cousin as my aunty was in Jordan. He [cousin] had something wrong with his back and he wanted to take natural treatment there and my aunty told me come here and take holiday. At that time I was not to leave my country as I am engineer, no engineers, no doctors, they can go out of the country. After that I went to Jordan and stayed three weeks with my cousin and my aunty. When I come back to the factory, the government knew I went to Jordan. They then took everything from me. I had land, they took that, they took my passport, and they stamped my passport so I couldn’t go anywhere after that. Like in a prison. They make some interviews with me and I am in jail for maybe one year. For two months I am in one room. But they didn’t hurt me [possibly she means they didn’t rape or torture her], just the question and the jail. Because I didn’t do anything, I mean something bad. When I went home, I didn’t know everything, but my mother told me he [father] is dead. Very bad things happened.

I thought I had physical problems in my body. But after I did everything [all the medical tests] and they told me I have nothing, I have no problem in my body, that’s why I wanted to change my life
because I was always thinking about what happened and I wanted to forget everything. I think this is my problem. Maybe the sadness attacks [my] stomach I think. Yes, [excitedly], sometimes when I think about past problems, I feel headache, I feel stomach pain, I feel pain in my stomach. The stomach talks. Because it affects on my stomach. But when I relax, I try to forget everything. I say this is my fate, and I think nothing, just relax, I take the herbal medicine and I feel better. Because it is out of my control. I am thinking about the past, and my stomach feels tied up. Yes, it is tied up. Sometimes I feel like my stomach is tied up. I try to relax and breathing … you can’t separate [mind and body]. I think it is these problems have happened in Iraq. Not just me, now there are many people in Iraq they have these problems. From, not crazy, but thinking too much. Some have diarrhoea, some have pains in the stomach, some people have headache. Some have very strong headaches. I took tablets for the fist time [after imprisonment]. But every day I had to take tablets and I became very skinny in Iraq. Everyday pains come in my stomach.

Yes, she [naturopath] tries to know everything, what happened to me, how I am suffering now, what problem I have now … the [naturopath] has to look at the person, how’s the mental, how’s the heart, how’s the health. Maybe the person has something with the mental, I don’t mean crazy, but something, some problems from the past, maybe something affects [the body] (Mary).

For most people, ‘distress’ is the stimulus for seeking some form of health care. Mary’s story highlights the complexity that is the refugee body: the amalgamation of physical pain with the complex social, political and cultural factors that define the refugee experience (Coker 2004a). Like Mary, the women’s stories also give voice to the particular explanatory models used to position how they ‘experienced their illnesses as simultaneously existing in all three dimensions of the individual, social and political bodies’ (Coker 2004a:409).

**Sita’s story**

I was extremely stressed and at times I know the effect was directly on my body as I would feel very weak and I would not even be able to digest any food so the stress had affected my stomach and digestion severely … I went through a very rough time in my life and that had
Chapter 6: The refugee body in the naturopathic encounter

put a lot of pressure on my body and on my physical health ... I was feeling stressed, it felt like my heart would break and would pop out of my chest, that’s how bad it was ...

The first and the very major effect that I experienced on my health [from naturopathy] was the treatment and behaviour that I received from Kate [naturopath]. I don’t even know how to describe this, but she was extremely caring and sympathetic towards me and it made me to love her and to trust her ... And she just give me the strength to trust again ... For me it [naturopathy] was an extremely positive experience, because I always had difficulty, I always experienced headaches, severe and unbearable type of headaches that would last for three to four days and I don’t want any other human being to see me and I was taking the strongest painkillers and it wasn’t doing anything. After seeing Kate that problem is gone completely and also that pain that I had in the back, that’s gone completely and I was told that was due to too much pressure on the nerves around the neck area. And that thing has gone now, so of course for me it is a positive result and positive experience. And I was also suffering from sleeplessness. At night, sometimes I would never be able to sleep through the night. But now I am much better ... I’m more relaxed now and not that stressed as in that my mind is at ease now, in peace.

The women described their experiences of ill health in language that was evocative of their life circumstances: the physical symptoms symbolising the complexity and trauma inherent in their experiences. Counteracting the devastating effects of torture and trauma are the women’s descriptions of the naturopathic encounter. Individually, the women described a significant decrease in physical pain, often improved sleep patterns and energy levels, less headaches and an improved experience of wellbeing. For many, the naturopathic treatment also took on a metaphoric role – it became like a soothing balm, calming the wounds of torture/refugee experience. This was the case for Amar:

[S]ometimes I go in [to the appointment with Anna] in a very depressed mood. I go out after the massage hopeful again, optimistic again ... So she does two things at the same time, she treats me emotionally while she is treating me physically. Like she is treating me physically, but it is also emotionally.
In this context the aim of the massage treatment was not to cure Amar’s depression (torture, loss etc.), but rather to provide a safe and healing place for her to take respite, and enable emotional healing to occur.

In the naturopathic encounter the women are not dismissed or disregarded if their symptoms are not cured by the treatment. The understanding that symptoms may represent a ‘moral response’ (Green 1994:246) to distress and therefore could possibly exist life-long is legitimised. There is the opportunity for simply offering care and respite from relentless pain of pain. Conceptualised in Antonovsky’s (1990) continuum concept, dis-ease is understood to move fluidly between ease and dis-ease in response to a broad range of experiences and interventions. This position is antithetical to the biomedical directive in which cure is the imperative. What is evident through these women’s multifaceted stories is their need for an approach to health care that honours and respects the lived experience of pain however it is expressed, as well as their metaphorical expressions.

**Metaphors for the body: Healing the social body**

The body is in the social world but the social world is within the body (Bourdieu 1990a:190)

In traditional societies, as discussed in Chapter Three, the experience of deep care on an interpersonal level between the practitioner and patient does not necessarily seem to be a core feature of the healing process – it is often a far more pragmatic relationship. However, healing the ‘heartache’ manifested as fractured relationships within families or society is a central feature of the healer’s work, as within most traditional healing systems an individual’s illness is linked to the social, political and cultural functions of the community. In a refugee health context, many of the illnesses or symptoms experienced are understood as being a consequence of the refugee experience and cannot be separated from the social and political context (Coker 2004b). In contrast, in the very private and individualised practitioner-patient dyad that exists in most Western contexts, healing is located primarily with the individual, in isolation from the broader context of their lives.
Although the naturopathic encounter is based on a Western, individualised approach in which the practitioner and patient develop a confidential rapport, the outcomes of treatment seem to have broader social implications. As described by the women I interviewed, their experiences of naturopathy were not limited to healing at only the personal level, but extended to relationships with family and often their wider communities. For example, as a consequence of the trust and care experienced in the relationship with their naturopaths, many of the women spoke about being able to make the therapeutic encounter broader by feeling more confident and connected socially, thereby creating a stronger sense of coherence and meaning in their current lives. For Hati, the therapeutic relationship with Lucy, her naturopath, was emotionally strengthening:

*She is like a sister ... it does help a lot on the psychological level, not just on the physical. Like when I come here to see Lucy, we would talk, during the massage, she would talk to me. I would find there are lots of things that I am talking about and I get relieved, like lots of those things out of my chest, so it helps a lot with my psychological condition and emotionally as well. Even my daughters were really pleased with Lucy, they told her a word in Arabic, that is 'habibi', it means sweetheart, and whenever Lucy comes to do a home visit the girls say to me 'your habibi is here'.*

Similar to Hati’s experience of deep care, many of the women re-established meaningful and loving connections within their existing families despite the burden of overwhelming trauma and ongoing separation from other family members. For Faduma, a young Somali woman, the murder of her entire family, and the grief for her only remaining sister who is stuck in a refugee camp in Kenya and is continually refused a humanitarian visa, is unbearable. Yet, through the gentle interaction with her naturopath, who used herbs and massage which were deeply familiar to Faduma and connected her to positive memories of her mother, she found a tender and meaningful way to attend to her violated body, and in turn bring some comfort to her deep wounds:

*I’m very happy to see Lucy, she changing my world, she gives the medicine, they work, she gives the massage and ... I sleep well, I’m more patient with my kids now ... this was like in my country, I remember my mum she don’t like the Western medicine, she says it’s more affected the body, and she didn’t like it, only she liked the*
natural things ... she use and her friends, they put massage where they feel the body ache ... she would mash up [the herbs] and put on my body.

Through the relationship with Lucy, Faduma was able to weave positive memories, the healing connection with her mum, into her present painful life, finding some comfort in these connections. The familiarity of herbal medicine and massage was a tangible link between past and present, directly building a sense of coherence through re-establishing these connections, and for Faduma, enabling her to be more patient with her children.

I would argue that although the naturopathic encounter is based on a Westernised practitioner-patient dyad, the therapeutic responses are experienced at the broader social level because of the holistic nature of the approach and the explicit emphasis on the embodied experience. Within Antonovsky’s (1987) salutogenic model the significance of the social is a key factor in developing coherence and meaning. This is reflected in the comment that ‘strong personal ties to others; deep roots in the broader community; and homeostatic flexibility or resilience’ (Antonovsky 1990:75) are important factors in determining health.

In the context of the naturopathic encounter Soula expressed Antonovsky’s emphasis on the importance of social connections when she said:

I looked upon David like a father ... I feel as if they [the naturopaths] are like my family, my friends and family.

Soula’s father was killed in Afghanistan. I suggest that through the experience of deep care generated in the naturopathic encounter, Soula was able to experience a quality of care that was akin to the love she received from her father. In turn, Soula expressed that she was more able to begin the process of healing:

When I first came [to Foundation House], I had no hope, I thought that I was going to die. But slowly, I picked up.

Connecting past with the present may provide important ways of remaking the self in a new world, one in which there is hope for a future.
The experience of deep care and the feeling of being at ease in their bodies enable some women to re-establish meaningful and loving connections in their families, despite the profound and ongoing separation from other family members. They spoke about being able to take the love and deep care that they experienced in the naturopathic encounter into their family lives. Healing moved beyond the individual to the social context:

When I came here and feeling lonely in the country, there was no one ... and she [naturopath] made it like I'm in my home ... she made me feel like I am one of the group here (Hati).

Although grateful for the extensive medical treatment available to them, the women described encounters with biomedicine which left them feeling dismissed, unheard and distressed in their social worlds. In most of these situations the conflict appears to stem from conflicting explanatory models and biomedicine’s inability to deal with the refugee body, the embodied emotion of the refugee experience. The following narrative is Lani’s example of the problematic clash between these two differing positions:

On one occasion, I remember, it happened about 9 or 10 months ago. This was at night all of a sudden I started experiencing extreme pain on my left side near my rib area. And the pain was of course unbearable and my daughter was very scared and she was panicking and worried. She called an ambulance straight away and they came and they thought something was wrong with my heart so they decided to take me to the hospital. And my daughter was weeping, she was devastated, she didn’t know what to do. She wanted to come to the hospital, but the paramedics told her to stay at home and look after her two children and that I would be fine. So she had to do that, she was forced to do that basically. So they took me to the hospital, and my daughter called another family friend and told them. He came to the hospital. I spent the night there and they did some research and told me that my heart was perfectly fine. They dismissed me early in the morning. They told me to see my family doctor. So I did that. Nothing was wrong with my heart, but they couldn’t find out what was it, what was wrong with my heart, what caused that particular pain. And my daughter was devastated. So I know how difficult is for her to see me not feeling well.
In all this time that I have experienced pain in my chest no one had ever given me clear explanation for that. When I saw David [naturopath] he told me what is causing that pain, when I told him that I had that operation, where the vertebrae had been removed, and he said that because the lungs have been pushed and putting to much pressure on the sternum, as in coming closer to each other, that’s why you feel this particular pain. So at least I know there is an explanation ... That’s why he is giving massage to these particular areas. It is so helpful.

In this narrative Lani had been complaining of heart pain and she was rushed to hospital. Rather than having her unbearable heart pain acknowledged and validated as ‘real pain’, she was unfortunately dismissed by the doctors with no explanation for her pain. Undoubtedly, appropriate care for an elderly woman rushed to hospital suffering ‘chest pain’ is of course a full cardiovascular examination. In this situation, it could be inferred that the doctor’s explanatory model was that the arteries were blocked and the patient maybe suffering a heart attack.

The broader concerns for Lani and her family arose when all possible pathologies were eliminated and the doctors dismissed her with a ‘clean bill of health’. Unfortunately they were unable to provide an alternative explanation for her ‘heart pain’. Being dismissed in front of the family can be understood as a social dismissal. Not only did the machines and doctors tell her that nothing was wrong with her, but this was done in a family situation. Lani had been complaining of chest pain for some time and now the ‘authorities’ were dismissing her pain, delegitimising her suffering. It is feasible that after being dismissed from hospital without an explanation for her pain, Lani would have experienced ongoing anxiety as the pain did not suddenly stop. Symbolically in this scenario Lani and her family were socially dismissed by biomedicine and their trauma totally denied. Through the biomedical lens there is no problem, but for the refugee body, the pain and confusion continue.

Conversely, in the naturopathic encounter Lani’s refugee body was validated. Her pain was acknowledged as real and explained to her in a way that was meaningful for her. What is more, she could take this explanation to her family, confidently feeling that her pain (her
experience) was legitimate. This interaction allowed her to be validated as a social person in the context of her family. Importantly it also provided Lani with physical treatment that I speculate was efficacious because it attended to her refugee body.

On a symbolic level Lani’s chest pain can be understood as ‘heartache’, the result of the irrevocable separation from most of her family, and a broader social diagnosis is needed to address this complexity. Kleinman et al. (1978:252) suggest that one of the core tenets of non-biomedical systems is the healer’s emphasis on providing a ‘meaningful explanation for illness and to respond to the personal, family and community issues surrounding illness’, which in turn generates a greater sense of coherence and the subjective experience of wellbeing.

In the naturopathic encounter, David’s healing hands were treating the human experience (Kleinman, Eisenberg & Good 1978) of Lani’s pain, massaging and soothing the physical pain in her body which intensified whenever she thought about her irrevocable separation from her grandchildren. Thinking about her grandchildren being so far away, Lani felt the level of the pain rising. Receiving massage diminished that pain. In this situation I suggest that the embodied engagement between Lani and David enabled Lani to have a meaningful understanding of her lived experience of distress and in turn she was able to feel at ease. I suggest it was not necessary for David and Lani to articulate this analysis in the context of their consultations. What is paramount is Lani’s lived experience of renewal through her treatment with David.

Lani’s therapeutic encounters with David can be understood as salutogenic in that she was able to understand and therefore manage her pain more effectively. It did not take away the cause of her pain – in part, the result of irrevocable separation and loss, but in the contact of the naturopathic encounter, the massage gave her an experience of feeling attended to and she experienced an improvement in wellbeing, better sleep patterns, a reduction in pain and it increased her ability to be at ease:

*If you are calm, if you are relaxed and have comfortable nerves, that means that your body is working alright. And you will be fine (Lani).*
The relaxation experienced from the massage enabled Lani to spend more quality time with her two grandchildren which gave her a greater sense of fulfilment in her life through actively taking on her role as grandmother.

In the context of the social body, I suggest healing occurs in the therapeutic relationship. At this interface the individual’s experience of deep care is actualised. And through this experience, the women spoke of being able to step back into their families and communities with some renewal. In this way, the naturopathic therapeutic relationship facilitated healing beyond the individual to broader family and social relationships and had significance for re-establishing coherence and meaning in their lives.

For Frasa, understanding that her wellbeing, spiritually, physically and emotionally is more than an individual concern, but connected to her home country and lineage, is captured in this story she told:

*Someone travelled from Egypt to Afghanistan and they got sick. And different sort of treatment he received for his sickness, but he didn’t get better. There was a very knowledgeable person who came to the patient to give his advice. He said to take him back to his country and then he will get better. When they take him back to Egypt, he got better. And I feel that is the same, I feel the same experience actually would happen to me* (Frasa).

The bodily expression of distress was a strong feature in all the interviews, and the salience of the naturopathic encounter was the space to give voice to the refugee body and for the body to experience care. In contrast to the search for a pathogen or the exploration of intrapsychic determinants devoid of social context or a physical reality (Kirmayer 1992), naturopathy gives primacy to the subjective or lived experience of the body. In this context, the body is seen as a conduit for communication and symptoms may represent embodied metaphors (Coker 2004b).

Significantly, all the women came to the naturopathic encounter experiencing pain; they brought their embodied refugee distress, the physicality of their suffering. In the naturopathic encounter the women were able to let their bodies speak in an environment of mutual respect and understanding.
Chapter 6: The refugee body in the naturopathic encounter

So far this portrayal of the women’s narratives has explored the tensions arising from biomedicine’s limited ability to effectively address the refugee body, and in contrast, the experiences or renewal and respite in the naturopathic encounter. In the following section I take up a detailed exploration of the women’s connections to and practices of traditional medicine in their home countries. This discussion provides insights into a different and often ignored layer of the refugee body, the importance of the women’s embodied cultural knowledge.

Embodied cultural knowledge: Interconnecting home, mothers and herbal remedies

The focus of my research was to explore the women’s recent experiences of naturopathic treatment. In order to evoke this discussion in the interviews I began by asking the women about the types of medicines they used and the practitioners they consulted when they were sick in their home countries. In most of the interviews, what followed were positive descriptions of a mainly pluralistic approach to health care in their home countries where biomedicine and traditional medicine coexisted reasonably harmoniously. This is described by Frasa:

> We got a very good radio broadcast … I heard a very qualified professor … talk about a herbal medication that was good for this and that, and they kept talking about the traditional treatment … in a very famous hospital in Afghanistan, they tried to use this information and they give herbal medication to the people, which is like a mix of herbs and they give this mixture, this traditional medication to the patients and the patients are getting very well. So, we got the treatment in our very huge hospital … they [Western and traditional medicine] work next to each other, both of them.

Embedded in culture and embodied in self, most of the women strongly connected to both their own traditional medicines, and to the experience of naturopathy at Foundation House. They were very keen to tell me about their experiences. Many had extensive knowledge about traditional medicine and had been educated in the craft by mothers, aunts and grandmothers and knew the herbs and foods to take to treat a variety of illnesses.
A connection with familiar health care produced a sense of connection and facilitated the experience of deep care as it was a tangible link between past and present. The stories told by the women of their experiences of herbal medicine at Foundation House connected their past with the present and possibly established hope for the future (Antonovsky 19897).

Particularly for refugees, re-establishing connections is pivotal in order to begin the process of healing. For many of the women the place of naturopathy at Foundation House was as a way of reconstituting these aspects of their identity as they grappled with the new life in Australia.

**Traditional medicine knowledge**

The natural therapies program at Foundation House does not set out to ‘identify a set of “traditions” in order to create artificial contexts for their execution’ (Englund 1998:1172), but rather, the intention is to create the opportunity for refugees to connect with and access health care services that make sense and are meaningful (Coker 2004a). On many levels the naturopathic treatment available at Foundation House is different from the numerous traditional practices recognisable to the refugees who present for treatment. Often the herbs prescribed by the naturopaths differ from the herbs used by refugees in their home countries and they do not necessarily recognise the herbs in the dispensary at Foundation House. But what they are familiar with is the concept, the familiarity of a shared understanding, a shared cosmology. Naturopathy is a vehicle that connects the women and the practitioners in a culturally meaningful way.

**Humoral principles: Hot/cold theory**

One of the significant understandings of traditional medicine practice that emerged through most of the women’s stories was their knowledge of humoral principles.

As discussed in Chapter Three, hot/cold theory is a central component of a vast number of ethnomedical systems throughout the world and is a deeply ingrained belief for many of the refugees who live in Western countries like Australia (Sargent & Marcucci 1984). The collision of humoral theory and biomedicine is frequently experienced in cross-cultural settings when the biomedical practitioner is ignorant of other ethnomedical systems.
(Harwood 1998; Macintyre 1994; Weerasinghe & Mitchell 2007). This was highlighted by an interpreter I worked with on several occasions during my research. She spoke to me about her experiences of interpreting for refugees clients during their medical appointments:

One thing that I have come across when I go with clients to doctors and hospitals, the patients always say to the doctor ‘doctor what should I not eat?’ and the doctor says you can eat anything. But the clients say ‘why?’, they can’t believe that the doctor is not giving them a regime (Interpreter).

Most of the women gave examples about their own experiences. Rosa described her mother’s dietary advice:

My mother … would organise everything [if] we had too much yoghurt then she would give us two dates to counteract the coldness of yoghurt, if we had watermelon which is cold, then she would give us a couple of walnuts to counteract the cold. She always did that with everything we ate and she was always worried about not too much of one thing, so now I’ve got the habit of saying to my kids, ‘don’t have too much of this, it’s too cold’.

As Rosa explained to me, the hot/cold theory can be applied to an individual’s overall constitution. Her mother had diagnosed her as a ‘cold constitution’ from her skin tone and therefore encouraged Rosa to eat predominantly warming foods. Rosa’s sister, on the other hand, had a darker complexion and therefore was a hotter constitution and required a diet based more on cooling foods. As Rosa explained:

For instance my sister, she would come to mum and say ‘my head is heavy, my eyes are heavy, I feel heavy’. Mum would say ‘what did you have’ and she probably had had too many walnuts or too much dates and because she was on the warm side this would affect her straight away and mum would say, ‘ok, no problem’, she would give her a glass or two of yoghurt, like lassi, but she made it without sugar or fruit, so it is just sour and she would have two glasses of this and otherwise if she let it go, then the headaches would get worse and get more problems.

Soula regulated her daughter’s diet from humoral principles:
My 14 year old daughter, she is more white, when she has her period she can’t eat melon, nuts, egg plant and tomatoes. She gets very sick if she eats this.

And Raza used certain herbs and spices for balance:

Cinnamon is considered warm in nature, so if we had the opposite, being cold, we would add more cinnamon to the food or make a tea … if too much heat, then there is ‘hatchi’, which is tiny little seeds, sort of yellow-goldie colour. Also yoghurt and watermelon.

Sita used humoral principles to treat ailments:

When people are suffering from a specific skin condition … they would say this is due to too much heat in the body. And straight away they would give you that particular plant … you dilute that with water and you drink that … it has a detoxifying effect, like cleansing the system completely and making it cooler.

The women’s knowledge and wisdom were further evident in their capacity to engage both traditional and biomedical health care.

Medical pluralism

In their search for treatment and care women move pragmatically between conflicting sites and bodies of knowledge, at times accepting the discourses and practices entailed in their choice, at other times resisting, subverting or transforming it to create new meanings (Whittaker 2000:68).

Whittaker’s (2000) analysis reflects the experiences of most of the women I interviewed who described utilising traditional and biomedical health care in their home countries. The women’s stories about this interface in their home countries demonstrate their ability to navigate two distinct medical systems. Most described a practical approach to seeking out the most appropriate medicine for the particular situation at hand.

Soula lived in the mountainous terrain on the outskirts of Kabul. During the winter months, access to the city was slow and difficult and at times impossible. Soula explained to me that during these times she was quick to use antibiotics at the first sign of a serious infection in her
children. If the infection worsened and if they became trapped in the mountains, accessing further medical treatment would be impossible and the situation could become fatal.

Alongside the antibiotics, she used herbal medicines to assist the body to deal with the illness:

Say if it was really severe, we go to the doctor and he might give injections. Say if they had a very bad cold, because in the mountains it would get very cold and the children could get very severe colds and they needed medicines. But then we go to the herb doctor to get some herbs to loosen the phlegm and get rid of it. And medicine that I mentioned, with the thorns, we use and also flowers which are similar to hibiscus, the white one is usually very good for chest and throat problems.

Soula’s rationale for selecting appropriate health care was pragmatic:

If there was a problem with the stomach for example, I would go to the Western trained doctor and he would examine me and tell me the diagnosis and give me some medicine. But if that medicine didn’t help then I would go to the shop that has the herbs and speak to them there and take the herbal medicine. So I’d try both of them … probably on the whole we would go to the herb doctor more often than the other doctor. They would give you some herbs and you boil it and drink it.

Lani’s pragmatism in navigating between biomedicine and herbal medicine was equally straightforward. Described previously, Lani came from a ‘family of doctors’ and had access to the best medical treatment in Afghanistan. However, whenever she suffered a bad cough, Lani would immediately take her herbal remedies. When I asked her why she chose herbs over pharmaceuticals she simply said:

Because it was very useful. The particular medicine was extremely helpful.

She then went on to explain:

Of course we did have conventional medicine but it would take a while for them to react or to show some benefit. But with the herbal medicine … I remember that I would boil and drink it and before you knew it, in less than five minutes the problem [cough] would be starting to cure.
In Rosa’s experience:

When we had upset stomach, or pain or bloating, or food poisoning, we never went to the doctor, mum used these flowers, they grow everywhere here, but I don’t know what they are called in English, she would give us tea made from the flowers … We only went to the doctor if it was really, really not curable.

The practice of medicine in Iraq after the United Nations sanctions were enforced provides an interesting insight into the combined practice of traditional and biomedicine. According to Amar many biomedical doctors became proficient in using herbal medicines because of the shortages of pharmacological medications and they would combine their prescriptions:

Remember when the sanctions came to Iraq? All doctors resorted to herbal medications, there was no choice … most of the time [they used] the two medicines together … say if you go to the doctor suffering from high blood pressure, kidney problems, diabetes etc. he’ll give you two or three Western medications, but often one of those medications will not go well with the others, so he’ll say instead of giving you three chemical medicines, he would give a herbal medicine instead, that can work together.

For most, the use of herbs is familiar. It is intrinsic to family life. It exists at the local level of the women’s lives; it is their lived experience, in their realm of knowing, and is common sense knowledge. Although biomedical treatment was also widespread and well regarded in the home country, it appeared to hold a different position in women’s lives. It was a formal or professional approach – a removed experience that required seeking out a professional and consulting in a didactic manner, as opposed to the informality of calling into the apothecary for a conversation with a learned person, or a comforting chat with mother, aunty or grandmother.

Connections to home

Sally is a young and vulnerable Burmese woman. She was forced to flee her country, leaving her entire family behind. Scarred by her traumatic experiences and with no English language skills and unaware of Western cultural norms, she found herself in Australia, isolated and
emotionally fragile. Visibly impassive during most of our interview, Sally became lively when talking about traditional medicine use in Burma. She spoke about how her family, particularly her grandparents and parents, used different herbal medicines to treat all their ailments:

*My grandma and grandpa they just go and find the bush ... like a leaf and you boil it and drink it. When you very sick they find all the herbs and bring all the herbs and mix it up and tie it and boil it and then you drink it.*

Sally described some of the differences between the way herbal medicines are used in Burma and Australia. She was comfortable and I suspect comforted by the contact she had with her naturopath and the access to a familiar kind of medicine:

*I think the medicine [herbal] is better than the Western doctor and I'm more comfortable than [with] the Western ... sometimes you need to talk with someone about your health, about your life and she [naturopath] like counsellor ... [I] trust her, feel better.*

For many of the women like Sally, this deep care experienced in the naturopathic encounter directly connected them with loving memories of home, memories of healing experienced with mothers, aunts and other family members. Their naturopathic experiences were often strongly entwined with memories of using similar traditional medicines in the home country. The emphasis on herbal remedies, humoral principles and mind-body concepts tangibly linked many of the women with aspects of their cultural heritage and practices and for many, ‘mother’s wisdom’.

So important are herbal medicines that some women packed seeds and dried herbs with them as they fled their home countries. In the interview with Lani, she proudly went to the kitchen and brought out a jar of herbs that she brought with her from Afghanistan. She explained to me that this mixture of herbs, called *dosundiseina which means boil for the chest* was the most effective treatment for her ongoing respiratory problems and it was one of the few possessions she carried with her in the long journey from Afghanistan. This is a striking image: an elderly woman, hasty in her dangerous escape from her home country, insists on packing her precious herbal remedies for fear that she may not find them in the new country.
Connection to mothers

I believe in my mum [her use of herbal medicines] a hundred per cent … she did have a small garden and she knew every plant that was in it (Frasa).

Significantly, through their familiarity with herbal medicine, many of the women experienced a positive sense of self and remembered loving memories of family, which for some revealed their strong and deeply meaningful connections with their mothers. Revaluing self through the familiarity of a shared wisdom enabled some of the women to move from the place of amorphous refugee victim to knowledgeable wise woman. And this also took place in both the context of the naturopathic encounter and the interview space.

This was the case for Frasa whose strong attachment to her mother was largely defined by meaningful dialogue about health issues and traditional treatments. Now in Australia, Frasa’s greatest sorrow was her irrevocable separation from her mother, who due to global refugee politics, received asylum in a European country. Frasa described to me through different anecdotes how the significance of naturopathic treatment (and the interview encounter) was intimately connected to memories of her mother and how this was a source of deep comfort in her difficult life as a refugee woman:

I appreciate this moment, I am very glad for this moment to be speaking with you in this environment … right now, what I’m speaking with you [about herbal medicine and her mum] … I am feeling very, very relaxed and I’m feeling very good, I think my mother is here. Because I’m speaking about my mum because the environment is good, I feel my mum is around.

For Frasa, deep care was also related to the opportunity to keep connected with memories of her mother that were evoked in the naturopathic encounter, and significantly also in the interview context. I take up the reflective significance of the interview process in Chapter Eight.

Notably, most of the women had strong and heartfelt memories of their mothers using traditional medicines in the home to treat the family. Some women told stories of their mothers and grandmothers who were well known herbalists and midwives in their local communities. Soula described her mother’s work as a traditional midwife:
Chapter 6: The refugee body in the naturopathic encounter

Everyone knew her in Kabul ... my mother had a space under the house, like a room, a clinic and another lady and myself used to help her to make medicines ... some women who couldn’t get pregnant for 5 or 10 years, then they would come to mum and they would get pregnant ... there was another woman who had trouble conceiving, she might have had problems with her ovaries and mum used a plant, it grows like a weed ... the leaves are round, she would pound that and put it on the woman’s belly.

