

BC's
Mental
Health
Journal

Visions

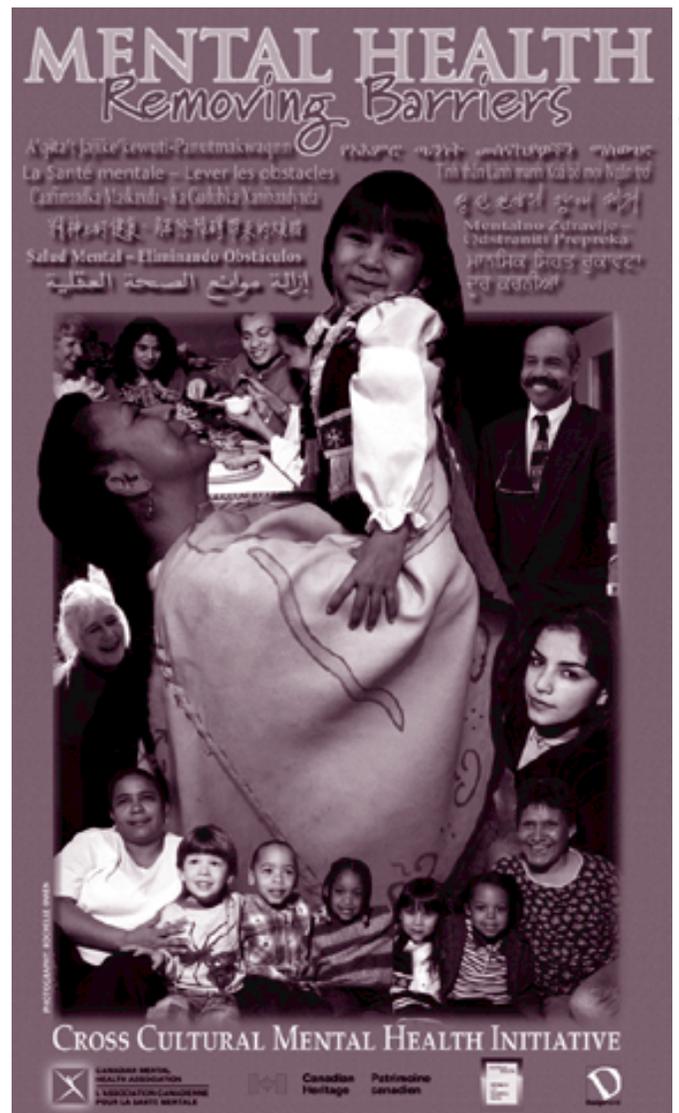
Cross Cultural Mental Health

Attitudes

Approaches

Accessibility

Acceptance



poster (original in full-colour) c/o CMHA, Nova Scotia Division's Cross Cultural Mental Health Initiative

BC's
Mental
Health
Journal



is a quarterly publication produced by the Canadian Mental Health Association, BC Division. It is based on and reflects the guiding philosophy of the CMHA, the "Framework for Support." This philosophy holds that a mental health consumer (someone who has used mental health services) is at the centre of any supportive mental health system. It also advocates and values the involvement and perspectives of friends, family members, service providers, and community. In this journal, we hope to create a place where the many perspectives on mental health issues can be heard.

The Canadian Mental Health Association invites readers' comments and concerns regarding articles and opinions expressed in this journal. Please e-mail us at office@cmha-bc.org or send your letter with your contact information to:

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Subscriptions are \$25 a year for four issues. For more information, call us at **688-3234** or if you are calling from outside the Lower Mainland, dial our toll-free number: **1-800-555-8222**.

The opinions expressed in this journal are those of the writers and do not necessarily reflect the views of the Canadian Mental Health Association, BC Division, or its branch offices.

The story underlying Dr. Terry Tafoya's editorial [opposite page] is a powerful illustration of the simple truth laid out in its final sentence: "There are different methods of healing because there are different needs of people." And while the lesson applies to what the biomedical model might think of as "treatment," it obviously relates to the other issues of cross cultural mental health that this edition of *Visions* will address: access to services, appropriate methods of assessment, and "healing" in all its manifestations (treatment, rehabilitation, and community support).

People have different needs because they come from different backgrounds and have different experiences. As the articles in this issue will explore, they understand "mental health" in different ways; they view "mental illness" and the stigma so often attached to it, differently. As we will also explore, being an immigrant, a refugee, or a visible minority brings another layer of experience that must be understood if we are to respond with equal care to all those who come through the doors of the mental health system.

Are the concepts and approaches we use to foster recovery meeting the challenge for all our citizens, regardless of their ethnic, cultural, or racial back-

ground? If not, where are the gaps? And what can we learn from the people who deal with mental illness — i.e., consumers and family members — who come from different backgrounds? What can we learn from the traditions of knowledge and wisdom that people bring with them?

Considering this issue of cross cultural mental health is crucial, because there is still a long way to go, and much to learn in relation to all of these questions. Let it be said, too, that discovering answers to these questions is not just a narrow endeavour, done for the benefit of certain citizens. Expanding the wealth and scope of our approaches to mental illness brings increased hope to all individuals. As with the legend (see Dr. Tafoya's article), this process will transform our understanding of mental illness into "not something that will disappear, but something that can be dealt with," and a trouble from which people can heal, regardless of who they are and from where they come.

This edition of *Visions* carries forward the work of the CMHA BC Division's Cross Cultural Mental Health Project, which has promoted organizational change aimed at making BC Division reflective and inclusive of the ever-changing face of this province. The latest census figures show BC to be the fastest growing province in the country. Of this growth, 43% was

due to migration from countries outside of Canada, 76% of whom were people from an Asian country.

This edition reflects changes in the CMHA Editorial Staff. Eric Macnaughton takes over the duties as Editor from Dena Ellery, who has returned to school full-time. Sarah Hamid continues in a Design and Production Editor capacity. Vinay Mushiana, the Coordinator of the Cross Cultural Mental Health project, has acted as Co-Editor of this special issue.

With these changes, we remain committed to ensuring that *Visions* addresses topical issues for people with mental illness and all those — family members, friends, and professionals — who play a significant role in their lives. We recognize that some of these issues may be controversial, and that this edition is perhaps no different, as it deals with sensitive issues related to ethnicity, culture, and race. While some disagreements are inevitable, we feel strongly about ensuring that the journal remains a forum for dialogue between people of differing or opposing viewpoints. We hope you enjoy and benefit from this edition of *Visions* on Cross Cultural Mental Health and look forward to your responses.

**Eric Macnaughton
and Vinay Mushiana**

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Befriending Demons: Healing Across Cultures

Imagine a Native American anthropologist working on his PhD by documenting the healing ceremonies of a major North American hospital. He comes in at his convenience and observes a man in white, decorated with colourful writing utensils in a pocket and a shiny medallion hanging from a narrow rubber tube that he will periodically place on the chest of his patients to make them well. He draws strange designs on a small square of white paper that he will give patients to take with them. Because the anthropologist does not fully understand the biomedical culture, and is not spending twenty-four hours of every day in contact with the man in the white coat, he will make a number of errors in understanding the structure of healing.

A serious mistake would be to assume that anyone who comes in with a similar symptom would obtain a similar treatment. But in reality, the treatments are not the same — not all patients will receive a type A blood transfusion; not everyone with an infection will be given penicillin.

Unfortunately a great deal of information on healing ceremonies of other cultures suffers from this problem: conclusions are based on an outsider's direct observation of a limited number of interactions looking for a structure and technique of intervention. In watching my relatives heal in our traditional approaches,



Trained as a traditional Native American Storyteller, Dr. Tafoya is a Taos Pueblo and Warm Springs Indian who has used American Indian ritual and ceremony in his work as a Family Therapist while serving as Clinical Faculty and Senior Staff for the University of Washington's School of Medicine. He has worked extensively in Canada, Mexico and Europe, training mental health professionals and educators in the areas of transcultural concerns and bilingual education. He is presently a Visiting Professor in the Department of Applied Human Science at Concordia University in Montreal. He also acts as an Adjunct Professor of Educational Policy Studies at the University of Alberta.

whether they worked on other North American Indian people, or on non-Indians, they would not treat all people the same, even if the symptoms were the same. Indeed, some of the preliminary activities, like cleaning and purification, would be the same, but the actual healing actions are different. A comparison would be to a medical doctor who will “scrub up” in the same manner, even though he or she might be performing a variety of operations.

In the traditional training of the *Walsakasla*, or Storyteller (a related field to Healing), a story is told four times. The fifth time, the neophyte Storyteller must tell the story verbatim: to fail to do so would result in a beating. But if the new Storyteller is successful, then he or she can “alter” the story to make it appropriate for a specific audience. Just so, the

traditional healer, or *Twati* can adjust actions to meet the needs of his or her patient. Some people seeking healing come as a last resort to a *Twati* or a surgeon, some will come with complete confidence that this is what has to be done, while others will come in terror, uncertain of what might happen during the healing process or if the healing is successful. How can both groups be treated in exactly the same way?

I would like to present an example of how a traditional purification ceremony was modified in the treatment of a Cambodian woman. She had been admitted to a major county hospital, feeling she had been possessed by evil spirits. She had also been diagnosed as anorexic and spoke little if any English, and came into the treatment room almost hysterical. My work with her

was done through a hospital interpreter.

Dr. Terry Tafoya

I began by telling her a traditional story from the Pacific Northwest. The story tells of a cannibal woman who steals young children, whisking them away in an enormous basket she carries on her back. Eventually the young hero of the story outsmarts her and mobilizes the other kidnapped children to push her into a fire, where her ashes fly up and become mosquitoes. (Which, of course, is why mosquitoes bite even today.)

The story is one I frequently use with suicidal patients, since their problems parallel the structure of the legend: their problems are devouring them alive, and the story provides the frame for understanding that with appropriate action, trouble won't disappear, but will transform into something that can be dealt with. Before the story was half-told, she had calmed down, and was quietly listening.

I then conducted a cleansing ceremony for her, modified to reflect her Southeast Asian heritage. Through the translator I gave a detailed explanation of the ceremony, discussing the spirit body of each human which extends approximately one and one half inches beyond the physical body. Harmful thoughts — anger, greed, or hate — result in a spiritual pollution which attaches to the spirit body and must be directly removed through various techniques; I use an eagle



feather. Around her were psychiatrists and psychiatric nurses from her ward who drummed for me.

While many Native American ceremonies have four elements, a number of Asian cultures stress five elements, expanding to include metal. For that reason I altered the ceremony to include five elements. For example, I burned incense of sweetgrass and sage in a large abalone shell. This combined fire (the burning), air (the cloud of incense), water (the sea shell), earth (the red paint and the plants used for the incense), and metal (used to light the incense). While I don't think it's necessary for patients to understand all the details of treatment for it to be effective, I believe having a framework for making sense of what is going on serves to strengthen the ceremony.

While “brushing” her with the eagle feather, I felt a blockage around her abdominal area, and suggested she alter her eating program from the standard three meals a day to five (number sound familiar?) smaller ones. This again addressed the problem of not eating properly by altering her pattern of eating while not telling her to increase her food intake. (I should mention that I had made some minor additions in the legend to provide embedded commands for increased appetite.)

Having finished the brushing, I provided her with a small prayer stick of eagle and parrot feathers tied with sage and sweetgrass. She was instructed to keep this in her bedroom where she had previously had the nightmares that triggered her fears of possession. I intended the strong fragrance of the sage and sweetgrass to remind her of the cleansing ceremony, anchoring the sense of mastery and support.

While this description singles out only some of the actions and explanations involved, I hope it serves to illustrate the need to not be rigidly tied to only one way of dealing with people in need of help. There are different methods of healing because there are different needs of people. ■

Glossary

OF TERMS

*Adapted from “The Terminology of Diversity”
Edited by Sandy Berman and Mary Anne-McInnes,
Multicultural Change in Health Services Delivery.
Vancouver, 1995.*

Cross Cultural means moving from one's culture to another. This may refer to communication (exchanging information or ideas) between individuals coming from different cultural backgrounds.

Cultural Sensitivity is the awareness of one's own cultural assumptions, biases, behaviours, and beliefs and the knowledge and skills to interact with people from other cultures without imposing one's own cultural values on them. Cultural sensitivity is required at individual, professional, and organizational levels.

Culture (noun) refers to the patterns of learned behaviors and values that are shared among members of a group, are transmitted to group members over time, and are often used to distinguish the members of one group from another. Culture can include ethnicity, language, religious and spiritual beliefs, ethnicity, gender, socio-economic class, age, sexual orientation, geographical origin, group history, education and upbringing, and life experiences.

Diversity is a broad term used to reflect the unique characteristics of us all. Its components include race, colour, ethnicity, ancestry, place of origin, age, gender, sexual orientation, physical and mental abilities/qualities, socioeconomic status/class, education, language, family and marital status, religious beliefs, and criminal background.

Ethnicity is, like race, a social and political construct used by individuals and communities to define themselves and others. Ethnicity tends to be based on a common culture, language, or nationhood.

Ethnocultural Group is a group of people who share common distinctive ethnicity, heritage, culture, language, social patterns, and sense of belonging.

Inclusive Organizations understand, accept, and respect all aspects of diversity. They involve people who reflect the diverse groups in their community in the development of policies, services, and programs which are appropriate and relevant to them. An inclusive organization respects differences and pays attention to the dynamics of difference. It does continuous self-assessment, expands cultural knowledge and resources, and adapts its service models to accommodate needs. Such organizations consult with diverse communities and are committed to hiring open-minded employees.

Multicultural Organizational Change This term refers both to the process of dismantling visible and invisible barriers to full participation of all people in a community – especially people from traditionally non-dominant groups – and the establishment of an organization reflective of, responsive, and responsible to the entire community.

Racism is (1) any action or practice which denies equality to a person because of their race, religion, ethnicity or culture (=individual racism); (2) social and organizational structures including policies and practices which, whether intentionally or not, exclude, limit, and discriminate against individuals not part of the traditional dominant group (=systemic racism/discrimination); (3) a set of beliefs, whether conscious or not, rooted in the superiority of one race over other races (=ideological racism).

Stereotype is a false or generalized view of a group of people which results in the unconscious or conscious categorization of each member of that group, without regard for individual differences. Stereotyping may relate to race or age; ethnic, linguistic, religious, geographical or national groups; social, marital or family status; physical, developmental or mental attributes; and/or gender.

Tokenism is a process and action of involving an individual group member, primarily based on their membership to that group. It does not take into account individual differences or contributions. Some possible results of tokenism include (a) unspoken pressures placed on that individual to have input based on their group membership, (b) expectations that the individual will behave like “mainstream” group members while still representing their group, and (c) expectations that the individual will give evidence of the worthiness or unworthiness of their group.



Culture-specific syndromes:

It's all relative

"Of all the medical specialties, ... psychiatry has the most pervasive relationship to culture. Psychiatry is, to begin with, a window on a culture's sources of distress and on the human consequences of such distress." (Kleinman, p. 183)

I'm a living, breathing example of the ethnic diversity of BC, indeed, Canada. Despite a mixed Parsi and Afghan ancestry, two mother tongues before English, and a non-Canadian birthplace, I have been immersed in Canadian society since the age of five — almost as far back as my memory begins.

I'm also a living, breathing example of a visibly ethnic individual with a mental illness. And like so many others in this increasingly multicultural North American continent of ours, I am in a unique position of having access to at least two ways of interpreting the root of my illness: the North American way, and an "Asian" way.

Lower Mainland clinicians have given me the label "major depressive disorder." However, whenever I make progress with my medications, my Afghan aunt tells me she essentially wishes that no one should *nazar* me. That is, no one should give me the "evil eye," long thought of in Latino, Mediterranean, and Islamic cultures as a main cause of sickness and misfortune. My aunt's statement doesn't have the same power in my Canadian home as it would

have had in the Afghan one I could have grown up in, but it comforts me nonetheless. Her saying she doesn't want *nazar* to take place is a statement of protection and luck, given almost in the same spirit that "break a leg" is to a stage actor.

Many people may think my aunt's way of interpreting my emotional distress is "folksy" or even "cute." But it's not. In its own cultural context, it is not only *just* as viable an explanation as "major depressive disorder" is, but it is in fact *more* so because it has a meaning to middle-easterners that the Western diagnosis just can't touch.

When I say "it's all relative" in the title of this article, I mean exactly that: describing mental illness is relative to the culture that is interpreting that illness. I can't even remove the Western bias that I've grown up with in writing this article. After all, calling mental illness an "illness" at all (or "disorder" or "disease" with "symptoms," "diagnosis," and "treatment") places a psychological phenomenon firmly in the world of

biology, medicine, and physical causes of human behaviour. But as Table 1 (pp. 7-8) hopefully illustrates, the medical model is not the only way to interpret a problem. Just like a native language is a shorthand by which people of a nation or culture can communicate with each other easily, so is a locally understood way of talking about psychological problems a kind of shorthand. It's a point of entry for talking about feeling out of sorts within one's self. It's a metaphor a person in that culture knows he or she can use to express distress, initiate discussion, and negotiate help from the family or community. That metaphor carries a special power because it has instant meaning in the system of understanding the entire community shares.

My use of the word "metaphor" here is not accidental. Anthropologists have identified a culturally-sensitive way of talking about culturally different types of interpretations as "idioms of distress." "Idiom" is another way of saying a culture-specific metaphor or symbol; "distress" covers the feelings of pain, negative changes, and general "not-

feeling-myself"ness. So whether a psychological condition is attributed to the loss of one's soul (see *susto* in Table 1), the loss of the vital essence of semen (see *dhat*), the interference of evil spirits or other supernatural forces (see *bebainan*, *hsieh-ping*, or *zar*), or problems with the heart (see *narahatiye qalb*), the point is that each culture has, in the course of its unique evolution, come up with an interpretive tool its citizens can accept and use with each other to describe what's wrong in the head, heart, and body.

In the wake of all the cultural awareness messages in the '90s, all of this may seem like common sense. But the fact of the matter is the study of psychiatry in the Western world still maintains a strong bias in favour of finding similarities rather than differences across cultures and of uncovering "universals" in mental disorder. Kleinman says, "This bias should not surprise us. Much cross-cultural research in psychiatry has been initiated with the desire to demonstrate that psychiatric disorder is like any other disorder and therefore occurs in all societies and can be detected if standardized diagnostic techniques are applied" (p. 18). Although the biomedical model of North

Sarah Hamid

Sarah Hamid is Visions' Production and Design Editor. In addition to her Visions role, she will be taking on the job of Public Education Coordinator at BC Division in the new year.



America and Western Europe has been certainly useful in managing a vast number of psychiatric symptoms, it may have been pushed so far as to obscure other models for interpreting similar complaints.

Kleinman and other cultural psychiatrists and medical anthropologists have gone on to argue that too much cross cultural psychiatric research assumes that cultural differences are a superficial “mask” — a layer that must be peeled away to reveal the real, biological “fact” underlying the disorder. The danger of this bias though is illustrated by the old cliché “in the eyes of a hammer, everything looks like a nail.” In the cross cultural psychiatry context, this saying warns that even if there are *some* universal mental disorders, that doesn’t mean there are *only* universal mental disorders with variations only in name. When dealing with human culture, it is much more complex than that. Biology and environment are too intertwined. A failure to understand this complexity can lead to misdiagnosis and inaccurate research.

For an example of easy misdiagnosis, *taijin kyofusho*, as explained briefly in Table 1 is a Japanese phobic reaction associated with fear of others in social situations. A Western psychiatrist unfamiliar with this disorder in its native context might gloss over the entry in the table thinking it must be “just another name” for “social phobia.” However, there is an important difference in Japan that a treatment approach based on the diagnosis “social phobia” would not recognize. In our individual-centred rather

than group-based society, the Western concept of social phobia typically sees a person’s fear and anxiety as being directed towards potential criticism by others. So, for instance, you obsessively worry about your zipper being down because you are worried about being laughed at. But in Japan’s *taijin kyofusho*, the focus is not on the self but rather on the embarrassment the individual does not want to inflict *on others*. It may be hard for us to understand that a person could worry about making someone else uncomfortable with virtually no thought of one’s own potential embarrassment, but it is just this kind of subtle yet significant nuance that Western psychiatrists need to understand if they hope to serve a multicultural clientele made of such differing worldviews.

In terms of research consequences, poor understanding of the cultural contexts of mental complaints does not bode well for being sensitive to translation in cross-cultural research. For example, “feeling blue” or “feeling down” is a common idiom of distress in the English language and can be useful in diagnosing depression when asked on written tests. However, a straight translation of this conversational phrase would have no meaning in non-Western languages. Only spending time living in other cultures could pinpoint the conversational phrases used to talk about various emotional states.

For another example, Kleinman relates the story of a test translated into Hopi, an American Indian language. The screening test had concepts of guilt, shame, and

sinfulness in the same sentence, but the bilingual researchers realized each term had distinctive meaning and had to be separated out into three questions to get an accurate response. The findings would have had little meaning without this realization.

Kleinman notes that attention to culturally meaningful translation can yield amazing findings. For example, a Vietnamese-language depression scale for use with U.S. Vietnamese refugees found “shameful and dishonored” but not “guilt” to be important factors in discriminating depressed from non-depressed Viet-Americans. Further studies of *why* guilt is less a symptom of depression among Vietnamese than it is for Westerners could yield valuable insights into stigma across cultures which could, in turn, spark further research into cultural conceptions of mental illness.

Culture and ethnicity are part of our personhood. Individuals who are living with a mental illness necessarily come up with their own ideas of what’s going on inside them even before they visit a clinician (if they do at all). And those ideas are often shaped by one’s cultural background and the ways of understanding the world with which one has grown up. Any successful client-centred approaches to therapy have to mesh with the individual’s own worldview. Therefore, the only way to suggest the best courses of treatment action is to understand culture-specific “idioms of distress” as well as the person’s own unique take on those idioms. Only when modern psychiatry can embrace this kind of

ethnocultural study for its own sake, not just as a means to proving the universality of mental disorder, do people stop becoming nails to the biased eye of the hammer and start becoming people again.

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▼ TABLE 1: A Sampling of Conditions of Distress from Around

Local name given to the condition	Part of the world where it has meaning	Defining features of the condition
amok or meta elap	Malaysia	an episode characterized by a period of brooding (usually caused by what seems to the person to be an insult or betrayal) followed by a violent outburst.
"anorexia mirabilis" or "holy anorexia"	Europe in medieval times (around 476-1450 AD)	very restricted eating patterns associated with the experience of religious devotion. Usually was not considered a serious problem within the culture (n.b.: terms are modern)
anorexia nervosa	North America, Western Europe	very restricted eating patterns associated with the fear of becoming overweight. Sometimes combined with excessive exercise. See also bulimia nervosa.
ataque de nervios	Latin America, Latin Mediterranean groups, Latin Caribbeans	literally means an "attack of nerves." Frequently occurs as a result of a stressful family event like a death or divorce. Symptoms include uncontrollable shouting, attacks of crying, trembling, heat in the chest rising to the head, and verbal or physical aggression.
bah-tschi or bah-tsi or baah-ji	Thailand	similar to latah.
bebainan	Bali (Indonesia)	onset of sudden illness attributed to the ill individual's soul being possessed by an evil spirit called bebai. Symptoms include emotional stress, confusion, hopelessness, and a cold feeling beginning in the legs and spreading to the rest of the body.
bilis and colera	Latin America	physical or mental illness as a result of extreme emotion which upsets the balance of hot and cold in the body. Bilis and colera specifically point to anger as the cause of illness.
boufée deliriante	West Africa, Haiti	sudden outburst of agitated and aggressive behaviour, confusion, and muscular excitement. Sometimes accompanied by paranoia or hallucinations.
brain fog or brain fog	West Africa	experienced mainly by male high school or university students. Symptoms include difficulties concentrating, remembering, and thinking. Students often state their brains feel "fatigued." Pain, pressure, tightness, blurred vision, and/or the feeling of heat or burning are often felt in the head and neck regions.
brujeria	Latin America	similar to rootwork.
bulimia nervosa	North America, Western Europe	an extreme fear of being overweight. Strategy for preventing weight gain is not self-induced starvation like anorexia nervosa but rather binge eating followed by self-induced vomiting or overuse of laxatives to "expel" food from body.
cafard or cathard	Polynesia	similar to amok.
dhat	India	semen-loss syndrome characterized by severe anxiety around the discharge of semen and general feelings of weakness or exhaustion.
falling out or blacking out	Southern U.S.A., Caribbean	episodes characterized by sudden collapse either without warning or preceded by feelings of dizziness or "swimming" in the head. Person's eyes are usually open, but the person claims blindness. Also, the person hears and understands what is happening around him or her, but feels powerless to move.
ghost sickness	various American First Nations groups	preoccupation with death and the dead, sometimes associated with witchcraft. Symptoms may include loss of appetite, nightmares, weakness, fear and anxiety, confusion, a sense of being suffocated, hopelessness, and fainting.
grisi siknis	Miskito Indians (Nicaragua)	symptoms include headache, anxiety, anger, and aimless running. Some similarities to pibloktoq.
hi-wa itck	Mohave American Indians	insomnia, depression, loss of appetite, and sometimes suicide associated with the unwanted separation from a loved one.
hsieh-ping	Taiwan	a brief trance state during which a person is possessed by an ancestral ghost who often tries to communicate with other family members. Symptoms include shaking, confusion, and hallucinations.
hwa-byung or wool-hwa-bung	Korea	anger syndrome. Symptoms are attributed to the holding back of anger and may include insomnia, panic, fear of impending death, indigestion, heart palpitations, and a feeling of a mass in the gut.
iich'aa	Navaho Indian	similar to amok.
imu	parts of Japan	similar to latah.
involutional paraphrenia	Spain, Germany	paranoid disorder occurring in midlife.
irarata	Meru tribe of Northern Tanzania	severe reactionary depression which usually affects menopausal women who have lost a spouse; often results in death from loss of appetite and thus loss of body weight.
jinjinia bemar	Assam (India)	see koro.
jiryān	India	similar to dhat.



koro	Malaysia	sudden and intense anxiety that the penis will recede into the body and possibly cause death. See suo yang, jinjinia bemar, and rok-joo.
latah	Malaysia, Indonesia	a hypersensitivity to fright often in a trance-like state.
locura	Latin America	a severe form of chronic psychosis (i.e., where a person's personality becomes disorganized or confused and his or her reality highly changed). It is attributed in the culture to an inherited vulnerability, the effect of many life difficulties, or a combination of the two.
mal de ojo	Spain, Latin America	the Spanish term for "the evil eye." Evil eye occurs as a common metaphor for disease, misfortune, or social disruption throughout the Mediterranean, Latin American, and Muslim worlds.
mal de pelea	Puerto Rico	similar to amok.
mali-mali or silok	Philippines	similar to latah.
mal puesto	Latin America	similar to rootwork.
narahatiye qalb	Iran, other Middle Eastern countries	heart distress. Characterized by a physical sensation of the heart pounding, quivering, or feeling squeezed along with other symptoms of anxiety. Is closely associated with feelings of sadness or being trapped.
nazar	Islamic nations	see mal de ojo.
nervios	Latin America	refers to a general state of vulnerability to stressful life experiences and to a syndrome brought on by these stresses. Symptoms can be very broad but often include emotional distress, headaches, sleep disturbances, nervousness, and difficulty concentrating.
nevra	Greece	similar to nervios.
pibloktoq or Arctic hysteria	Greenland Eskimos	an abrupt psychotic state with extreme excitement and often followed by seizures and coma lasting up to 12 hours. The individual performs unusual, irrational, or dangerous acts during the episode but will usually report not being able to remember any behaviour after the attack has passed. This condition is found throughout the arctic region with local names.
qi-gong psychotic reaction	China	a time-limited episode characterized by paranoid and other psychotic symptoms. Can occur after participating in the Chinese folk health-enhancing practice qi-gong.
rok-joo	Thailand	see koro.
rootwork	Southern U.S.A., Caribbean	illness explained as the result of hexing, witchcraft, voodoo, or the influence of an evil person.
sangue dormido	Portuguese Cape Verdeans	literally means "sleeping blood." Symptoms include pain, numbness, shaking, convulsions, blindness, heart attack, infection, stroke, and miscarriage.
shenjian shuairuo	China	symptoms may include physical and mental fatigue, headaches, difficulty concentrating, sleep disturbance, sexual dysfunction, anxiety or irritability, and memory loss.
shenkui	China	anxiety or panic symptoms accompanied by bodily complaints for which no physical cause can be found. Symptoms attributed to semen loss. Similar to dhat, jiryan, and sukra prameha.
shin-byung	Korea	anxiety or panic symptoms accompanied by various bodily complaints and followed by possession by ancestral spirits.
shinkeishitsu	Japan	marked by obsessions, perfectionism, social withdrawal, and irrational fears of being ill.
spell	Southern U.S.A.	a trance state in which individuals communicate with deceased relatives or spirits. Are not considered medical problems in the culture but can often be misunderstood as "psychotic episodes" by clinicians.
sukra prameha	Sri Lanka	similar to dhat.
suo yang or shuk yang	China	see koro.
susto	Latinos in North America and Latin America	an illness attributed to a frightening event that causes the soul to leave the body, leading to symptoms of unhappiness and sickness. Alternate names include espanto, pasmó, tripa ida, perdida del alma, and chibih.
tabanka	Trinidad	depression associated with a high rate of suicide. Seen in men abandoned by their wives.
taijin kyofusho	Japan	a syndrome of intense fear that one's body, body parts, or bodily functions are displeasing, embarrassing, or offensive to other people.
zar	Ethiopia, Somalia, Egypt, Sudan, Iran, and elsewhere in North Africa and Mid-East	experience of spirit possession. The person often acts totally unlike him or herself with symptoms including laughing, shouting, hitting the head against a wall, singing, or weeping.