Often the lived experience of herbal knowledge was linked with loving memories of their mothers as wise, capable women. Their current experiences of naturopathy often re-established these connections to the past, validating the women’s cultural heritage, making these feelings accessible in their current refugee situation. Many of the women I interviewed continued to rely on their mother’s knowledge and herbal wisdom. Significantly, these women, now adults with their own families, frequently phoned their mothers on the other side of the world for advice on health issues. As Soula explained; every time I need something I ring her and she advises me. This level of interaction was perhaps a comforting way to remain connected in ways that generated a sense of meaning and coherence in what often were chaotic life experiences.

For Rosa, her mother’s herbal knowledge was life saving. On their flight from Iran to Australia, Rosa and her immediate family transited in Pakistan where her husband suddenly became seriously ill. The doctor’s diagnosis was acute hepatitis with a very poor prognosis:

The doctor said he doubts if he will survive because nobody survives this. I quickly rang my mum and she gave me lots of instructions. One of the things she told me to do was to get barberry, like a big spoon full and boil it, and leave it overnight for the flavour to come out, then some plums, special plums, add that to it and leave it overnight ... Also, the roots of dandelion, we found it there, and we boil it and it is very bitter and it is one of the best things for jaundice. So we boiled that as well and he had that. Then another recommendation, some of our friends went to the river and caught some tiny little fish and quite a lot of them and then we would put that in his mouth, alive. Because they say it will eat the jaundice from inside. It has to be alive so that it will do some work inside and absorb some of the poison that the jaundice has caused and take it away from him. Then after he got a little bit better we had to introduce some more food to his body, it had to be the rooster, not the
hen, because that is cooling. So we would boil that and skim all the fat and the meat away and just give him the soup. And I would put some special cooling vegetables as well and he would have that as a meal.

After two months Rosa’s husband recovered and they were able to continue their flight to Australia.

Using herbal remedies in the home to treat family members was also an important part of their identity as women. Many of the women came from cultures where the social structure endorsed women’s knowledge and practice of traditional medicine. The women were accustomed to using herbal medicine and they described their mothers and grandmothers as well known in their local communities for their knowledge. In this context woman’s ‘local’ knowledge was valued and legitimised. For these women, growing herbs, visiting the local apothecary, sharing knowledge was taken for granted – it was an important part of their identity that is also socially located in their home countries, for example:

[Mum] knew all the plants that grew in the field and in the river beds, she knew which one would bring the blood pressure down, which one take the blood pressure up, which would be good for headache, for stomach, so she knows all the different plants and what they did (Rosa).

My mother would tell me a few things, for example, to use chamomile and I would use it myself and give to the children to them sleep better, or to relax a little bit and also nettle is something I would use, and its not only my mother, but older people would give you the same advice (Vesna).

Reconnecting with self

For these women, knowledge of herbal medicine was embodied in their sense of identity. Conceptually it was not only deeply familiar, but also brought a profound level of comfort in daily life. This comfort was experienced at both a practical and a spiritual level. Some women described taking comfort in being able to effectively treat their families with folk remedies. This was the case for Frasa:
Chapter 6: The refugee body in the naturopathic encounter

I’d like to tell you about the situation in Afghanistan with my own kids. I’d like to express my own experience of how I treated my own children … I keep taking my children to herbal therapy. For example when they get the diarrhoea I actually treated it by myself, if they got the chest problems or some cold or flu, I just treated my children by myself and they got better.

For others, dislocated from all that was familiar in their day to day lives, the connection to herbal medicine seemed to take on a spiritual significance. Now in exile, it helped many to relocate themselves in a new and unfamiliar place; it was an important link in maintaining their deep bond with their mothers and their culture. The opportunity to feel at home within a new cultural context is tenuous for many refugees. I argue that it was the familiarity of herbal medicine that made it possible for many to feel at home within their new country. The philosopher Madan Sarup (1998:95) points out that ‘the concept of home seems to be tied in some way with the notion of identity’ and as the women’s stories reveal, in the naturopathic encounter the women were able to confidently reclaim important parts of their identity.

In this way naturopathy facilitates the process of ‘social becoming’ (Vigh 2006:33) by legitimising past health care practices and connecting these to the embodiment of the present experiences. For Frasa, now living in Australia, the ability to treat her mother-in-law in the present context is an example of social becoming:

Now my mother-in-law is here with me and now when she is getting sick she actually asks me what she should take and eat. And I actually treat her by myself (Frasa).

Vigh (2006:33) uses the term ‘social becoming’ to describe the necessary ‘movement along an expected and desired life trajectory’. Vigh (2006) argues that without culturally relevant social foundations there is real danger of social starvation. He (Vigh 2006:45) states that ‘social death’ results from the inability to progress in a culturally and socially meaningful way thereby truncating the possibility for achieving social becoming. In the context of Vigh’s research, the notion of social becoming provides a conceptual understanding of the women’s experiences of naturopathy. It can be seen to open up the opportunity for connection to past and connecting past with the present through access to familiar/meaningful healing practices. Frasa explains:
Chapter 6: The refugee body in the naturopathic encounter

The very important part of my life, my treatment, is herbal therapy, which is traditional therapy (Frasa).

The naturopathic encounter allows social becoming through legitimising the connections between past and present in a new and unfamiliar culture. It thus enables the process of social becoming to continue in a cross-cultural context.

For many of the women interviewed, a significant aspect of the naturopathic encounter, and the interview process, was the recognition of an important part of their identity as wise women that they experienced through dialogue with their naturopath and in being able to use herbal medicines once again. I speculate that for these women the knowledge of herbal medicine, which they shared with their naturopath, generated feelings of self-worth as they felt this aspect of their personal identity and cultural heritage was respected by their naturopath. I suggest they were able to legitimise this part of themselves that had been eclipsed by the refugee experience and immersion into a culture that for the most part did not value non-biomedical knowledge(s).

The women described the social context of health care in their home countries that included a range of experiences, such as informal gatherings at the local apothecary, as Rosa describes:

Yes everybody knows about the apothecary shop and they are everywhere, easily accessible ... [mum] also went to the apothecary and learnt from them as well.

Or, as Sally describes, they would call on a neighbour to get advice about a health matter or to get a particular herb (like borrowing a cup of sugar):

When I in Burma, if I ask at home [for a herb and] they [my family] don’t have it, just ask neighbour and they give it to you.

For others, sharing a herbal recipe with a friend or a meaningful interaction with mother, grandmother or daughter about foods and herbs was part of their everyday experience.

Through the experience of naturopathic treatment at Foundation House, I argue that many of the women felt encouraged to re-establish a strong and meaningful connection with positive and loving memories of their home country and also with a core part of self that for many had been overshadowed by the refugee experience, leaving them feeling marginalised, invisible
and ignorant. For most of the women, the connection with their naturopathic practitioner enabled them to re-enter a familiar world, one in which they experienced themselves, and were seen as, knowledgeable and strong. For many this experience had been an essential part of their identity before becoming a refugee, and I speculate that the re-emergence of this quality now was intrinsically connected with the experience of deep care and the validation they felt in the naturopathic encounter.

**Summary**

The women’s diverse refugee experiences include the anguish of interpersonal loss brought about by the death of loved ones through war, torture, or disappearances, and through the ongoing torment of irrevocable separations caused by global refugee politics. The women’s refugee bodies are located within this landscape of loss and dislocation. In the face of such loss, it became apparent that the naturopathic encounter offered these women an opportunity for respite and healing.

Described by the women, the naturopathic encounter provided a meaningful space to express the physicality of their symptoms in ways that legitimised and valued their experiences. This was intrinsically connected to the experience of shared knowledge and the validation of their body’s voice. In the naturopathic encounter the women were able to make positive connections between past and present in ways that were culturally and socially appropriate. It is as Sita described, *I’m more relaxed now … my mind is at ease now, in peace.*

In keeping with a grounded theory approach, the themes outlined in this chapter guided my choice of theoretical lenses which I now take up in Chapter Seven. The themes that emerged are strongly focused on connections and coherence. I have contextualised these themes in the notion of the refugee body (Coker 2004a; Scheper-Hughes & Lock 1998) and in Chapter Seven I extend the theorising on the refugee body into the discipline of cultural studies by taking up, in particular, Elspeth Probyn’s (2005) embodiment lens.
Chapter 7
The naturopathic meeting place

Raza’s story

When we were in Turkey my father passed away and then when we came to Australia my sister passed away and I know I shouldn’t allow myself to get so upset, but because I don’t have anybody here, no family, it is really hard and it has affected me ... I was really, really in pain. It was caused by a few things, but mainly the stresses we had in Iran, the revolutionary guards attacked our house and took my father and my brother away and that was really stressful and then my job, I was a seamstress, and that could have had a lot to do with it [the pain]. They were not just happy to take my father and brother to prison, they were harassing us everyday, they wanted us to go and be interrogated and so it was very, very stressful time ... Anna [naturopath] works very hard, because my muscles are very hard and tense, she works very hard to loosen them up ... because I know the massage loosens up and that helps the pain, lessens the pain, so it is very useful ... I used to go to physiotherapy, and the physiotherapy was good, but when I went to Anna, it was very different, it was very beautiful and very relaxing ... the physiotherapy was mainly trying to find where the pain was and why there was pain. She would move my hand back and forward and it wasn’t relaxing whereas Anna is very relaxing, good feeling and I believe in Anna and it is really beautiful ... when the pain lessens then the feeling is emotionally better too ... with Anna there is compassion and you feel you are loved. There is a feeling that another person, somebody cares whether I’m better or not ... it brings the value of the treatment a lot higher than if it was
just a physical massage ... So here when I go to the massage, ... It's a feeling like I want to fly, my body is so much lighter, I feel I'm taking off. That is how I feel.

Raza's description of embodied freedom expresses the essence of the naturopathic encounter. Raza can now fly into the future because she has been able to attend to her refugee body and make sense of it in ways that meaningfully allow her to integrate the past into her present. I argue that this is possible because Raza feels ‘in place’ in the naturopathic encounter. Here she has a sense of belonging – where she experiences compassion and feels that she is loved. The notion of being in place is central to her experiences of healing that are generated by this praxis – the interlacing of past and present through recognition and validation of her refugee body. Raza's story exemplifies the themes that emerged from all the women's stories and which I analyse in this chapter. Under the rubric of what I call the ‘naturopathic encounter’ the women's stories in Chapter Six gave voice to these themes which include biomedical inadequacy, the refugee body and embodied cultural knowledge. The emergence of these themes led me to explore the theoretical lens and type of analysis I take up in this chapter.

The notion of the refugee body, developed from Scheper-Hughes and Lock’s (1998) conception of the ‘three bodies’, is the fundamental assumption from which I begin the analysis in this chapter. By taking up other theories from different disciplines I aim to deepen the theoretical position of the refugee body. To this end, I develop what I call the ‘naturopathic meeting place’ (NMP). As an overarching theoretical concept I argue that the NMP is useful for linking emergent themes and extending the theoretical analysis of the women's naturopathic encounters.

The focus of my analysis is the women's lived experience of their refugee bodies. Implicit in my position is the view that to understand the embodied experience of others we must engage with the subjectivity of the other (Coker 2004a:403). In order to access this depth of understanding I employ the notion of habitus to theorise the women's experiences and to deepen the understanding of the phenomena articulated through their narratives.
I begin this chapter by briefly introducing French ethnographer, Pierre Bourdieu’s notion of habitus and mention some of the ways that his ideas have been taken up across disciplines. I particularly draw on his concept of habitus by taking up Elspeth Probyn’s (2004; 2005) rearticulation through the lens of embodiment theory.

**Habitus: lineage of knowledge**

In Bourdieu’s (1990b) terms, habitus is a concept that helps us explain our individual responses in any given situation. It is our ‘second nature’ (Bourdieu 1995:35) way of being in the world and is informed by class, gender, ethnicity, personal histories and is influenced by political affiliations, culture, and in this context, the refugee experience. In his most recent work Bourdieu (2005:43 original emphasis) defines habitus:

> [A]s a system of dispositions, that is of permanent manners of being, seeing, acting and thinking, or a system of long-lasting (rather than permanent) schemes ... of perception, conception and action.

Habitus is a significant concept particularly because it provides a way of thinking about embodied or inscribed knowledge. It also provides a vehicle for theorising about how past experiences can be relived in the present through the body’s automatic and often unguarded responses.

In an earlier work Bourdieu (1995:35) states:

> The habitus – embodied history, internalised as second-nature and so forgotten as history – is the active presence of the whole past of which it is the product.

In this chapter I argue that in the NMP the women feel safe to allow their ‘forgotten history – their embodied, internalised past’ to emerge. As such, the women engage with ‘the active presence of their past’ in the NMP and the opportunity for healing is generated.

Although the term habitus is largely associated with Bourdieu, according to Probyn (2005:57) its origins in sociology date back to an earlier theorist, Marcel Mauss. However, it is Bourdieu’s work which has provided the impetus for much of the recent scholarly discourse
on habitus (for example Hillier & Rooksby 2005b). His work has influenced academics from a wide range of disciplines who have taken up the concept, often further developing and applying it to their own particular fields. The point I wish to make is that following on from Mauss, Bourdieu and others, scholars have continued to theorise and apply the concept in what I suggest can be understood as generating a lineage of knowledge of habitus.

**The fluidity and multiplicity of habitus**

One area of scholarly debate that is of interest to this thesis questions whether by definition the habitus is a static structure (Hillier & Rooksby 2005b, 2005a; Noble & Watkins 2004; Sweetman 2003). Adding complexity to this debate is the fact that over the years that he was theorising on habitus, Bourdieu systematically revised and modified his original views and thus it is problematic to assume a definitive position. Comparing Bourdieu's writings in 1990 with those from 2002 highlights this challenge and also reflects the various positions put forward by different scholars.

In Probyn's (2005) reconsideration of habitus she comments that there is a sense of inevitability inherent within what Bourdieu (1990a:79) articulated in his definition of habitus and which she challenges in her theorising of the 'feeling body'. In Dovey's (2005:285) view 'the habitus is easily, but falsely, seen as deterministic'. In contrast, Friedmann (2005:318) is more critical of Bourdieu's position, arguing that particular life situations, such as migration, will significantly change the habitus. Furthermore, Friedmann (2005:318) argues that it is even possible for the habitus to 'break down' in situations where the social order has collapsed. In picking up on a minor reference by Bourdieu (1990b:67–69) to the notion of a 'second birth' – that is, a second birth in a new context, Friedmann (2005:317) further develops his position stating that a 'second birth' occurs when a person is:

\[
\text{[F]orced (or may choose) to enter another field than the one in which we are at home} \text{ [and] this involves learning a new set of rules, a process that is slow and painful.}
\]

Dovey (2005:285) states that the 'habitus is subject to constant change, but such revisions are always based on existing social practices'. Thus Dovey seems to be suggesting that although change is inevitable, it is constrained within, to use Bourdieu's (2005:47) words, 'the limits inherent in its originary structure, that is with certain bounds of continuity'. An example of
this position is articulated in Gale’s (2005) analysis of the plight of Aborigines in Australia. She argues that the entrenched colonial habitus within sections of the Howard Government continued to block the possibility for reconciliation. Thus the ingrained ‘existing social practices’ (Dovey 2005:285), the colonial habitus, limited the possibility for change during this era.

Bourdieu (2005:43) himself, writing not long before his death, asks ‘... is habitus a definitely static concept?’ He goes on to state that the habitus can be ‘changed by history ... [however] any dimension of habitus is very difficult to change, but it may be changed through this process of awareness and of pedagogic effort’ (Bourdieu 2005:45). In a collective sense, the habitus is ‘learnt, not as a set of fixed categories but as a set of dispositions to act; it is the “feel for the game” of social practice’ (Bourdieu 1993:5 quoted in Dovey 2005:284).

In his later work Bourdieu (2005:43–45) questioned the permanence of habitus, arguing that although change is difficult to effect, it nonetheless is possible. Having the last word in response to how habitus has been taken up by various scholars, Bourdieu (2005:45) has this to say:

The habitus is not a fate, not a destiny. I must insist on this, as I have done many times before, against the interpretation which was proposed and imposed by some of the first reviews of my work and then constantly repeated by most of the English-speaking commentators (as if they spent more time reading the previous exegeses – according to a scholastic tradition which dictates that every reviewer reviews all the previous reviews at the beginning of his or her reviews). The model of the circle, the vicious cycle of structure producing habitus which reproduces structure ad infinitum is a product of commentators.

Thus the understanding that habitus is far from a static fixture has been well documented by scholars, for example Probyn (2005), Hillier and Rooksby (2005b), and by Bourdieu himself (2005). In the introduction to the book edited by Hillier and Rooksby (2005:14), they comment that Bourdieu’s earlier work on habitus has evolved to incorporate a greater capacity for individual agency. This development paves the way for habitus to be theorised and applied in broader ways than was previously possible.
Drawing from these debates, I position my analysis from the perspective that, although the habitus is not static, by virtue of it being an inscribed or embodied mode of knowing about the world, it will anchor us to particular ways of knowing and being within particular contexts. As such, habitus imbues our subjectivity. Underpinned by Probyn’s (1996; 2003; 2005) theorising on the body, I apply this understanding of habitus to the women’s experiences in the NMP. I argue that in the NMP the women’s subjective experiences were validated by the naturopaths and this sense of validation was critical for generating the opportunity for healing.

**Theorising the naturopathic meeting place**

In the following sections I theorise the movement from naturopathic encounter to naturopathic meeting place (NMP). I draw particularly on Probyn’s (2004; 2005) reconsideration of Bourdieu’s notion of habitus which she articulates in her theories of embodiment applied to reconsidering shame in the everyday. Specifically, I take Probyn’s (2004:336) analysis of habitus as ‘a description of everyday lived realities … which generates practices, frames for positioning oneself in the world, and indeed ways of inhabiting the world’. I became interested in Probyn’s (2004; 2005) conceptualisation of habitus because it offers a way to consider the women’s narratives through the lens of embodiment theory articulated in the notion of being at ease and out of place. Probyn (2004:334) says:

> [O]ur bodies seem to know when they are at ease in a situation, when they know the rules and expectations, and conversely they also tell us loudly when we are out of our leagues, fishes out of water.

Aligned overall with Bourdieu’s approach, Probyn extends his conceptions with a commitment to the experience of ‘the everyday’. This is well suited for analytical application to agents (or people) who are more likely to be positioned on the fringes of a given field. I argue that the explicitly feminist theoretical orientation in Probyn’s (2005:55) work combined with her claim for the place of the ‘feeling body’ is critical to an embodied
analysis of the women’s stories in this thesis. The fittingness of Probyn’s theoretical position is particularly relevant for the alternative landscape of this thesis given that the agents investigated, naturopaths and refugee women, are considered marginal in Western society.

Furthermore, I link the notion of habitus to the concepts of space and place I introduced in Chapter Three. This connection allows me to theorise the relationship between naturopath and refugee woman, which is at the core of the NMP. Issues of space and place are critical for most refugees whose circumstances are often defined by displacement and dislocation. To this end, I briefly take up the concept of liminality to contextualise the ‘out-of-placeness’ (Probyn 2005:50) that the refugee experience evokes, and in contrast, the sense of being in-place experienced in the NMP. Notions of space and place within a refugee health setting provide the background for my exploration of the NMP as a locale of being in place. Contextualised by Antonovsky’s (1990) health continuum concept described in Chapter Three, I suggest that the feelings of respite, renewal and healing described earlier by Raza were possible because she felt in place in the NMP.

**Resettlement, liminality and the NMP**

The refugee experience is inherently one of displacement and loss. This may occur as physical dislocation from one’s geographical home, socially from connections to place and to people, and bodily because of the torture and trauma which many have been endured.

An essential factor in Western refugee resettlement contexts is to develop ways that facilitate an experience of feeling in place in the new country of resettlement.

[...] refugees are people who have undergone a violent ‘rite’ of separation and unless or until they are “incorporated” as citizens into their host state (or returned to their state of origin) find themselves in “transition”, or in a state of ‘liminality’ (Harrell-Bond & Voutira 1992:7).

As Harrell-Bond (1992) explains, the refugee experience, and process of resettlement, is often one of transition or liminality. It is often defined by conflicting feelings associated with being ‘betwixt and between’ worlds (Turner 1974:232). For Vesna this feeling is associated with grief for her home country:
I really appreciate what we are having here in Australia and the life that we have and people being so trustworthy and helpful, wherever we go and over these years no one ever asked us anything that would make us feel uncomfortable, there’s no pressure. But I remember my country and the life we had when life was normal, it was a fabulous place to live and I miss that a lot even though there are so many, many things that we appreciate here.

The concept of liminality was introduced by van Gennep (1960) in his work on ritual processes and rites of passage. He proposed that there were three stages involved when going through a rite of passage from one social state to another: separation, transition and reincorporation. Taking particular interest in the transition stage, Victor Turner (1964; 1974) and Mary Douglas (1970) are noted for further developing this concept in their own theoretical work. The term liminality comes from the Latin word for ‘threshold’. In Turner’s (1974) theorising on the concept he proposes that a liminal space is a transitional state in which social structures are removed and new possibilities are created. It is an in-between phase.

Turner (1964; 1974) and Douglas’s (1970) work on liminality have been taken up by other scholars and applied in a range of theoretical contexts (Bettis & Mills 2006; Chan 1999; Harrell-Bond & Voutira 1992; Jackson 2005; Malkki 1995b). In particular, the concept is useful as a way to explore betwixt and between situations. In Jackson’s (2005) research on chronic pain, described in Chapter Three, she draws from Turner (1964; 1974) and Douglas (1970) to distinguish two different yet related notions of liminality: ‘betwixt and between’ coined by Turner (1974) and ‘matter out of place’ based on Douglas’s (1970) work on dirt and pollution. In her work on refugees in Tanzania, Malkki (1995b) also takes up both connotations of liminality to conceptualise the refugee experience as both out of placeness and inbetweeness.

Following these scholars, my interest is in the conceptualisation of the refugee experience as generating a betwixt and betweenness and an out of placeness geographically and sociopolitically and subjectively in terms of the refugee body. The women’s stories about their experiences of being in place or out of place in the naturopathic and biomedical encounters can be understood as examples of liminality. The experience of feeling out of place will often stem from disjunctions between the past and present. For most of the women, the
biomedical encounter in their home countries was experienced as an at-ease situation, but here in Australia, the biomedical encounter created a sense of being out of place because the symptoms that they sought assistance for could not be attended to in the biomedical context – symptoms intricately woven into the experiences of becoming a refugee, embodying loss, trauma, dislocation and grief. Such symptoms do not necessarily have corresponding biomedical categories – they ‘transgress the categorical division between mind and body’ (Jackson 2005:332). In contrast, these symptoms were able to be legitimised and attended to in the naturopathic encounter. Here the women could bring their refugee bodies, vulnerable with pain, and experience respite and renewal.

[In Australia] when I got prescription from the doctor, I worried a lot, I got worried that I am getting addicted to the medication. And they keep saying to me, when I go to the doctor, you must take your medication, you must take your medication. And I was thinking, I’m getting addicted. It was a fear, a worry in my body. I discussed my situation with my social worker, and I said to her that I am going to die, it's my end of life, and she introduced me to Kate [naturopath] and when I visited Kate I think she gives me a second life (Frasa).

Significantly, liminal spaces can be both safe and risky spaces. In order to create a safe liminal space it needs to be highly proscribed socially. The NMP was a safe liminal space for these women as boundaries around time through set appointments, professional interpreters, the professional therapeutic relationship with the naturopaths and the safety and familiarity of Foundation House. Kenworthy Teather (1999:13) argues that ‘place’ is an integral part of rites of passage. For these women, the NMP was experienced as a meaningful place which was generated physically in the actual naturopathic consulting room, and metaphorically in positive memories of home. In the NMP these women’s sense of place and identity was affirmed in the broader resettlement context.

In the NMP the women could let their refugee bodies speak to the complexity of their circumstances. As they reconnected with aspects of their embodied cultural knowledge within a setting where they felt safe to express their bodily distress, the women reclaimed a sense of self that was able to move beyond their lived reality as refugee women. In this space their sense of identity as women was not overshadowed by a ubiquitous refugee-ness. Thus it was possible for the women’s sense of identity to shift from that of ‘refugee victim’ to ‘wise
woman’, one who is more at ease within her body and her life situation. The possibility for transformation was generated and the women were perhaps no longer dominated by an acquired habitus of displacement.

**A shared cosmology**

Contextualising the NMP is what I call the ‘the shared cosmological understanding’ between the naturopaths and the women. These shared understandings are what the women and naturopaths bring into the naturopathic encounter and in effect they underpin the main themes that emerged from the women’s narratives that are discussed in Chapter Six. At a subtle level, the shared cosmological understandings are underpinned by the particular relationship between the women and their naturopaths. The relationship ‘becomes a space of mutual occupation, where a shared intersubjective relation is born’ (Johnston & Barcan 2006:35).

Taking up Probyn (2005), I argue that the NMP is a socially and culturally constructed field that is generated through the engaged interaction between the refugee women and the naturopaths. I theorise the NMP as a hybrid space that draws on a range of shared cosmological understandings inherent in traditional healing systems; it is framed by the embodied knowledge of the agents within this field, and it takes up particular conceptions of space, place and home within a refugee health care context. In my theorising of the NMP, I propose that it is the space where the possibility for healing is actuated. The NMP is both a temporal and spatial entity, physically contained and influenced by the organisational structures of Foundation House and temporally informed by the people who meet there.

In Chapters Five and Six I described the circumstances that led to the women receiving naturopathic treatment and the context of this encounter. In sum, the women were referred to naturopathy by their counsellors because biomedicine had been unable to effectively attend to their health concerns. Thus the women came into the naturopathic consultation with unresolved health issues which for many had been dismissed in some way by biomedicine. In this way they had become further marginalised. The predominant feature of the women’s health concerns were the experience of pain, the physical and emotional manifestation of their embodied suffering, their refugee body. As Johnston and Barcan (2006:33) explain ‘alternative healing modalities are particularly attuned to dealing with pain, whether identified
as physical, emotional, mental or metaphysical (spiritual). The women's bodily narratives reveal at once the obscene atrocity of torture and the refugee experience, and in extreme contrast, the profound experiences of healing generated in the naturopathic encounter.

The discussion in Chapter Six also highlighted what the women brought to the encounter: their particular understandings of health, illness and their bodies. For many, this included a pluralistic approach to health care where the combined use of traditional medicine and biomedicine was familiar and formed part of their everyday experience. Significantly, all the women expressed a level of bodily awareness, a bodily sense of place-ness which I analyse in this chapter by taking up Probyn's (2004; 2005) descriptions of feeling at ease or out of place.

As described earlier, the notion of dispositions is a concept twinned with habitus. Burkitt (2002:225) suggests that inseparable from the habitus are 'modes that predispose individuals towards particular forms of practical actions in given situations'. Although Burkitt is specifically referring to moral concerns, it is important in this thesis to acknowledge the predisposing factors that enabled the women and naturopaths to connect in the naturopathic encounter. To this end, I take up Bourdieu's (1992:133) reflection that people are drawn to 'circumstances that tend to agree with those that originally fashioned their habitus'.

The practitioners came into the naturopathic encounter with their naturopathic knowledge and practice skills. Although the naturopathic training of the practitioners at Foundation House is orientated to a holistic cosmology, the naturopaths are also at ease practising within an integrative system where they are comfortable making referrals and liaising with biomedical practitioners, as described in Chapter Five. In Bourdieu's (2005) terms, the practitioners' proclivity to naturopathy can be explained by the particular set of dispositions that has attracted them to study and practice naturopathy, specifically from a holistic rather than scientific approach. They are orientated towards a particular world view about health, illness and conceptions of the body, one that values the social context from which the women come and in their consultations they engage their clients in conversation about the healing traditions and practices of their home countries. Also important within their dispositions is an affinity towards what can broadly be called a social justice orientation and hence
their interest in this area of work. I argue that both the women and the practitioners in this project were drawn to the naturopathic encounter because they shared certain cosmological understandings.

An ethics of care

The practitioners also brought into the naturopathic encounter their ability to engage in a particular kind of therapeutic relationship. In Chapter Six, I described the women’s experiences of this therapeutic relationship as one of feeling ‘deep care’. This, I argue, is influenced by the non-discursive methods of naturopathic treatment and by the naturopath’s non-biomedical conceptions of the body.

To extend this notion of deep care, I briefly extrapolate from Fiona Robinson’s (1999) concept of an ‘ethics of care’, and Sonia Tascon’s (2002) application of Emmanuual Levinas’ ‘ethics of relationship’ to a refugee context. These substantial investigations, mentioned only briefly here, provide important insights into core qualities of the naturopathic therapeutic relationship. Robinson (1999:29–30) writes: ‘care ethics involves learning how to listen and be attentive and responsive to the needs and suffering of others’. It is a relationship in which knowing how to care for others is something that should not be assumed (1999:11). Applying Levinas’ work to the treatment of refugees, Sonia Tascon (2002:13) argues that an ethical relationship ‘enables each human being to be seen and understood before they are constructed within a label’. Developing this theme, Oliver (2001), quoted in Johnston and Barcan (2006:42) states that ‘for Levinas responsibility is for the Other’s response; it is response-ability’.

I argue that an ‘ethics of care’ (Robinson 1999:29–30) was generated in the naturopathic encounter because the naturopaths were able to hear and respond to the women’s needs. As such, the women’s subjective, lived experiences were validated and legitimised. As a result of being able to tell their story and for the body’s voice to be heard, the women were able to make sense of their refugee bodies. They were able to tell their story as a whole person, as opposed to the biomedical setting where they are seen as symptoms or disease states, seemingly dislocated from the rest of their body and lived experience. As Probyn (2005:40) states, ‘listening carefully to narratives, we can hear snatches of what it feels like to be “out of place”’. Equally important, I suggest that in the naturopathic encounter, and in the interviews...
themselves, the space was created for listening carefully to hear and learn from the women's stories of being at ease and in place, and this was possible, in part, because a biomedical label was not superimposed onto the women's experiences. Fundamental to the establishment of the NMP are the qualities inherent in an ethics of care.

'Return to one heart': Non-Western conceptions of health, illness and the body

An important component of the shared cosmology between the naturopaths and the women is their familiarity with non-biomedical approaches. As shown in Chapter Two, the primary health care of the vast majority of people in developing countries is traditional medicine (Shein & Maehira 2005). The majority of the world's refugees come from developing countries. Thus, traditional health care knowledge and practice informs refugees' understandings of health, illness and concepts of the body. In Probyn's (2005) terms, it is the inscribed knowledge of their habitus. It informs how they are in the world, their automatic and second nature responses.

Some of the important concepts in non-Western traditional healing systems are also found in naturopathic philosophy. According to Harwood (1977:171), the aim of healing in this context is a ‘return to one heart’. As a metaphor, this captures the essence of the women's experiences of feeling in place in the naturopathic encounter. In this section I briefly revisit some of these traditional healing concepts, described previously in Chapter Three, in relation to the women's experiences of the naturopathic encounter.

The Javanese word, tjotjog used by Geertz (1977:148) describes the ‘fittingness’ that is essential in the relationship between healer and patient. This concept seems to describe the relationship between the naturopaths and the refugee women, and also the relationship in the interview setting. As I discussed in Chapter Six, the women spoke of the importance of this rapport, or tjotjog, with their naturopaths as generated not only through the deep care shown by the practitioner, but specifically in the shared values and understandings of traditional approaches to health care and particularly, in the acknowledgement of the refugee body. The shared values between healer and patient are vital (Edgerton 1977). The tjotjog can be translated into what Probyn (2005) calls the experience of feeling at ease and in place, particularly as the social context of the women's distress was legitimised. As a result, I argue, a safe meeting place was generated.
For some of the women, engaging in the naturopathic encounter was a validation of their own belief systems about health and illness. Even though the naturopaths’ beliefs are culturally Western, their traditional orientation created common ground and enabled a resonance to develop in the naturopathic encounter. Kunz (1981) argues that a level of cultural compatibility between the person’s background and that of the new country is fundamental to establishing effective resettlement for refugees. Finding people who ‘speak the same language and share their values, traditions, lifestyle, religion, political views and food habits’ enables a smoother resettlement process (Kunz 1981:47). In this sense access to traditional approaches to health care in Western countries of resettlement is particularly important, but often absent.

Many of the central tenets of traditional healing systems are echoed in Antonovsky’s (1987) salutogenic principle and in Probyn’s (2005:55) notion of the ‘feeling body’ and its relation to place, which I explore later in this chapter. I align these concepts to the literature on traditional healing systems where emphasis is given to healing the patient within their social/political/cultural context. The aim is to re-establish the sense of connection symbolically, and the actual symptoms the patient presents with are often understood as the conduit enabling healing to occur. The body in this context constitutes far more than simply ‘a container for what it has been’ (Probyn 2005:55).

As stated earlier, traditional medical knowledge entails particular conceptualisations of the body and understandings of health and illness. It is based on an essentially different metaphysical understanding from that of biomedicine (Scott 1998). For example, in her study of women’s health and traditional medicine practices in north-east Thailand, Whittaker (2000:67) notes that ‘alternative readings of the body’ and notions of health and illness appear to be incommensurable with biomedical knowledge. However, Whittaker (2000) also notes that these Thai women were essentially pragmatic and readily able to blend the two systems. This pragmatic approach was also evident in narratives of the women I interviewed, particularly when they described their experiences in their home countries.

The women in this study had on the whole a strong connection to the traditional healing practices of their home countries. This was an important aspect of their social world and their sense of place in their community. In their home countries many of these women
were negotiating within a pluralistic health care model where access to both traditional and biomedical care was second nature. Using herbs was part of their everyday experience, as was going to the doctor for problems they determined were better treated by biomedicine:

*I received both. Traditional medicine from my mum. When it was a serious matter, then I would attend the medical doctor. And we had a very good medical doctor … they [traditional and biomedicine] work next to each other (Frasa).*

*My mum would say ‘doctors only give you antibiotics and the antibiotics dries the phlegm and then it comes back’. But she would try and give us warming things and soothing things … the seeds of quince are black and when you put them in your mouth, slowly they release a smooth juice and that really sooths the throat … And if it wouldn’t go away and there was a deeper infection then we had to go to the doctor (Raza).*

Research by Mignone et al. (2007:21) into the practice of traditional medicine and biomedicine in five Latin American countries has shown that these practices ‘do not [necessarily] function in opposition to each other’. Similarly, the women in my study demonstrated this view. In both their country of origin and in their experiences at Foundation House these women benefited from a genuinely pluralistic approach to managing their health care.

Equally important in developing a sense of wellbeing is the opportunity for establishing connections between past and present. Applied to refugee health research, connections to the past re-establishes the possibility for the future, which represents the possibility for hope. In the context of this research, connection to the past was through knowledge and practice of traditional medicines. For most, this was contextualised to their relationships with mothers, aunts and grandmothers. As shown in Chapter Six, re-establishing these connections in the naturopathic encounter also validated these relationships. Connection to the past might also be biological, material, cultural, symbolic, or religious. Similar to other salutogenically oriented refugee research, such as that conducted by Jenkins (1996), Coker (2004a, 2004b) and Ying and Akutsu (1997), in this project the women’s narratives show how many
refugees are able to re-establish connections and rebuild their lives given the appropriate opportunities. Thus, honouring their pasts reconstitutes the present and enables a future to be envisioned.

**Probyn’s reconsideration of habitus: The ‘feeling body’**

In her theorising on the body, Probyn (2005) takes up Mauss and Bourdieu’s ideas in particular ways. Also informed by Althusser and Foucault, she emphasises everyday lived experience in which ‘our individual and collective histories inform how we are in the world’ (Probyn 2005:39). She says:

> [H]ow we experience ourselves is deeply structured by historical processes that make us into subjects ... the body provides us with key knowledge about the working of our subjectivities. The body then becomes a site for the production of knowledge, feelings, emotions and history, all of which are central to subjectivity (Probyn 2003:290).

In her work on subjectivity and space Probyn (2003) makes the point that subjectivity and identity are different but mutually implicated concerns. Identity carries a broader, overarching dimension, whereas subjectivity relates to the individual’s experience in the everyday. This difference can be expressed in the following way: ‘I am a refugee woman’ is a claim for identity. ‘I am a refugee woman and I feel unwell’ is a subjective position. My aim in this research is to give primacy to exploring the subjective experiences of the women I interviewed in order to theorise their embodied knowledge. Probyn’s (2003) analysis of the importance of subjective bodily knowledge was expressed in various ways by the women’s narratives:

Mary:

*I was always thinking about what happened and I wanted to forget about everything. I think this is my problem. Maybe the sadness attacks [my] stomach I think. Yes, sometimes when I think about past problems, I feel headache, I feel stomach pain ... the stomach talks.*
For Amar:

*I went once to the hospital [in Australia] for physiotherapy, you know how in the first session she was examining, feeling certain pressure points. She put her hand on my right knee and I looked at her eyes and I suspected that she was a bit scared. She didn’t tell me her feelings, but I felt doubtful and I never went back ... The moment someone offers to help I look at their eyes and I feel if they are genuine or not.*

Taking these concerns further, Probyn (2005:41) argues that thinking on the body has ‘tended to overly privilege the body’s cultural meanings and have not really tried to tell the psychosomatic body’s story’. Capturing this sentiment, Probyn quotes from somatic psychotherapist Katherine Young: ‘Bodies are passed down in families ... The body is the flesh of memory’ (Young 2002 cited in Probyn, 2005:47). Probyn (2005:48) states that the strong Cartesian lineage of dualism is entrenched in much of sociological theory, in particular in the separation of ‘the body and the social’. Bourdieu’s work however, ‘has done much to promote an analysis of how and why the social enters our bodies and selves ... how the social is embodied and how the body carries the social’ (Probyn 2005:47–8). In Bourdieu’s words (2000:141 cited in Dovey 2005:284), ‘we learn bodily. The social order inscribes itself in bodies ...’ Similarly, the pioneering work of medical anthropologist Arthur Kleinman, discussed in Chapters Two and Three has been critically important in connecting the social and the body in the field of anthropology and biomedicine.

Many of the symptoms and illnesses that the women brought to the naturopathic encounter did not fit within the reductionist biomedical model. The women’s narratives explicitly explained the causes of their ill health as at once physical, social, political and spiritual. As many of the women described, there is little separation in their understanding of physical ailments and the complex sociopolitical context of their lives.

Faduma explicitly conveys this understanding:

*If you have problem like with your finger, you fix it, but I feel pain about my family. Sometimes when I call my sister I don’t sleep for two weeks because she tells me a lot of things, bad things, ‘we don’t have food, we don’t have clothes, we don’t have safe place’. Because they live in refugee camp and at night time guards come and they*
rape her, take what she has ... But when she tells me lots of things and I can't do nothing, I feel very sad ... I feel tired and headache and nervous.

This was also evident for Mary, who although culturally aligned with a biomedical health care model in her home country, found that in her current situation her ill health could not successfully be treated within a biomedical context. Mary’s ill health stemmed from the complex interaction of psychosocial factors, rather than from an isolated pathogenic agent:

When I feel lonely, when I feel I’m homeless, no job, no home, no family, and many problems from the past ... then I feel the physical symptoms ... when I go to Western doctor, they don’t talk, he just puts some information on computer [and] give you some medicine.

Probyn (2005) clearly acknowledges Bourdieu's significant contributions in the disciplines of sociology and anthropology to understanding the relationship between the body and the social. However, she is also quick to point out Bourdieu’s equivocation in ‘the place of emotion within the habitus’ (Probyn 2005:50). Probyn (2005:55) suggests that Bourdieu's focus was dominated by the need to understand practical knowledge and this came at the expense of what she terms the ‘feeling body’. Thus in Probyn’s (2005:56) reconsideration of habitus she gives greater emphasis to the possibility that there is a ‘mutual exchange’ between the feeling body and social structures.

Probyn takes the body’s knowledge seriously. In calling for the place of the feeling body as it inevitably impacts on habitus Probyn (2005: 55) states that ‘there may also be times when emotions shake up the habitus, when the feeling body outruns the cognitive capture of the habitus’. Moreover, Probyn (2005:56) proposes that new bodily knowledges are developed which have the potential to ‘shake up the embodied order of things ... [which] certainly places more emphasis on the “mindful body”’. 

Similar to Scheper-Hughes and Lock’s (1998) notion of the three bodies discussed in Chapter Three, Probyn's (2005) feeling body emphasises the body’s role in generating ways of knowing that speak to the women’s embodied experiences in this research. For example, the NMP treatment is not perceived as having failed if the women's symptoms are not ‘cured’. The aim of treatment is renewal and respite, not curing or fixing. It gives value to the subject’s
experience of distress and is a radically different position to that of biomedicine. It allows the body to be responsive to the social, emotional, cultural and political environment. This is what I understand Probyn (2004:329) to be calling for in claiming a deeper respect for ‘what bodies do and say as they inhabit everyday places’. In the NMP the causes of the person’s symptoms are not seen as separate from the broader sociopolitical context. As Green (1994) emphasises, often the symptoms refugees experience are not curable or fixable, but rather, the person requires an approach that allows for respite and renewal in the context of experiencing ongoing life-pain (physical and emotional). This was expressed by Faduma:

I feel very tired and body ache and much nervous and even sometimes I don’t even want to get up from the bed, because I feel bad. My kids come and say ‘mummy, mummy, do this one do that’, and I can’t get up from the bed, my body feels tired and when I come to Lucy for massage and herbal [remedies] they work, I am happy now.

Probyn’s (2005) reconsideration of habitus is a clear example of what Hillier and Rooksby (2005a:14) suggest are the ways in which Bourdieu’s original work on habitus has now evolved to incorporate a greater capacity for individual agency. This development paves the way for the concept of habitus to be theorised and applied in broader ways than was previously possible.

Taking up this possibility, Hawke (2007:57–8) employs the terms ‘primary’ and ‘secondary’ habitus as a way of framing the multiple and evolving nature of habitus. She takes up this qualification in her ficto-critical writing about her own experiences and those of Australian expatriate women in Greece and the reverse experience of Greek women apatriated to Australia. Drawing specifically on Bourdieu and Probyn’s work, Hawke (2007:57–8) makes the distinction between what she terms ‘primary habitus’ – second nature knowledge, and ‘secondary habitus’ – acquired (and then inscribed) knowledge that develops in a new set of circumstances:

Bourdieu talks about habitus as the active presence of the past, and those non-discursive elements inscribed in the body. We all have a ‘primary habitus’ born of social, cultural, class and gender informants, deeply embedded in us, not just psychically and socially but in a very embodied sense. To succeed in a new
place ... involve[s] active adaptation in all these areas. Some academics have taken up Bourdieu’s work further and allude to a mutable habitus ... or as I suggest, a ‘secondary habitus’ when such a significant cultural or social shift takes place. But I argue that the primary habitus lurks intact but deferred beneath skin presenting itself at odd moments that demonstrates Elspeth Probyn’s (1996) notion of ‘outside belonging’ (Hawke 2007:58).

Following Probyn’s (2004; 1996) theorising on the body, Hawke (2007) explores this interplay of habitus in the context of how we adapt within a different cultural landscape. In this analysis, Hawke (2007) also echoes Dovey’s (2005:318) sentiment, that no matter how familiar we become in a new place, ‘the deep structure of the first habitus is never quite erased.’

There is an interesting distinction between Friedmann’s (2005) and Hawke’s (2007) ideas of habitus. While Friedmann (2005:318) argues that the habitus can ‘breakdown’ in the migratory experience and the development of a new habitus is thus required, Hawke (2007:58), argues that the primary habitus remains intact and ‘lurks beneath’ the surface. Hawke’s (2007) position thus suggests that it is possible for the habitus to remain subterranean, resurfacing in certain situations. I argue that in this project, it is, to use Hawke’s (2007:58) language, the women’s primary habitus lurking beneath their skin which readily and positively surfaced in the NMP because they experienced this place as safe and supportive. The NMP became a healing place.

In the NMP, the women’s primary habitus, their embedded herbal knowledge was affirmed, demonstrating their experience of being in-place. Unlike in the biomedical setting, in the naturopathic encounter the women were safe to respond automatically from their primary habitus. They did not have to use an acquired secondary habitus. Or, in Friedmann’s terms, they did not have to develop a new identity in order to fit in. This is an important point that differentiates experiences in the naturopathic encounter from the biomedical consultation. For many refugees, in order to fit into their new cultural contexts they often have to suppress or moderate the habitus, the second nature ways of being in the world. However, in the NMP and the interview encounter the women’s habitus is given legitimation and they are not compelled to suppress this aspect of themselves; they can as Probyn (2005:49) suggests, feel ‘at-ease’.
Chapter 7: The naturopathic meeting place

As Frasa said:

*I appreciate this moment, I am very glad for this moment to be speaking with you in this environment. I am very glad you felt my feelings … when you are speaking with me, I feel relaxed and I’m feeling very comfortable.*

In the NMP it is the emerged habitus that resonates with this aspect of the naturopath’s habitus and this connection, I argue, facilitates the experience of being at-ease. The experience of being in place and at ease is of course particularly significant for refugees who are often characterised by feeling out of place in unfamiliar cultural landscapes.

**Resonance of habitus**

Building my argument for the in-place-ness of the women’s habitus in the naturopathic encounter I argue that there is a dynamic engagement between aspects of the women’s and naturopaths’ habitus. I call this a ‘resonance of habitus’. For some women this resonance was directly related to the experience of sharing traditional knowledge with their naturopath – their primary habitus, their embodied traditional medicine knowledge was validated in the NMP. For the women with no history of using traditional medicine in their home countries, the resonance of habitus experienced in the NMP was generated primarily through the experience of the refugee body being heard and attended in the NMP, as was the case for all the women I interviewed.

The resonance between aspects of the naturopaths’ and the women’s habitus created a bridge between past and present. There was an ease of connection between the women and the naturopaths which is enacted through their shared cosmological understandings. It was therefore possible to move beyond the cultural, social, class, economic, language, religious, and gender (one naturopath is male) differences, as well as their vastly different embodied histories as women. In this meeting place it was possible for a bodily communication between the naturopath and the refugee woman to occur. The concept of habitus is thus a useful analytic tool to explore the naturopathic encounter, particularly the relationship between the individual and society. As Bourdieu (1990a:91) states, it is a:
Chapter 7: The naturopathic meeting place

[Product of individual history, but also ... of the whole collective history of family and class, in particular, experiences in which the slope of the trajectory of a whole lineage is expressed.

‘Familial habitus’

To develop my argument that a resonance of habitus existed between the women and the naturopaths in the NMP I further draw on Probyn’s (2005) analysis of the feeling body. Probyn (2005:126) uses the term ‘familial habitus’ in her investigation of shame in the everyday to question:

[The manner in which we may inherit a capacity for being interested in ways that open us up to shame. Does my shame in relation to my grandmother relate to a similar structuring of shame within the familial habitus?]

In a sense Probyn is asking whether it is possible to inherit certain dispositions: in her project she is questioning the prospect of inherited ancestral shame. In my research, I take Probyn’s (2005:126) term ‘familial habitus’ and reconsider it from the perspective of the women’s connection to their traditional medicine knowledge. I suggest that these women had a ‘familial habitus’, which included a disposition of knowing about herbal medicines. This knowing came alive in the NMP and in the interviews when the women told stories about the traditional medicine practices in their home countries. Often these stories were intimately linked with relationships with mothers, aunts and grandmothers, and were inseparable from their sense of self and cultural identity, for example:

*My mum, actually, she learnt this part of the herbal therapy from her mother. Her mother was the best and my mum actually got from her mother [the knowledge] and she got a special box, with tiny little boxes inside that hold different herbs inside of the box. And my mum actually give herbs to the people and the people actually get well very quickly (Frasa).*

And as Sita explained:

*We do have herbal medicine everywhere and there is nothing strange about it to go and get those herbs. Most people would rely on herbal medicine, for example for people who are experiencing hair loss, instead of conventional medicine they would rely on natural*
There are lots and lots of herbs grown in Iran. We have so many kinds of herbs and spices. I mentioned turmeric, and there is a larger version of that which is called ‘marigberger’. There is one called ‘gulgadsaban’. This was extremely helpful for heart problems, headaches and also tension. I was using that myself. That is how it is in Iran, there we have different plants that they use for different issues or problems.

As refugee women, dealing with the complexity of unfamiliar circumstances, there are few places outside the privacy of the home in which this aspect of their habitus can be easily revealed. Yet in the NMP the women’s embodied familiarity with herbal medicines can be unguardedly expressed. It is in this place that positive memories of home are evoked and the women are able to connect the past with the present. I argue that it is in making this connection that the opportunity for healing is actuated. Quite literally, in the naturopathic encounter the women were enveloped by the familiarity of herbs: the smells of herbal remedies, pictures of herbs on the walls, and the naturopaths’ conversation about using herbs. These women described feeling immediately at home in this recognisable space, for example:

*I feel very good the day I have appointment with Kate ... As soon as I get into this room and sit in this chair, I feel good. I feel relaxed, I feel very free, ease every pain from my body, I feel completely well (Frasa).*

It is clear that for the women who had a strong and significant, even soulful, connection to the traditional medicine practices of their home countries, this aspect of their habitus found a home in the naturopathic space. I argue the familial habitus was evoked through the naturopathic encounter. It was this deep sense of recognition, of feeling at home, that generated the feeling of being at ease, being in the right place in the naturopathic encounter. To take up the philosopher Casey’s (2001:688) argument, the women embodied ‘traces of the places’ of healing through their connections to home, mother and local knowledge and these were now evoked in the NMP.

Developing this discussion, I employ Probyn’s (1990) work on notions of local knowledge. Exploring ideas of the ‘local’ in feminist critique, Probyn (1990) challenges the embedded power structures inherent in knowledge generation by illuminating the hidden voices of what she terms the ‘subaltern’. Here Probyn (1990:188) refers to the voices of women who
are literally in a subordinate position, those who are ‘excluded and not legitimized’. Through an exploration of the concepts of locale, location and local, Probyn ‘consider[s] both the construction of sites and the methods of researching sites’ (1990:177), in order to deeply challenge ‘epistemological questions of what constitutes knowledge: of where we speak from and which voices are sanctioned’ (1990:178). In this way, Probyn is questioning the ‘ways in which women’s practices and experiences have been historically dismissed as local’ (1990:178).

This concern is also highlighted in Dyck’s humanistic geographical research (2003) which explores health and the everyday experiences of South-East Asian migrant women. It demonstrates that for many refugee women local cultural knowledge forms an important part of their identity, and I would argue, their habitus (See also Bodeker, G. et al. 2005; Neumann & Bodeker 2008). Dyck’s research (2003) shows that using Desi medicines (home remedies) was an intrinsic part of these women’s identity and ways of inhabiting the world. Dyck (2003:8) argues that migrant women’s ability to keep healthy is ‘closely related to place’. In this way, access to traditional medicines is empowering and enables place-making.

Local knowledge is mostly invisible, yet when given the opportunity to speak about traditional healing practices, the women in Dyck’s (2003) research, and in mine, spoke knowledgeably of home remedies, the use of herbs and spices and foods:

*There is a particular flower and they make a tea out of it. It released the tension and it is use for nerves and calming. And the oil of mint, which is called ‘atta’ … and this is used for stomach problems. And the rosewater, or ‘atta of roses’ is very good for heart (Raza)*.

*We used saffron most of the time … it has a positive effect on your mood, it makes you be happy (Sita)*.

From the findings of this research, herbal medicine and herbal knowledge was the domain of women within the context of their families and communities. It was family medicine. For most of the women in their home countries, herbal knowledge was considered a form of local knowledge. In Probyn’s (1990) feminist critique, women’s local knowledge is mostly delegitimised and excluded from the mainstream. Significantly however, most of the women
I interviewed described how their local herbal knowledge was respected and endorsed within their families and communities, and in some cases, by their biomedical practitioners in the home country:

\[
\text{[Mum] was also very experienced, although she only studied to grade five, but she was very good at midwifery and they wanted her to go to the villages and other places where the newly trained midwives were, so that she could see over them. Even though she hadn't studied, she was so good at it they wanted her to be like a supervisor. She would look at the women and say 'she needed caesarean' or tell the doctor 'no, she doesn't need caesarean she can have a normal delivery'. Mum was very clever (Rosa).}
\]

Thus the women came from a social structure that legitimised herbal and other traditional medicines. It was not marginal in the way that it is in most Western countries. The significance of the naturopathic encounter for these women was that they not only had access to herbal remedies, but that this important part of their identity was respected and validated in the experience of consulting with the naturopaths who also highly valued herbal knowledge and practice. In a scientifically dominant medical culture such knowledge is predominantly perceived as less relevant, less important. Probyn’s (1990) point that local knowledge is mostly dismissed as not legitimate is clearly demonstrated in a mainstream refugee, cross-cultural health context where the local knowledge of herbal remedies of these refugee women (clearly subalterns) is mostly disregarded by biomedical authorities in the Western countries of resettlement (for example, Gronseth 2001). From the findings of my research the women’s knowledge was highly valued by the naturopaths. The place then of naturopathy at Foundation House in these women’s lives becomes even more significant in validating local, subjective knowledges which, I argue, in turn generates a sense of wellbeing for these women.

In the context of the NMP I posit that this sense of wellbeing can be further conceptualised as an embodied sense of ‘home’. Metaphorically, I suggest that the women are describing the feeling of coming home, where they no longer feel self conscious, but rather, aspects of their habitus are at ease in this familiar and comfortable place. The women’s stories tell of what home was like for them before the upheaval of becoming refugees. For these women, traditional medicine took place in the home, in the feminine, domestic space (for example see Neumann & Bodeker 2008). In this way the NMP evokes these women’s memories, both
in the body and the environment. The NMP is recreating this sense of home through smell, place, interaction, deep caring relationships, and comfort. I would suggest in no other Western therapeutic encounter does this form of interaction take place.

**Being in-place**

(S)pace presses against our bodies, and of necessity touches at our subjectivities (Probyn 2003:294)

The women’s narratives of traditional healing practices in their home countries and their recent experiences of renewal in the naturopathic encounter, in part, give voice to Malkki’s (1995a) argument, discussed in Chapter Three, that identity, culture and traditions are potentially transportable. In Probyn’s terms the familial habitus is transportable. The vitality inherent within the women’s stories attests to the strength of their familial habitus and their ability to maintain identity and culture in the naturopathic encounter. This supports Warner’s (1994) contention that ‘home’, for refugees, does not necessarily equate to one’s country of origin, and is very often experienced in the country of resettlement or exile (see also Kibreab 2004).

Place, as described previously by Dovey (2008) is connected to identity, community and home. This perspective disrupts the notion of place as fixed to a geographical locale, immovable and static. Rather, place can be evoked by memory and activated through meaningful practices. Dovey is suggesting therefore that if place, aligned with the experience of home, is transportable, then place and home can be generated in other contexts in which meaningful connections are made. Taking up the notion of ‘place attachment’ described by Low (2003), a space is transformed into place through shared culturally meaningful symbols. This may include ‘cultural beliefs and practices that link people to places’ (Low & Lawrence-Zuniga 2003:165).
From the findings of this research, I argue that place-making occurs in the naturopathic encounter with the familiar aromas (herbs and oils), pictures of herbs on the walls, homely atmosphere and shared cosmological understandings about health and healing between the naturopaths and the women. Place is created in the naturopathic encounter if/when this engagement is meaningful to the participant – when a resonance of habitus exists:

Because I lived for such a long time with my mum and I got experience from my mum ... My mum raised her 10 kids and she was the family doctor. She was giving the traditional treatment first ... Whatever happened to me, I would just contact my mum, and my mum always treated me and I received the treatment very quickly. Even when I speak with my mum, the actual conversation give me the comfort ... And now Kate gives me some more teas and they are very useful for me. Kate gives me almond oil mixed with other oils and when I have aching knees I rub it in and even my son, when he feels aching, I rub it in and he feels well very quickly (Frasa).

In this way, the significance of the naturopathic encounter is as an intervention that fosters place making because it creates an opportunity for this aspect of the habitus to be freely expressed. Feeling in-place and at home, facilitates wellbeing (Dyck 2004) and moves a person towards the ease end of the ease/dis-ease continuum (Antonovsky 1990).

As explained by Sarup (1998) and others, culture and tradition are not static or imprisoned by borders or within territories. Described in their narratives, the women brought their culture/traditions into their new country of resettlement. For some, like Lani, this was quite literal in that she carried precious dried herbs with her from her home country. For most, attachment to their healing traditions was firmly in place as embodied knowledge. As Sita described:

We use turmeric and another spice called ‘amala’ and that is the dried skin of lemon. You would dry that and turn it to a powder ... I’ve got some would you like to have a look at it? ... we use saffron most of the time ... it has a positive effect on your mood, that it makes you be happy ... we have so many different kinds of herbs and spices ...

For Frasa, embodied knowledge was deeply connected to her mother:
We got a little farm and [mum] grew some special herbs and the rest of them that she couldn’t find from the farm she got from the shop. There was a special herb, like mint, not mint, but brother of mint, I don’t know what you call it in English. It was very useful for all stomach pain and problems, for the intestine pain and problems, even for the haemorrhoids.

In this sense place can be fluid and embodied and therefore movable. Thus it is possible for displaced people to make place in new countries, given the appropriate contexts. Within Foundation House’s original rationale for implementing a natural therapies program, described in Chapter Five, was the understanding of the importance of ensuring that clients could access culturally meaningful approaches to health care, and thereby feel more at home in their new country.

Refugees lose their homeland when they flee. They lose their sense of place if in exile/country of resettlement (or country of origin) they are unable to express their cultural identity, experience a sense of community, or generate the feeling of home because their ‘otherness’ precludes them from being accepted, if their difference is not ‘permitted to intrude [into a] purified place’ (Dovey 2008:85) – such as in the biomedical setting. However, in ‘places of difference’, defined by Dovey (2008:85) as ‘sites for new spatial practices, for the production and performance of new identities and cultures in everyday life … [and which] … give voice to the displaced’, such as the naturopathic encounter, I argue it is possible to ‘make-place’ and therefore feel in-place/at-ease/at home.

The women in this research project did not lose identity/culture/tradition by virtue of crossing a geographical border (Malkki 1992). However, as a marginal/minority group, their position in their new country is not necessarily safe; in certain contexts their space is constantly challenged and thus feeling in-place is not guaranteed. For example, when many refugees go to the doctor, who does not understand their culturally different notions of health, they lose cultural identity and in this process, are delegitimised for their difference (Weerasinghe & Mitchell 2007). As Frasa explained:
They are very surprised, the Eastern people, they are very surprised when they go to the doctor to receive treatment, as the doctor only gives the prescriptions and then says go home. I wish, it is my desire, that the doctor says to me, eat this it's good for you, don't eat this it is not good for you. It is my desire that they say this.