How Does Stigma Present Itself in Different Cultural Communities?



The BC Resource Centre for the Elimination of Stigma

This article is proudly supported by CMHA, BC Division's anti-stigma campaign OPEN MIND (based on Nova Scotia Division's program).

Stigma about mental illness is still highly prevalent in North American society. *Visions* asked the Multicultural Mental Health Liaison workers of the Greater Vancouver Mental Health Service to describe views about mental illness and manifestations of stigma in their own communities. Most provided suggestions on what can be done to counter this stigma.

Stigma and the First Nations Community

Perry Omeasoo

There's been so many negative stigmas around the native communities such as alcohol, substance abuse, the natives at Musqueam, the Nisga'a Treaty. People in the white community look down and frown upon all these things ... so we have so many stigmas, we're not about to jump up and say "Oh, we have mental illness too."

And historically, when a Native person got diagnosed with mental illness, everybody made sure he didn't have a substance-use issue, and he would be shipped to a substance program and the mental illness would be left behind. You know Native people drink sometimes to try to forget they have a mental illness; it came first.

So mental illness around na-

tive communities is kind of new and we're accepting the fact that some of our members have mental illness, and we're trying to educate ourselves, but it's long hard work, but that's where funds for education would come in — to have that domino effect.

It's shame-based kinds of stuff. We never know what's next: tuberculosis, diabetes, Fetal Alcohol Syndrome. These are all issues that are floating around our communities all the time, and it's so difficult. There's all kinds of negative stigmas that we have already, so native people aren't too open to have mental illness [on top of the others].

I remember about ten years ago HIV hit the Native population and as a result people were running scared, and Native communities were ostracizing people with HIV, and I think today, by providing education about HIV and how it's not going to be transmitted by holding hands [things are better]...

I think the whole educational process has to be done for mental illness, and maybe my children will look at someone with mental illness as somebody we don't have to be ashamed of, and something that's just accepted and part of our community, and not something we asked for, or something we got because our grandparents went to residential school, or because our parents beat us. Mental illness is a disease that just happens, and

I'm talking about severe mental illness, more around schizophrenia. ■

Stigma and Mental Illness in the Vietnamese Culture

Cho Van Le

The Vietnamese community has been in Vancouver, BC for the past 24 years, but as of today, Vietnamese patients have still underutilized the Canadian mental health services, due to one predominant reason: "STIGMA".

The notion of mental illness is quite dreadful to the Vietnamese people, who believe that once a person contracts mental illness there is a very remote chance of recovery. Along the way the person also brings shame and disgrace to the family due to, as culturally believed, possible bad deeds in a past life — even though nothing was done wrong in the present.

The individual, believing that he or she will bring shame and disgrace to the family, automatically forms a strong internal stigma. Stigma due to misconceptions of mental illness imposes a bitter burden that ruins the person's life and relationships with others, because the individual rarely maintains a healthy self-image and instead manifests in his or her life whatever he or she expects at the deepest level.

The mental illness, which is

◀ *Cho Van Le is the Southeast Asian Mental Health Liaison Worker for the Greater Vancouver Mental Health Service, based at the Kitsilano Mental Health Team.*

► *Perry Omeasoo (pronounced O-me-a-sue) is the First Nations Mental Health Liaison Worker for the Greater Vancouver Mental Health Service, based at the Strathcona Team. This excerpt is from our feature interview (pp. 19-22 of this issue).*



impossible to disclose to others, turns the Vietnamese patient's life into a meaningless and lonely existence. ■

Stigmatized Views of Mental Illness in the Latin American Community

Norma Sanchez ▶ *Norma Sanchez, MD is the Latin American Mental Health Liaison Worker for the Greater Vancouver Mental Health Service, based at the Mt. Pleasant Mental Health Team.*

Latin American people, in general, are very open to seeking help for themselves, a family member, or a friend, when they "do not feel well."

But in spite of this openness in the Latin American community, which is a very diverse and heterogeneous community, there is, as in other communities, some stigma about mental illness or seeing a psychiatrist.

When they can access mental health service providers who speak their language, they do so with little hesitation. For this reason, Latin American people show the highest rate of service utilization among the Greater Vancouver Mental Health Service's clientele.

Stigma is greatly reduced by education and by calling the

illness by its name. People feel less stigmatized when they can name their illness and when they can say that they suffer from depression, an anxiety disorder, or schizophrenia rather than saying that they have "a mental illness." They accept very well the biological explanation of mental illnesses as we understand them today. Without proper education about the illness, individuals and families tend to isolate themselves from sources of support because of the stigma.

In general, there is less stigma in seeing a counselor or a psychologist than in seeing a psychiatrist. For some people, the hesitation about seeing a psychiatrist who does not speak Spanish stems from the fear that the professional might not understand their cultural beliefs and values. This is sometimes much more evident when parents have to seek help for their children. They fear that they themselves or their child-rearing practices will be blamed for the child's problem. They also fear that their parental authority could be undermined by a professional who does not understand the family cultural background.

Because many individuals in the community have a history of severe trauma, the issue of trust is very relevant when they seek individual and/or group therapy. ■

Mental Disorder and Stigma in the South Asian Community

Kala Singh, MBBS

In the South Asian community, mental disorder, in the past and even now by some, is considered to be a form of punishment by God or possession by demons or evil spirits. If a child is born with mental retardation or a physical defect, it is considered that God has punished the child and the family for deeds in a previous life.

Mental disorder in an adult was (and is still considered by some) to be possession by demons or evil spirits. Rituals to please God and exorcism were practiced. A mental health worker was consulted only as a second choice, when these rituals failed. In some cases these rituals serve as a form of psychotherapy and are helpful. As more and more peo-

Related Resources

- *Reducing Stigma about Mental Illness in Transcultural Settings: A Guide.* Australian Transcultural Mental Health Network.
- Rooney, R. & K. O'Neil. "Investigation of Stigma and Mental Illness Amongst non-English Speaking Background Communities & Development of Approaches to its Reduction." *Australian Transcultural Mental Health Network web site:* <http://ariel.uccs.unimelb.edu.au/atmhn/www/research/stigma1.html>

◀ *Kala Singh is the South Asian community Mental Health Liaison Worker for the Greater Vancouver Mental Health Service, South Team.*

ple are becoming aware of mental disorder, more clients are being brought to the attention of mental health workers as a first choice. This shows that stigma attached to mental disorder is decreasing but more is needed to educate the community through pamphlets, newspaper articles, radio, and television talk shows. ■

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Sophia Woo

Sophia Woo is the Chinese community Mental Health Liaison Worker for the Greater Vancouver Mental Health Service, based at the Grandview-Woodlands Mental Health Team.



Chinese Culture and Mental Health

Canada today is home to increasingly diverse cultures. The demographic profiles have changed from predominantly European to a rich, cultural mosaic. There are at least eighty cultural groups and more than one hundred languages spoken by the various ethnic groups in Canada. Approximately 30% of the population in the Greater Vancouver area is of Chinese origin.

These changes give rise to special issues that concern mental health and health care professionals. Ethnocultural groups are found to be under-utilizing existing mental health and social services. One possible interpretation is that new immigrants do have unique experiences and needs which require particular attention and care.

On the other hand, it is challenging as well as rewarding for mental health care professionals to discover and understand the beliefs, values, and health practices of various cultures, and to provide culturally sensitive and appropriate health care and counseling services for ethnocultural clients and their family members.

When we work with Chinese clients, we have to treat each of them as individuals rather than as a homogenous group. We have to take into account their immigration pattern, the social structure of their environment, their education, and their economic background. We also have to consider their country of origin (whether they are from Mainland China, Taiwan, Hong Kong, Southeast Asia, or even Latin America). There are cultural differences among these countries. Last but not least, we have to consider their immigration status: whether they are independent or sponsored, permanent or temporary residents, and whether they are immigrants or refugees. Adaptation and acculturation are also influenced by the length of time in their new country and by their familiarity with its cultural characteristics, customs, and health beliefs.

The Chinese family system is patriarchal. Seniority and age, position and gender determine power and respect within the generations. Financial status and one's ability to speak English can enhance power bases of certain family members within the immigrant families; this is particularly relevant in North America. When a person of Chinese origin is

diagnosed with mental illness, it is often more therapeutically effective to seek a treatment alliance with those family members who are influential and those who are closest to that person. By understanding the dynamics of the hierarchical system within that particular family, a therapist is able to provide a holistic treatment approach.

Chinese family members are usually less verbal in expressing their affections and feelings. Many may choose to

show their concern in concrete and indirect ways, or through subtle actions. For example, they will bring food to their loved ones in hospitals and group homes, or will provide continual financial support to an adult child with mental illness. When a professional makes family assessments, it is important to take into consideration family closeness from the perspectives of the Chinese culture.

Chinese families often think they are accountable and responsible for their family members with mental illness. Their tolerance for inappropriate behaviours is relatively high when compared to Western cultures. They usually have internal ways of dealing with problems. It is not uncommon for parents to provide refuge to their adult child with mental illness, and many will stay under the same roof. Removing a mentally ill person from his or her family is often perceived as a failure or loss of control by the family. However, when an individual with mental illness is exhibiting chaotic behaviours which uproot the family, health care professionals must intervene patiently to explain and negotiate alternative arrangements such as group homes or supervised semi-independent living programs before the problems become insurmountable.

While the Westernized Canadian-born Chinese may adopt Western health care practices, the Chinese-speaking, first-generation immigrants tend to incorporate traditional Chinese health beliefs and practices. For example, it is common among Chinese to understand that illness is caused by an imbalance of yin and yang, a condition often triggered by the types of food one ingests. Certain types of food, such as raw vegetables, cold drinks, watermelons, and bananas are perceived as "yin" (cold) foods. Others such as deep-fried food, chili and curry are perceived as "yang" (hot) foods, whereas ducks, geese, and shellfishes, which may cause allergic reactions to some, are perceived as "poisonous". An elder will appreciate a cup of warm water more than a glass of cold water fresh from the fountain. A mother may not allow her children to drink pop when offered, particularly when they have asthma or any type of respiratory condition.

Certain Chinese health concepts could be a hindrance to treatment plans and procedures. For example, some Chinese are reluctant to have blood tests because blood is considered



a “vital” agent and one’s vitality may be diminished when it is taken out of the body. Others are reluctant to take Western medications because they are perceived as potentially addictive and upsetting to the body’s homeostasis, particularly medications that carry side effects like constipation or any other type of digestive distress.

While most Chinese will seek Western medicine for acute illnesses such as appendicitis, gallstones, tuberculosis, and even acute phases of mental illness, many will turn to Chinese formulary or herbal medicines to treat chronic conditions such as persisting cough, common cold, hypertension, insomnia, and a lack of appetite. Some Chinese may seek cures from substances which they identify as boosters to their own deficiency. For example, some Chinese parents may serve cow or pig brains to their school children, believing that this will help boost memory and intelligence. Walnut is another favorite brain tonic because of its striking resemblance to the brain. Others with anemia may consume foods with red color such as red beans and red grapes.

While a lot of Chinese health concepts are not exactly scientifically-based, many are results of generations of experiences and are to the culture what grain is to wood. We all have a need to connect with our roots, our social network,

and our ethnic communities. It is psychologically comforting for Chinese people, just as it is for many to listen to old Chinese songs, to have a cup of Chinese tea, or to eat Chinese food.

Education and communication can facilitate treatment. The Greater Vancouver Mental Health Service has produced fourteen brochures in Chinese and several videotapes on various types of mental illness and mental health services in the community. We also conduct an annual Cantonese Conference on Mental Health and Mental Illness. In the spring of 1993, the Northeast Mental Health Team embarked on culturally specific family psychoeducation support groups. The Cantonese Family Support Group, which is psychoeducational in orientation and began in 1993, is held on every second Wednesday of the month.

The responses from families have been very positive. Due to the demand for more support for family members, a Cantonese-speaking satellite group (for family members only) was started in the summer of 1996, running every fourth Wednesday of the month. A Mandarin psychoeducation group was begun in the spring of 1999, again backed by demands for education on mental health issues in Mandarin. This group runs the first Wednesday of every month. ■

Early Intervention and Cross Cultural Mental Health

Eric Macnaughton

Eric Macnaughton is the Coordinator of Policy & Research at CMHA BC Division. He is the author of the BC Early Intervention Study.

Evidence is growing that the earlier one intervenes, the better the outcome will be for a young person with a major mental illness such as schizophrenia. On the other hand, the longer it takes to get help, the poorer the person’s response to medication, the chances of having a relapse grow, and the more disrupted the person’s relationships and life plans become. The extent of delays in “mainstream” society is surprisingly high: typically around *one year* elapses after the first psychotic symptoms to the point when care is received. This occurs for a number of reasons which, as this article will discuss, are likely more pressing in ethnocultural minority groups. An under-

standing of these factors is necessary for intervening earlier and more effectively for all young people with mental illness, regardless of their background.

First of all, let us consider the range of factors that contribute, in general, to these delays. Lack of accurate information makes it difficult for the person and his or her family to interpret early problems as being due to “mental illness.” If the family does suspect that “something is not right,” fear and stigma often prevent them from taking steps to get help. When they do seek help, primary care “gatekeepers” (e.g., school counselors, family doctors, etc.) themselves have trouble detecting men-

tal illness in its earlier stages. Help sought in emergency situations can be especially hard to come by, as local emergency wards often lack specialist expertise and hold a very high threshold for admission.

Again, it is likely that these barriers are more troublesome for a person or family from an ethnocultural minority group. Public education about the early signs of illness is usually not tailored to culturally diverse audiences. Cultural communities may vary in their openness to information. This, in turn, may depend on the extent to which there are persons or agencies in a position to act as brokers between mainstream and minority cul-

tures. In the absence of information, the tendency to “normalize” early signs of mental illness, for example to explain them in relation to certain spiritual traditions, may be higher. Educational resources must be sensitive to the explanations offered by diverse cultures and be able to promote accommodation between different understandings of the illness experience.

A recent Australian report suggests that stigma is considerably stronger within recent immigrant groups, and that this was a main reason people did not reach out for help. Fear of stigma may be particularly great for cultures who lack understanding about confidentiality,



and believe their problems will become publicly known. Sensitivity to stigma was also a main reason why agency people consulted in the Australian study were reluctant to refer people on to specialist services. Negative perceptions about services may have been shaped by experience in the country of origin where in some cases mental health care was associated with being “locked up for life” or put to death. These views may also have been shaped by hearing accounts from other recent immigrants of negative experiences in the host country. A study done in Montreal among the Filipino, Anglo-Caribbean, and Vietnamese communities showed that in addition to fear and stigma, the other significant barrier to help-seeking was the belief that services would not be sensitive to their cultural needs.

Vancouver- and Toronto-based studies have pointed to other delaying factors, such as a fear by Chinese families that an acknowledged mental illness will affect the marriage prospects of siblings. Poor coordination between formal mental health services and cultural agencies has also been identified as a factor. The Montreal study further illustrated that seeking help from culturally appropriate alternatives delayed access to formal services, but did not replace the need for them. People who were higher users of alternatives eventually made high use of formal mental health services.

When people do access help from formal services, they face problems having their problem correctly interpret-

ed, due to a tendency to define mental health problems in terms of bodily complaints (known as “somatization”), rather than in psychological or mental terms. While this phenomenon is quite common across all cultures, it is believed that for people from African and Asian backgrounds, it is more likely that mental health problems will be presented solely in terms of physical complaints. Lack of awareness by mainstream practitioners and lack of appropriate assessment tools decreases the chances of detection and appropriate referral to specialist services.

There are many other barriers preventing access to care which affect people from ethnocultural minorities to a greater extent. Language and communication problems are obvious barriers, along with lack of adequate cultural interpretation services. Refugee claimants may be reluctant to seek out help for fear of deportation. In BC, service mandates often restrict care to the “seriously mentally ill.” Under this mandate, services often do not reflect the unique needs of refugees dealing with trauma, for example, or immigrants dealing with psychosocial problems relating to adapting to an alien or unfriendly environment.

Access to care is not the only issue related to effective early intervention. Successful *engagement* in care depends on a non-traumatizing and effective initial experience with admission and treatment. It also requires help for the person and the family in understanding and coming to terms with the illness. These issues relate to the treatment environment, but also to the “cultural

competence” of the treatment setting, as discussed in other articles in this journal.

To summarize, intervening in a timely and effective manner depends on public education, appropriate to people from all backgrounds, which addresses informational needs and also deals with stigma in its various forms across cultures. Next, our gatekeepers must have the skills and resources to correctly identify and refer potential problems. Connection to specialist resources also depends on close coordination between the formal mental health system and agencies or persons who can act as “culture brokers.” Finally, successful engagement and care, leading to recovery, depends on a non-traumatic, culturally competent environment of care, and comprehensive community support.

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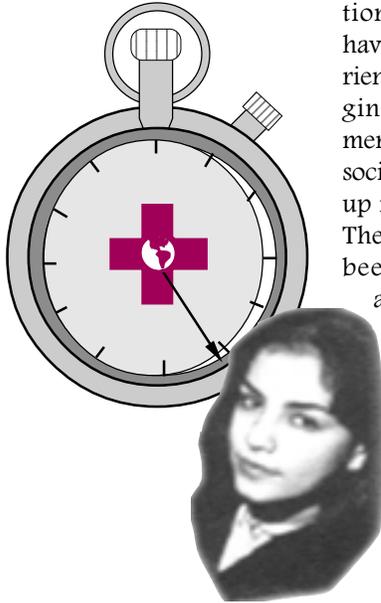
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“**The earlier one intervenes, the better the outcome will be for a young person with a major mental illness. Unfortunately, delays are surprisingly high, reasons behind which are likely more pressing in ethnocultural minority groups.**”

”



Cultural Competence and 'The Knowledge Resource Base'

Eric Macnaughton

Eric Macnaughton is the Coordinator of Policy & Research at CMHA BC Division.

The "Framework for Support" is the conceptual basis guiding the activities of the CMHA. The "Community Resource Base," in turn, is a key concept underlying The Framework. It outlines a range of possible resources in addition to the formal system which can provide support to a person with mental illness. These include self-help and peer support; support from family and friends; from "generic" community resources, such as the

cal model, but should include experiential knowledge gained from the person with the illness and his or her family. More relevant to the issue at hand, it also should include concepts of mental health or illness that come from different cultural traditions.

Without a fuller knowledge base, the potential of our efforts to promote recovery will be significantly hindered. At the same time, these other sources of

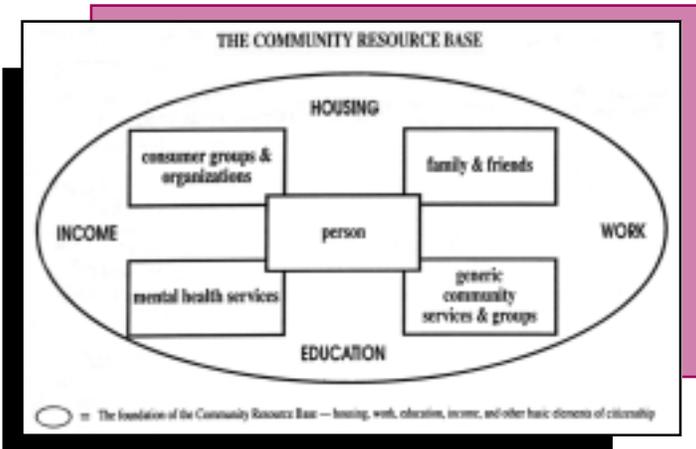
conference identified a number of Western assumptions about the way "mental health" is conceptualized, which would not be shared across cultures, for instance:

- **separation of mind and brain and the brain/body:** in contrast to the Western psychological methods which look at "the mind" independently, techniques based on Eastern traditions such as meditation, tai chi, Ayurvedic breathing, in fact, have positive benefits on the mind by concentrating on aspects of "physical" being such as posture and breathing.
- **separation of "illness" and "health"; equating mental health with "control":** in contrast, ideas about wellness in non-Western cultures tend to be more holistic, and concentrate on balance or harmony (between bodily elements, or between the body and one's environment) rather than on control over the environment.

ial order rather than independence; in this context, Western ideas of therapy which are based on working through one's own personal history may be inappropriate and ineffective.

Another area of difference to consider is in the way mental distress and illness are experienced and expressed. Factors to consider include the following facts:

- **stress and distress are culturally relative:** distress may be experienced and expressed differently depending on the cultural background of the individual, and since mental distress is often expressed as bodily complaints in non-Western cultures, our assessment instruments must reflect and be sensitive to these differences; to take another example, while in the West we assume the most extreme expression of depression, suicide, is more common in men, recent evidence suggests that this does not hold true cross culturally.
- **mental distress and interpersonal difficulties often reflect social factors related to the immigrant experience rather than an underlying "disorder":** mental health professionals, therefore, must be sensitive to the emotional stages often associated with the immigrant experience, from initial elation related to high



YMCA, the community centre, or local religious and cultural institutions; and finally from the formal system itself, with respect to acute care, crisis services, or ongoing community support.

A concept which goes hand in hand with the Community Resource Base, "The Knowledge Resource Base" is outlined in "The New Framework for Support" (Trainor, Pomeroy & Pape, 1993). The idea here is that the knowledge we use to inform our efforts to provide support should not be limited to the Western biomed-

course of action. The first task is documenting different experiential and cultural understandings while at the same time becoming more aware of the assumptions underlying the Western biomedical model. The next undertaking is then promoting dialogue, doing professional education, and influencing policy makers.

With these tasks in mind, what then can we say about the assumptions and knowledge base of the Western tradition, in relation to other points of view? A recent cross cultural mental health



expectations, to disenchantment, to a balanced view which reflects both the strengths and weaknesses of the host country. In the context of the immigrant experience, distress or interpersonal conflict can be associated, among other things, with culture shock, unfriendly reception in the host country, unfamiliar social rules, drops in status due to changes in occupational and social roles, and changes within familial roles.

■ **“symptoms” of apparent mental illness may reflect the immigrant or visible minority experience rather than simply an underlying illness:**

for refugees, what appear to be psychotic symptoms can be dissociative symptoms related to post-traumatic stress disorder; similarly, paranoia may not be pathological, but instead reflective of political conditions in the country of origin, or racism in the host country.

■ **illness syndromes may be “culture bound”:** the Western assumption that cross cultural variations in symptoms reflect underlying “core” illnesses may not always be warranted (see, for example, pages 5-8 in this issue).

Finally, some of the fundamental evidence about illness epidemiology (a field related to determining the health of a given population), effectiveness of treatments, and outcomes related to serious mental illnesses such as schizophrenia needs revisiting in light of cultural factors. For example, a review by Warner & de

Girolamo (1995) relates evidence that

- long-term outcomes of schizophrenia appear more favourable in developing nations, probably due to increased opportunities for social inclusion in economies not yet highly industrialized.
- incidence of mental illness is rising in the developing world, as industrialization proceeds.
- in Western countries, for complex reasons, incidence of schizophrenia may increase in second-generation immigrants.
- finally, according to a review by Beiser, response to medications varies culturally.

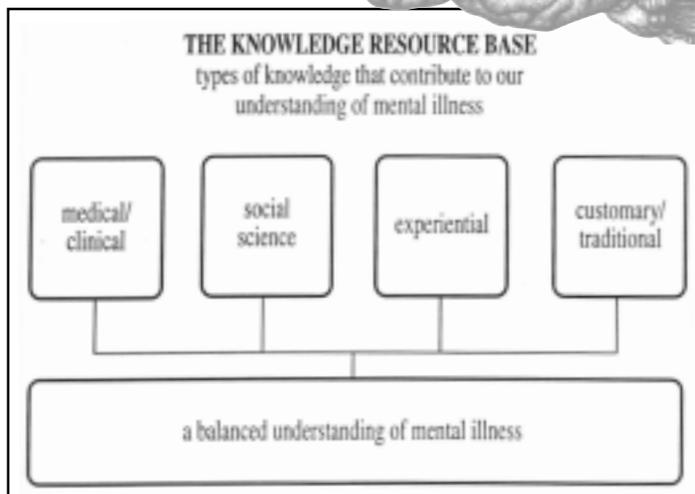
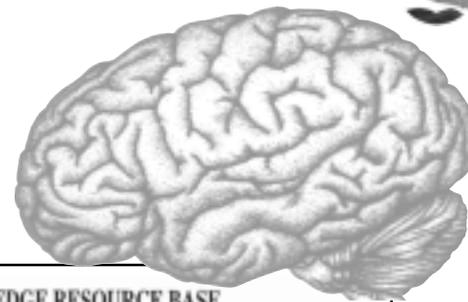
There are doubtless many other areas of knowledge and practice that will require revision when considered in cross cultural perspective. A thorough reevaluation of the Western knowledge base, along with careful evaluation of rehabilitative alternatives from all areas of the “Knowledge Resource Base” can only improve the “cultural competence” of our mental health providers in our communities. This in turn, will improve our ability to meet the guiding philosophy of The Framework for Support: “to help people with mental illness live rich and fulfilling lives in the community.”

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Related Resources on Cultural Competence

- Cultural Competence Assessment Tools. Boulder, CO: Western Interstate Commission on Higher Education. (Report: 97 pages, 1996).