Theoretically, place making appears straightforward provided there is cultural relevance within the particular contexts. However, in practice, as described by Frasa, creating culturally meaningful situations is problematic. This is particularly evident in relation to health care for refugees in Western countries of resettlement (Gronseth 2001), or in host countries (Neumann & Bodeker 2007) where the dominance of biomedicine within global refugee health care has displaced traditional medicine beliefs and conceptions of the body. This issue has become a central theme in this thesis. I argue the NMP offers a significant therapeutic strategy for addressing this dissonance in a Western context. Similarly, Neumann and Bodeker’s (2008) research investigating traditional medicine clinics on the Thai-Burma border demonstrate the benefits of providing culturally meaningful health care in a refugee camp context.

I argue that cultural identity, embodied knowledge, a sense of home – the intricacies of one’s habitus – are transportable. The women realise the transportability of their cultural identity in the NMP and it is here that place-making is actuated. Into the NMP the women bring their habitus imbued with cultural meanings and knowledge(s) including their embodied knowledge of traditional medicine. They also bring what Hawke (2007:58) qualifies as secondary habitus – acquired and then inscribed embodied knowledge that is born out of a new set of circumstances – what is learnt in order to survive in an unfamiliar situation. In this context, the women bring their biomedically delegitimised bodies into the NMP where they are now able to be validated. It is in relationship with the naturopath that a reflexive experience occurs in which the women are able to reveal their primary habitus.

Thus the women’s identity is not necessarily lost on leaving their homeland. But sustaining cultural difference within a dissimilar dominant culture does create a tension. Fitting into the mainstream requires modification of habitus, or developing a secondary habitus. I argue that
the NMP offers a coherent transitional space between past ways of being in the world and the necessary adjustment into the new, and at the same time, legitimises and validates the primary habitus.

In sum, I take ‘place’ to be the space in which the primary habitus experiences feelings of being at ease and at home. It is subjectively defined by lived experience, and as embodied knowledge, it is transportable. In the context of the women’s experiences the naturopathic space, imbued with particular meanings, was transformed into place. For many of the women, this place then came to symbolise aspects of home. Offering a different perspective on this theme, cultural studies scholar, Baden Offord (2002:5) argues that:

[T]he human being is the meeting place or confluence, of a range of diverse and complex narratives that are inscribed through the knitting together of discourses of belonging, identity and participation.

The women actively participated in the NMP (and the interview encounter) creating a meeting place in which they experienced a sense of belonging and strengthened their ability to not lose certain important parts of their cultural identity. This I argue enhanced the women’s sense of being at home.

‘Genetic knowledge’: Being ‘at-ease’, being ‘out-of-place’

[T]he body becomes living proof of all that we have experienced … [o]ur bodies continually speak of their pasts in everyday actions – gestures, manners, and small ways of being and inhabiting social space. Habitus delimits how we can move and in which spaces we can move (Probyn 2005:49).

Importantly, some of the women did not share a familial connection to traditional medicine practices. In their home countries, these women had not been acculturated to traditional medicine practices, and thus it was not part of their habitus. Yet, these women described remarkable experiences of healing in the naturopathic encounter. Thus, the notion of familial habitus cannot in isolation elucidate these women’s experiences of feeling at ease. In these
stories, I suggest that the women’s experiences can be understood using Probyn’s (2005:126) notion of ‘genetic knowledge’\(^\text{10}\) that describes an aspect of habitus that is a form of bodily knowledge that lets us know whether or not we ‘belong within a certain space’ (2005:49).

Put plainly by Probyn (2004:334), ‘our bodies seem to know when they are at ease in a situation, when they know the rules and expectations, and conversely they also tell us loudly when we are out of our leagues…’. The women I interviewed experienced a level of bodily knowing in the NMP that generated a feeling of being at ease in their bodies in that setting. Probyn names the body’s awareness of being ‘at ease’ (2005:49) or ‘out-of-placeness’ (2005:50) as ‘genetic knowledge’ (2005:49) – as embedded ways of inhabiting the world. I suggest that the women’s experiences of renewal in the NMP were due, in part, to the connection to their bodily genetic knowledge. The women felt at ease in the naturopathic encounter because they were able to ‘connect with [their] inhabited body, and its histories of place’ (Probyn 2004:333). And significantly, this was not dependent on past experiences of traditional medicine in the home country:

She [naturopath] feels with me, out feelings together get engaged with one another … Myself and my body are very happy to go to see Anna. I count the days to go and see Anna (Amar).

Through contextualising and theorising the notion of the body’s experience of being at ease and out-of-placeness, Probyn (2004; 2005) calls for a greater respect for the body’s voice in articulating what is often unspeakable. In the naturopathic encounter a space is created for the women to bring their bodies and for their bodily knowledge to be validated. In Probyn’s body-centred framework, symptoms are understood as an important communication of lived experience. In this way Probyn’s work (2005) is aligned with Scheper-Hughes and Lock’s (1998) overarching conceptualisation of the three bodies, and combined, I argue, they offer a deeper analysis of the women’s subjective experiences in this research:

... as soon as I am tense and worried, the pain in the shoulder becomes stronger … its just that I’ll picture all my children and grandchildren and I’ll miss them and that puts too much pressure on me and I can feel the level of the pain rising (Lani).

---

\(^\text{10}\) Probyn’s use of the term ‘genetic knowledge’ is metaphoric, used here to describe an embodied way of knowing. Probyn is not referring to biological determinism.
The emphasis on respite and renewal allowed Lani to bring her pain into the naturopathic encounter without the assumption that she would be cured. In the NMP the link between her life experiences and her physical pain was implicit. Similarly, in Antonovsky’s (1987) terms Lani’s pain could fluctuate on the health continuum, shifting between pain and respite in response to the broader sociocultural context. Thus Lani’s symptoms were legitimised and attended to in ways that were meaningful and validating:

*When I came home [from the naturopathic appointment] the old pain was a lie. It didn’t even exist, I was feeling so comfortable ... I still remember the experience of that first day that I received massage. From the time I came to Australia, I remember that was the happiest day I had ever had.*

Lani’s refugee body is at ease within the naturopathic encounter because her symptoms were validated and understood as part of the totality of the refugee experience. In other words, her life pain expressed through physical pain was not medicalised into a disembodied Western disease state. Furthermore, in the NMP it is understood that the experience of bodily distress was usually fluid, changing from ease to dis-ease according to the broader context of their lives.

Faduma described this connection:

*I really feel good, because I get nervous when thinking too much [about her sister], I always have neck, shoulder burning, when they give the massage, I feel better.*

Further extrapolation of Probyn’s (1990) views on local knowledge also informs an important expression of genetic knowledge. Here the women’s local or subjective knowledge about their bodies often represents the complex interaction between the lived experience of pain and symbolic representation of extensive sociopolitical suffering. This local knowledge about the body is often dismissed within a biomedical context as irrelevant and irrational, or at worst, part of a psychiatric condition. Probyn (1990:178) argues that:

*... the epistemologies that this [issues of the local] suggests most often works to fix the subaltern outside the sanctified boundaries of knowledge, determining the knowledge of the subaltern as peripheral and inconsequential....*
However, in the NMP, where legitimate knowledge of the body is not based on scientific rationality, psychosomatic bodily experiences tend to be validated:

*The level and care and attention I received from Kate [naturopath], I never received from conventional doctor. Like she pays attention to my concerns (Sita).*

*When I have constipation I feel my pressure is high ... and I have headache ... I was taking doctor’s medicine but it was not enough for me ... I feel better with Lucy [naturopath] ... when I talk to her she makes me comfortable and she tries to help me, not just to give me herbal medicine, but she tries to find out what my problems are, how can she help me (Mary).*

Within the biomedical system, treating the non-pathologically diagnosable body or non-biomedical body is problematic. It reveals biomedicine’s inability to adequately address health problems that do not fit into disease categories. In a biomedical context it is difficult to claim a space for the undiagnosable body/symptom because the underlying assumption is that all disorders have a specific biological cause. Presenting as a whole body, in the naturopathic space, is a different project from presenting as a categorised symptom in the biomedical context. Antonovsky’s (1987) theoretical work reflects these differences and he calls for broader conceptualisation of health and dis-ease. He states that ‘all human distress ... always has a psychic ... social ... and a somatic aspect’ (Antonovsky 1996:11). Similar to Scheper-Hughes and Lock (1998) who also note the embedded dualism in health-related discourse, Antonovsky (1996) is quick to caution against classifying people within dualistic categories, as such concepts do not address the broader complexity of people’s health concerns. Mary captures these sentiments when she describes her distress:

*I thought I had physical problems in my body. But after I did everything [all the medical tests] and they told me I have nothing, I have no problem in my body ... Maybe the sadness attacks my stomach ... sometimes when I think about past problems, I feel headache, I feel stomach pain ... the stomach talks ... But when I relax, I try to forget everything. I say this is my fate ... I take the herbal medicine and I feel better ... Because it is out of my control. I am thinking about the past, and my stomach is tied up ... you can’t separate [mind and body].*
Chapter 7: The naturopathic meeting place

The NMP gave Mary the space to talk about her stomach pain from a psychic, social and somatic point of view. The language that she used to describe her symptoms had very little relevance within a biomedical context. As her medical tests showed, pathologically there was no logical reason for her pain. Thus her pain, her sense of self, had been delegitimised and decontextualised in the biomedical setting. However, in the NMP where health and ill health are conceptualised on a continuum, and space is created for the refugee body, legitimising the multifaceted nature of the physical distress of many refugees. Like Mary, many of the women felt unheard and dismissed in the biomedical encounter. In the NMP where emphasis is on attending to the body’s voice, to provide respite and renewal, not cure, the women have the space to make sense for themselves about what is going on.

Contrasting the women’s experiences of renewal and healing generated in the naturopathic setting are their encounters with Western biomedicine. For many of the women, the biomedical space generated feelings of ‘out-of-placeness: what happens when a body knows it does not belong within a certain space’ (Probyn 2004:334).

Probyn (2004:330) argues that although it is difficult to describe the ‘body’s movement and feelings’ in a sociological framework, in the process of story telling the experience of the everyday is made available. The women’s stories generate an everyday knowledge through their subjective experiences, creating what Bourdieu (1990a:131) argues is central to the habitus, ‘a world of common sense, a world that seems self-evident’ and which for many refugees is buried in the upheaval and dislocation of the refugee experience. The refugee experience/or refugee-ness then becomes the lived experience of out-of-placeness and, I argue, the NMP becomes the place of being in-place where the primary habitus is not taken over by the secondary habitus. Furthermore, I argue that it is the suppressed primary habitus which may create the feeling of out-of-placeness for these women who are already dislocated by the refugee experience and by resettlement in an unfamiliar country. Probyn (2005:49) describes this as a feeling of being uncomfortable within one’s skin, like a ‘fish out of water’.

The women’s narratives demonstrate that the NMP, as a place of non-biomedical conceptions of the body and notions of health, was a critical factor in their experiences of feeling at ease. In the NMP the women and the naturopaths shared what I describe as a ‘reconfigured cosmology’. It became a place where different traditional healing knowledge(s) could
harmoniously exist, creating the conditions in which it was possible for a broader scope of ‘explanations of sickness’ (Kleinman, Eisenberg & Good 1978:252) to be expressed and where treatment of ill health was not limited to a biomedical framework. This is an example of what Englund (1998:1172) is calling for in suggesting that Western approaches to refugee health care need to move beyond solely discursive interventions and attempts at creating an artificial set of traditional practices, but rather, need to ‘create conditions under which vital existential and aesthetic orientations can be realized’.

Rather than being a prescriptively shared explanatory model, the significance of the naturopathic approach in this context is that it is ‘treating the human experience of sickness’ (Kleinman, Eisenberg & Good 1978:252), rather than a named disease state. Particularly relevant within refugee health discourse, Kleinman (1987:252) claims this is the principal concern of traditional healing practices in both Western and non-Western societies.

In the refugee experience of dislocation and disembodiment, the experience of feeling at-ease is metaphorically synonymous with experiences of coming home through re-engaging with their bodies. Symbolically, the women’s narratives convey a ‘coming home to my body’ where the body’s knowledge is taken seriously and where the body can be at one, even if it is in pain. Unlike the biomedical setting, in the NMP there is legitimacy for the body to be in pain and at-ease concurrently. In the NMP the women do not have to get better in biomedical terms. What is important is that they feel better – and this is clearly expressed in their narratives.

**Summary**

In this chapter I have theorised the movement from naturopathic encounter to naturopathic meeting place to the concepts of space, place and habitus in relation to the refugee experience. As a theoretical construct the NMP has enabled me to link the emergent themes from the women’s narratives with different theoretical lenses and thereby deepen my analysis of the naturopathic encounter. This discussion is framed from a salutogenic (Antonovsky 1987) perspective that understands the importance of linking past with the present in order to envisage a future. This connection, I argue, is essential for a genuinely embodied analysis.
Weaving Probyn’s (2005; 2004) reconsideration of habitus and theories on place with the women’s voices, I have brought together my analysis of what it is about the naturopathic encounter that generated such remarkable experiences of healing for these women. Probyn’s work significantly contributes to the lineage of knowledge that continues to contest, expand and influence the way habitus is understood and applied by different scholars.

From a salutogenically informed understanding of the women’s experiences of respite and renewal in the NMP I have identified two interwoven themes. First, the women were able to make meaning of their refugee bodies; they were treated as a ‘whole’ person, rather than as a disease or symptom. Their body’s voice was heard and attended to within an approach to health care that made sense to them. Second, the NMP characterised by the shared cosmology and resonance of habitus, created a relationship where the women felt at-ease and in-place. The experience of being in-place enabled the women to create a bridge between the past and present which allowed them to feel more at home in their current situations. By feeling in-place and making the connections between past and present, I argue, the women were able to envisage the possibility of a future.
CHAPTER 8

‘She made it feel like I’m in my home’: Concluding discussion

The beautiful pictures and the smells of oils are very relaxing environment. I feel very good the day I have appointment with Kate, the day I know I am coming towards this centre, I feel very good … I feel very free, ease every pain from my body, I feel completely well … As soon as I come to sit in this room, I think about my children and my husband, how they suffer if I’m sick … And I think to myself, thank God, everything is getting ready for me and I’m getting better (Frasa).

In this thesis I have examined the space of the naturopathic encounter through the concept of the naturopathic meeting place (NMP). I have argued that in this transitional space the women I interviewed were able to make sense of their pasts, through their present bodily experiences, and were thereby in a position to reconstruct a future. The NMP can be understood as a space in which these women were able to experience a ‘re-placing’ in terms of geography, social connections and embodiment, without losing important aspects of their past identities. In the NMP, past ways of being in the world – aspects of their habitus – were legitimised and validated by the naturopaths, enabling a sense of continuity and incorporation in the new resettlement context.

For many refugees, the challenges embedded in the resettlement process continue life-long and even transgenerationally. I began the thesis with my family story of transgenerational loss and dislocation embodied in the metaphor of inherited blindness. The lens of embodiment
theory and the concept of habitus literally and metaphorically opened my eyes to a deeper understanding of my family’s experiences of displacement. In Bourdieu’s words (1995:35), it was my ‘forgotten history’ which inevitably intersected with the present – my early onset glaucoma – and, as I reflected, also engaged my sense of identity as the daughter of Holocaust survivors. With this understanding comes a sense of resolution and acceptance – an awareness of finding my place in my lineage and connecting me with what the storyteller Arnold Zable (2002 foreword) calls ‘the missing links in the ancestral chain’.

I begin this final chapter by revisiting Frasa’s story from Chapter One and weave together the central theoretical concepts that I have drawn on in my analysis of the participants’ experiences in the NMP – as inherently about fostering the feeling of being in-place in the resettlement context. As I have discussed throughout this thesis, a person becomes a refugee when they lose their sense of place (but not necessarily their homeland) and are no longer safe. I argue that the concepts of place and ‘refugee-ness’ are thus intrinsically linked and critical to the healing process.

**Frasa’s story revisited**

The use of herbal remedies and certain foods to treat her family was embedded in Frasa’s everyday experience. She learnt the craft from her mother, who had been trained by her own mother. As a *traditional doctor* Frasa’s mother had effectively treated her ten children and others in the community from the herbs she had grown and harvested at her small farm. This matriarchal lineage of herbal knowledge and practice was embodied in Frasa’s sense of identity as a woman and as a mother. Generated by the practices and rituals of everyday life over the generations, herbal wisdom was second nature to Frasa.

Integral to her sense of self, Frasa was resolute in her belief in herbal remedies. She was pragmatic in her understanding that traditional medicine and biomedicine work well alongside each other. As I quoted in Chapter One, *I received both. Traditional treatment from my mum ... when it was a serious matter I would attend the medical doctor.* Her conviction was strong enough for her to oppose her mother-in-law and her husband. Frasa explained to me that when she married and moved to her husband’s family, her
mother-in-law opposed her traditional ways and took her children to see doctors at the hospital where she worked as a nurse. The doctors gave *injections and medications and antibiotics that made my children weaker and weaker*. With time Frasa not only gained the courage to defy her mother-in-law by treating her children with traditional medicine, but she also managed to educate her into the benefits of herbal remedies. *I just treated my children by myself and they got better and better. And my mother-in-law became convinced with my way of treating my children and my mother-in-law is now convinced that herbal therapy is the best.* Within the social structures of a traditional Afghani family, for a daughter-in-law to challenge her husband’s family takes strength and courage.

In the naturopathic space at Foundation House, with the familiar smells and the talk of herbal remedies, Frasa’s immediate sense of ease was possible because she was instinctively comfortable in this setting. I have argued in this thesis that the atmosphere of the NMP linked Frasa to positive memories of her past – memories and feelings that enabled her to carry a sense of self and place with her into the present resettlement context. It was possible for Frasa to make these connections because she was able to respond from her habitus – from the second nature part of herself that was deeply connected to her familial lineage and to the traditional medicine of her home country. In the NMP she had a bodily sense of being at-ease because she was free to respond from her habitus. Her bodily knowledge, which Probyn (2005:49) refers to as ‘genetic knowledge’ let her know that she belonged in this space – *I feel very free, ease every pain from my body.*

I have argued the significance of having a sense of place and the feeling of belonging in a refugee resettlement context. A sense of place often refers to places that hold meaning. It describes an existential quality that includes aspects of one’s identity and connection to loved ones – often it is represented as the notion of home (Kenworthy Teather 1999). It is this personal sense of home and the feelings of being in-place and of belonging that are often at stake in the process of becoming a refugee. For Frasa this was exemplified in the loss of her homeland, her family, her social networks and her health when she fled Afghanistan. Like so many refugees, Frasa is appreciative of her
new life and at the same time she is painfully aware of her challenging circumstances. 

*God has given us food, clothes, house. But our family is not here. My children they have no one here, no uncle, no aunty, no grandparents, nothing.* Understanding the importance of social relationships in creating a sense of place and belonging, Frasa has worked hard to create this for her children.

When Frasa first arrived in Australia she was unwell. Her ill health was intrinsically linked to her experiences of loss and displacement. She had sought medical treatment which was unable to effectively treat her symptoms, and in fact made her more distressed. For many refugees, the inability of biomedicine to explain the physicality of their symptoms is a common and often distressing experience and is one of the main reasons for referral to naturopathy at Foundation House. Frasa’s refugee body – the representation of her physical, emotional, social, political and even metaphysical (spiritual) distress could not be attended to in the biomedical setting. Her pain did not fit biomedical categories – it was ‘liminal: that which is neither this nor that, and yet is both’ (Turner 1964:99). Frasa was fearful of becoming addicted to pharmaceutical medications and she was frustrated that her GP did not prescribe her a diet based on humoral principles. After the birth of her last child she felt isolated as there was no one to assist her with the particular dietary requirements postpartum. Frasa felt ‘out-of-place’.

In contrast, she experienced being in-place in the NMP. *I have hope and good feelings.* This thesis has charted Frasa’s transition from her original medically plural environment in Afghanistan, to a biomedically dominant context in Australia, and her return to a plural setting which included naturopathy medicine, at Foundation House. In the NMP, Frasa was able to transform her pain and distress. She was able to make sense of her body. She was not alienated because of her different conceptions of health and illness. She could respond instinctually – she did not need to rely on a secondary habitus (Hawke 2007) – an acquired way of being – in order to be accepted and to feel that she belonged.
Turner (1964) argues that liminal spaces hold the opportunity for transformation. I suggest in the NMP Frasa was able to transform her refugee body – the embodied loss and displacement represented as physical symptoms. She was able to move physically and metaphorically beyond a liminal state of inbetweenness to experience a re-placing, a grounding in the present. She expressed this by saying I think [Kate] gives me a second life. This feeling of having a ‘second life’, I argue, was possible because she had a sense of place which was generated by the relationship with Kate and by the validation of her refugee body in the NMP. Frasa’s sense of place was re-grounded in a new setting:

As soon as I come here, I feel, actually before Kate starts to treat me, as soon as I get into this room and sit in this chair, I feel good … all the feelings of tension go away from me …

The experience of feeling in place further enabled a meaningful and healing rite of passage in which Frasa’s biomedically undiagnosable pain (her refugee body) was transformed into valid and legitimate lived experience. In her encounter with Kate, her pain was understood and legitimised and thus she was able to feel at-ease and in-place in her body, and, in turn, in her country of resettlement. She now had a greater sense of coherence in her life as everything is getting ready for me and I’m getting better.

In this rite of passage the resonance of habitus generated between Frasa and Kate enabled Frasa to reintegrate aspects of her past, and as Antonovsky (1987) suggests, pave the way for creating the possibility for a future. Frasa experiences Kate as the most beautiful woman around the world … she is special to me. This therapeutic relationship creates the possibility for healing. Csordas (1996:11–12) suggests that the ‘therapeutic process is analogous to the idea of ritual process, the prototype of which is the rite of passage’. Metaphorically this rite of passage can also be understood as creating a pathway to finding a sense of place in her new resettlement country.

Frasa’s story illustrates the social aspects of displacement and loss through physical symptoms. Her transformation in the NMP is typical of the experiences of the twelve women I interviewed. In this rite of passage there was a bodily shift from being out-of-place to feeling in-place – to feeling at-ease. As I explored this transition in the data I began to question whether it was possible for these women, fluctuating between ease/dis-ease (Antonovsky
1987) on the health continuum, to experience pain yet to no longer identify as a refugee – when is a traumatised body no longer a refugee body? At what stage does Frasa cease ‘being a refugee’?

In contemplating these questions I propose that what the NMP offers is a grounding in the present by validating past practices and lived experiences. I suggest that in the NMP, even though the women’s pain might continue, a re-embodiment is taking place. Adams (2006:36) refers to this phenomenon as a ‘break in symptoms’ in that naturopathy is seen to potentially ‘interrupt chronic symptoms, thereby creating a [transformative] space where clients may experience themselves in a different way’. From a phenomenological perspective, embodiment in this sense implies bringing together of the disparate parts within the NMP. The body is no longer separate from self or from experience. A ‘shared intersubjective’ (Johnston & Barcan 2006:35) experience is created between the naturopaths and the women, and the space opens up possibility for transformation – for what Frasa calls a second life.

**Contributions of this research to refugee health care practice**

The healing process, like the resettlement process is an ongoing experience – it is not a static or discrete stage in a refugee’s life. Frasa’s story demonstrates the fluidity of the transposition from displaced to in-place through her bodily experiences in the NMP. The connection between place and wellbeing for immigrants (Dyck 2004, 2006) and for refugees in a refugee camp context (Neumann & Bodeker 2008) has been previously documented. However, in this thesis I have argued that the application of this understanding to a Western refugee health care service is unique. The thesis demonstrates that providing efficacious health care for refugees in Western countries of resettlement cannot be separated from processes that assist people to ‘find place’. I have critically explored the lived experiences of these women through their narratives of being in and out of place. I have argued that the NMP provided the grounding in which these women could navigate their way into a new place because they felt safe to draw on aspects of their primary habitus and their bodily knowledge was validated. The women’s experiences in the NMP are a testimony to the ways in which the naturopathic encounter generated the feeling of being at home – feeling in place.
According to Mignone et al’s (2007:21) research, the practice of ‘intercultural health’ care within Latin American communities led to the ‘revalorization of indigenous knowledge, cultural continuity and pride as a people’:

Intercultural health [describes] practices in health care that bridge indigenous medicine and Western medicine, where both are considered as complementary. The basic premises are that of mutual respect, equal recognition of knowledge, willingness to interact, and flexibility to change as a result of these interactions (Mignone et al. 2007:3)

Similarly, I have argued in this thesis that access to naturopathy at Foundation House significantly assisted in the process of place-making for these women. In this way naturopathy contributes to the development of ‘cultural continuity’ (Neumann & Bodeker 2007:199) within the resettlement context. The findings of this research show that one’s sense of identity, culture and community can be maintained and even enhanced by having access to naturopathy.

In the context of Foundation House the physical existence of the natural therapies program is immediately evident when arriving at the organisation. The naturopathic consulting rooms, with their aromas of essential oils and herbs, are the ones closest to the entrance of the building – they are not hidden or out of the way. The positioning of the natural therapy rooms is, I suggest, a tangible sign of the organisation’s public validation of the use of traditional health care approaches. For the clients coming to Foundation House, this stance assisted in bridging the gap between biomedicine and traditional medicine practices. It acted as a ‘cultural linker’.

The importance of traditional medicine knowledge and practice for many people from Middle Eastern, African, South-East Asian countries is well established (Bodeker, G et al. 2005). The 2007 Annual Report published by Foundation House shows that the vast majority of clients in this year were from Middle Eastern and African countries and included a high proportion of people from Burma (VFST 2007:6). Thus the significance of an intercultural approach in the practice of refugee health care in Western contexts creates greater opportunity for a more
efficacious health care system. It opens a door to an inclusive approach where difference is celebrated rather than disparaged. It enables a sense of continuity across and between worlds; it is the linking thread in the liminal experience of refugee resettlement.

In the broader global perspective the UNHCR states that the number of ‘people of concern’ increases each year (UNHCR 2007). The challenge is in finding holistic ways of healing for organisations like Foundation House and in the broader context of refugee camps (Neumann & Bodeker 2007). Although this is a small qualitative study it is instructive for other Western torture and trauma rehabilitation services and for people living in refugee camps. My study is aligned with Neumann and Bodeker’s (2008) current research into traditional medicine clinics on the Thai-Burma border which demonstrates the improvement in wellbeing for refugees when traditional medicine is practised alongside biomedicine. In this study I have shown that traditional medicine is not in competition with biomedicine, but offers a genuine complementarity. And, it supports the understanding of the importance of finding safe spaces through healing practices and rituals. I argue that this thesis gives voice to a hitherto under-researched area: the agency of refugee women and the place of traditional medicine and non-biomedical conceptions of the body in facilitating a healing rite of passage in the resettlement environment.

**Contributions to theory: Interdisciplinary research**

I argue that this research project contributes to interdisciplinary dialogue by extending anthropological, sociological and cultural studies theories into the field of naturopathy. In addition, the inclusion of naturopathy into refugee health discourse has imparted new understandings about the place of traditional medicine in refugee health care practice.

Currently, there is a dearth of published research by naturopaths. However, from my engagement with this field I am aware that in the last few years a number of naturopathic practitioners have taken up postgraduate studies from within disciplines that include sociology, anthropology and public health (for example Adams 2006; Thorpe 2006). As a result, there is greater potential to further develop the knowledge base within the naturopathic field, and to contribute naturopathically informed research to the broader literature.
Chapter 8: Concluding discussion

As I have mentioned, some scholars (Baer et al. 1998; Johnston & Barcan 2006; McKee 1988) have been critical of the tendency within areas of the naturopathic field to ignore the broader sociopolitical and environmental contributors to ill health. I suggest that the growing interest by naturopathic practitioners in taking up interdisciplinary research has the potential to address these concerns. As naturopathic scholars revisit notions of holism and vitalism, and apply different disciplinary critiques to the existing knowledge base, there is greater opportunity to move the debate beyond the current applications.

In this thesis I have drawn from the disciplines of cultural studies and embodiment theory to theorise the naturopathic encounter, and have employed aspects of humanistic geography as a contextualising strategy. Referring specifically to the notion of the ‘subtle body’ in particular alternative healing practices, Johnston and Barcan (2006:28) suggest that ‘alternative therapies have much to offer cultural analysis of the body’. I further suggest that these disciplines have much to contribute to the field of qualitative naturopathic research, as demonstrated in this project, in that they broaden the ways in which naturopathic philosophy and practice can be conceptualised.

As a theoretical model, Antonovsky’s work also has significant implications for the development of philosophically congruent qualitative and quantitative naturopathic research. As I have discussed earlier, internationally there is very little social science qualitative research investigating the practice of naturopathy (Baer 2006; Coulter & Willis 2007). By far the majority of research consists of quantitative studies, oriented by a pathogenic understanding to determine the efficacy of active constituents of herbs on named disease states. Most sociological research has focused on CAM and its engagement with biomedicine. One implication of my research is to introduce Antonovsky’s work to the naturopathic field, thereby expanding a sociologically focused approach to naturopathic inquiry.

From the findings of this research I suggest that Antonovsky’s salutogenic theory offers an important framework for researching refugee health, which has implications for the development of refugee health policy. A salutogenic approach enables a ‘shift of focus from refugee pathology to refugee health … [and thus] provide[s] exits from the reductionism of medicine and from the medicalisation of problems of living in society’ (Muecke 1992: 521).
As I write these concluding comments I have been informed that Foundation House has now increased funding for the natural therapies program by employing a new naturopath for a full-time position. This is the most significant increase in resourcing that the natural therapies program has received since its inception in 1989. The allocation of extra resources brings further validation and affirmation of the place of the natural therapies program within the organisation.