Included as an appendix in the Western Interstate Commission on Higher Education's 1996 report "Developing Culturally Competent Systems of Care for State Mental Health Services," these assessment tools were designed for various stakeholders working with mental health and cultural competence. This report includes a patient satisfaction survey containing suggested modifications; a service provider version of a cultural competence self-assessment questionnaire; clinical performance assessment; cultural competence assessment instrument focusing on organizational environment, public relations, community work, human resources, and clinical issues; and program self-assessment survey for cultural competence. It also includes a cultural competency administration self-assessment; cultural competence self-assessment questionnaire, administrative version; administrative performance assessment including financial performance standards; and a community survey on cultural competence. A copy of Bloch's Ethnic/Cultural Assessment Guide is also included. (Excerpted from the web site of the National Technical Assistance Centre for State Mental Health Systems (U.S.); URL is [http:// www.nasmhpd.org/ntac/cultural.htm](http://www.nasmhpd.org/ntac/cultural.htm))

ORDER FROM: Western Interstate Commission on Higher Education, P.O. Box 9752, Boulder, CO 80301-9752, Phone: (303) 541-0200, Fax: (303) 541-0291.
- From the Australian Mental Health Network Publications Catalogue (at special price, using order form available from CMHA BC):
 - Evaluating Mental Health Services for Non-English Speaking Background Communities
 - Assessing Needs for Mental Health in Culturally and Linguistically Diverse Communities: A Qualitative Approach
 - Culturally Informed Clinical Practice (1999): CD-ROM
- Article:

"Rehabilitation & Cultural Diversity," By Ron Peters, *Visions* issue on Rehabilitation & Recovery, CMHA BC.



Doing Cross Cultural Clinical Assessments

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[EDITOR'S NOTE: The workshop described below examines ways of conducting cross cultural assessments which are sensitive to the health beliefs of people from various ethnocultural backgrounds. While the focus is generic in nature, its application to mental health care is apparent.]

The objectives of the workshop were to:

- identify factors affecting cultural assessments,
- identify explanatory health models, and
- negotiate the differences.

Some identified factors that influence cultural assessment are differing health beliefs, family of origin, role in the family, rural or urban background, religious/spiritual beliefs, sexual orientation, education level, socioeconomic status, and level of acculturation. There are likely to be more differences within a culture than between people of differing cultures who possess similar educational levels and/or socioeconomic status.

Avoiding stereotypes.

Using knowledge about a given culture as working generalities.

The importance of avoiding stereotypes and using information about a given culture as working generalities that must be explored with clients was stressed.

Berry's framework that in-

dicates whether a person's ethnicity/culture is likely to be an indicator of a challenge in accessing health care was discussed. This refers to acculturation: the process of adaptation through first-hand contact between cultural groups.

Four models of acculturation: integration, assimilation, separation, and marginalization

Berry defines four models of acculturation: integration, assimilation, separation, and marginalization. Integration refers to individuals retaining their original cultural identity, as well as becoming an integral part of the dominant society. Assimilation occurs when one's cultural identity is abandoned and the person merges into the dominant society. When the cultural identity is maintained without any significant relations with people from the dominant group, separation occurs, or, if imposed by the dominant group, segregation results. Marginalization refers to people who have lost psychological and cultural contact both with their own culture and that of the dominant society; this may be a result of either withdrawal or exclusion.

It was next suggested that four dimensions of illness be exposed: patient's ideas about what is wrong; their feelings, especially fears, about their problem(s); their

expectations of the health care provider; and the effect of the illness in functioning.

Kleinman's questions to elicit a patient's explanatory health model were offered as one of the tools available to health care workers. The questions state the intent and the wording. Order or timing depends on the worker's assessment of the specific situation. The questions are:

- What do you call your problem/what name does it have?
- What do you think has caused the problem?
- Why do you think it started when it did?
- What do you think your illness does to you (and) will it have a long or short course?
- What do you fear most about your sickness?
- What are the chief problems your sickness has caused for you?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from the treatment?

[EDITOR'S NOTE: Kirmeyer suggests another key question is whether the person sees their health problem as similar to that of another person or experience with whom or with which they are familiar. For example, a similar experience among a family member may affect their interpretation of what is going on.]

A process of "principled negotiation" was discussed as a method of resolving discrepancies between people providing care and those receiving health care. Fisher and Ury describe this method of negotiating differences:

- First, **separate the people from the problem.** It is better to see the problem as being "out there" and have people working together to attack the problem not each other.
- Secondly, **focus on interests, not positions.** People tend to stake out a position and defend it as if it were personal territory. Often the underlying interests are forgotten in the battle.
- Thirdly, **generate a variety of possibilities** before deciding what to do. Having too much emotional investment in one approach inhibits creativity.
- Finally, **use objective criteria to judge the solution** rather than pitting one personal opinion against the other.

In conclusion, the key considerations in doing cultural assessments are process is more important than content, there is no magic recipe, self-awareness is crucial for understanding, valuing diversity is vital, and interest in and respect for others is necessary. ■



Caring and the Culture of Mental Health Professionals

In this discussion, I hope to present briefly the position that the environment (the mental health system) combined with individual characteristics of professionals can impact the care we provide, especially to minority group patients.

The medical/health care environment affects the way we perceive patients and therefore provide care. For instance, it is not unusual for a patient presented to the emergency department as having a prior psychiatric illness to be referred to the psychiatrist without detailed physical examination. The same is true of psychiatric settings where we focus more on mental illness to the neglect of physical conditions. Because health care professionals are human, and interact with each other, they are affected by their own environment and influenced in their practice by this same environment which includes their colleagues and their colleagues' belief systems.

Our attitude and approach to mental illness results from our beliefs about the condition. As professionals, we speak our own languages and in codes that may not be easily understood by others. We belong to a group. When we speak in this way, our care may be misinterpreted as non-caring. It is often difficult for our patients to break this language barrier. Our language, which is evidence of our belonging and our education, may unintentionally put a barrier between us and those we are trained to serve.

A thirty-eight year old woman was furious about the way she was treated by staff at a hospital. She complained that she was maligned with the diagnosis of borderline personality disorder. Once this diagnosis was made, her treatment, the approach to her, and her perception of her illness changed — it became more negative. She felt that staff no longer took her distress seriously. The technical language with its own unique, often non-traditional meaning, must be translated.

Studies of work environment and related issues in “non-English speaking background” nurses in New South Wales, Australia concluded that professional relationships and status are often altered when one goes into a work environment in a different country. This is especially so if one were to be classed as a minority. Instead of being seen as a professional competent in one's work, one is seen first and foremost as a minority with associated expectations. This modified role and “deprofessionalization” happens not only with colleagues but also with patients. This often results in a situation in which non-majority ethnic group members are stripped of whatever powers or privileges are associated with their professional groups. They are treated differently than other professionals who belong to the majority ethnic group.

Minority ethnic group professionals may strive harder to belong to the majority group as a validation of their professional standing. In the process, they adopt belief systems that are consistent with the majority. What accompanies this adoption of the majority belief system is a rejection of minority belief systems. To show oneself as being professional, one rejects what is considered non-professional, i.e., minority belief systems. In fact, the Australian report concluded that nursing is a socially and culturally constructed profession with practices that are shaped by dominant ideologies within the country of training and qualification. This is true of all professions. In the medical profession, it results in increased focus on biomedical models despite the promises of biopsychosocial medicine. The profession should heed the warnings of Rothschild (1998) and Ruiz (1995) that if physicians focus solely on the biomedical approach to treatment of disease, they will invariably misunderstand the patient and miss valuable diagnostic cues. Poor outcome and non-compliance inevitably follow from this.

Our individual belief systems as human beings and as professionals influence the way we apply the scientific data that we acquire. A recent discussion of the intersection between various cultures noted the potential for conflict between the collectivist cultures of Asia and Africa with the individualist culture of North America. This is not limited to the political arena or financial arena, but also operates within the health care system. For instance, the role given to family members in decision making and participation in the health care delivery system has been limited. (I recognize that the new Mental Health Act seems to have recognized the role of the family, i.e., the extended family system in the health care delivery of individuals with mental illness.) Mental health professionals often conclude on the “rights or wrongs” of a particular set of cultural beliefs or practices that they encounter in their professional practice. The assumption is that the predominant North American set of beliefs is the right one. While the health care professional's values may differ from those of the patients, it is the recognition and implications of these differences that count.

This discussion hopes to raise our awareness of the fact that in various areas within our practice we will respond to specific aspects of the way patients present themselves. This starts with the description of the symptoms and carries through to our diagnosis and treatment. Our responses are influenced by our belief systems. Though we use the scientific model as a basis for our actions, the actual result is a combination of restrictions imposed by other pressures, i.e. the system, and our individual characteristics. In a past era, when it was not considered a scientific crime to quote Freud, this idea would be referred to as “counter-transference.” It exists within all interactions whether at an individual or systemic level. ■

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The Multicultural Mental Health Liaison Program

GVMHS



The Multicultural Mental Health Liaison Program was created in 1990 with grants from all three levels of government and a private foundation. The program model was the culmination of two years of community consultation involving more than two hundred people¹. It has been a permanent program of the Greater Vancouver Mental Health Service since 1992-93.

The purpose of the program is to increase the appropriate utilization of community mental health services by seriously mentally ill members of ethnocultural minorities in Vancouver and Richmond. We hope to achieve this by increasing the accessibility and responsiveness of these services.

To accomplish this purpose we defined a new role in the system — one that acts as a link and a mutual change agent between community mental health services, the ethnic communities, and the existing network of individuals and agencies providing human services to immigrants and refugees. The program currently has a staff of five, consisting of one full time person to work with each of the following communities: Chinese, South Asian, Latin American, Southeast Asian (mainly Vietnamese), and First Nations.

The approach focuses on indirect or facilitative services such as education, consultation and training, service brokerage, and service coordination. Some direct clinical services are offered, depending on the skill set of the staff member, and almost always in the form of co-therapy with existing clinical staff.

The target populations of the program include members of the general ethnic public, community gatekeepers (e.g., ethnic workers in immigrant-serving agencies or in private practice), community mental health staff, and other mainstream service providers who work in areas such as immigration, education, welfare, and the broader health disciplines.

A basic premise of the program is that improved working relations between community mental health, the ethnic general public, and community gatekeepers will come about as a result of a process of mutual learning and accommodation. This must involve a flow of information, a correction of misinformation, a modification of attitudes, and a sharing of expertise that moves in both directions. The purpose of the program is to create positions that could act as “middle men” in facilitating and directing the required flow of information and expertise.

In terms of education, our first priority is to provide the

ethnic general public with information on serious mental illness: What are they? What are their causes and outcomes? What treatment options are available? How does one access these services? We also target staff in the mental health system with education on topics related to cross cultural service delivery, as well as providing them with information on existing settlement and adaptation services for immigrants and refugees. Education is given to ethnic community gatekeepers (e.g., about the components and mandates of the mental health system and how to make well-targeted referrals), and to other human service providers. The general goal is to provide information that increases the chances that people with serious mental health concerns will be recognized and referred into the system in a timely and effective manner.

There are two main targets for consultation and service brokerage activities: ethnic community gatekeepers and clinicians. Ethnic community gatekeepers can be provided with mental health consultations to determine whether a referable problem exists and assistance in connecting clients with appropriate resources. Clinicians can receive cultural case consultations and active assistance in connecting clients with the full range of services needed from settlement and adaptation agencies.

We have intentionally de-emphasized direct clinical services in this program. The intent is that the Liaison Workers act mainly as systems change agents — the goal is to increase the capability of all staff within the mental health system to work effectively with the full range of people in the community they are mandated to treat. Our concern is not to overload the workers with requests for direct service to the point where they cannot provide the other (primary) services of the program. We also do not wish to create parallel service systems for ethnic minority groups.

This program has been evaluated very positively in meeting its specified goals. To more fully meet the needs of seriously mentally ill individuals from ethnic minorities, the program should be supplemented by other activities. The Greater Vancouver Mental Health Service has submitted a proposal to the Regional Health Board to develop English as a Second Language programs directed specifically at people with mental illness. We are also helping the Regional Health Board to develop an implementation plan for their recently approved employment equity policy. Finally, we believe that encouragement should be given to recent pilot projects that have created certification programs for health interpreters, that this should be expanded to include additional training for mental health interpreters, and that clinicians also need to be trained to work well with interpreters. ■

Footnote

¹ Peters, R. “Increasing the responsiveness of mainstream mental health services to ethnocultural minorities.” (1993). In R. Masi, L. Mensah & K.A. McLeod (Eds.) *Health and Cultures: Exploring the Relationships. Volume II.* Oakville, ON: Mosaic Press. 187-203.



First Nations Liaison Work:

A Feature Interview with Perry Omeasoo

What follows are the highlights from our feature interview with Perry Omeasoo (pronounced O-me-a-sue), the First Nations Liaison Worker for the Greater Vancouver Mental Health Service (GVMHS).

Visions: Can you tell our readers a bit about yourself and your background?

PO: “Hi, my name is Perry Omeasoo. I’m a Cree Native from Hobbema, Alberta, a mental health worker for the GVMHS, and I’ve worked in the counseling field for the last nine years. I’ve had extensive experience as an outreach worker. I’ve worked as an HIV/AIDS worker down here, as an alcohol and drug counselor, and I’m also trained in critical incident stress management and conflict resolution. I sit on a number of boards and committees in the Lower Mainland, and I try to keep pretty busy within the community.”

“So I come from a wide variety of experiences, but where my passion for helping the community all stems from is my strong spiritual basis, as a pipe carrier. And my strong spiritual base comes from my family, and especially my grandfather, who I guess white people would call a medicine man, but I always looked at him as someone who did ceremonies ... and always had people coming to the house and seeking advice from him on

spiritual matters. So I kind of followed in those footsteps.”

“We have such a wide assortment of people from all over the province who come (to the Lower Mainland)... and from all over Canada ... In reality, it becomes almost flowing with Natives as people flood in, and other people who’ve gotten tired, disillusioned, or bitter about big city life are going back to the smaller communities — from where they came.”

“...You know, I can see the single mother on Commercial Drive with six kids, living on social assistance and trying to access a youth worker for her teenage children so they don’t get caught up in alcohol and drugs, and her trying to be a positive role model for her children. It’s a difficult, difficult place to be and lot of people think they’re going to find a better life, and that doesn’t always happen here...”

Visions: Tell us a bit about your job.

PO: “I work at GVMHS under the Multicultural Liaison position and I’ve been working here for almost a year and a half. Though the Multicultural Liaison program was started seven or eight years ago, it’s in the past year that they finally got money from the Vancouver/Richmond Health Board, and another part from the Van-

couver Foundation, to set up the First Nations Liaison Worker position. All the Multicultural Liaison workers from the different communities are situated within different teams within the city, and I’m at the Strathcona Team at 253-4401. One of the reasons they put me here was because of the high number of First Nations people that come through the downtown core ...”

“I spend a lot of time down here at the Team, and I’m at a place called Native Counseling & Courtworkers. I rent a space there because it’s more accessible for First Nations people to come through the door — they won’t be coming to a white institution and it’ll be a bit more comfortable for them to see me.”

“There’s four aspects to my position. The first one is education: I’ll provide educational workshops around mental illness for First Nations communities, for First Nations professionals, and even for some of the Native reserves in the area — the Musqueam, the Squamish if they wanted it, to all the Native organizations within the Lower Mainland, probably about 60 or 70. It’s a big community, probably 60 or 70 thousand in the Lower Mainland...”

“There’s also the education of non-native people: psych

nurses, doctors, hospitals. It’s important that health care professionals be educated on First Nations culture and spirituality. In my opinion, that would make them more approachable. It’s amazing how some of the younger professionals [especially] are more prone to be asking questions and want to follow me around and ask to attend workshops and attend sweats and native ceremonies, talking circles. It’s amazing how they’re really open to that.”

“Another part of my job is to provide consultation, and that would include giving advice to doctors and psych nurses regarding First Nations people, again around spirituality, culture and language. For the other multicultural workers, language is a big part of their programs, for mine it isn’t: all Native people know how to speak English. ...The doctors and psych nurses will come in, give the clients their medication, and then they’ll come back in two weeks to get their medication again, and there’s no kind of connection. Part of my job is bridging that gap — that’s where consultation comes in.”

“...Because I’m a fairly experienced outreach worker, I don’t have any problem going in people’s homes, or hotels, or Native housing units to get clients and bring them in for their appointments. That’s part of my job. Another part is



making them feel comfortable, because a lot of times when a client is suffering from mental illness, he's a little uncomfortable to talk to a psych nurse or a doctor, because we're asking the client a lot of personal questions regarding sexual abuse, substance abuse, family violence. We're really probing at this point: that's part of what the assessment is all about, but it's amazing how Native people feel more comfortable with another First Nations person sitting in the room. It takes some of the harshness out of it."

"Another part of my job is actually providing a face to mental health; that's important. A lot of people look at me and think 'mental health, that's such a broad definition,' but, to us at GVMHS, our mandate is clients with serious mental illness, so I really have to make that clear. We deal with clients with PTSD (Post Traumatic Stress Disorder) — we'll do follow-up or emergency short term care — but we'll refer them on to therapists. Especially in downtown core areas such as Strathcona, we'll have clients who'll come in with serious mental illness, but they'll also come with an assortment of illnesses, such as substance use, or HIV, or maybe they'll have long-term sexual abuse issues to deal with...so how do we deal with that?"

"...And I think by providing education for the staff here the clients are always going to leave with something, and if the staff don't contact me personally, there's enough information that I've left around...that they'll always be able to find a phone number for one of the Native organizations in the community. And again,

that's where service brokerage comes in, because that's what it is, to provide services to a client with a long time abuse history, or finding the addict a referral to a therapist. Maybe a First Nations therapist would be easier than a non-Native one."

"Another part of my job is to provide co-therapy with clinical services. I probably carry a caseload of four or five now; I do a lot of crisis/emergency kind of stuff. If a client has an episode, and as a result is hospitalized, the caseworkers will call me after he's been stabilized and find out what we can do for the client, whether it's housing, going to Longhouse ceremonies, going to Native AA meetings, or maybe connecting with the families: I have access to every Native reserve in Canada. [For example,] I phoned up Manitoba and contacted a cousin who then contacted a sister of the client."

"... I don't carry a lot of clients anymore, but with that, it's maintaining a good relationship with them, educating them around spirituality and around culture; because there's a lot of native people who've kind of gotten lost in the system over the last twenty years, coming from foster care, and being raised in a white environment and living in the cities all their lives, they're really unaware of what's out there regarding spiritual practices."

Visions: Can you describe a typical day at your job?

PO: "When I first started, I'd have to do workshops — two or three a week...probably over a hundred in my first year. Now that I've covered all the teams and the hospitals I'm educating the Native

community... So, I'll come in, and find out if staff have booked appointments for me, I'll attend assessments with clients, or I'll go to St. Paul's or other hospitals to try to connect with clients... This morning I spent an hour on Main & Hastings trying to track down a client who moved from one of his hotel rooms last welfare day and we don't know where he's living, and because he's late for his meds, we're making an effort to find him..."

"Lookout is a big [place to] access people because a lot of clients who migrate will end up being homeless and penniless and need housing; and Lookout is an emergency shelter like Triage, so I always make an effort to check in there a couple times a week to see if there's anything I should be knowing about, or if there are any new clients there. Lookout's really good actually because they're quite open to phoning Strathcona as soon as a First Nations person comes in where they suspect a mental illness."

Visions: What are the main barriers to accessible and acceptable treatment for First Nations communities?

PO: "I look around the city and I see what's missing...and a lot of that would be providing advocacy for housing units. The thing about mental illness is that when you provide housing, the illness goes away. I'm actually doing that at this point and it's working out quite well. A Native housing unit in town is providing housing for some of my clients if I can ensure that my client is coming with a psych nurse and a full team. [This is] because a lot of the Native

community, especially in housing complexes, are fearful about clients with mental illness coming in."

"Another [barrier] is communication... it really seems that I have to be vocal and to be seen for the services to be utilized because the First Nations people are prone to not use the services if they're not right there. And they're not too keen on coming to a non-Native agency anyway, especially with all the history... Any kind of white institution they're a little bit hesitant to come in and seek services because a few things are going to happen: they're going to be filed, numbered, and given a diagnosis... and there's a long history of non-trust there, so they're very hesitant."

"...That's where First Nations workers like myself are really a valuable resource for non-Natives...but there's definitely a big issue of not having enough Native mental health workers. I've been here for a year now, and I can see there's a need for somebody in my position, there should be somebody in First Nations housing, there should be a First Nations worker for education — let's say, the CMHA should have a permanent First Nations worker who'd go around and educate about the services — there should be a full-time education worker at Riverview Hospital and... Forensic — there's probably 120 Native people out there, so there'd definitely be a need. I think there should be a First Nations worker for every Health Board across the province. If we lobby for that it would be incredible. It would take care of people from every area in the province... there would be such a wonderful resource."



Visions: In your work, how do you separate what part of the client's experience is spiritual and what is clinical?

PO: "I had this doctor one time and he asked me to see one of his clients, and (according to the doctor) he didn't want to take his medication,

"Not to take anything away from the psychiatrist. He was definitely sick, but I persuaded the client how important it was to take the medication in order to stabilize him and not to starve himself for eight or nine days at a time, and to have

in general; they're looking to make that connection..."

Visions: What kinds of resources are available in Vancouver and in the rest of the province?

PO: "I have to say not a

homes, they have brown skin, and they don't know anything about being a First Nations person, except by the way people treat them."

Visions: What about services in other parts of the province?

It's amazing how Native people feel more comfortable with another First Nations person sitting in the room. It takes some of the harshness out of it.

and he was starving himself and he was delusional and he was hallucinating, and he was a very angry Native man. He didn't want anything to do with the doctor's suggestions. I was a bit hesitant because of his description — anybody would be — but after about 10 or 15 minutes with this man I walked away thinking he was a wonderful fellow...he told me he was fasting and that he *wanted* to have visions, and that he saw an animal spirit walking with him and watching over him, and he saw himself making a drum... Because I knew where he came from, from the Brandon area, and I knew a great deal about what kind of spirituality comes out of there (I could see that) all these things that the psychiatrist thought were delusional, are all consistent [with that spirituality] ... And the client didn't want to take any medication because he thought that it would destroy the connection with the spirit if he took medication, which isn't uncommon for First Nations people to believe."

supervision when he was being medicated, to go to a medicine man, and not to fast for more than four days. You know fasting is not uncommon, but white people would call that starving yourself."

Visions: How can Western-concept medicine complement Native approaches to achieving wellness for people with mental illness?

PO: "I think it's programs like this that are in the forefront today. GVMHS, by hiring a First Nations worker, is looking at the wellness and not the illness. The First Nations people's philosophy on life is to look at the positive aspects of the human being, like the medicine wheel, where we look at what's positive in all aspects, whether that be emotional, physical, spiritual, or mental. We look at wellness vs. illness so having [a program like this] is positive for the clients we serve. I think there's a lot of controversy around my position, but Native people have a strong spiritual sense

whole lot, especially in the Vancouver area, and I think that's where an organization such as Canadian Mental Health could really [provide a] benefit by providing educational posters, pamphlets, and educational material around mental illness and making them First Nations-based — having a First Nations Educator to talk about issues around mental illness. You know this isn't a job for one man, there should be a whole team of First Nations mental health workers, and its unfortunate we'll look at this program as an experimental program [and question]: is there a need for it? I think that the research last year found that out of the clients of GVMHS, 375 were First Nations, but that didn't include the referrals to other agencies and didn't account for the people who came through the doors, where we did some crisis management, and then went on their way. Plus, a lot of clients won't acknowledge themselves as First Nations, because of internal racism: they were raised in foster

PO:
"There's a mental health worker in the Squamish Band, and I'm pretty stumped; if there are others I don't know about them."

Visions: What more needs to be done?

PO: "It would be great if there was extra money for a big poster or pamphlet campaign to run across the province. Actually, that would be ideal. But a poster takes twelve hundred dollars to make. Because Native people speak English, it would be as small as taking the posters and pamphlets we have now and putting Native designs on them so that they would be approachable and acceptable. A Native person could pick one up and say 'hey what's this thing? It's got Native designs on it,' and they could read about schizophrenia or bipolar disorder or whatever. [I'd need to first] adapt them and make the wording a bit simpler, because there's not a lot of my clients that would pick up the ones that are there. Unfortunately, if you want to get something done, it comes down to resources. ■



Working with the South Asian Community:

Difficulties in Cross Cultural Assessment

Karin Rai

Karin Rai is a Mental Health Liaison Counselor for the Surrey Delta Immigrants Services Society. She can be reached at 597-0205 (ext. 282).

In recent years, there has been a greater recognition that culture and language influence individual expression of mental distress, psychiatric diagnosis and treatment, and the delivery of mental health care community-wide. Cultural concepts, values, and beliefs shape the way mental symptoms are expressed and how individuals and their families respond to such distresses.

Cultural norms also dictate which symptoms and behaviours are labeled “normal” or “abnormal,” and influence the acceptability of mental health services. Clearly, effective mental health care cannot be separated from the cultural context in which the formation and expressions of psychic distress occur.

Working as a Mental Health Liaison counselor for the last three years at the Surrey Delta Immigrant Services Society, one of my roles has been to provide cross cultural case consultation to mental health staff in the South Fraser Health Region. As a cross cultural consultant for the South Asian community, many difficulties have been apparent in the assessment process — difficulties which affect people’s ability to engage in mental health services. “Immigrants of South Asian descent” refers to people who identify India, Pakistan, Sri Lanka, Bangladesh, or Nepal as their countries of origin. People of South Asian descent may also be from Fiji, parts of Africa, and some Caribbean islands.

Assessment of the patient’s cognitive functioning is critical in determining the nature of the mental health disorder. Assessment is ultimately an interpretive process, where the health professional, influenced by his or her own culture, determines through interpretation the mental state of the patient. When patients of immigrant groups express a distinctly different reporting of culturally structured “familiar terms,” interpretation of the assessment can be misleading.

To give a very simple example, the depression screening tool THE H.A.N.D.S asks, “Over the past two weeks, how often have you been feeling blue?” When using this screening tool for multicultural/multilingual consumers, it was noted that literally translating the question into other languages was not sufficient. Many clients did not understand what is being asked of them, even if they could read or write English. Unless a client had the cultural understanding that *blue* is not only a colour, he or she would have misunderstood the question.

Surrey Delta Immigrants Services Society has had a Multicultural/Multilingual Depression Screening Day event for the last four years. Working with multicultural/multilingual clients, it was noted that when Western diagnostic cat-

egories, such as depression screening tools, were applied cross culturally to address mental health concerns in different cultural settings, an inherent bias was apparent. Simply translating screening tools into different languages overlooks the point that Western psychiatric categories are not objective and free from the influences of a cultural system.

Depression assessment tools also disregard the fact that other cultural communities express mental distress differently. Working with the South Asian community, I have often found that many South Asians communicate mental illness with reference to social circumstances and physical sensations which are often expressed through a storytelling style. A predetermined search for particular patterns of behaviour may miss the meaning of symptoms. It may also miss an emphasis on feelings and concepts conveyed by metaphors, imagery, and narrative styles of other cultures (Bose, 1997).

Research also supports the phenomenon that “patients from India, Pakistan, and other non-Western countries ‘somatize’ their emotional distress, in contrast to patients in the Western world who ‘psychologize’ their emotions more often” (Mumford, 1992). Somatization means to experience and attribute mental distress and symptoms to physical illness. Anxious and depressed patients are very commonly found in hospital medical settings seeking physical treatment for their somatic symptoms.

Cross cultural assessment difficulties are also evident when there is a lack of understanding that many contemporary non-Western languages generally lack specific words for anxiety and depression. Punjabi, for example, is a rich and expressive language for communicating emotional states, but no *one* word means depression; often a whole phrase is needed to express depression or anxiety. Unfortunately, most depression screening tools used in the South Fraser Health Region do not include assessment questions which would address clients who somatize their emotional distress.