**Further research possibilities**

Since finishing this research, one other study has come to light – a Masters research project that investigates the experiences of naturopathic treatment for African refugees in Queensland, Australia (Ross 2007). Ross’ (2007) work further contributes to this field. As I reach the end of my project I am aware that the thesis has shown me that there is more work to be done. This rich and productive research ground has generated several recommendations for future research at Foundation House. First, I suggest it would be of value to investigate the experience and meanings of naturopathic treatment for male refugees. In my time as a naturopath at Foundation House I worked extensively with men. It has been noted in some of the sociological literature investigating the demographics of naturopathic use in Western society that the majority of people seeking treatment are women. However, in my experience at Foundation House, the gender ratio is at odds with this information. Certainly in my practice I consulted with as many men as women, and the men I treated embraced the opportunity for naturopathic treatment as readily as the women did, and were just as responsive to treatment.

Second, in order to complete the profile of the natural therapies program, I suggest a research project that would further investigate the experiences of the naturopaths. This would complement my project and the research conducted by Adams (2006) into the reasons for referral to naturopathy by the counsellors at Foundation House.

Third, in the naturopathic field there is a gap in research methodologies between qualitative methods that focus on experiences and those with a strong biomedical approach. I suggest that the next step for the natural therapies program at Foundation House would involve a quantitative research project, informed by the social sciences and philosophically aligned
Chapter 8: Concluding discussion

with naturopathic philosophical tenets. Perhaps Antonovsky’s (1987) work, informed by a salutogenic paradigm could be utilised in designing an evaluation of the natural therapies program.

Reflections on the research process

In this final section of the thesis I reflect on the research process, focusing on the unexpected experiences that emerged in the interview encounter. Many of the experiences that the women described in the naturopathic encounters were paralleled in the interviews – thus the interview space became a second meeting place. It was in this meeting place that the unexpected experiences and ‘ah-ha’ moments occurred both for me and the participants.

The women’s delight in my interest and respect for their traditional medicine knowledge became one of the rewarding experiences of the interviews. This was apparent in the interviews conducted in women’s homes where they brought out herbs and spices from their kitchen cupboards, explaining to me their medicinal properties. Often we shared information about our different experiences with particular remedies. In this way some of the women were able to make positive connections with the past through the interview process.

Amar was so enthused by my interest in her herbal knowledge that part of our interview was spent tasting and talking about the different herbal remedies she kept retrieving from her kitchen. Of particular fascination to me were the concentrated date paste and the pomegranate juice which she explained had many medicinal virtues. Interestingly, pomegranate has recently become popular in Western countries because of its antioxidant properties. The interview became a space for sharing knowledge:

Cinnamon, yes, for colds, boil cinnamon and for tummy aches and for woman after birth ... Also for the woman who has given birth we give the juice of dates which is very, very dark. It cleanses her inner organs

The day I went to interview Raza in her home she apologised for having a bad head cold, but was very keen for the interview to go ahead. By the end of our conversation Raza was inspired from talking about herbal remedies and remembering many of her mother’s recipes and she told me she was now was going to make up one of her mother’s remedies:
My mother used to make a soup with onions because they believe that onions have antibiotic properties and I am going to make it now. We also boil the turnips and have the water which is good for colds ... the sweet pumpkins, they are so sweet like honey, so they are good for sore throat and cough.

In another interview, Hati was excited by my interest in her experiences of using herbal remedies and she invited me to come with her to visit a local market where she had discovered an Arabic traditional healer who imported many of the herbs, spices and foods that were staples in her medicine cupboard. When some time later we went together to this man's shop, Hati took great pride in introducing us. It seemed that two important parts of her life came together in this meeting: the blending of old spices from the home country with her new experiences discovered in Australia.

In my interview with Rosa she revealed extensive knowledge and pride in Iranian traditional medicine. Rosa talked about the great Persian physician, Avicenna. Having studied the history of Western herbal medicine I was familiar with Avicenna and when I spoke about this Rosa was overwhelmed by our unexpected connection. With great excitement she told me that:

[T]raditional medicine [based on Avicenna's teachings] is called 'sonnat', and it [is] handed down in the family, in culture, it has been in families from generation to generation and passed on.

Frasa was heartfelt in her appreciation of our conversation about herbal remedies as this connected her with her mother in a profound way:

I am relaxed with you, that you like my mum, that you said that you wish my mum is here, this is very much a gift for me.

In the interview space most of the women felt an urgency to convey to me the importance of their naturopathic treatment. Many felt an imperative to communicate the beneficial effects they had experienced. By contrast, I suspect that the stories most refugees must repeatedly tell are their experiences of suffering and the circumstances that led them to their current identity as 'refugee'. However, in the interviews many of the women seemed to take pride in describing their experiences of healing in the naturopathic encounter.
Chapter 8: Concluding discussion

The interview space created an opportunity for these women to express an important part of their identity that would not otherwise be readily seen. The women's stories are a testimony to the rich knowledge and practical wisdom of traditional medicine that many refugees bring with them to their new country of resettlement, and which is often overshadowed by the exclusivity of the dominant biomedical culture.

Significantly, most of the women felt an imperative to participate in the research; they wanted an opportunity to formally acknowledge the beneficial effects of naturopathy to ensure that this knowledge was made public. Amar felt passionately about having her experiences documented and offered to come with me to present my findings to government officials. Hati told me at the end of our interview that participating in my research was a priority for her and she had kept her kids home from school that day so that she wouldn’t have to rush off to pick them up in the afternoon. She wanted to ensure that she had as much time to give me as I needed:

*I needed to do this … I needed to help you and to give some proof that those things really help, so the people would know that … if you have [more] questions, I am at your disposal.*

The women came to the interviews with the clear understanding that their experiences of naturopathy would be documented. What came out of our conversations was, I believe, an affirming experience in which their knowledge of traditional medicine was legitimised and their body’s voice was heard (this paralleled the experiences of naturopathic treatment). In turn, the women felt validated and expressed this sentiment at the end of the interviews by thanking me for the opportunity to speak about these issues. Lani said:

*I’m actually thankful to you coming here and talking about these things with me … the pleasure is all mine and even in the future if you think that I could be of any assistance, if you think that I could give you more information, I’m more than happy to sit here and talk to you or meet with you in your office.*

The reflective space in the interviews created an opportunity for both the women and me to make meaning of our prior separate experiences of the naturopathic encounter. For the women, the interviews offered an opportunity to consolidate and validate their earlier experiences of naturopathy. In the process of telling me their stories, the women articulated
and integrated their naturopathic experiences, and this, I argue, further deepened their sense of respite and renewal. The therapeutic process generated in the naturopathic encounter continued and was strengthened in the interviews. The interview space became a healing place. As Frasa explained:

What you are saying is true, you can feel my feelings. I’m pretty happy at this moment, I got good communication with you. I am crying, don’t feel bad, it is the happiness crying. I’m very happy to have the company of you.

As the researcher, the reflective space of the interview enabled me to formally explore the exceptional healing experiences that I had witnessed in so many of my clients when I worked as a naturopath at Foundation House. In the role of researcher I stepped away from the demands and intensity inherent in the practitioner role and I had the opportunity to experience insightful ‘ah-ha’ moments. In reflecting on what the research has meant for me I am aware that my original values and the understandings I had developed over my years of clinical practice have not shifted, but rather they have strengthened and have been validated and affirmed. I am now able to articulate what were previously ‘gut feelings’ and intuitive knowledge. These understandings have deepened through the process of the research in several ways.

As I immersed in the women’s stories I came to see how sophisticated most of the women’s experiences and knowledge of herbal medicine was in their everyday lives. The women were comfortable and pragmatic in moving between traditional medicine and biomedicine. Their knowledge was generated in the everyday – it was not formalised, nor was it revered. Rather it was a kind of commonsense wisdom that was mostly constituted through practice and improved on with experience. For these women, herbal medicine was far from ‘New Age’ or alternative; rather, it was an ‘old wisdom’ which was so much part of their habitus that it could even be considered conventional. Conversely, I had to acquire and develop my herbal knowledge to become a competent practitioner. It was not part of my culture and it was not initially second nature for me. I adopted this knowledge through learning. To use Hawke’s (2007) terms, herbal knowledge for me became part of my secondary habitus. The distinction between primary and secondary habitus, described in Chapter Seven, can be used to show this important difference between the women’s generationally embodied knowledge and the
practitioners’ (including my) academically acquired knowledge of herbal medicine, which with experience became inscribed. Speculating on this dualism, it could be said that it was the women’s primary habitus which resonated with the naturopath’s secondary habitus in the NMP (and with mine in the interview space).

In the Australian context Western herbal knowledge tends to be specialised. In contrast, herbal knowledge for these women was integral to the fabric of their daily lives. It is passed down from mother to daughter, from aunt to niece. Health knowledge is shared between neighbours; is it not hidden, and nor is it exclusive. Herbal knowledge is widely understood. It is connected to understandings about food and diet and there are strong humoral components. Rosa explained that every house that you go into in Iran there is a book on folk medicine. And when people need it, they just use it. In the interviews when I was asking questions about the use of herbs I often felt that the women were saying to me something like ‘yeah, yeah, what’s the big deal, of course herbs work, of course we use herbal medicines, of course foods have different properties and natures (hot/cold), what’s all the fuss about’. Yet for me, the extent of the women’s knowledge and practice-based wisdom was exciting – for me this was a big deal.

As I developed a theoretical understanding of the deeper meanings of the women’s everyday knowledge it helped me to articulate my intuitive understanding of the significance of having access to naturopathy at Foundation House. It gave validation to the women’s knowledge and sense of self and gave legitimacy to common wisdom. Through theories on embodiment, home and place, I came to understand that place is transportable and that people have the ability to make place when they have a sense of cultural validation and acknowledgement of their beliefs and values. The theory and the data came together in such a satisfying way that it enabled me to make these connections that I had not previously seen.

Studying the literature gave me a way of grounding the understanding that having access to familiar health care practices brought a deep sense of comfort – as the women described in the interviews and as clients had described to me in practice. This comfort was often quite visceral – entering the naturopathic consulting rooms with the smells of herbs and essential
Chapter 8: Concluding discussion

oils was a direct link back to the familiarity of home. Smell is the most immediate trigger of memory, and the aroma of the naturopath's room is such a different olfactory experience from the doctor's surgery or the hospital.

Personally, my most significant ah-ha moment was articulating the heartfelt and emotionally charged gratitude that the women expressed towards their naturopaths. In the interviews, as was my experience in practice, the women expressed profuse appreciation towards their naturopaths. When I was a practitioner on the receiving end of such gratitude there were times when I felt overwhelmed by the extent of my clients' thankfulness. I felt that my clients did not need to thank me so much. In the interviews the women shared with me their profuse heartfelt appreciation and gratitude towards their naturopaths. However, in this context, because I was a witness to their appreciation, rather than the recipient, and I did not feel uncomfortable, I was able to hear the deeper meaning of their gratitude.

The expressions of gratitude from the women were not just an offering of thanks but a sharing of genuine affection for their naturopaths. This was an act of intimacy. Given the extent of trauma and loss these women had endured, the capacity for intimacy – to love and to experience love, in the therapeutic relationship, was recognition of their healing process. As Raza explained, there is compassion and you feel you are loved. This intimacy was also expressed physically through the massage. In the NMP the loving care generated in the massage was healing the brutality of torture – reconnecting with humanity after having been so dehumanised. The deep gratitude that emerges from this intimacy, from the exchange of love through the massage and engagement with the naturopaths creates an unconditional space. In this space there is the possibility of countering the embodied violence of the refugee experience. Thus the notion of the 'healing body' possibly suggests a fourth dimension to Scheper-Hughes and Lock's (1998) model of the individual, social and political bodies – one which connects the spiritual dimension to the broader sociopolitical. As Amar so clearly states:

I feel that she is doing this work with all her heart, it is coming from her heart ... she feels with me, our feelings together get engaged with one another. She is like an angel that touches me ... I feel that there is someone who really loves me.
References


Correa-Velez, I. 2006, Personal communication 18/10/06: Defining Multidisciplinary and Interdisciplinary Health Care Practice to J. Singer.


References


Dyck, I. 2003, ‘Making Place, Keeping Healthy: South East Asian Immigrant Women’s Accounts of Health and Everyday Life’, paper presented to 8th International Metropolis Conference, Vienna, Austria.


References


References


References


Offord, B. 2002, 'Meeting Places and Ecologies of Belonging: De-naturalising Whiteness in between Camps', paper presented to Critical Contexts and Crucial Conversations: Whiteness and Race, Griffith University, Queensland, Australia.

Oliver, K. 2001, *Witnessing: Beyond Recognition*, University of Minnesota Press, Minneapolis, MN.


References

Payer, L. 1990, Medicine and Culture: Notions of Health and Sickness in Britain, the U.S., France and West Germany, Victor Gollancz LTD, London.


References


References


Naturopathic Reference List


APPENDIX 1A

SCU ethics application

Southern Cross University

RESEARCH PROPOSAL

TITLE OF PROJECT:
‘The meanings and experience of complementary therapies (CT) treatment for refugee survivors of torture’

RESEARCH QUESTIONS:
• What are the experiences of refugees who have received CT during their recovery?
• What meanings do they attach to their experiences of CT treatment?

AIMS OF PROJECT:
The aim of this project is to explore in detail the experiences of refugees who have received complementary therapies during their recovery period at the Victorian Foundation for Survivors of Torture (VFST/the Foundation). By examining the meanings refugees attach to their experiences of CT treatment, the research aims to investigate the potential role of CT to provide a culturally congruent and holistic strategy for the health care provision of refugee survivors of torture. This work arises from my ten years (1992-2002) experience as a complementary therapist at the Victorian Foundation for Survivors of Torture.

PURPOSE OF PROJECT:
Some of the literature regarding refugee health issues supports the implementation of non-biomedical holistic approaches (Bracken, Giller & Summerfield 1995; Chung & Kagawa-Singer 1995; Silove 1999; Turner & Gorst-Unsworth 1990; Watters 2001). Torture/trauma services within Australia have been using complementary therapies for the last 14 years but there has been no research investigating the use of CT within a torture/trauma service. The purpose of this project therefore, is to investigate the use of CT in this context.

BACKGROUND AND RATIONALE:
As a signatory to the United Nations convention relating to refugees, Australia offers protection to approximately 12,000 refugees per year who have suffered gross human rights abuses (Victorian Foundation for Survivors of Torture 2001). In Australia today, refugees arrive from all parts of the world including Bosnia, Iraq, Somalia, Turkey, Ethiopia, Afghanistan and Sudan. These people come from a diverse range of cultures, religious affiliations and socio-economic groups. Almost all refugees have been exposed to trauma prior to their migration. A report published by the Victorian Foundation for
Survivors of Torture states that most refugees have either witnessed or endured physical or psychological violation (VFST 1996). However, the provision of specific health care for refugees has only been available in Australia since the late 1980’s after research documenting the prevalence of torture and refugee trauma could no longer be ignored (Reid & Strong 1987). In response to this research, government and non-government organisations established torture/trauma services throughout Australia. Their aim is to meet the needs of refugees suffering the on-going effects of torture and trauma.

Over the past decade, the national and international debate on treatment strategies for refugees has included an emerging body of research advocating the need for holistic interventions. (Bracken, Giller & Summerfield 1995; Chung & Kagawa-Singer 1995; Hollifield et al. 2002; Silove 1999; Turner & Gorst-Unsworth 1990; Watters 2001). This interest has developed predominantly in response to concerns of ethnocentric bias in current treatment models, and the subsequent need to establish relevant cross-cultural strategies within existing models (Bernstein-Carlson & Rosser-Hogan 1994; Bracken, Giller & Summerfield 1995; Kleinman 1987; Marsella et al. 2001). Holistic approaches, endorsing the interconnectedness of body, mind and spirit, are seen to address some of these concerns.

A central tenet of holism is the notion of treating the ‘whole person’, rather than the uniform treatment of symptoms or disease states (Jagtenberg & Evans 2003), and value is attributed to the client’s subjective experience of their illness (Kleinman 1987). In contrast to the reductionism often found in a biomedical approach, holism advocates interconnectedness of body, mind and spirit as a total entity in healing (Samson 1999). In the critical review by Hollifield et al., the researchers question whether a purely biomedical approach to refugee health is indeed adequate, as many symptoms described by refugees cannot be classified within existing bio-medical structures (Hollifield et al. 2002).

Endorsing the value of a holistic approach, Watters argues that in many cultures an explicit relationship between mind and body is central to notions of health and illness (Watters 2001). As demonstrated in the research by Chung et al., many South East Asian refugees express their symptoms within a traditional Asian or holistic paradigm where psychological and somatic symptoms are recognized as co-existing as a total entity (Chung & Kagawa-Singer 1995). Furthermore, Turner et al. contextualise refugee trauma as a ‘whole person phenomenon’ in which the aftermath of trauma cannot be reduced to wholly physical or psychological symptoms (Turner & Gorst-Unsworth 1990).

As the response to trauma is mediated by cultural context, effective health care for refugees requires awareness of differences in the meaning attributed to symptom expression (Kleinman 1987). As Bracken argues, it is not difficult to find the same signs and symptoms existing in various cultures, but universal meaning cannot be assumed (Bracken, Giller & Summerfield 1995). Establishing a range of treatment approaches that includes holistic strategies better accommodates cultural difference and minimises the tendency towards the medicalisation of refugee trauma (Bernstein-Carlson & Rosser-
As a holistic strategy, complementary therapies, incorporating the use of herbal medicine and massage therapy have become increasingly popular within torture/trauma services in Australia. Despite growing interest, no research investigating this holistic approach has been conducted. The Foundation is one of the first torture/trauma services nationally and internationally to incorporate a multi-disciplinary approach and to include complementary therapies as an integral component of its overall program.

**STUDY DESIGN & METHODOLOGY:**
This research will use qualitative methods in order to investigate refugees’ experiences of complementary therapies at the Foundation. Qualitative approaches in health related research amongst culturally and linguistically diverse groups is particularly appropriate where values about health and illness may differ from mainstream Western society (de Laine 1997). Theoretical perspectives drawing from medical anthropology will inform the research. As medical anthropology is concerned with how different cultures construct and understand notions of health and illness, it provides a framework for holistically connecting key themes that may emerge in the research. This approach is relevant to the cross-cultural setting of this project where the emphasis is on exploring patterns of meaning and context from a cultural and holistic perspective.

Grounded theory will be used to interpret and analyse the data. A key component of grounded theory is the potential for theory to develop through the process of the research, rather than starting out with a theory and then attempting to test its accuracy (Minichiello et al. 1999; Patton 1990). Grounded theory provides an interactive and interpretive approach and will enable the researcher to engage with the complexities of meanings, interpretations of culture, the refugee experience and concepts of health and healing (Rice-Liamputtong & Ezzy 2001). Grbich argues that Grounded theory analysis is particularly effective when there is a dearth of research ‘where exploration of definitions, understandings, meanings and actions would be essential’ p. 129(Minichiello et al. 1999).

**METHOD OF DATA COLLECTION:**
In-depth interviews are a well established method for conducting health-related qualitative research (Rice-Liamputtong & Ezzy 2001) and will be used in this study. The flexibility of this method allows issues to be explored in some depth. Hollifield et al. argue that in-depth interviews reflect cultural specificity, sensitivity and the social context of the refugee population under examination (Hollifield et al. 2002). In qualitative research, in-depth interviews apply interpretive theoretical perspectives that allow meanings to be co-constructed through the interaction between researcher and participant (Rice-Liamputtong & Ezzy 2001). This is consistent with the principles of Grounded Theory, where themes and understandings are developed through the interview process (Rice-Liamputtong & Ezzy 2001).
Appendix 1a: SCU ethics application

**POPULATIONS:**
The research populations for the study will come from the Victorian Foundation for Survivors of Torture (VFST/the Foundation), following approval from the Human Research Ethics Committee (HREC) and the Victorian Foundation for Survivors of Torture Institutional Ethics Committee (VFST-IEC)

Refugee clients from the Foundation will be invited to participate (N=10)

**INCLUSION CRITERIA:**
**Refugee Clients:**
- Over the age of 18 years
- Psychologically stable as determined by their counsellor/complementary therapist
- Have received either long or short term complementary therapies
- Female participants
- From Middle-Eastern backgrounds, including; Iraq, Iran and Afghanistan
- Have not been previous clients of the researcher

**EXCLUSION CRITERIA:**
**Refugee Clients**
- Under the age of 18 years
- Psychologically unstable as determined by their counsellor/complementary therapist
- Clients who have not received complementary therapies at the Foundation
- Male clients
- Previous clients of the researcher
- Clients not from the designated ethnic background

**RECRUITMENT:**
Participants for the study will be invited from the Victorian Foundation for Survivors of Torture.

**Selection of refugee client participants:**
Refugee clients, fitting the selection criteria, will be invited to participate at the discretion of their counsellors/complementary therapists, the Clinical Director of the Foundation and on the basis of the client’s expressed interest in the study. The researcher will seek permission from the VFST ethics committee to write to all counsellors/complementary therapists’ at the Foundation providing details of the project (attachment 3). On the basis of this request, counsellors/complementary therapists can determine appropriate client participants for the study. They will then make the initial contact with the client. The rationale for this method of client selection is primarily to ensure the psychological safety of the clients participating in the project:
• Counselors/complementary therapists have an in-depth understanding of the psychological and overall health status of their clients and are therefore well positioned to inform appropriate clients about the study (only clients who comply with the inclusions/exclusions criteria will be invited to participate).

• This selection process enables counsellors/complementary therapists to have an initial discussion about the research project with the client, without the presence of the researcher, thereby making it easier for clients to decline participation if desired, at this initial stage (attachment 4 – phone script for counsellors/complementary therapists speaking to potential client participants/subject information sheet/consent form).

• If the client is interested to participate, the counsellor/complementary therapist will give the client a copy of the subject information sheet (attachment 4), in English, and pass on the client’s contact/phone details to the researcher. The researcher will then phone the prospective participant. The purpose of this phone call is to provide the client with further details of the research project (attachment 5 – phone script). Speaking to the researcher does not commit the client to participate in the study. If the client is interested to participate, an interview time will then be made with the client’s preferred professional interpreter, if requested. A professionally translated subject information sheet/consent form will then be given to the client at their interview (attachment 4). Interviews will be undertaken at the Foundation in a private interview room, or at the participant’s home.

This approach provides necessary screening to ensure that only clients who are psychologically stable are invited to participate. As the researcher, I recognise that the actual process of being interviewed could trigger traumatic memories in vulnerable clients. Therefore, I have elected the counsellor/complementary therapists’ at the Foundation to recommend stable clients in order to minimise possible re-traumatisation.

In order to gain an understanding of the historical context of the complementary therapies program it will be important to interview the Director of the Foundation, Mr. Paris Aristotle. This interview will not include personal information about staff or clients. The Director was instrumental in initiating the complementary therapies program and maintaining its funding since inception 14 years ago. Data from this interview therefore informs the background on the complementary therapies program (attachment 6 – subject information sheet/consent form).

**DURATION OF THE STUDY:**
The field work is expected to take approximately four weeks.

**FREEDOM OF CONSENT:**
Participants are free to discontinue participation at any time without giving a reason and without in any way prejudicing their on-going treatment or work at the Foundation.
STUDY ENVIRONMENT:
Participants may choose to be interviewed at either the Foundation, in a private interview room, or at their home. The reason for this choice is that some clients may find it easier to speak about their treatment away from the ‘treatment setting’. The interviews will take between one and two hours. If it is necessary to extend an interview, permission will be sought from the participants. With the participants’ permission, interviews will be audio-taped. Permission to take written notes during the interview will also be requested.

CONFIDENTIALITY & PRIVACY:
When not in use by the researcher, original records of interviews, including notes, transcripts and audio-tapes will be kept in a locked and secure place at the Foundation (only the researcher will have access to this storage space at the Foundation to ensure confidentiality for Foundation participants) and at Southern Cross University. Only the researcher (and possibly an external transcriber) will have access to the audio-tapes. The researcher and supervisors will have access to transcripts (participants will be referred to by pseudonyms on transcripts). In the event that an external person is employed to transcribe data, they will be bound by confidentiality policy. Client participants will be referred to by their ‘real’ name during the interviews (on audio-tape), but will be allocated a pseudonym used for transcripts (participants will be told their pseudonym in order to recover material if requested, before analysis, if they decide to withdraw). The code detailing participants’ names with allocated pseudonyms will be stored securely in a separate location from the audio-tapes. Participants will be allocated a unique number and not referred to by their name in the research documents. Data will be reported in aggregate form. No data will be reported that identifies their name, number or pseudonym. The Director will be given a copy of his transcripts to check for accuracy. In order to minimise discomfort to the refugee client participants, transcripts will not require checking.

RISK MANAGEMENT:

<table>
<thead>
<tr>
<th>Potential Risk for Client Participants</th>
<th>Precautions for Client Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible emotional stress of participating in an interview. Potential for difficult issues from the past to emerge.</td>
<td>• Informed consent to include identifying this possibility to the interviewee.</td>
</tr>
<tr>
<td></td>
<td>• Ensuring the interviewees are aware they may withdraw from the research at any time without penalty.</td>
</tr>
<tr>
<td></td>
<td>• Ensuring interviews do not exceed the allocated interview time without seeking permission to continue.</td>
</tr>
</tbody>
</table>
### Appendix 1a: SCU ethics application

- **Availability of debriefing for client interviewees if requested, following the interview and if thought necessary by the researcher.**
  
  Counsellor/complementary therapist will be available either in person at the Foundation, or over the phone if the interview takes place at home.

- **If requested by the client, preferred interpreters will be employed for all interactions associated with the research.**

<table>
<thead>
<tr>
<th>Publishing information in the public domain and maintaining confidentiality.</th>
<th>Publishing in the public domain and maintaining confidentiality</th>
</tr>
</thead>
<tbody>
<tr>
<td>- <strong>Ensuring 3rd party data is not collected.</strong></td>
<td>- Ensuring third party data is not collected.</td>
</tr>
<tr>
<td>- Any information obtained will be securely stored at the Foundation (only the researcher will have access) and at Southern Cross University.</td>
<td>- Any information obtained will be securely stored at the Foundation (only the researcher will have access) and at Southern Cross University.</td>
</tr>
<tr>
<td>- All participants will be allocated a unique number and not referred to by their name.</td>
<td>- Should consent to being identified in any publication using interview data be given, permission to</td>
</tr>
<tr>
<td>- Data will be reported in aggregate form. No data will be reported that identifies the participants name or number. Pseudonyms will be used on transcripts.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Potential Risk for the Director</th>
<th>Precautions for the Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>Publishing in the public domain and maintaining confidentiality</td>
<td>Ensuring third party data is not collected.</td>
</tr>
<tr>
<td></td>
<td>Any information obtained will be securely stored at the Foundation (only the researcher will have access) and at Southern Cross University.</td>
</tr>
<tr>
<td></td>
<td>Should consent to being identified in any publication using interview data be given, permission to</td>
</tr>
</tbody>
</table>
TIME FRAME:
SCU ethics committee – October/November 2004
Foundation House ethics committee – August 2004
Field work – To commence following ethics clearance and in accordance with the Foundations timeframe. As requested by the Foundation, field work to commence in February 2005 (the Foundation are moving premises in December/January 2004/5).

INTERVIEWS WITH CLIENTS:
I’d like to start by asking you some personal questions about your background, then some questions about your life here in Australia and your time at the Foundation. Then we will talk about your experiences of complementary therapies.

- Let’s begin by you telling me a bit about yourself now in Australia…what are you doing now? Tell me about your family.
- Do you remember the things that were helpful for you and your family in assisting you to become at home here in Australia?
- Tell me how you found out about Foundation House?
- What were the kinds of services that you had from the Foundation?
- What were the things that you liked or that helped you at the Foundation?

Now I would like to ask you some questions about health care treatments:

- Can you tell me a bit about what you did if you were sick in your home country? What kinds of sickness?
- In many countries, people use herbs, magic, massage…and there are different kinds of healers. Tell me a bit of this for your home country.
- How about here in Australia?
- Tell me about your experiences with CT at the Foundation.
- Can you tell me how you found out about the CT at the Foundation?
- Can you tell me a bit about your health problems when you were first referred for CT?
- What would you say were the most important aspects of your CT treatment?
- How was this different from other types of health care you have received?
- How did you notice the effects of CT on your overall health and well-being?
- What sort of changes occurred and how do you understand these changes?
- Is there anything else you would like to tell me so that I can understand your experiences of CT?

INTERVIEW WITH THE DIRECTOR:
Appendix 1a: SCU ethics application

- Can you describe for me you work at Foundation House?
- How long have you worked at the Foundation?
- What was the background context in which the Foundation was first established?
- How would you describe the background circumstances for implementing the CT program and how did that come about?
- When was the CT program first implemented? Can you describe this process?
- In your understanding, what were some of the reasons for incorporating CT into the Foundation’s service delivery?
- What is your observation about the role of CT within the overall service delivery of the organization?
- What is your understanding of how CT works with clients?
- Can you describe your understanding about what constitutes ‘healing’ for survivors of torture/trauma?
- You have been involved in this work for many years and have had extensive experience, both nationally and internationally. From this perspective, how would you describe the place of CT within torture/trauma services?

REFERENCES:

Appendix 1a: SCU ethics application


Reid, J & Strong, T 1987, Torture and Trauma: The health Care of Refugee Victims in New South Wales, Western Metropolitan Health Region of NSW Department of Health, Sydney.


VFST 1996, Refugee Health and General Practice, VFST, Melbourne.


APPENDIX 1B
VFST ethics application

The Victorian Foundation for Survivors of Torture Inc.
A0016163P

Postal Address:
P.O. Box 96, Parkville, Vic., 3052 Australia
Residential Address:
House 23, 35 Poplar Road, Parkville, Vic.