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Mental Health and the African Community: A Service Provider's Account

Visions talked to Dawit Shawel from Immigrant Services Society (ISS) about a client — a recent immigrant from East Africa — and her experience with the mental health system. What follows is based on his account:

The woman's unfortunate experience was triggered by something which most of us understand and take for granted: an outside light which is activated by a motion detector. When she came in or out, the light went on; after she'd returned inside, it went off. Not being familiar with such things, she became puzzled and troubled. In her culture, it is common to believe in spirits; what she came to believe about the lights was that they were telling her that there was something wrong with her place, that she was in great danger, and that she should leave immediately."

And so, she came to be spotted on an East Vancouver street, running along with her young daughter. A neighbour, seeing something outside the ordinary, and being concerned for the child, phoned the police, who came and confronted the woman. Because of the language barrier, she became extremely frightened and agitated, and was then

arrested. While the Ministry of Children and Families apprehended the young child, the woman was taken to a local hospital."

"There, she became even more agitated, to the point of becoming violent, at which point she was involuntarily hospitalized in the psychiatric unit, where she was heavily medicated. No attempt was made to call in interpretive help, and ISS wasn't called until two days later. By this time, she was completely uncommunicative due to being heavily medicated.

Visions: Can you suggest how this situation could have been prevented?

DS: "One of the things that agencies like ours are doing, and especially ISS, which is the first contact for most government-sponsored refugees, is that we have orientation sessions to the lifestyle that awaits them, though we may not go through all the little things like motion detectors. But they do know they can call us for information before anything happens. They have standard contacts with workers of the Immigrant Services Society."

"On the other hand, I guess before any action is taken by anybody, be it police or hospital, someone has to make sure that things are communicated correctly before they reach any [further] stage. The call for an interpreter is

very important."

Visions: What kind of mental health issues does ISS see with its clients who are from the various African communities?

DS: "At this time we mostly deal with people who are depressed, then at times with traumatized people. So what we do is we only see them initially, then we refer them to the appropriate resources, in [the latter] case to the Vancouver Association for Survivors of Torture."

Visions: What kind of mental health needs are faced by people from African backgrounds?

DS: "In most cases, people from African backgrounds are faced with all kinds of things due to major culture shock as the differences between the two places are very huge. Aside from that, the Africans tend to go through bigger racial discrimination from every direction, not just from one, so there is a need for more support."

Visions: Is there a need for more education for people of African background about mental health and mental illness?

DS: "Mental illness and mental health issues are a taboo in the African community, so I know it is necessary, there is a need, but if you ask me how and where and

when, I can't tell you. That's the kind of question I ask myself, but definitely there is a need. There are so many people [who have issues]. Most refugees from Africa can be traumatized because of previous experiences. They come from war-torn countries in most cases, military dictatorships, there are refugee experiences ... For many, they don't realize what they're going through, and even if they do know, they find it difficult to communicate because it's very taboo. They don't want to be seen as someone with a mental health problem; that can be seen as a big failure on their part. So as it is, in most cases, they don't even acknowledge that it exists."

Visions: Thank you very much for talking to us Dawit. This has been very valuable. Before we end, are there any other issues you'd like to talk about, relating to the African community and mental health?

DS: "Yes, the number of



Dawit Shawel is a Community Settlement Counselor with the Immigrant Services Society of British Columbia.

Related Resource

MOSAIC offers bilingual counseling (including information, referral, interpretation, and translation services) in twelve languages including Somali/African. The others are Arabic, Punjabi, Hindi, Urdu, Chinese, Korean, Persian, Polish, Russian, Spanish, and Vietnamese.

Phone (604) 254-0244 for more information.

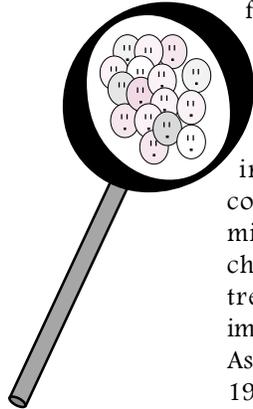


Mental Health and Disorder in Recent Immigrants:

Notes from a workshop delivered by Dr. Soma Ganesan, May 1998

Dr. Soma Ganesan

Dr. Ganesan is the Medical Director, Department of Psychiatry, UBC/VGH and Director of the Cross Cultural Psychiatry Program at VGH.



f the 215,000 people immigrating annually to Canada, 17% arrive in Vancouver and many settle here soon after arriving elsewhere in the country. The patterns of migration are constantly changing, with a recent trend towards increased immigration from Southeast Asian countries. There are 197 different dialects spoken in Vancouver.

vulnerable). Immigrant populations have a higher proportion of younger people, who are closer to the typical age of onset of major mental disorder.

The factors that affect mental health status of recent immigrants are similar, but not identical, to the risk factors for mental disorder. Age at time of migration is the top factor, followed by conditions surrounding pre-migration (stress, family composition, expectations), and post-migration variables (reception, community composition, drop in socioeconomic status). People from higher socioeconomic brackets are affected to a greater extent, at least initially, which may be due to a greater initial drop in status.

prevalence of mental disorder more difficult in immigrant populations. For example, many recent refugees initially go through a period of elation upon arrival. This could be confused with mania. In many countries, it is normal and adaptive to maintain a level of suspicion that may be considered pathological in Canada. It takes some time before people learn to relax their guard. Some recent local research has shown that Southeast Asians in particular are vulnerable to being misdiagnosed with schizophrenia. These are all issues that researchers, service planners, and practitioners must consider. ■

There are issues that make detecting and measuring

“African Community” – (cont'd)

Africans that I see in danger of being on the street has increased. So that number scares me. I wonder where that is heading, because there is so much unemployment and so much discrimination towards this group of people. There’s definitely a need for closer attention to this community in the mental health area. ■

The risk factors affecting the chances that recent immigrants develop mental disorder include language difficulties, unemployment, separation from family, lack of friendly reception from the host country, isolation of people from their cultural background, trauma in the homeland (for refugees and non-refugees), and age at time of immigration (adolescents and seniors are most

Cross Cultural Psychiatry Program, Riverview Hospital

This is a multidisciplinary cross cultural program intended to deal with communication barriers, medication difficulties, and issues related to the client’s perception of the illness.

The major goals of the program are to provide culturally sensitive treatment, and to equip clients with basic skills to function within the Canadian culture. The program also provides psychological and occupational therapy, as well as providing educational events for clients and family members.

The staff members have provided cross cultural psychiatry in-service sessions on such topics as “Refugee: Who, What, When?”, “Training of Interpreters,” and “Meeting the Challenge of Treating South Asian Clients.”

CONTACT: Dr. Daszkiewicz, 524-7000, or other members of the team, E2 Ward



When Two Cultures Collide:

Let's face it, a lot of "us" never considered when we decided to emigrate what it would really be like once the dust of moving finally settled

“They” come here and want to change every thing. “They” want to enter our legions with their turbans on while we have to take our shoes off to enter their Gurdwaras (Sikh Temple). “We” don’t want “them” to wear *Hijab*¹ because “we feel” that it is not simply a religious symbol but primarily one of oppression. Sound familiar? So is what I heard from a respected elder from our community at a recent funeral: “They” are teaching “our children” that women are equal to men when everyone knows that is untrue. Men are superior, you know. Can there be two kings in a kingdom? A king and a prime minister perhaps, but never two kings. And “they” are also telling “our” children that it is OK to put “our” old people in retirement homes.

Although it may seem like sheer ignorance, what we read and hear is not completely due to ignorance but to the dynamics of acculturation. When two distinct cultures intersect, conflict occurs, sparks fly and, fortunately, both cultures change. The headlines with which we are confronted every day are groans of the acculturation change. Let's face it, a lot of “us” never considered, when we decided to emigrate, what it would really be like once the dust of moving finally settled — especially the psychological adaptation that would be required of us, our children and future generations.

Our understanding of this adaptation is very important as it has a profound impact on ourselves and those closest to us. I will attempt to explain the process of acculturation, both for the group and the individual, the majority and the minority culture. Let's also look at the dynamics and the stress involved.

What is acculturation? It is the interaction, conflict, adjustment, and evolution of two different cultures when they come in contact with each other. The changes occur at both the group and individual levels. At a group level, the changes are economic, residential, political and social. For the individual, the changes may be in thinking, behaviour, type of attire, mannerisms, and language.

When a non-dominant minority culture interacts with a dominant majority culture, one might assume that it is invariably the minority that must change, for example, people having to choose between wearing turbans and securing employment. This isn't necessarily so. Both cultures adapt, such as in the case of the RCMP adopting the turban as an acceptable form of headdress, acknowledg-

ing the fact that it has no bearing on a person's ability to carry out his or her duties as a member of the force.

When a minority (Punjabi) group comes in contact with a majority (Canadian) group, the members of the minority group have to ask themselves two important questions:

- is the individual cultural identity of such value that it should be retained?
- should positive relationships with the dominant culture be sought?

Potentially, the answers to these two questions will influence the degree of stress experienced by the group and the individual.

A positive response to both questions would lead to the least degree of stress and the result would be integration. A negative response to both questions would lead to the greatest degree of stress and the outcome would be marginalization. A positive response to the question of retaining ethnicity and a negative response to the question of seeking relationships with the dominant culture would lead to an intermediate degree of stress and the result would be resistance. A negative response to the first question and a positive response to the second would lead to assimilation and intermediate stress.

To illustrate the four major options, let's take the hypothetical example of an immigrant family. Balwant, an accountant sponsored by his sister, decides, after getting a good job at a large firm, to keep his turban but adopt a suit and tie for work, giving up his ethnic clothes. He is enrolled in speech classes to improve his accent so as to maximize his chances of success globally. He gets involved in the local political and social scene. He attends and helps organize social events at work. His main socialization, however, remains with people from his own cultural background. He has decided to integrate.

His wife, Jaswinder, sticks to her ethnic clothes, speaks Punjabi, and socializes exclusively with others of Indian origin. She rejects the idea of having anything to do with the dominant culture, taking the resistance or separation pathway.

The couple's son Preet, now called Pete, has cut his hair with his parent's permission, is sick and tired of everything East Indian, including the language, culture, clothing, movies, and especially the food. Pete is determined to completely immerse himself in Canadian culture, earring and all. He excels in academia and sports, and enjoys snow boarding and rapping with his *gora* (white) buddies. He has opted for assimilation. Assimilation has its advantages: Preet is considered

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Footnote

¹ A *Hijab* is a head scarf worn by some Muslim women.



cool by his peers, but his relatives, especially his mother and sister, find his transformation somewhat nauseating.

Binder, Pete's sister, still speaks with a faint Punjabi accent, and has refused to join her father's speech classes. She is still seething at her parents' decision to move to an alien culture. She misses her friends back home. Smelling of pungent curry powder occasionally, she is rejected by her peers. She, in turn, doesn't accept them. Feeling trapped and in perpetual conflict, she is marginalized.

Balwant said yes to both questions, choosing integration. The stress of doing so is the least. In this scenario, stress increases if the majority pursue a political policy of blocking such integration because of a wish to deny the importance of a minority group's identity by, for example, attaching social stigma to the turban or *hijab*. In the case of Jaswinder, the stress is rather high. Having said yes to keeping her identity, she gains the respect of her peers and this increases her self-esteem. But having chosen a path of resistance, by saying no to the second question, she is in conflict with the majority group. Opposition to seeking a positive relationship with the dominant group can be expected to take its toll in the political and economic arena.

The position of assimilation, which Pete has taken by rejecting his ethnic heritage, is a fragile one. No matter how wholeheartedly he has been accepted by his peer group, he is setting

himself up for a narcissistic injury. Sooner or later, some ignorant person is going to prick his assimilative bubble by asking him, "Where are you *really* from?" Consequently, one could argue that the assimilative position is, by definition, potentially painful, particularly in the psychological sphere.

The most painful existence is that of Binder. Marginality represents a hopeless and negative view of life. People who adopt it are most likely working at the periphery of society, vulnerable to the ills of stress and dysfunction. Fortunately, there are only a few such people.

Everyone has to bear his or her own cross of acculturation. Based on all that I have read, taught, come into contact with during clinical practice, and personally experienced while living in England, the USA, and Canada, I have come to the conclusion that the optimal option is that of integration. It is superior to assimilation, since assimilation is an option for a visible minority only if members of the majority dominant culture volunteer to go colour blind.

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Structural Barriers to Recovery in First Nations Communities

Glen Schmidt

The rehabilitation and recovery process is a difficult journey. In recent years, many people who experienced a serious mental illness have gained a sense of hope through psychosocial rehabilitation programs and approaches that are increasingly respectful of consumers' needs and wishes. These programs emphasize choice and citizenship. However, the majority of rehabilitation and recovery programs originated in urban centres. This fact leads to some particular beliefs. These include a belief that communities have a range of housing options available for consumers. There is also a belief that the employment

market is diverse and reflects multiple opportunities for work. Finally there is a belief that various services such as psychiatry, hospitals, social work, and nursing are readily available within the community or at least available within close proximity.

These beliefs about rehabilitation and recovery do not fit well for people in northern and remote locations. The difficulties are especially acute for First Nations communities which face additional structural problems related to poverty, lack of economic opportunity, and systemic racism.

Health and social services in

the north have been organized in a manner that can be described as "vertical," meaning that programs and funding arrangements are controlled from a central point: a provincial capital like Victoria in the case of provincially funded services, and Ottawa in the case of federally funded services. Vertical control creates problems for northern people and First Nations people in that their needs are marginalized and programs are often designed with a southern, urban population in mind.

The history of jurisdictional disputes between the federal and provincial govern-

ments has produced further difficulty where First Nations people have been denied services normally available to other Canadian citizens. This situation is compounded by what might be called the two-tiered system of mental health services that exist between urban-dwelling Canadians and those who reside in remote northern communities. Access to community mental health is difficult and services taken for granted in an urban centre are non-existent in most First Nations communities. Psychiatrists rarely travel outside of urban centres and nurses and social workers who specialize in mental health and



recovery programs also tend to be urban-based. The result is that people with a serious mental illness are poorly supported in their communities and they may experience frequent and disruptive acute care admissions to distant urban hospitals.