OFFICE USE ONLY
Project Identification No.: __________________
Received Date: __________________
Approval Date: __________________

VFST Institutional Ethics Committee (VFST-IEC)

Application Form for Approval of Research Projects

Please refer to the information sheet developed to assist with the completion of this application form. Application forms and information sheets may be obtained by email from the VFST Research & Policy Unit. Please request a copy by emailing bakopanose@survivorsvic.org.au

1. DETAILS OF INVESTIGATOR(S)

(a) Applicant

Name of Principal (or student) investigator:
Judy Singer (student)

Organisation/Department/School:
College of Indigenous Australian People
Southern Cross University
Lismore NSW

Address for correspondence:
4 Cedar Court
Bangalow NSW 2479
Fax No.: n/a
Email address: judysinger@bigpond.com

(b) Other Investigators

Please list the names, titles, qualifications and organisational affiliation of all other investigators:

Professor Judy Atkinson (supervisor)
Head of School
College of Indigenous Australian People
Southern Cross University
2. PROJ ECT DETAILS

(a) **Title:** ‘The meanings and experience of complementary therapies (CT) treatment for refugee survivors of torture’

(choose a short, simple and self explanatory title which will identify for research participants the essential point of the study)

(b) **Please provide a brief summary of the project: (50 words or less)**

This project seeks to explore the role of complementary therapies (CT) practiced at the Victorian Foundation for Survivors of Torture. In-depth interviews with Foundation clients who have received CT will be conducted and analysed. The aim is to further understand and to document this approach to refugee health care.
(c) Type of Project: (tick whichever is applicable)
[    ] Research by staff
[ X ] Research by student
[    ] Other       Please specify:

(d) Is this project part of a larger project?
[    ] Yes          [ X ] No
If Yes, please specify the details of the larger project (i.e. project name, title and affiliation of the Chief Investigator, name of ethics committee(s) that has approved the larger project and the ethics approval number)

(e) Aims and Objectives of Proposed Project:
(Brief explanation of aims/main objectives, including the key research questions or hypotheses. No more than half a page)

RESEARCH QUESTIONS:
- What are the experiences of refugees who have received CT during their recovery period?
- What meanings do they attach to their experience of CT treatment?

AIMS AND OBJECTIVES OF PROJECT:
The aim of this project is to explore in detail the experiences of refugees who have received CT during their recovery period at the Victorian Foundation for Survivors of Torture. By examining the meanings refugees attach to their experiences of CT treatment, the research aims to investigate the potential role of CT to provide a culturally congruent and a holistic strategy for the health care provision of refugee survivors of torture. This work arises from my ten years (1992-2002) experience as a complementary therapist at the Victorian Foundation for Survivors of Torture.

(f) Project Rationale and Design:
(Brief description of the background to the project. This should include the problem that the study addresses, why the study is worth doing, the research design and why the research design proposed best fits the research questions. No more than 1 page)

PROBLEM ADDRESSED BY STUDY:
Some of the literature regarding refugee health issues supports the implementation of non-biomedical holistic approaches (Bracken, Giller & Summerfield 1995; Chung & Kagawa-Singer 1995; Silove 1999; Turner & Gorst-Unsworth 1990; Watters 2001). Torture/trauma services within Australia have been using CT for the past 14 years but there has been no research investigating the use of CT within a torture/trauma service. The purpose of this project therefore, is to investigate the use of CT in this context.
RATIONALE FOR STUDY:

This study will provide information about CT as a treatment strategy for refugee survivors of torture. The research will seek to contribute the Foundation’s expertise in the area of CT and to existing treatment approaches for refugees in Western countries of asylum. Gaining a deeper understanding of the role of CT within the Foundation could potentially improve the way CT is delivered, substantiate existing services and inform future funding opportunities.

RESEARCH DESIGN:

This research will use qualitative methods in order to investigate refugees’ experiences of complementary therapies at the Foundation. Qualitative approaches in health related research amongst culturally and linguistically diverse groups are particularly appropriate where values about health and illness may differ from mainstream Western society (de Laine 1997). Theoretical perspectives drawing from medical anthropology will inform the research. As medical anthropology is concerned with how different cultures construct and understand notions of health and illness, it provides a framework for holistically connecting key themes that may emerge in the research. This approach is relevant to the cross-cultural setting of this project, where the emphasis is on exploring patterns of meaning and context from a cultural and holistic perspective.

Background Literature and Related Research:

(Brief description of the existing knowledge in the field and existing or other related research. No more than 1 page)

BACKGROUND LITERATURE:

This literature review will focus on the evolving interest in ‘holistic approaches’ to refugee health care in Western countries of asylum. Over the past decade, the national and international debate on treatment strategies for refugees has included an emerging body of research advocating the need for holistic interventions. (Bracken, Giller & Summerfield 1995; Chung & Kagawa-Singer 1995; Hollifield et al. 2002; Silove 1999; Turner & Gorst-Unsworth 1990; Watters 2001). This interest has developed predominantly in response to concerns of ethnocentric bias in current treatment models, and the subsequent need to establish relevant cross-cultural strategies within existing models (Bernstein-Carlson & Rosser-Hogan 1994; Bracken, Giller & Summerfield 1995; Kleinman 1987; Marsella et al. 2001). Holistic approaches, endorsing the interconnectedness of body, mind and spirit are seen to address some of these concerns.

A central tenant of holism is the notion of treating the ‘whole person’, rather than the uniform treatment of symptoms or disease states (Jagtenberg & Evans 2003), and value is attributed to the client’s subjective experience of their illness (Kleinman 1987). In contrast to the reductionism, often found in a biomedical approach, holism advocates interconnectedness of body, mind and spirit as a total entity in healing (Samson 1999). In the critical review by Hollifield et al., the researchers question whether a purely bio-medical approach to refugee health is indeed adequate, as many symptoms described by refugees cannot be classified within existing bio-medical structures (Hollifield et al. 2002).

Endorsing the value of a holistic approach, Watters argues that in many cultures an explicit relationship between mind and body is central to notions of health and illness (Watters 2001).
As emphasised in the research by Chung et al., many South East Asian refugees express their symptoms within a traditional Asian, or holistic paradigm where psychological and somatic symptoms are recognised as co-existing as a total entity (Chung & Kagawa-Singer 1995). Turner et al. contextualise refugee trauma as a ‘whole person phenomenon’ in which the aftermath of trauma cannot be reduced to wholly physical or psychological symptoms (Turner & Gorst-Unsworth 1990).

As the response to trauma is mediated by cultural context, effective health care for refugees requires awareness of differences in the meaning attributed to symptom expression (Kleinman 1987). As Bracken argues, it is not difficult to find the same signs and symptoms existing in various cultures, but universal meaning cannot be assumed (Bracken, Giller & Summerfield 1995). Establishing a range of treatment approaches that includes holistic strategies better accommodates cultural difference and minimises the tendency towards medicalising refugee trauma, thereby attending to the central tenet of ‘whole person treatment’ (Bernstein-Carlson & Rosser-Hogan 1994; Cunningham & Cunningham 1997; Morris et al. 1995; Silove 1999; Tuong & Silove 1999).

As a holistic strategy, complementary therapies, incorporating the use of herbal medicine and massage therapy have become increasingly popular within torture/trauma services in Australia. Despite growing interest, no research investigating this holistic approach has as yet been conducted, hence the imperative of this project.

(h) Project Methods and Procedures:
(an outline of the specific methods of data collection, the sample (who will be sampled, how many and how the sample will be selected) and methods of data analysis. No more than 2 pages.
Please attach questionnaire/s and/or interview schedules that will be used)

METHOD OF DATA COLLECTION:

In-depth interviews are a well established method for conducting health-related qualitative research (Rice-Liamputtong & Ezzy 2001) and will be used in this study. The flexibility of this method allows issues to be explored in some depth. Hollifield et al. argues that in-depth interviews reflect cultural specificity, sensitivity and the social context of the refugee population under examination (Hollifield et al. 2002). In qualitative research, in-depth interviews apply interpretive theoretical perspectives that allow meanings to be co-constructed through the interaction between researcher and participant (Rice-Liamputtong & Ezzy 2001). This is consistent with the principles of Grounded Theory, where themes and understandings are developed through the interview process (Rice-Liamputtong & Ezzy 2001).

SAMPLE:
The research populations for the study will come from the Victorian Foundation for Survivors of Torture (the Foundation), following approval from the Human Research Ethics Committee (HREC) at Southern Cross University and the Victorian Foundation for Survivors of Torture Institutional Ethics Committee (VFST-IEC)

Refugee clients from the Foundation will be invited to participate (N=10)
METHOD OF SAMPLE SELECTION:

Selection of refugee client participants:
Refugee clients, fitting the selection criteria, will be invited to participate at the discretion of their counsellors/complementary therapists, the Clinical Director of the Foundation and on the basis of the client’s expressed interest in the study. The researcher will seek permission from the VFST ethics committee to write to all counsellor/complementary therapists at the Foundation providing details of the project (attachment 2). On the basis of this request, counsellors/complementary therapists can determine appropriate client participants for the study (according to selection criteria: see section 3c). They will then make the initial contact with the client. The rationale for this method of client selection is primarily to ensure the psychological safety of the clients participating in the project:

- Counsellors/complementary therapists have an in-depth understanding of the psychological and overall health status of their clients and are therefore well positioned to inform appropriate clients about the study (only clients who comply with the inclusions/exclusions criteria will be invited to participate).
- This selection process enables counsellors/complementary therapists to have an initial discussion about the research project with the client, without the presence of the researcher, thereby making it easier for clients to decline participation if desired, at this initial stage (attachment 3 – phone script for counsellors/complementary therapists speaking to potential client participants, subject information sheet/consent form).
- If the client is interested to participate, the counsellor/complementary therapist will give the client a copy of the subject information sheet (attachment 3), in English, with the researcher’s contact details. The counsellor/complementary therapist will inform the client that they may (a) phone the researcher directly (contact details on information sheet), (b) if the client prefers the researcher to call them, the counsellor/complementary therapist will forward the client’s phone number onto the researcher, or (c) if the phone call is interstate or on a mobile, the client may initially prefer to call the researcher who will then phone the client back, in order to reduce any financial cost to the client. The purpose of this phone call is to provide the client with further details of the research project (attachment 4 – phone script). Speaking to the researcher does not commit the client to participate in the study. If the client is interested to participate, an interview time will then be made with the client’s preferred professional interpreter, if requested. A professionally translated subject information sheet/consent form will then be given to the client at their interview (attachment 3). Interviews will be undertaken at the Foundation in a private interview room, or at the participant’s home.

This approach provides necessary screening to ensure that only clients who are psychologically stable are invited to participate. As the researcher, I recognize that the actual process of being interviewed could trigger traumatic memories in vulnerable clients. Therefore, I have elected the counsellor/complementary therapists at the Foundation to recommend stable clients in order to minimise possible re-traumatisation.
A list of the interview questions pertaining to the client participants is disclosed in full on the 'subject information sheet/consent form' (attachment 3), thereby ensuring certainty for the clients about what they will be asked in the interviews.

In order to gain an understanding of the historical context of the complementary therapies program it will be important to interview the Director of the Foundation, Mr. Paris Aristotle. This interview will not include personal information about staff or clients. The Director was instrumental in initiating the complementary therapies program and maintaining its funding since inception 14 years ago. Data from this interview therefore informs the background on the complementary therapies program (attachment 5 – subject information sheet/consent form).

**METHODS OF DATA ANALYSIS:**
Grounded theory (GT) will be used to interpret and analyse the data. A key component of GT is the potential for theory to develop through the process of the research, rather than starting out with a theory and then attempting to test its accuracy (Minichiello et al. 1999; Patton 1990). Grounded theory provides an interactive and interpretive approach and will enable the researcher to engage with the complexities of meanings and interpretations of culture, the refugee experience and concepts of health and healing (Rice-Liamputtong & Ezzy 2001). Grbich argues that Grounded theory analysis is particularly effective when there is a dearth of research ‘where exploration of definitions, understandings, meanings and actions would be essential” p. 129(Minichiello et al. 1999).

See Attachment 1 – Interview schedule

(i) **Duration:** (i.e. period of data collection involving human participants)
    Proposed commencement date:

    May 2004 (depending on ethics clearance form SCU and VFST and in accordance with the Foundation’s timetable)

    Estimated duration: approximately 4 weeks, beginning in May 2004

(j) **Project Time Line:** (clearly indicating each stage of the project)

    Fieldwork: Estimate 4 weeks
    Write-up: Masters thesis to be completed by February 2006

(k) **External Funding:**

    [ ] has been received
    [ ] has been applied for
    [ X ] has not been applied for

    Name of funding source:

    Please attach grant application if applicable
(l) Resource Requirements:
(Brief outline of resource requirements, including staff time, use of VFST space and any other resources that VFST would be expected to contribute. No more than half a page)
Resource Requirements:

<table>
<thead>
<tr>
<th>Staff</th>
<th>Time commitments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counsellors and Complementary therapists</td>
<td>• Time involved for counsellors/complementary therapists to discuss research project with potential client participants.</td>
</tr>
<tr>
<td></td>
<td>• Providing debriefing for client participants after their interview, if requested by the client.</td>
</tr>
<tr>
<td>Clinical Director Dr. Ida Kaplan</td>
<td>• Clinical discussions with counsellors/complementary therapists regarding potential clients for the research.</td>
</tr>
<tr>
<td></td>
<td>• Overseeing clinical issues of the project.</td>
</tr>
<tr>
<td>Director Mr. Paris Aristotle</td>
<td>• Two hour interview.</td>
</tr>
<tr>
<td>Organisational Resources</td>
<td>• Desk space for the duration of the fieldwork.</td>
</tr>
<tr>
<td></td>
<td>• Access to phone, photocopier and fax for purposes of fieldwork.</td>
</tr>
<tr>
<td></td>
<td>• Access to secure storage space for data.</td>
</tr>
<tr>
<td></td>
<td>• Access to counselling room for interviews (participants have option for interviews to be conducted at their homes).</td>
</tr>
</tbody>
</table>

3. PARTICIPANT DETAILS

(a) Does the research involve direct contact with participants?
[ X ] Yes [ ] No
If Yes, complete (b) to (d)

(b) Number, age range, and other selection characteristics of participants:

10 participants, all over 18 years of age
Selection characteristics: Noted in section 3 (c)

(c) Are there any criteria that will determine whether participants are included or excluded from the research?
[ X ] Yes [ ] No
If Yes, please provide details and explain why:

Selection Criteria for Refugee Clients:
• Over the age of 18 years
• Psychologically stable as determined by their counsellor/complementary therapist
• Have received either long or short term complementary therapies
Female participants
From similar ethnic background (specific details to be decided after consultation with the Clinical Director)
Have not been previous clients of the researcher

Rationale:
In order to minimise the risk of re-traumatisation, only psychologically stable clients are appropriate for the research project.
In order to ensure that the participants are not too heterogeneous, consideration will be given to gender and ethnic background.

(d) Source of participants, and means by which participants are to be recruited:
Participants for the study will be invited from the Victorian Foundation for Survivors of Torture.
See question 2 (h) for recruitment details

(d) Is there any payment or financial remuneration (e.g. vouchers, bus fares, etc.) of participants proposed?
[ X ] Yes [ ] No
If Yes, how much will participants be paid?

If client participants elect to be interviewed at the Foundation, they will be given public transport travel cards to cover the cost of transport to the Foundation. Estimated cost is up to $20 per client.

Justification for payment or remuneration:
To ensure clients are not financially disadvantaged by participating in the research

(f) Premises/location at which project is to be conducted:
The research project will be based at the Foundation’s main centre in Parkville. Client participant interviews will be conducted at the Foundation (Dandenong site) or at the client’s home.

4. RESEARCH USING EXISTING DATA BASES

(a) Does this project involve access to existing data bases provided by an institution?
[ ] Yes [ X ] No
If Yes, complete (b) to (d)

(b) Describe the source(s) and number of records:
N/A

(e) Indicate whether the data will be de-identified, potentially identifiable (e.g. coded), or identified:

Has permission been granted by individuals to use their data for research purposes?
Appendix 1b: VFST ethics application

[ ] Yes  [ ] No
If No, please explain why:

Has formal permission/clearance been sought or obtained from the relevant institution(s)?
[ ] Yes  [ ] No
If No, please explain why:

5. POTENTIAL RISKS
(a) Indicate any physical risks connected with the proposed procedures:
(b) Indicate any psychological risks connected with the proposed procedures:
(c) Indicate any social risks connected with the proposed procedures:
(d) Indicate any legal risks connected with the proposed procedures:
(e) Indicate if there are any other risks connected with the proposed procedures:
(f) Management of potential risks - indicate how each of these potential risks will be minimised and/or managed if they occur

I. how risks are to be minimised:

II. how adverse events would be managed if they were to occur:

<table>
<thead>
<tr>
<th>Type of Risk to Client Participants</th>
<th>Potential Risks</th>
<th>Minimisation and Management of Potential Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Physical Risks</td>
<td>None apparent</td>
<td>N/A</td>
</tr>
</tbody>
</table>
| (b) Psychological Risks             | Possible psychological stress of participating in an interview. Potential for difficult issues from the past to emerge | • Informed consent to include identifying this possibility to the participant.  
• Ensuring the participants are aware they may withdraw from the research at any time without penalty.  
• Ensuring interviews do not exceed the allocated time without seeking permission to continue.  
• Availability of debriefing for client participants by their practitioner, if requested, following the interview, and if thought necessary by the researcher. |
### Appendix 1b: VFST ethics application

<table>
<thead>
<tr>
<th>Type of Risk for the Director</th>
<th>Risk</th>
<th>Minimisation and Management of Potential Risk</th>
</tr>
</thead>
</table>
| (e) Other                     | Publishing in the public domain and maintaining confidentiality | • Ensuring third party data is not collected  
• Any information obtained will be securely stored at the Foundation (only the researcher will have access) and at Southern Cross University.  
• Participants will be allocated a unique number and not referred to by their name.  
• Data will be reported in aggregate form. No data will be reported that identifies the participant’s name or number. Participants will be allocated a pseudonym for transcript documentation. |

- Clients preferred interpreters will be employed, if requested by the client.

(c) Social Risks | None apparent | N/A |
(d) Legal Risks  | None apparent | N/A |
(e) Other Risks  | Publishing information in the public domain and maintaining confidentiality |
Appendix 1b: VFST ethics application

(g) If you consider there to be no potential risks, explain fully why no potential risks have been identified:

6. POTENTIAL BENEFITS

(a) If you consider the participants to be ‘at risk’, give your assessment of how the potential benefits to the participants or contributions to the general body of knowledge would outweigh the risks:

The Foundation has been using CT for over 14 years. As this approach has become increasingly more popular, some torture/trauma services nationally have incorporated CT into their service delivery. To date, no research has been conducted in this area. It is important to conduct research in order to provide analysis of the role of CT and to then contribute the Foundation’s expertise in this area to existing knowledge in the field of refugee health. This research project will give voice to the clients’ experiences of CT, thus contributing to existing treatment approaches for refugee survivors of torture. Gaining a deeper and clearer understanding of the role of CT within the Foundation could potentially improve the way CT is delivered, substantiate existing services and inform future funding opportunities.

(b) Give a brief description of how the project will benefit participants, where it involves VFST clients: (No more than half a page)

Benefits of participating in this research project for VFST clients may include:

• Opportunity for reflection on experiences of CT and other services that may increase awareness of themselves and their ‘healing journey’.
• Clients may come to new understandings of their experiences.
• Values clients’ knowledge and experience.
• Clients will have an opportunity to express their views about CT at the Foundation.
• Allows clients the opportunity to contribute to the development of knowledge in this area.

7. INFORMED CONSENT

As part of the informed consent process, it is necessary to provide information to participants prior to obtaining consent. Please attach the information about your research project which you intend to give to potential participants.

This needs to:
state briefly the aims, procedures involved and the nature of the project, as well as a clear indication of any potential risks associated with this project;
if you consider participants to be ‘at risk’ (see question 4), state exactly what you tell him or her in lay language to obtain informed consent to each procedure whereby he or she is ‘at
risk’. This must be in a written format that is given to the subject particularly for this purpose; and be written in language which may readily be understood by members of the general public, with explanation of any technical terms.

Refer to:
Attachment 3 – subject information sheet/consent form for VFST clients
Attachment 5 – subject information sheet/consent form for VFST director

Will the informed consent of participants be obtained in writing?
[ X ] Yes  [    ] No

If Yes, please attach a copy of your consent form (including the information to participants about the proposed research and their role within it which you supplied in answer to question 6a. See attachment A for a sample consent form)

(c) Will the project information and/or consent form be translated into the participant’s first language?
[ X ] Yes  [    ] No

If No, please explain:

State the process you will use to obtain informed consent from participants:
(written or other)

Informed consent for perspective client participants:

Step 1: Prospective client participants will initially be informed about the research by their counsellor/complementary therapist (see Method of Sample Selection page 6). A subject information sheet/consent form in English will be made available (attachment 3) to the counsellor/complementary therapist for this discussion.

Step 2: If the prospective participant is interested to find out more about participating in the research, their phone number will be given to the researcher and phone contact will be made.

Step 3: The researcher and prospective client participant will make initial contact over the phone. The researcher will explain the topic and purpose of the research in detail to prospective participants over the phone and through a professional interpreter, if requested by the client (attachment 4). Questions relating to the research will be answered as they arise.

Step 4: If the prospective client participant is interested to participate, oral consent will be requested over the phone, and an interview time will then be made for a later date. Written consent will be obtained at the time of the interview.
3. Informed consent for the Director of the Foundation:

The Director will be informed about the research through a letter detailing the project and inviting participation. This letter will include the subject information sheet/consent form, clearly specifying issues of consent (attachment 5)

Are any of the proposed participants under the age of eighteen?

[ ] Yes  [ X ] No

If Yes, give details about how parental/guardian consent will be obtained

8. CONFIDENTIALITY AND MANAGEMENT OF DATA

(a) How will data be recorded? (eg. Written questionnaires, interview notes, photographs, audio/visual recording, direct electronic data entry)

With the participant’s consent, data will be audio-taped and notes will be taken during the interview.

(b) How will the data be stored and at what location?

Data will be stored in a locked storage space at Foundation House (only the researcher will have access to the audio-tapes and notes stored at the Foundation in order to protect confidentiality) and at Southern Cross University.

(c) Describe the procedures you will adopt to ensure confidentiality:

Confidentiality will be ensured by:

- Conducting the interviews in either a private room at the Foundation, or in the privacy of the participants’ home
- When not in use by the researcher, any data collected will be securely stored at the Foundation and at Southern Cross University (only the researcher will have access to audio-tapes and notes at the Foundation to ensure confidentiality for participants)
- Participants will be referred to by their name during the interview, but will be allocated a pseudonym that will be used on transcripts. In the event that an external person is employed to transcribe tapes, they will be bound by confidentiality policy
- Only academic supervisors involved in the project will have access to transcripts (pseudonyms used on all transcripts)

(d) Indicate who will be responsible for the security of confidential data, including consent forms, collected in the course of the research:

The researcher will be responsible for the security of confidential data collected in the course of the research.

(e) Name all people who will be granted access to the data and the reason for the access. People identified are required to maintain all aspects of confidentiality:
Appendix 1b: VFST ethics application

Only the researcher (and possibly external person employed to transcribe) will have access to audio-tapes. In the event that an external person is employed to transcribe tapes, they will be bound by confidentiality policy. Only academic supervisors involved in the project will have access to transcripts. The supervisors are: Professor Judy Atkinson (SCU), Mr. Paul Orrock (SCU) and Professor Sandy Gifford (LaTrobe University and Foundation House).

The Director will be given a copy of his transcript to check for accuracy. In order to minimise discomfort to the refugee client participants, transcripts will not require checking.

(f) Will data be kept for possible future use in another project?
[ ] Yes  [X] No

If Yes, explain when and how the data might be used in another project and for what purpose. Also indicate who might be given access to the data for another project:

9. PRIVACY

(a) Does this project involve the use of personal information obtained from a Commonwealth Department or agency?
[ ] Yes  [X] No

If Yes, you may need to comply with the requirements of the Privacy Act 1988.

Under the Commonwealth Privacy Act 1988 disclosure of personal information by Commonwealth agencies is not permitted except in a number of circumstances specified in Information Privacy Principle (IPP) II. These include consent by the individual concerned. Where consent has not been given, and where none of the other circumstances specified in IPP II apply, additional guidelines for consideration of the project application and for conduct of research apply. Note that the Act does not apply to publicly available material (such as electoral rolls).

If a Commonwealth agency (for instance, the Australia Bureau of Statistics, Commonwealth Government departments, Australian Electoral Commission, most Repatriation Hospitals) is involved in the collection, storage, security, access, amendment, use or disclosure of personal information for a research project investigators must ensure that the project complies with the requirements of the Act.

10. DISSEMINATION OF FINDINGS

(a) In what form will the findings be published or made accessible?

The findings will be published as part of a master’s thesis.
This thesis may inform further documentation produced by the Foundation, such as a manual on CT in torture/trauma services, or it may provide additional information for existing Foundation publications.

(b) Will participants be informed that the project findings may be included or appear in publications, a thesis, reports, or conference presentations?

[ X ] Yes [    ] No

If No, please explain:

(c) Will participants be informed that their personal data and/or the project findings will be available to them on request?

[ X ] Yes [    ] No

If No, please explain:

11. EXTERNAL APPROVALS

If a project requires approval from other institutions or ethics committees, copies of approvals must be provided to the VFST-IEC at the time of application, or as soon as possible thereafter.

(a) Has formal clearance/permission been sought or obtained from other institutions or ethics committees?

[ X ] Yes [    ] No

If Yes, please complete (b) & (c)

(b) Indicate the name(s) of institution/ethics committee/authority:

The Human Research Ethics Committee (HREC) at Southern Cross University

(c) Are copies of approval from the institutions/committees indicated above provided with this application?

[ X ] Yes/Attached

[    ] Yes/To follow

[    ] No (please explain)

12. DECLARATION

I, the undersigned, have read the current NH&MRC Statement on Human Experimentation and the relevant Supplementary Notes to this Statement, and accept responsibility for the
conduct of the experimental and research procedures detailed above in accordance with the principles contained in the Statement and any other condition laid down by the Human Research Ethics Committee.

Principal Investigator  
(or Supervisor for student project) Date

Associate Investigator**  Date

Associate Investigator  Date

If the project is to be undertaken by a student, Student's signature: Date

Co-Investigator  Date

Co-Investigator  Date

Head of Department  Date

**The Associate Investigator will assume responsibility for the project in the absence of the Principal Investigator

Please return the completed original application with required attachments, plus 14 copies to Christine Bakopanos, c/o VFST, Research & Policy Unit, PO Box 96, Parkville, Vic, 3052

REFERENCES:


Tuong, P & Silove, D 1999, 'An overview of indigenous descriptions of mental phenomena and the range of traditional healing practices amongst the Vietnamese', *Transcultural Psychiatry*, vol. 36, no. 1, pp. 79-94.


‘The meanings and experience of complementary therapies treatment for refugee survivors of torture’

Introducing the researcher and project to all counsellors/complementary therapists at Foundation House for consideration of informing potential client participants

Dear [first name],

As you may know I am undertaking research as part of my Masters project that is exploring the experiences of refugees who have received complementary therapies (CT) during their recovery period at the Foundation. My research will be based on interviews with clients who have had access to complementary therapies at the Foundation. By examining the meanings refugees attach to their experiences of CT treatment, the research aims to investigate the potential role of CT to provide a culturally congruent and a holistic strategy for the health care needs of refugees. This work arises out of my ten years experience as complementary therapist at the Foundation.

I am writing to ask you to consider informing suitable clients about the research project. The selection criteria below will assist you in your considerations:

- Clients who are psychologically stable, as determined by you, their practitioner.
- Clients who you think would enjoy and benefit from talking about their experiences of complementary therapies at the Foundation.
- Clients who have received either long or short term complementary therapies.
- Clients who are over 18 years of age
- Female clients from Middle-Eastern backgrounds (including: Iraq, Iran and Afghanistan), or African backgrounds
- Clients who were not treated by me when I worked at the Foundation.

I hope to interview 10 clients as part of this project. The interviews will take place at either Foundation House or client’s home, with the client’s preferred interpreter, if requested and take approximately one to two hours.
Appendix 2: Introductory letter to staff at VFST

If you can inform appropriate clients, and wish to do so, I would then ask that you:

1. Make the initial contact with the client to discuss their possible interest in participating in the project. You will be given an outline of key points relating to the research.
2. If the client is interested to find out more about the research, a ‘subject information sheet/consent form’ will be available for you to give to the client as well as requesting permission from the client to give me their contact details and I will then ring them, for a more detailed conversation about the research. Speaking to me does not commit the client to participate in the project. Following this conversation, if the client is still interested to participate, then I will seek oral consent over the phone and make an appointment time for the interview.

Topics which might be discussed in interviews with clients include:

- Demographic information
- Resettlement issues
- Services involved at the Foundation
- Main interest will focus on the client’s complementary therapies experiences

Your help in this project is appreciated. Because you have an in-depth understanding of the psychological and overall health status of your clients, you are able to determine appropriate clients for the project.

Thank you for taking the time to consider your involvement. If you have any questions please give me a call on (02) 6687 1013.

Kind regards,

Judy Singer
Master’s Candidate
Southern Cross University
Appendix 3
Introductory telephone script (VFST staff)

This page not for distribution to participants

‘The meanings and experiences of complementary therapies treatment for refugee survivors of torture’

Introductory Telephone Script Outline

Introducing the research project to potential client participants at Foundation House by their counsellor/complementary therapists’

The following script is an outline only and has been prepared for Counsellors/complementary therapists to ensure they have appropriate information to introduce the research project to prospective client participants.

Information Content:

1. A research project is being conducted at the Foundation. It will look at the value of complementary therapies in treating refugee survivors of torture.

2. From this project we hope to learn more about the experience of refugees who have received complementary therapies (herbal medicine and massage therapy) during their recovery period at the Foundation. By looking at the role of complementary therapies at the Foundation, this project aims to further understand the ways complementary therapies may assist in the health care of refugees.

3. The research will be conducted by Judy Singer as part of her master’s project through Southern Cross University. Judy is a complementary therapist who previously worked at the Foundation.

4. If you chose to participate, Judy will then have a conversation with you. She will ask you a range of questions, including some questions about your life here in Australia, the good and difficult things about resettling here. She will then ask you about your contact at Foundation House and your experiences of
complementary therapies the Foundation. To ensure your privacy, your name will not be used in this project. At the time of your meeting with Judy, she will give you a ‘pseudonym’, that is, a different name and no material will be published that identifies you.

5. It is your choice to participate or decline participation, and your decision will not affect your on-going treatment at the Foundation in any way. You are not expected or obliged to participate.

6. If you are interested in this research, I will give you some written information about the project (attachment 3 – subject information sheet/consent form). If you are interested in participating, I will pass on your phone number to Judy and she will call you to discuss the project and make an appointment time. Or, if you would like further information or to speak with Judy, I can give Judy your phone number and she will call you and discuss the project with you. Other counsellors and complementary therapists will also ask clients who have had complementary therapies if they would like to also participate.

7. At the conclusion of the research project, you can receive a summary of the findings.
Subject information Sheet – Given to Client Participants with Consent Form

Once clients have been selected (that is languages identified) this form will be professionally translated into the client’s preferred language.

Name of Project:

‘The meanings and experience of complementary therapies treatment for refugee survivors of torture’

Purpose of the Project:

You are invited to participate in a study looking at the role of the complementary therapies (CT) practiced at Foundation House.

From this project we hope to learn more about the experiences of refugees who have received complementary therapies (herbal medicine and massage therapy) during their recovery period at the Foundation. By looking at the role of complementary therapies at the Foundation, this project aims to further understand the ways CT may assist in the health care of refugees. This work arises out of my ten years experience as complementary therapist at the Foundation.

Who is Conducting the Study:

This study is being conducted by me, Judy Singer, as part of my master’s thesis through Southern Cross University at Lismore in NSW and the Victorian Foundation for Survivors of Torture.

Procedures to be Followed:

Your counsellor informed a number of their clients, including you, about this project. It is entirely your choice to participate or decline to participate, and your decision will not affect your on-going treatment or involvement with the Foundation in any way. You are not expected or obliged to participate. Speaking to me about the research in order to find out more about it, does not commit you to participate.
If you would like to participate, I would then like to have a conversation with you, covering topics relating to your experience of complementary therapies at the Foundation. The conversations will take place at the Foundation in a private room, or in your home. A professional interpreter of your choice will be provided if you wish.

The conversation will take between one and two hours and if we need more time I will ask your permission. With your permission I will audio tape the conversations. I also ask your permission to take handwritten notes during our conversation. You would be required for one interview.

**Topics which might be discussed in our conversations:**

I’d like to start by asking you some personal questions about your background, then some questions about your life here in Australia and your time at the Foundation. Then we will talk about your experiences of complementary therapies.

**Follow-up Support:**

I am aware that this experience may cause difficult issues from your past to emerge. For this reason your practitioner will be available to speak to you either immediately following the interview or at a later time if you wish (either over the phone or in person).

**My Responsibilities as the Researcher:**

Any information that I obtain from this study will only be used with your permission. Your name will not be used in this study. When we meet for our conversation, I will give you a pseudonym (a different name) which will then be when used on the transcripts. All information is confidential. No material will be published that identifies your name, number or pseudonym. The name of the organisation, (the Victorian Foundation for Survivors of Torture), will be identified in the study.

**Security of Records:**

Original records (tapes, transcripts, notes) of our conversations will be kept in a locked and secure place at Foundation House (only I will have access to these records at the Foundation) and at Southern Cross University. This material will then be analysed and used as data for the master’s thesis. Audio-tapes will be transcribed by the researcher. In the event that an external person is employed to transcribe data, they will be bound by confidentiality policy. Only the researcher (and external transcriber) will have access to the audio-tapes. In accordance with the Australian Vice Chancellors Committee (AVCC), data will be securely kept at Southern Cross University for five years and then destroyed.
Freedom of Consent:

Your permission is essential for you to be involved in this project. You are also free to discontinue participation at any time without giving a reason and without in any way prejudicing your on-going treatment or involvement at the Foundation. If you withdraw from the research, any tapes or material that you have given will be destroyed or, if you wish, will be given to you if you let the researcher know you pseudonym. However, after data analysis, if any data has been coded it would not be possible to withdraw it as it would be unidentifiable. This would be approximately six months after the interview.

Inquires:

If you have any questions at any stage, please contact me on (02) 66 87 1013.

You may also contact my supervisors regarding any aspect of this project:

- Professor Judy Atkinson at SCU on (02) 66 2033003 email: jatkinso@scu.edu.au
- Mr. Paul Orrock at SCU on (02) 66 203557 email: porrock@sce.edu.au
- Professor Sandy Gifford at Foundation House on (03) 9388 0022 email: sgifford@latrobe.edu.au

If you have any problems associated with this project, please contact:
Mr. John Russell
Ethics Complaints Officer
Southern Cross University
(02) 6620 3705
jrussell@scu.edu.au

You will be given a copy of this form to keep.

Thank you for taking this time to consider your involvement
Kind regards,

Judy Singer
Masters Candidate,
Southern Cross University

Continued over…
Appendix 4a: Subject information sheet (English)

Consent to Participate in a Research Project

Project Title: ‘The meanings and experiences of complementary therapies treatment for refugee survivors of torture’

I have read the Information Sheet and agree to participate in this study. I am over the age of 18 years.

Name of subject (print) ___________________________________________________

Signature of subject ____________________________________________________

Date _____________________

I _________________________________ certify that the terms of the form have been verbally explained to the subject, that the subject appears to understand the terms prior to signing the form, and that proper arrangements have been made for a professional interpreter where English is not the subject’s first language. On advice given I asked the subject if she/he needed to discuss the project with an independent person before signing and she/he declined (or has done so).

Signature of witness ____________________________ Date _____________________

Signature of Researcher ___________________________________ Date ___________
Appendix 4b

Subject information sheet (Arabic)

اسم المشروع:
"معاني وتجربة التدابير بأشكال العلاج المتمم للاجئين الناجين من التعذيب"

الفضاء من المشروع:
أنت مدعو للمشاركة في دراسة تتضمن في دور أنواع العلاج المتمم المعاونة لدى مؤسسة فاونديشن هاو (Foundation House).

وتأمل من هذا المشروع أن تتعلم المزيد من تجربة اللاجئين الذين تلقوا أنماط العلاج المتمم (طب الأمراض وعلاج التقدم) خلال فترة شفافهم لدى المؤسسة. وننظر في دور أنماط العلاج المتمم لدى المؤسسة فإن هذا المشروع يهدف إلى فهم أكبر للسبل التي يمكن بها للعلاج المتمم أن يساعد في العناية الصحية للاجئين.

هذا العمل ينطلق من خبرتي على مدى عشر سنوات كخبير سابقاً علاج متمم لدى المؤسسة.

من يجري الدراسة:
يتم إجراء هذه الدراسة من قبل أنا جودي سنجر (Judy Singer) كجزء من أطروحة الماجستير التي أعدتها عبر جامعة صدرن كروس (Southern Cross University) في ليمور والمؤسسة الفكورية (Victorian Foundation for Survivors of Torture) للمفاهيم من التعذيب.

إجراءات المزعومات:
لقد قام مشترك بإعلام عدد من زبائنك، وأنت من ضمهم. بهذا المشروع. والخبر، لك كلياً في المشاركة في المشروع أو الالتزام عن المشاركة. ولن يؤثر قرارك بأي شكل من الأشكال في ملاءمة المستمر أو تعاملك مع المؤسسة. ولا يتوقع منك بل ستستمتع بالمشاركة. والتحدث إلى من البحث لمعرفة المزيد عنه لا يلزمك بالمشاركة فيه.

Research Project – Arabic version
"The meanings and experience of complementary therapies treatment for refugee survivors of torture"
Appendix 4b: Subject information sheet (Arabic)

٣٨٩

٣٥٨

٣٧٨

٣٧٩

٣٨٠

٣٨١

٣٨٢

٣٨٣

٣٨٤

٣٨٥

٣٨٦

٣٨٧

٣٨٨

٣٨٩

٣٩٠

٣٩١

٣٩٢

٣٩٣

٣٩٤

٣٩٥

٣٩٦

٣٩٧

٣٩٨

٣٩٩

٤٠٠

٤٠١

٤٠٢

٤٠٣

٤٠٤

٤٠٥

٤٠٦

٤٠٧

٤٠٨

٤٠٩

٤١٠

٤١١

٤١٢

٤١٣

٤١٤

٤١٥

٤١٦

٤١٧

٤١٨

٤١٩

٤٢٠

٤٢١

٤٢٢

٤٢٣

٤٢٤

٤٢٥

٤٢٦

٤٢٧

٤٢٨

٤٢٩

٤٣٠

٤٣١

٤٣٢

٤٣٣

٤٣٤

٤٣٥

٤٣٦

٤٣٧

٤٣٨

٤٣٩

٤٤٠١

٤٤٠٢

٤٤٠٣

٤٤٠٤

٤٤٠٥

٤٤٠٦

٤٤٠٧

٤٤٠٨

٤٤٠٩

٤٤١٠

٤٤١١

٤٤١٢

٤٤١٣

٤٤١٤

٤٤١٥

٤٤١٦

٤٤١٧

٤٤١٨

٤٤١٩

٤٤٢٠

٤٤٢١

٤٤٢٢

٤٤٢٣

٤٤٢٤

٤٤٢٥

٤٤٢٦

٤٤٢٧

٤٤٢٨

٤٤٢٩

٤٤٣٠١

٤٤٣٠٢

٤٤٣٠٣

٤٤٣٠٤

٤٤٣٠٥

٤٤٣٠٦

٤٤٣٠٧

٤٤٣٠٨

٤٤٣٠٩

٤٤٣١٠

٤٤٣١١

٤٤٣١٢

٤٤٣١٣

٤٤٣١٤

٤٤٣١٥

٤٤٣١٦

٤٤٣١٧

٤٤٣١٨

٤٤٣١٩

٤٤٣٢٠

٤٤٣٢١

٤٤٣٢٢

٤٤٣٢٣

٤٤٣٢٤

٤٤٣٢٥

٤٤٣٢٦

٤٤٣٢٧

٤٤٣٢٨

٤٤٣٢٩
Appendix 4b: Subject information sheet (Arabic)

الهيئة القياسية:

إن ذلك جوهري للمشارك في هذا المشروع، ولكل الحرية أيضاً في التوقف عن المشاركة في أي وقت دون إبداء أي سبب ودون الإشراف بلاءجع المستمر أو تعامل مع المؤسسة بأي شكل من الأشكال.

إذا انسحب من البحث، ستوفر بيانات إلى إعدادية أية أشرطة أو موارد تكون قد أعطتها، أو إن شئت ذلك.

يرجى إبلاغ المشرف بتفاصيل طلبك للإلغاء. إذا أطلقت البيانات، إلا إذا تم تزوير أية بيانات فلن يكون بالإمكان معرفتها تغذير التعرف إليها. ويكون ذلك بعد حوالي ستة أشهر من التقابة.

الاستعلامات:

إذا كانت لديك أي أسئلة في أي مرحلة فالرئياء الأساليب على الرقم 1013 87 66 (02) أو الرقم 0400400309

يمكنك الإتصال أيضاً بالتشريفي على بحث فيما يخص أي مشاكل من تواحي هذا المشروع، وهما: الدكتور جودي أتكينس بجامعة صدرون كروس والسيد بول أوروك بجامعة صدرون كروس، وكلة ساندي جيفورد، في مؤسسة فاونديشن هاوس. كالآتي:

Dr. Judy Atkinson at SCU on (02) 66 2033003 email: jatkinso@scu.edu.au

Mr. Paul Orrock at SCU on (02) 66 203557 email: porrock@sce.edu.au

Dr. Sandy Gifford at Foundation House on (03) 9388 0022 email: sgifford@latrobe.edu.au

إذا كانت لديك أي مشاكل تتعلق بهذا المشروع فالرئياء الأساليب بالبريد، للمؤسسة، من:

Mr. John Russell
Ethics Complaints Officer, Southern Cross University, (02) 6620 3705, jrussell@scu.edu.au

ويتم اعتماد نسخة من هذا النموذج للاحتفاظ بها.

أشرك على الوقت الذي سترفه لتذكر في المشاركة في هذا المشروع.

ودتم...

جودي سنجير، مرشحة لشهادة الماجستير
جامعة صدرون كروس

القبة على الصفحة التالية...

Research Project – Arabic version
"The meanings and experience of complementary therapies treatment for refugee survivors of torture"
تأميم قبول المشاركة في مشروع البحث
Consent to Participate in a Research Project

اسم المشروع: معاني وتجربة التداحي بأسمات العلاج الالترادي للناجين من التعذيب
Project Title: ‘The meanings and experience of complementary therapies treatment for refugee survivors of torture’

قد قرأت بيان المعلومات وأوافق على المشاركة في هذه الدراسة. أنا فوق سن الثامنة عشرة.

اسم المشارك (أكتب بخط واضح):

توقيع المشارك:

التاريخ:

أنا _______ أشهد بأن المعلومات في الصفحات السابقة وفي هذه الاستمارة قد تم شرحها شفهياً للمشارك وأن المشارك يبدو أنه فهم المعلومات قبل توقيع هذه الاستمارة.

وأن الترتيبات المناسبة قد اتخذت لضمان تجنب مشتركة إذا لم تكون الإنجليزية اللغة الأولى للمشارك. وبناء على التوصية المقدمة فقد سألت، أنا الباحثة. المشارك فيما إذا كان يحتاج إلى مناقشة المشروع مع شخص مستقل قبل إتمام الاستمارة فقعت عن ذلك (أو فعل ذلك).

توقيع الشاهد:

التاريخ:

توقيع الباحثة:

التاريخ:

Research Project – Arabic version
"The meanings and experience of complementary therapies treatment for refugee survivors of torture"
APPENDIX 4C
Subject information sheet (Dari)

پوهنون ساوترن کراس
Southern Cross University

نام طرح:
"مفهوم و تجربه معالجات تکمیلی برای پناهجوگان شکنجه شده.

مقصود از طرح
از شما دعوت می کند که در یک تحقیق مطالعاتی درباره نقش تکمیلی که در خانه موسسه انجام می شود، شرکت کنید.

ما این‌وریم که با اجرای این طرح، در مورد تجربه پناهجوگان که تداوم های تکمیلی (دوالگیاهی و تداوی ماسال) را در مدت بهترین صحبت خود در موسسه (Foundation) استفاده کرده‌اند، بیشتری نماید. با تحقیق در مورد نقش تداوی های تکمیلی در موسسه، مقصود این طرح پیدا کردن راه های بیشتری برای کمک به مقابله از صحبت پناهجوگان با استفاده از تداوی های تکمیلی می باشد.

این گزارش به عنوان منبع تحقیق درباره طرح تداوی تکمیلی در موسسه پناهجوگان موجود است.

این تحقیق مطالعاتی را چه کسی انجام می دهد:
من، جودی سینگر (Judy Singer) این تحقیق مطالعاتی را به عنوان قسمتی از رساله فوق لیسانس خود از طریق (Southern Cross University در لیسمور) و موسسه شکنجه دندان و ویکتوریا (Victorian Foundation for Survivors of Torture در اجرای) در استرالیا (NSW) انجام می‌دهم.

طریق های عملی که باید رعایت شود:
مشارکت شما به تعاونی از مراجعین خود، از جمله شما، در مورد این طرح معلومات داده است. این محتوای انتخاب خود شما است که در این طرح شرکت کنید یا تفاوت داشته کنید، و این تقصیم شما اصل باید از شما نتیجه گیری شود. از شما توقع داشت که شرکت کنید و شما ملزم به تحقیق باشید. نهاد یا گروهی که شرکت کنید، به عنوان تحقیقات و مطالعات بیشتر در مورد طرح، شما را متعهد به شرکت کردن شما نمی کند.

اگر خوش دارید در این طرح شرکت کنید، من ممکن است شما صحبتی را در مورد موضوعات مربوط به تجربه شما از استفاده از تداویهای تکمیلی در موسسه داشته باشید.
The meanings and experience of complementary therapies treatment for refugee survivors of torture

Appendix 4c: Subject information sheet (Dari)
Appendix 4c: Subject information sheet (Dari)
Appendix 4c: Subject information sheet (Dari)

Research Project – Dari version

‘The meanings and experience of complementary therapies treatment for refugee survivors of torture’
دانشگاه ساوترن کراس

Southern Cross University

پروژه:

"مفهوم و تجربه معالجات دامنه تکمیلی برای پناهندگان شکنجه دیده"

هدف پروژه:

از شما دعوت می‌کنیم که در یک پرسی مطالعاتی در مورد نقش درمان‌های تکمیلی که در خانه بیاند، شرکت کنید.

ما امیدواریم که با اجرای این پروژه، در مورد تجربه پناهندگان درمان‌های تکمیلی (داروهای گیاهی و ماساژ) را در مورد بهبودیای خود در بیاند (Foundation). دریافت کرده اند، بیشتر بیماری ویژه. با پرسی نش درمان‌های تکمیلی در بیاند. هدف این پروژه فکر به های یکدیگر برای مدد می‌گردد به سلامتی پناهندگان با استفاده از درمان‌های تکمیلی می‌باشد.

این است که سال تجربه من به عون درمان‌گر درمان‌های تکمیلی در نیاز دیده است.

این بررسی مطالعاتی را چه کسی انجام می‌دهد:

من، ژودی سینگر (Judy Singer) این بررسی مطالعاتی را به عنوان یکی از پایان‌نامه‌های لیسانس خود از طریق دانشگاه ساوترن کراس (Lismore) در نیو ساوتون (NSW) ویل (Victorian Foundation for Survivors of Torture) و نیز در سازمان ویکتوریا (Foundation) انجام داشته‌ام.

شبه‌های علمی که باید پروری شود:

مشارکت شما به شماری از مراجعین خود، از جمله شما، درباره این پروژه آگاهی داده است. این منحصراً انتخاب خود شما است که در این پروژه شرکت کنید یا از شرکت کردن خودداری کنید و توصیم شما هیچگونه تأثیری در درمان در حال حاضر شما را با باید نخواهد داشت. از شما انتظار می‌رود که شرکت کنید و شما ملزم به آن نیستید. صحبت با من درباره این تحقیقات برای آگاهی پیدا کنید و یکین در مورد پروپوزال، شما را سعی کنید به شرکت کردن نمی‌کنید.

اگر تمایل به شرکت کردن دارید، می‌توانید در مورد موضوعات مربوط به تجربه شما از استفاده درمان‌های تکمیلی در بیاند داشته باش.
گفتگوهای دو در یک اتاق خصوصی در بینداز، یا در منزل شما صورت خواهند گرفت. اگر مکان باید یک مترمجر
حرارتی باشد که انتخاب خودتان در اختیار خواهید بود. مدت گفتگوهای بین یک دو ساعت خواهد بود و اگر به وقت بشیری نیاز دارید از شما اجازه خواهید گرفت. با اجازه شما، گفتگو از روی نوی نوار ضبط خواهند گرفت. همچنین اگر شما اجازه خواهید گرفت که در طی گفتگویمان با یکدیگر توسط نوشترنیز بدارید.

موضوعاتی که در گفتگوی ما ممکن است مطرح شوند

من می‌خواهم پرسی‌های خود را در مورد زندگی‌شما در استرالیا شروع کنم، جنگ سیاسی و باره خانواده شما.

و بعد از این، شما می‌توانید به‌عنوان یکی از درمان‌های تکنیکی صحبت خواهید کرد.

پشتیبانی‌پس از گفتگو

من آگاه هستم که این گفتگو ما انتظار است بخشهای صشنامه‌ای از گفتگهای شما شود. یک دلیل گفتگو شما با بی‌پایان، مشاور / درمانگر تکمیل شما، با بالاصله پس از مصاحبه، با زمانی پس از آن، به‌عنوان یکی از مشاوران/ درمانگری‌ها نشان داده می‌شود. این مشاوران/ درمانگران مشاور از نظر شما می‌توانند در دیدگاه‌های گفتگوی دوستسالمان، (هیچ عصبیتی وجود ندارد در دسترس خواهید بود. اگر به نلی اجازه می‌دهید، در خانواده شما، شما می‌توانید با مشاوران/ درمانگری‌ها مشورت کنید)

موضوعات هایی که ممکن است مطرح شوند

اهورنونات اطلاعاتی که از این بررسی مطمئنی یافت می‌کنیم، فقط با اجازه شما یا از استفاده خواهد شد. از نام شما در این بررسی مطلوبیت شما در استرالیا یافت شده که تاکنون ما برای گفتگوی مطمئنی کمی، نمی‌توانیم نام شما، ملاقات‌های تکمیلی شما، با بالاصله پس از مصاحبه، با زمانی پس از آن، به‌عنوان یکی از مشاوران/ درمانگری‌ها نشان داده می‌شود. این مشاوران/ درمانگران مشاور از نظر شما می‌توانند در دیدگاه‌های گفتگوی دوستسالمان، (هیچ عصبیتی وجود ندارد در دسترس خواهید بود. اگر به نلی اجازه می‌دهید، در خانواده شما، شما می‌توانید با مشاوران/ درمانگری‌ها مشورت کنید) همان زمانی که نام شما، مشاور مطلوبیت شما، نام مستعار شما، همین چنین می‌کنیم، شما می‌توانید مشاور معنی‌داری که منشترتان از دوستسری‌ها در نهایت خواهید بود. (The Victorian Foundation for Survivors of Torture) خواهید شد.

ضوابط و مستندات

نام شما در این بررسی مطلوبیت شما در استرالیا یافت شده که تاکنون ما برای گفتگوی مطمئنی کمی، نمی‌توانیم نام شما، ملاقات‌های تکمیلی شما، با بالاصله پس از مصاحبه، با زمانی پس از آن، به‌عنوان یکی از مشاوران/ درمانگری‌ها نشان داده می‌شود. این مشاوران/ درمانگران مشاور از نظر شما می‌توانند در دیدگاه‌های گفتگوی دوستسالمان، (هیچ عصبیتی وجود ندارد در دسترس خواهید بود. اگر به نلی اجازه می‌دهید، در خانواده شما، شما می‌توانید با مشاوران/ درمانگری‌ها مشورت کنید) همان زمانی که نام شما، مشاور مطلوبیت شما، نام مستعار شما، همین چنین می‌کنیم، شما می‌توانید مشاور معنی‌داری که منشترتان از دوستسری‌ها در نهایت خواهید بود. (The Victorian Foundation for Survivors of Torture) خواهید شد.

آزادی رضایت دادن:

برای شرکت در این پروژه اجازه شما ضروری است. شما همچنین مختار هستید که شرکت خود را در پروژه در هر زمانی که خودتان بخواهید، بدون اینکه به هیچوجه در درمان در حال حاضر شما یا رابطه شما با با بی‌پایان وارد شود.

Research Project – Farsi version

“The meanings and experience of complementary therapies treatment for refugee survivors of torture”
در صورتی که محترم، آلمان مستاجر خود را یاد کنید، اینجا به شما داده خواهند شد. لازم به ذکر است که اطلاعات پیشین درآمده بخشی از امکان ندارد که مربوط مربوط به یک شرکت کننده باشد. اطلاعات را استخراج آن را حذف کرده، چون قابل شناسایی نخواهند بود. مراحل تجزیه و تحلیل حدوداً شک مطلو، خواهند شد.

گرفتن آگاهی برای:

اگر در هر مرحله ای سوالی داشتید، لطفاً با این شماره تلفن ها بیانات گیرنده: 0400400309

شمار های همچنین در استادان راهنمای مورد منابع در مورد جنبه های این پروژه تماس بگیرید:

Dr. Judy Atkinson at SCU on (02) 66 2033003  email: jatkinso@scu.edu.au
Mr. Paul Orrock at SCU on (02) 66 203557  email: porrock@sce.edu.au
Dr. Sandy Gifford at Foundation House on (03) 9388 0022  email: sgifford@latrobe.edu.au

اگر در مورد این پروژه مشکلی دارید لطفاً با این شماره تماس بگیرید:

Mr. John Russell
Ethics Complaints Officer
Southern Cross University
(02) 6620 3705
jrussell@scu.edu.au

یک گیپ این فرم برای یک هدایت به شما داده میشود.

از صرف وقتتان برای درنظر گرفتن شرکت شما در این پروژه متشکرم.

با احترامات محبتی آمیز

جواد سیمگر
کاندیدای فوق ابتدایی
دانشگاه ساواکن کراس

ادامه دارد...

Research Project – Farsi version
“The meanings and experience of complementary therapies treatment for refugee survivors of torture’
عنوان پروژه: "مفهوم و تجربه معالجات درمانی تکمیلی برای پناهندگان شکنجه‌ی دیده"

Project Title: ‘The meanings and experience of complementary therapies treatment for refugee survivors of torture’

Consent to Participate in a Research Project

اگر اطلاعات صفحات فوق را خوانیده و برای شرکت در این بررسی مطالعاتی موافقت می‌کنید، سند می‌بینند از

عملکرد شرکت کننده

امضای شرکت کننده

تاریخ

تأیید می‌کند که اطلاعات صفحات فوق و این رضایت نامه به شرکت کننده بصورت شفاهی توضیح داده شده است، و نیز ممکن است شرکت کننده شرایط را پیش از امضا کردن این رضایت نامه فهمیده است، و در مواردی که ندارد شرکت کننده انگلیسی نیست، ترجمه‌های خاصی برای حضوریک مطرح یافته باشد شاید این امضا نامه این مرحله دارد، هر یک از اعضای یا نویزه با مشابه یا مشابه دیگری بر مورد پروژه دارد و این مطلب را راه کرد (یا چنین کاری کرده است)

امضای شاهد

تاریخ

امضای پژوهشگر

تاریخ

Research Project – Farsi version

‘The meanings and experience of complementary therapies treatment for refugee survivors of torture’
Naziv rada:
"Značaj i iskustvo kod lječenja komplementarnim terapijama izbjeglica koje su preživjele torture".

Svrha ovog rada:
Pozvani ste na učestovanje u studij koji proučava ulogu komplementarnih terapija koje se prakticiraju u Fondaciji (Foundation House).

Iz ovog rada nadamo se naučiti više o iskustvima izbjeglica koji su primale komplementarne terapije (fitoterapiju i masažu) za vrijeme svog perioda oporavljanja u Fondaciji. Gledajući na ulogu komplementarnih terapija u Fondaciji ovaj rad nastoji prodbiti razumijevanje načina koje komplementarne terapije mogu imati kod zdravstvene njege izbjeglica.

Ovaj rad proizlazi iz mojeg desetogodišnjeg iskustva kao komplementarnog terapeuta u Fondaciji.

Tko provodi Studiju:
Ovaj studij provodim ja, Judy Singer, kao dio mojih teza za magistarski rad na univerzitetu Southern Cross University u Lismore-u, NSW i Viktorijske Fondacije za osobe koje su preživjele torture.

Postupci koje treba slijediti:
Vaš savjetnik je obavijestio više svojih klijenata, uključujući i vas, o ovom studijskom istraživanju. U potpunosti ovisi o Vama da li ćete sudjelovati ili odbiti sudjelovanje i Vaša odluka neće utjecati na bilo koji način na Vaše daljnje liječenje ili na Vašu suradnju s Fondacijom. Od Vas se ne očekuje i niste obvezni sudjelovati. Ako budete razgovarali sa mnom o ovom studijskom istraživanju kako biste bili više obaviješteni ne znači da ste uključeni u sudjelovanje.

Ukoliko želite sudjelovati, željela bih sa Vama popričati, o temama vezanim za iskustvo koje ste imali u lječenju komplementarnim terapijama u Fondaciji. Razgovor će se
obaviti u Fondaciji, u prostoriji koja će pružiti privatnost, ili u vašem domu. Po Vašoj želji biti će omogućen profesionalni tumač Vašeg izbora.

Razgovor će trajati od jedan do dva sata i ako nam bude trebalo više vremena ja ću zatražiti Vašu dozvolu za produženje. Uz Vašu dozvolu snimiti ću razgovore na magnetofonsku vrpcu. Također ću tražiti Vašu dozvolu za ručno pismeno bilježenje razgovora.

**Teme koje bismo mogli diskutirati u našim razgovorima:**

Željela bih započeti postavljajući Vam neka pitanja o Vašem životu ovdje u Australiji, neka pitanja o Vašoj obitelji, a onda ćemo pričati o Vašem kontaktu s Fondacijom i Vašim iskustvima kod lječenja komplementarnim terapijama.

**Potpora Vama nakon toga:**


**Moje odgovornosti kao istraživača:**


**Sigurnost materijala:**

Originalni materijali (vrpce, prijepisi, bilješke) naših razgovora će biti zaključani na sigurnom mjestu u Fondaciji (jedino ja ću imati pristup tim materijalima u Fondaciji) i na univerzitetu Southern Cross University. Ovaj materijal će onda biti analiziran i podaci korišteni za moje magistarske teze. Magnetofonske vrpce će biti prenijete u pismenu formu od strane istraživača. U slučaju da je vanjska osoba zaposlena za prijenos podataka u pismeni oblik, ista će biti zakonski obvezatna na povjerljivo čuvanje istih. Samo istraživač koji provodi studij (i vanjski prenositelj materijala u pismeni oblik) će imati pristup magnetofonskim vrpcama. Sukladno s Australian Vice Chancellors Committee (AVCC), podaci će biti čuvani na sigurnom na univerzitetu Southern Cross University pet godina, a potom uništeni.
**Sloboda pristanka:**
Da biste Vi bili uključeni u ovaj projekt neophodno je da date svoj pristanak. Također ste slobodni prestati učestvovati u bilo koje vrijeme bez davanja razloga za to, a ovo neće na bilo koji način utjecati na Vaše tekuće lječenje ili na Vašu suradnju s Fondacijom. Ako se povučete iz istraživanja, svi materijali ili vrpce koji su već bili napravljeni će biti uništeni, ili ako Vi to želite, će biti dati Vama ako budete rekli istraživaču svoj pseudonim. Premda, nakon analize podataka, oni podaci koji budu već kodirani neće moći biti povučeni jer će biti neprepoznatljivi. To bi bilo tako otprilike 6 mjeseci nakon razgovora.

**Pitanja:**
Ako sada imate bilo kakvih pitanja, molim kontaktirajte me na: (02) 66 87 1013 ili 0400400309.
Možete također kontaktirati osobe koje nadziru moj rad u vezi sa bilo kom aspektom ovog projekta:
Dr. Judy Atkinson na SCU na: (02) 66 2033003 email: jatkinso@scu.edu.au
Mr. Paul Orrock na SCU na: (02) 66 203557 email: porrock@sce.edu.au
Dr. Sandy Gifford u Fondaciji (Foundation House) na: (03) 9388 0022 email: sgifford@latrobe.edu.au

Ako imate bilo kakvih problema vezanih za ovaj rad, kontaktirajte molim: Gdin-a. John Russell
Ethics Complaints Officer (Službenik za žalbe)
Univerzitet Southern Cross
(02) 6620 3705
jrussell@scu.edu.au

Kopiju ovog obrazca koju ćete dobiti, možete zadržati.

Hvala Vam na učešću u ovom istraživačkom radu.

Uz pozdrav s štovanjem,

Judy Singer
Magistarski kandidat,
Southern Cross University

Slijedi nastavak…
Pristanak za učešće u istraživačkom radu

Naslov rada: "Značaj i iskustvo kod lječenja komplementarnim terapijama izbjeglica koje su preživjele torture"

Pročitao/la sam informativni list i pristajem na učešće u ovom studijskom istraživanju. Punoljetna sam osoba.

Ime učesnika/ce (štampanim slovima)______________________________

Potpis učesnika/ce _____________________________________________

Datum ___________________

Ja __________________________ potvrđujem da su uvjeti iz obrazca usmeno objašnjeni učesniku/či, da je učesnik/ka izgledao/la kao da razumije uvjete prije potpisivanja, i da je u slučaju da učesnik/ka ne govori Engleski kao svoj jezik, organizirano prisustvo profesionalnog tumača. Posavjetovala sam prvo učesnika, a onda ga pitala da li on/ona treba prodiskutirati učestvovanje u ovom projektu sa nezavisnom osobom prije potpisivanja i on/ona je to odbila (ili je to učinio/la).

Potpis svjedoka______________________________ Datum _____________________

Potpis istraživača __________________________ Datum _____________________
Appendix 5
Introductory telephone script (Researcher)

‘The meanings and experience of complementary therapies treatment for refugee survivors of torture’
Introducing the researcher and project to potential refugee client participants

The following is an outline only and has been prepared to ensure key points of the introductory call are covered.

A. Greeting

- Judy Singer, Masters student at SCU
- As your practitioner, (name), discussed with you, I am starting a research project that is looking at the role of complementary therapies at Foundation House.
- My research will include conversations with some of the clients who have received complementary therapies at the Foundation, in order to further understand the role of CT at the Foundation.
- As you have received CT at the Foundation, I am wondering if you might like to participate in this project. It would involve having a conversation with me covering topics relating to your experience of CT at the Foundation. The conversation can take place at either the Foundation or in your home. The conversation will take between one to two hours and an interpreter of your choice can be arranged.
- Client informed that discussing the research with me does not commit them to participate in the study; it is an opportunity to find out more about the project.

B. Interested in Participating:

- If client is interested to participate, more detail given about the project, covering follow-up support, confidentiality and consent issues.
- Interview time and place arranged, my phone number given.

C. Not Interested in Participating:

- Thank you for your time, apologies for this intrusion, farewell
## APPENDIX 6

### Participant details form

<table>
<thead>
<tr>
<th>PARTICIPANT DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
</tr>
<tr>
<td>Referring CA/CT</td>
</tr>
<tr>
<td>Participant’s name</td>
</tr>
<tr>
<td>Preferred title</td>
</tr>
<tr>
<td>Phone number</td>
</tr>
<tr>
<td>Ethnicity</td>
</tr>
<tr>
<td>Country of origin</td>
</tr>
<tr>
<td>Preferred language</td>
</tr>
<tr>
<td>Interpreter &amp; service</td>
</tr>
<tr>
<td>Preferred interview location</td>
</tr>
<tr>
<td>Name of participant’s CT</td>
</tr>
<tr>
<td>Interview date</td>
</tr>
<tr>
<td>Interview time</td>
</tr>
<tr>
<td>Interview location</td>
</tr>
<tr>
<td>CA/CT available for debriefing?</td>
</tr>
</tbody>
</table>

Has referring CA/CT gone through the subject info sheet (with interpreter) with participant? Yes/No
Has a consent form been signed? Yes/No
Received consent form: Yes/No

**NOTES:**
Appendix 7
Interview guide

INTRODUCTION

- Can you tell me what country you are from?
- Are you married?
- Do you have any children?
- What is your religion?
- How long have you lived in Australia?

A. BACKGROUND IN AUSTRALIA

- Let’s begin by you telling me a bit about yourself now in Australia…what are you doing now?

B. HOME STORY

- Can you tell me a bit about what you did if you were sick in your home country? What kind of sickness did you have when you were at home?

- In many countries, people use herbs, magic, massage…and there are different kinds of healers. Tell me a bit about this for your home country.

- In your country, are ‘Western/hospital medicine’ and folk/traditional medicine both available? Are they practiced together? For what kind of problems would you see a Western doctor? What about a traditional healer? Can you tell me more about that?
• I’m interested in how different cultures see health and illness, e.g. in many cultures the understanding of ‘hot’ and ‘cold’ is used to describe the cause of illnesses. For example, some headaches are understood to be caused by too much heat in the body, while other types of headache are seen as being caused by too much cold in the body. Is that sort of idea familiar to you?

• Also in many cultures health and illness are understood to be affected by not only the physical body, but also by emotions and feelings, as well as the influence of the spirit/soul and the environment, such as weather changes and foods. In your traditional culture is health and illness related to the connection of these different sorts of things? Can you give me an example from your culture or your own experience?

• How important is this sort of traditional approach to health and illness in helping you understand your own health?

C. BACKGROUND TO FOUNDATION CT EXPERIENCES

• Tell me how you found out about Foundation House?
Appendix 7: Interview guide

• What were the kinds of services that you had from the Foundation?
• Can you tell me a bit about your health problems when you were first referred for CT?
• How do you understand the cause of these health problems?

D. CT EXPERIENCES

• Tell me about your experiences with CT at the Foundation.
• What made the most difference to you?
• How was this different from other types of health care you have received in Australia?
• How did you notice the effects of CT on your overall health and well-being?
• How do you understand the changes that happened, if any (why do you think it worked or didn’t work?)

• In what ways was the CT at the Foundation similar or different to the folk/traditional medicines that you experienced in your home country? Can you tell me a bit more about that?

• Is there anything else you would like to tell me so that I can understand your experiences of CT?
APPENDIX 8

Introducing the researcher to the participants

My Introduction:

- As you know I am doing a research project looking at the CT program at the Foundation.
- I worked at the Foundation as a CT practitioner for 10 years
- I am very interested in ‘traditional or non-Western’ forms of medicine
- My aim is to write about CT from the clients point of view and to document why CT might be important for clients at the Foundation

- Thank you for agreeing to be interviewed
- Your experiences and knowledge about the CT program is very important
- How I’ll use the info from the interviews
- Confidentiality
- Using the tape recorder
- What happens to the tapes and notes

- Clarify definitions; folk/traditional medicine, Western medicine, CT

- The interview will take between 1 to 2 hours
- We can stop at any time for a drink, fresh air, or go to the toilet
- Please let me know at any time if you would like a break

- I’ll probably make some notes as we speak
- And I’ll keep checking my list of questions to make sure that I remember to ask you everything
- Changing the tape over after 45 minutes
- Testing the tape before we start
# APPENDIX 9

## Coding framework

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-category level 1</th>
<th>Subcategory level 2</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
<td></td>
<td></td>
<td>BG</td>
</tr>
<tr>
<td>Country</td>
<td></td>
<td>BG1</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td></td>
<td>BG2</td>
<td></td>
</tr>
<tr>
<td>Refugee</td>
<td></td>
<td>BG3</td>
<td></td>
</tr>
<tr>
<td>Health status</td>
<td></td>
<td>BG4</td>
<td></td>
</tr>
<tr>
<td>At home</td>
<td></td>
<td>BG4a</td>
<td></td>
</tr>
<tr>
<td>In Australia</td>
<td></td>
<td>BG4b</td>
<td></td>
</tr>
<tr>
<td>Getting to FH</td>
<td></td>
<td>BG5</td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td>BG6</td>
<td></td>
</tr>
<tr>
<td>Life style (work, education)</td>
<td></td>
<td>BG7</td>
<td></td>
</tr>
<tr>
<td>At home</td>
<td></td>
<td>BG7a</td>
<td></td>
</tr>
<tr>
<td>In Australia</td>
<td></td>
<td>BG7b</td>
<td></td>
</tr>
<tr>
<td>Traditional Medicine</td>
<td></td>
<td>TM</td>
<td></td>
</tr>
<tr>
<td>Availability at home</td>
<td></td>
<td>TM1</td>
<td></td>
</tr>
<tr>
<td>Types of practitioners</td>
<td></td>
<td>TM2</td>
<td></td>
</tr>
<tr>
<td>Cultural labels</td>
<td></td>
<td>TM3</td>
<td></td>
</tr>
<tr>
<td>Cultural practice at home</td>
<td></td>
<td>TM4</td>
<td></td>
</tr>
<tr>
<td>Food</td>
<td></td>
<td>TM4a</td>
<td></td>
</tr>
<tr>
<td>Weather</td>
<td></td>
<td>TM4b</td>
<td></td>
</tr>
<tr>
<td>Herbs</td>
<td></td>
<td>TM4c</td>
<td></td>
</tr>
<tr>
<td>Humoral</td>
<td></td>
<td>TM4d</td>
<td></td>
</tr>
<tr>
<td>Emotions</td>
<td></td>
<td>TM4e</td>
<td></td>
</tr>
<tr>
<td>Knowledge transmission</td>
<td></td>
<td>TM4f</td>
<td></td>
</tr>
<tr>
<td>Other traditional practices</td>
<td></td>
<td>TM4g</td>
<td></td>
</tr>
<tr>
<td>Effectiveness</td>
<td></td>
<td>TM5</td>
<td></td>
</tr>
<tr>
<td>At home/other country</td>
<td></td>
<td>TM5a</td>
<td></td>
</tr>
<tr>
<td>At FH</td>
<td></td>
<td>TM5b</td>
<td></td>
</tr>
<tr>
<td>Beliefs</td>
<td></td>
<td>TM6</td>
<td></td>
</tr>
<tr>
<td>Identity with TM</td>
<td></td>
<td>TM6a</td>
<td></td>
</tr>
<tr>
<td>Other beliefs</td>
<td></td>
<td>TM6b</td>
<td></td>
</tr>
<tr>
<td>Spiritual experiences/beliefs</td>
<td></td>
<td>TM6c</td>
<td></td>
</tr>
<tr>
<td>Experience at home</td>
<td></td>
<td>TM7</td>
<td></td>
</tr>
<tr>
<td>Experience at FH</td>
<td></td>
<td>TM8</td>
<td></td>
</tr>
<tr>
<td>Massage</td>
<td></td>
<td>TM8a</td>
<td></td>
</tr>
<tr>
<td>Herbs</td>
<td></td>
<td>TM8b</td>
<td></td>
</tr>
<tr>
<td>Therapeutic relationship</td>
<td></td>
<td>TM8c</td>
<td></td>
</tr>
<tr>
<td>Therapeutic environment</td>
<td></td>
<td>TM8d</td>
<td></td>
</tr>
<tr>
<td>Health outcomes (self-care)</td>
<td></td>
<td>TM8e</td>
<td></td>
</tr>
<tr>
<td>Holistic approach</td>
<td></td>
<td>TM8f</td>
<td></td>
</tr>
<tr>
<td>Relationship with WM</td>
<td></td>
<td>TM9</td>
<td></td>
</tr>
<tr>
<td>At home</td>
<td></td>
<td>TM9a</td>
<td></td>
</tr>
<tr>
<td>In Australia</td>
<td></td>
<td>TM9b</td>
<td></td>
</tr>
<tr>
<td>Cultural Practice in Australia</td>
<td></td>
<td>TM10</td>
<td></td>
</tr>
<tr>
<td>Appendix 9: Coding framework</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Comparison to WM</strong></td>
<td>At home</td>
<td>TM11a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In Australia</td>
<td>TM11b</td>
<td></td>
</tr>
<tr>
<td><strong>Health Understandings</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choices of practitioner</td>
<td>HU1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At Home</td>
<td>HU1a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At FH</td>
<td>HU1b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understanding of causes of health problems</td>
<td>HU2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comparison of TM at FH with home country</td>
<td>HU3</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Identity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spirituality</td>
<td>ID1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Role of prayer in health (practice)</td>
<td>ID1a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Role of faith in health (belief)</td>
<td>ID1b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>ID2</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Western medicine</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Availability at home</td>
<td>WM1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship with TM</td>
<td>WM2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At home</td>
<td>WM2a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In Australia</td>
<td>WM2b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practices</td>
<td>WM3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At home</td>
<td>WM3a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In Australia</td>
<td>WM3b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience</td>
<td>WM4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At home</td>
<td>WM4a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In Australia</td>
<td>WM4b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other country</td>
<td>WM4c</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beliefs</td>
<td>WM5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identity with WM</td>
<td>WM5a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effectiveness</td>
<td>WM6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>WM6a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At home</td>
<td>WM6b</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Interview process</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Importance of telling the story</td>
<td>IP1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>General Conversation (rapport building)</strong></td>
<td>GC</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Interviewer codes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Q</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paraphrase</td>
<td>P</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comment</td>
<td>C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Definitions</td>
<td>D</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Interpreter codes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comment</td>
<td>INT1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal experience of TM</td>
<td>INT2</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Request to repeat question</strong></td>
<td>RQ</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## INTERVIEW 1: ‘LANI’

<table>
<thead>
<tr>
<th>Query</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>J: Lani, just to begin can you tell me what country you are from</td>
<td>BG1Q</td>
</tr>
<tr>
<td>L: From Afghanistan</td>
<td>BG1</td>
</tr>
<tr>
<td>J: And what part of Afghanistan</td>
<td>BG1Q</td>
</tr>
<tr>
<td>L: From an area of Afghanistan called “Noristan”?</td>
<td>BG1</td>
</tr>
<tr>
<td>L: I was born in Noristan and I spent 5 years of my life there and then moved to Afghanistan and spent the rest of my life there</td>
<td>BG1</td>
</tr>
<tr>
<td>J: And how long have you been in Australia now?</td>
<td>BG1Q</td>
</tr>
<tr>
<td>L: Approximately one year and 7 months</td>
<td>BG1</td>
</tr>
<tr>
<td>J: Not long</td>
<td>BG2C</td>
</tr>
<tr>
<td>J: And how many children do you have?</td>
<td>BG2Q</td>
</tr>
<tr>
<td>L: I have 5 children together, 3 are biologically mine own and the other 2 are step children</td>
<td>BG2</td>
</tr>
<tr>
<td>J: And how many grandchildren?</td>
<td>BG2Q</td>
</tr>
<tr>
<td>L: I have 5 grandchildren from my older daughter, 2 grandchildren from my daughter that I’m living with here, 2 from my stepdaughter, and 3 from my son.</td>
<td>BG2</td>
</tr>
<tr>
<td>J: Fantastic</td>
<td>BG2C</td>
</tr>
<tr>
<td>L: But unfortunately they are not all with me here, just two are with me here</td>
<td>BG2</td>
</tr>
<tr>
<td>J: That is hard to be separated from family</td>
<td>BG2C</td>
</tr>
<tr>
<td>L:</td>
<td>That is why I am always crying, always in tears</td>
</tr>
<tr>
<td>J:</td>
<td>I think I spoke to one of your grandchildren when I rang to make our appointment. He was a lovely boy.</td>
</tr>
<tr>
<td>L:</td>
<td>That was Sharum, I was here when you rang.</td>
</tr>
<tr>
<td>J:</td>
<td>He was very good and had very good English and was very polite</td>
</tr>
<tr>
<td>L:</td>
<td>Yes, his English is good</td>
</tr>
<tr>
<td>J:</td>
<td>So, to begin with, can you tell me a little about how you are spending your days here in Australia</td>
</tr>
<tr>
<td>L:</td>
<td>Maybe I’ll be waiting for my daughter to come and then she’ll take me out walking because the doctor has told me that walking could be very helpful for my knees, and my health in general and at times if I’m feeling well I would do my bed and keep myself busy, otherwise I’m sitting here, watching TV, watching movies and saying my prayers, and keeping myself busy performing some kind of religious activity, saying my prayers.</td>
</tr>
<tr>
<td>L:</td>
<td>I do love knitting, but unfortunately I can’t do that as my hands are very shaky and my neck and shoulders are painful so I can’t do that much.</td>
</tr>
<tr>
<td>J:</td>
<td>And I’m sure that you then spend time with your grandchildren after school</td>
</tr>
<tr>
<td>L:</td>
<td>Yes, I definitely do that. I sit and watch them or I be with them while they do their homework, or at times we all go out for a walk together.</td>
</tr>
<tr>
<td>J:</td>
<td>And where do you like to walk, are there nice places around here?</td>
</tr>
<tr>
<td>L:</td>
<td>Most of the time I walk to Dandenong Plaza</td>
</tr>
<tr>
<td>L:</td>
<td>I go to the Plaza, I like walking there and I have a cup of coffee, and my grandchildren will</td>
</tr>
</tbody>
</table>
have some chips or they will play video games

| J: And I think its nice to see people, and see activity and be part of the community | BG2C |
| L: I’m actually involved in this other Afghan community group as well, and they are doing some kinds of activities and they have specific classes for women and sometimes my daughter will come too. | BG7b |
| J: Good | BGC |
| L: That’s good as I don’t get bored | BG |
| J: Exactly | BGC |
| J: Lani, in your country, in Afghanistan, when you were unwell what kind of medicines would you have taken | BG4aQ |
| L: Most of the time I would go to the doctor and get some kind of medication from them. | WM4a |
| L: I can’t remember using actual plants, but I do remember though at times when I was having cold and flu and a bit of chest congestion or pneumonia I would use this particular plants, we call it “doshonda”, which means these herbs are boiled and then you drink the water. This was very helpful and this was the only one that I had experience using. | TM7 |
| J: And generally, what kind of illness did you suffer from back home? | BG4AQ |
| L: Most of the time it was my back. You see three vertebra from my back have been removed and because of that I was in continuous pain either in the rib area or the lower back or spine in general. It was mainly that. | BG4a |
| J: And was the back problem from and injury or an accident? | BG4aQ |
| L: It was an injury. I fell of a horse. | BG4a |
| J: That must have been very painful | BG4AC |
APPENDIX 11

Biographical details

Biographical details
The following biographical information was part of the data from the interviews. As it was not incorporated into my presentation of women’s stories in the thesis, I have included it here in order to provide further details about the women’s lives, both in their home countries and in Australia.

Lani

Lani is an elderly Afghani widow. She was originally from a middle class rural background and moved to Kabul to live with an aunt some years before she married. It was her aunt who taught Lani about herbal remedies, educating her in a wide range of herbal treatments. When she married Lani lived in Kabul among her husband’s extended family, including his first wife, their three children and eventually, her own biological children. Lani spoke with admiration about her husband, describing him as a very good and kind man. Lani’s family was also well educated. Three of her cousins were Western trained medical doctors.

At the time of our interview Lani had been in Australia for a year and a half, living with one of her daughters and two grandchildren. Throughout our interview Lani told me many stories about her children, stepchildren and grandchildren. Family is extremely important to her and the separation from most of her family is a constant cause of deep sorrow. Since receiving massage treatment at Foundation House Lani’s health has improved. This is a great relief to her as she is now physically stronger and able to walk to the local shopping centre where she enjoys taking her grandchildren after school as a treat. They play video games while she enjoys a coffee. Her days are mostly spent quietly, attending to domestic chores., Prayer and religious activity are central pillars and Lani derives much comfort from her faith as a Muslim. The interview took place in her home.

Frasa

Most of Frasa’s details are described in Chapters One and Eight. Frasa is from a middle class Afghan background. She was born and raised in Kabul, and worked as a school teacher before her life was uprooted by the Taliban. Frasa is married and has five children, four of whom were born in Afghanistan. After fleeing Afghanistan, Frasa and her husband and their children spent several years living in a refugee camp in Pakistan before receiving humanitarian visas for Australia. At the time of our interview they had been living in Australia for two and a half years. Their extended family are spread across the globe and this causes enormous distress to Frasa who deeply misses her mother in particular. Frasa is a dedicated mother and wife. She works hard to create a warm and loving environment for her children, particularly because they do not have an extended family in Australia. Frasa is a practising Muslim woman and dresses in traditional style. The interview took place at Foundation House.
Mary

Mary is a 42-year-old Iraqi woman of Assyrian-Chaldean ethnicity and she is a practising Catholic. Mary has never married and has no children. She studied mechanical engineering at university and worked in Baghdad in a factory. Mary is westernised in her dress style and particular about her appearance. Her competence with English allowed us to converse without an interpreter. Confidentiality was of significant concern to Mary and she requested that I use a pseudonym during the interview. She chose the name ‘Mary’ and I assume this name held religious significance for her. In Australia she has completed a TAFE course in computer-based engineering and at the time of our interview she was looking for work as a mechanical draftsperson. She is continuing with further English language classes to improve her skills. Although Mary learnt some English at university in Iraq, she never spoke it until arriving in Australia. She has been here for two and a half years. When Mary first arrived in Australia she lived with her brother and his family. There were tensions within the family and she had a falling out with her sister-in-law and subsequently moved into a share house with an Australian woman.

Mary’s father had been killed by Sadam Hussein’s regime and the family was in danger. They eventually all fled Iraq – her mother and other siblings are spread around the world, some living in Europe, others in America. Separation from her mother is a continual source of grief. She hopes that when she gets a job she will be able to save enough money to visit her mother in America. Our interview took place at Foundation House.

Rosa

Rosa is an Iranian Muslim woman. She fled Iran with her husband and children, escaping to Pakistan before receiving visas for Australia. The family have been in Australia for two years. Rosa is recently separated from her husband and lives with her two teenage children. In Iran, Rosa had a fulfilling career. She initially trained as a social worker and worked in the area of drug addiction, specifically dealing with opium addicts which she said was as a big social problem in Iran. Rosa then took up an administrative position in the medical department of a university, and she also worked as a social worker in a hospital. Rosa is a spiritual person and enjoys drawing from a range of different modalities; she is particularly interested in areas of alternative and New Age healing practices. Due to tape recorder problems I interviewed Rosa twice at Foundation House.

Soula

Soula is an Afghani Muslim woman. She was born in Kabul and lived just outside the city in the surrounding hills with her husband and four children. For seven years she was separated from her husband who had been detained by the Taliban. During this time she had to fend for herself, protecting and providing for her children. Her mother and other family members had previously fled to Pakistan. She suffered extreme conditions, was subjected to intense fear and experienced times of starvation. Eventually she fled with her children to Iran, but life continued to be extremely dangerous. Finally her husband
escaped and the family was reunited in Iran before receiving humanitarian visas for Australia. They have been here for three years.

In Afghanistan Soula was in her final year of university, studying geography, psychology and history when ‘the war’ started and she could no longer continue with her studies. For many years she assisted in her mother’s midwifery clinic, collecting and preparing herbal medicine. Soula came to Foundation House for the interview.

**Hati**

Hati is a Muslim woman from Yemen. She is married and has three children. Hati and her family have been in Australia for two years. Her youngest daughter was born here. In Yemen, because of her husband’s political activism the family’s lives were in danger and they fled to Cairo in 1995 before receiving visas for Australia.

Hati explained to me that she is one of a minority of women who had access to a university education in Yemen. She described how very few girls get the opportunity for an education because of the financial expense, and because most places are reserved for boys. In Yemen Hati studied accountancy and after graduating she worked in a TV studio as an accountant. That was where she met her husband who was a journalist. Hati explained that she and her husband were part of a small, educated elite in Yemen. One of the joys about living in Australia for Hati is that she knows her three girls will get a great education. While proud of her university-based knowledge, Hati’s faith and religious knowledge are equally important to her. She described how she reads certain verses from the Koran in order to warn off the ‘evil eye’ from her children. I interviewed Hati at Foundation House.

**Amar**

Amar is a Muslim woman from Iraq. After enduring brutal torture in Iraq she fled with her young son to Jordan before receiving humanitarian visas for Australia. They had been living in Melbourne for just over a year when we met. Amar was born in Bagdad and lived in the city until fleeing the country. In Bagdad Amar trained as a professional belly dancer and taught in a prestigious dance school. As an art form, belly dancing had been highly regarded within Iraqi culture until fundamentalist factions of Sadam Hussein’s regime banned it as a sinful practice. Consequently belly dancers were targeted and often brutally tortured. Amar has never married. She has one child, an eight-year-old boy whom she is extremely proud of and adores. She showed me many photos of her son and some of the awards that he has received at school.

After the interview, as the interpreter and I were walking to our cars, the interpreter stopped me say that she had the utmost respect for Amar. She sees Amar as a courageous and intelligent woman who has suffered intolerable cruelty. The interview took place in Amar’s home.
Appendix 11: Biographical details

**Raza**

Raza is a Baha’i woman from Iran. She is married and has an eight-year-old daughter and a stepdaughter from her husband’s first marriage. Her stepdaughter is married and lives in Iran. Raza’s parents and siblings were targeted by revolutionary guards. They stormed their house and took her father and brother to prison. The rest of the household was constantly harassed and eventually they fled to Turkey where they lived before receiving humanitarian visas for Australia.

In Australia Raza is attending government-run English language classes several days a week as well as participating in a class run by the Baha’i community. Raza’s faith is a very important part of her life. At the beginning of our interview she showed me photo of the Baha’i spiritual leader and she told me about her faith. I interviewed Raza in her home.

**Sally**

Sally is a Burmese woman of Buddhist faith. She is 28 years old and has lived in Australia for seven years. At her request we did not work with an interpreter. However, in hindsight I think I would have understood more of our conversation if it had been interpreted. As Sally has an Anglo name, I chose an English pseudonym for her. Over the last seven years Sally has continued to study English and has completed several TAFE courses. She has no family in Australia and does not have many friends. She lives alone and spends her days either at TAFE or looking for a job. The few friends she has are mainly Vietnamese and Thai. She is not connected with the Burmese community in Melbourne. Our interview took place at Foundation House.

**Sita**

Sita is an Iranian Muslim woman. She has been in Australia for just over a year and recently separated from her husband. Her two teenage children live with her. After fleeing Iran the family spent a few months in Pakistan before receiving visas for Australia. She spends her days attending English classes and looking after her children. In Iran, Sita had several different jobs: she was a hairdresser, receptionist in a doctor’s clinic and a childcare worker. As I arrived at Sita’s house for our interview the interpreter rang saying she was caught in traffic and would be a little late. As it happened, Sita was watching a Bollywood video, so we sat together watching the film and chatted until the interpreter arrived.

**Faduma**

Faduma is a Somali Muslim woman. She has lived in Australia for nine years after receiving a humanitarian visa whilst living in a refugee camp in Kenya. During the war in Somalia she fled to Kenya where she met her husband. His family were known to Faduma as they were distant neighbours in Somalia. At this time Faduma was alone. She had been separated from her parents and siblings during the flight from Somalia. In
Kenya her future husband befriended her and provided her with support and protection. She had no knowledge of her family’s situation. They married in Kenya and came to Australia and now have three children. Faduma’s husband works full-time and she attends English classes and looks after the home. Faduma’s never-ending sorrow is that she has not been able to find her family and she doesn’t know what has happened to them. Once in Australia, she sought assistance from the Red Cross tracing department. They were able to find one sister who is stuck in a refugee camp in Kenya. The tragedy of the situation for Faduma is that the one family member she could find has been refused a visa for Australia. Because of immigration policies and politics it seems unlikely that Faduma will ever be reunited with her only surviving relative. Our interview took place at Foundation House.

**Vesna**

Vesna is a Serbian woman from the Former Yugoslavia and is a practising Catholic. She is married and has one daughter. Before the war the family was financially secure and Vesna was proud of her daughter’s academic achievements. Vesna lives in Melbourne with her husband, her daughter and her mother. Our interview took place at Foundation House.