A further consideration is that the cyclical nature of resource-based economies places northern people at periodic risk for unemployment. During the past two years, a downturn in the forest industry in northern British Columbia has resulted in high rates of unemployment. Even a relatively diversified economy like that of Prince George has seen unemployment rates hit 18%. However, the problem is most severe in First Nations communities where unemployment and poverty are at unacceptably high levels. Differences in unemployment rates between the general population and the First Nations population are significant, especially among younger groups who are most vulnerable to mental illnesses like schizophrenia. Census data from 1996 showed unemployment rates among 15 to 24 year olds at 10% for the overall Canadian population. Among First Nations people age 15 to 24, the unemployment rate stood at 32%. Such unacceptably high rates of unemployment make it difficult to incorporate employment as one of the cornerstones in recovery.

First Nations people also encounter major challenges when it comes to housing. The range and variety of housing stock is extremely limited and various restrictions on building mean that people can wait up to ten

years before they are at the top of the eligibility list for housing. The consequences of this are that people frequently live in multiple family arrangements that are overcrowded and quite stressful. The person struggling to manage a mental illness may find this type of environment to be extremely difficult.

There are a number of things that need to happen to address these structural barriers. First, provincial governments must do a better job of addressing service disparities experienced by northerners. Shortages of physicians and nurses as well as costs associated with specialist referrals are all considerations that require a committed

expenditure on the part of the province. The federal government, the provincial government, and emerging First Nations governments must also work to identify and eliminate jurisdictional barriers that affect service.

Second, the lack of housing and the access to housing within First Nations communities are a national disgrace. As the federal government contemplates its large budget surplus, it is clear that money from this surplus needs to be directed toward a major housing initiative within First Nations communities. The nature and form of housing construction also has to change to represent diverse community needs. Multiple dwelling units as well as larger single dwell-

ing units need to be more fully considered in housing construction plans. The needs of mental health consumers must be a part of any new housing initiative.

Finally, unemployment rates are high in First Nations communities and this can only be addressed through bold economic and political decisions. Treaty settlements and land claims are a vital consideration in this regard. Land claims settlements will not provide an immediate, magic solution, but fair settlements will create access to an economic base that, in the longer term, can improve employment prospects for all First Nations people, including those who struggle with serious mental illness. ■

Glen Schmidt used to be a mental health worker in northern Manitoba. He currently provides consultative services to a number of northern BC First Nations groups and communities. He is a board member of CMHA Prince George branch and an Assistant Professor of Social Work at the University of Northern British Columbia.

The Mental Health System ... as Racist?



I would like to explore the possibility that the publicly-funded mental health system is racist — and if it is — what can be done about it.

“Users of our one-size-fits-all, medical-model system are obliged to fit the box they make for them, and some of us would gratefully chop off body parts in order to make our square peg fit the round hole.”

The present system has a standard reason for peoples’ emotional distress: the medical model. This model says that people have a chemical imbalance that can be treated, though not cured, by medications. So people end up on pills, liquids, and needles for years. A one-size-fits-all system that presents itself as totally neutral, objective, and scientific seems removed from or elevated above ordinary people and their lives. Users of the system are obliged to fit the box they make for them and some of us would gratefully chop off body parts in order to make our square peg fit the round hole.

So, in effect there is no room for discussion or options. Other people (who are wealthy enough to afford private counselors, etc.) have their emotional pain recognized as coming from post-traumatic stress issues, abuse, issues of violence, etc. People who use hospital psychiatrists are told they suffer from chemical imbalances.

Sexism, classism, and racism and their effects on peoples’ lives are rarely seen as possible reasons for torment. Such “isms” exist, even if we don’t like to talk about them.

Helen Turbett

Helen is the coordinator of the “consumer”-run Vancouver-Richmond Mental Health Network.

cont’d left column next page ▶



Understanding White Power and Privilege

Gisèle Harrison, MSW

Gisèle Harrison is the Education Coordinator and a Rehab Counselor for the CMHA Vancouver/Burnaby Branch.

Over four years ago, I began one of the most difficult and challenging journeys of my life. The journey was one that would force me to understand, and then process, how racism has shaped and privileged my life. Until my journey began, I was under the false impression, like many other white people,

that racism was something that people of colour had to live and deal with, but not as an issue that generally involved or implicated me. I saw myself as non-racial or racially neutral, and considered myself to be “colour blind,” thus excluding me from any need to explore my participation in perpetuating racism.

In the last four years, I found that I learned the most about anti-racism when I participated in workshops and read books and articles that explored how racial oppression puts people of colour at a disadvantage and how race privilege puts white people at an advantage. Through this type of progressive training, I was able to understand how the illusion of “whiteness” as neutral, often makes it difficult for me, as a white woman, to see racism and/or to recognize when my own unconscious behaviour might unintentionally be racist (Kivel, 1996).

Most importantly, I learned that if my whiteness is the place from which I see the world, that I needed to be conscious of the enormous power differential between myself, as a white mental health worker, and a client of colour. As such, without a sound analysis of the extent of racism, and the power and privilege of being white, it is very likely that the relationship between a client of colour and a white mental health worker could unintentionally and unconsciously become an oppressive experience for the client. I found that understanding the power differentials posed by racism in my work as a mental health professional was further challenged in that all of my training and supervision has been with white people. Similarly the theories and approaches I was taught and currently practice were based on traditional white “Eurocentric,” male models, which

value white, anglo culture, history, achievements, and experiences as the norm (Dominelli, 1993).

In a study by T. John Samuel entitled “Visible Minorities in Canada: A Projection,” it indicates that by the year 2001, approximately 50% of the population of Toronto, and 40% of the population of Vancouver are expected to be visible minorities (CCIC, 1997). In other words, by the year 2001 between 20 to 50% of all mental health consumers could be people of colour. As such, mental health workers would be called upon to serve an increasingly multiracial and multicultural clientele (Pigler Christensen, 1996).

If our goal is to create inclusive mental health programs, which transcend racism, and facilitate equal, collective partnerships with people of all races, then white mental health workers should be encouraged to explore the “racialness” of their identities. Naming “whiteness” can only serve to displace it from its unmarked status and locate it in the relations of racism in the field of mental health (Frankenberg, 1997). Studying white privilege does not mean being responsible for racism; rather, its purpose is to raise the individual consciousness of white mental health workers by realizing the crucial differences that being white has had on the way we live and on the way we work (Kivel, 1996).

“The Mental Health System as Racist” – (cont’d)

Racism, individual or systemic, has a huge impact on peoples’ lives. Change is never easy for people and Vancouver is a rapidly changing city. It is one of the top three most culturally diverse cities in the world.

The response of the mental health system is to hire “multicultural” or “ethnic” workers to translate pamphlets and hold workshops on “multiculturalism.” In my opinion, most, if not all of this activity is aimed at helping people accept the medical model.

We don’t have workshops on what Aboriginal peoples believe to be the source of peoples’ distress or ways for the non-Aboriginal population to benefit from their wisdom — which is much older than the mainstream system. Chinese and other Asians also bring a different perspective, which like the Native one recognizes the mind-body connection. People from India have Ayurvedic medicine which also has traditions and learning from thousands of years of practice and observation.

Again many people (who can afford it) are beginning to appreciate other traditions — especially for physical ailments. However, the mental health system is still a closed door.

I predict it will be a long struggle to change this system, to make it more open and more responsive to other models. Those of us for whom this is an issue will have to demystify/simplify and move this system so that it can look at peoples’ lives and offer services that are culturally appropriate and not just window-dressing to maintain the status quo.

At first I was hesitant to write this article. As a white woman I thought it would be presumptuous of me. Now I’m glad I was asked. It is offensive to me, as an individual who has experienced the public mental health system, and as a peer worker, that a system that is supported by tax payers (and we are all tax payers) both ignores and contributes to the effects of racism. ■



The South Asian Women's Support Group

The South Asian Women's Support Club runs every Friday at the South Vancouver Neighbourhood House. The group is currently facilitated by a former member, and now volunteer, and is attended by up to nine women. The main aim of the group is to provide South Asian women who have been through the mental health system a place where they can socialize and provide mutual support. Most referrals to this group are made by the Broadway South Team of the Greater Vancouver Mental Health Service (GVMHS).



together to places such as the Gudhwara (Sikh Temple) and other places of interest.

The support group has been a much needed respite from the isolation that many of the women face in their everyday lives. Many are dependent on their families for transport and are homebound most of the time. Manjeet, a regular member for two years, agreed to share her story with me.

Manjeet's Story

After her husband died in India seven years ago, Manjeet became very ill, as she was unable to cope with the grief she felt at his death. She recalls she began acting hysterically like a "pagal" (mad person) after his funeral, which began to scare her family. She was then taken to see a doctor who eventually prescribed her medication for depression.

Shortly afterwards, Manjeet's eldest daughter, who was then living in Vancouver, sponsored her two younger sisters and her mother to join her. Within two weeks of arriving in Vancouver Manjeet became very ill again, acting "worse" than she had done before, and she remembers that she was not able to stop crying. She was admitted into hospital where she stayed for a month.

She remembers the hospital stay as a strange experience — none of the staff could speak Punjabi and she couldn't speak any English — but because there were some other Punjabi-speaking patients there, she didn't get too lonely. Over time, she came into contact with the Broadway South Team of the GVMHS and was referred by them to the South Asian Women's Support Club.

Manjeet finds her medication helps her but she still finds no joy in life. Sometimes the sadness she feels in her heart overcomes her and she loses all interest in the world around her. Although her daughters try to be supportive she feels that they have lost patience with her illness. She feels that they think she is making it up, that the reason she cannot get out

Vinay
Mushiana

Vinay is the
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of CMHA BC
Division's
Cross Cultural
Mental
Health
project.

Many of the women have limited or no English skills. This language barrier prevents them from accessing other consumer services and supports which could leave them totally isolated and solely dependent on their families for emotional support. The South Asian Women's Support Club provides a safe space for women which is culturally comfortable and has no language barriers as all of the women speak Punjabi or Hindi. For many of the women, it is a place where they can talk about their mental illness openly with other consumers. As in most cultures, the stigma surrounding mental illness is great and consumers and their family members often try to keep it hidden from the rest of the community.

The support group receives no direct funding but is supported by the South Vancouver Neighbourhood House which provides its operating costs. One of the Intensive Community Support Workers with the Broadway South Team of the GVMHS attends the group every two weeks. Her role is to provide support to the group whenever needed and to provide a link between the team and the group. As her team makes most of the referrals to the group, it is a natural link.

The activities of the group vary depending on the interests of the women but the emphasis is on keeping busy and active. In the past, there have been cooking classes, arts and crafts, and recently, knitting lessons. Speakers are sometimes invited to give talks on issues such as nutrition, medications, and exercise. The women also enjoy going on outings

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For further information on this support group contact Preet Pandhar, South Vancouver Neighbourhood House @ (604) 324-6212

of bed some days is because she is being lazy and doesn't want to help around the house. "What use are you to anyone if you're not productive?" she asks. Although she misses India, she knows there is no point dwelling on it, her family members are all here; there is nothing for her to go back to.

Manjeet finds the other women in the group to be supportive and she has been able to talk about many things with them. "I try and come every Friday, it makes me come out of the house, even when it's really cold like today" she adds. ■

Shakti group offers strength, enlightenment

Kanwal Grewalson

Excerpt from The Bulletin, official publication of the Vancouver-Richmond Mental Health Network, Vol. 4, No. 2, Summer 1999.

After my marriage in 1968, I migrated to Vancouver from Jalandhar district in the Punjab in India. My troubled marriage later ended in divorce. My husband took the liberty of taking my three daughters to India to be brought up by his parents.

For many years I led a very depressed life, which resulted in two major nervous breakdowns. I was introduced to the Shakti Group after my second breakdown in 1997, and I received a great deal of support for my emotional state.

I realized that I wasn't alone going through this terrible time. There are other like me facing the same life stresses. By interacting with other members, we shared our stories and understood that life can be better.

I was enlightened through discussions, seminars, and health fairs about alternative therapies. Unfortunately, the mainstream health system does not provide or inform us about healing our bodies through natural ways. This

group helped me to learn about the natural remedies that might be available for optimum health.

It is financially impossible for me to access these naturopathic remedies. So I would like to express my concern that consumers should have choice about their healing process and the Ministry of Health should recognize the necessity of alternative medicine and have all such treatments covered by medical insurance.

The Network's Shakti Group — based in the Lower Mainland — is open to women of South Asian descent who have experienced the mental health system. Its aim is rehabilitation through mutual caring and support, cultural solidarity, and help with adjustments into Canadian society. The group meets the first and third Sunday of every month, from 1:00 - 3:00 pm, and sometimes on Saturdays for special activities. Phone Helen at (604) 733-5570, or Nighat at (604) 682-3269 (ext. 8144), for more information. ■

New Mental Health Website:

www.mentalhealthconsumer.net

Terry Morris



Terry Morris is a long-time consumer advocate provincially and in the South Fraser Health Region.

The South Fraser Mental Health Consumer Advisory Network and Development Organization Society (CAN-DO), a consumer-run non-profit group, has launched a provincial web site for mental health consumers. The web site was featured as an interactive poster session at our National Conference in August and was enthusiastically received by all who viewed it. The site is intended as a method of facilitating consumer networking in the province and has many interactive features and areas for viewer input. The site includes an opinion page, links to clubhouses, and to consumer's personal pages as well as links to many sites of interest including those on self-help and recovery. There are lists of advocates throughout the province and there will soon be e-mail links to MLAs and MPs.

One feature of the site is the "What's Happening" page where upcoming conferences and workshops can be advertised so that consumers can both attend the events and see what other regions are doing and perhaps replicate it in their region.

The site's developers are looking forward to developing the aboriginal and multicultural components of the site and are in the process of establishing working groups to plan the content of those pages. It is important to the developers that the aboriginal and multicultural communities have an opportunity to plan and "own" their pages. They have a vision that these components may grow to be as large and diverse as the main site itself.

The site still has some areas that are "under construction" but is well worth a visit.

Funding for the project has been obtained from local and regional consumer, family, and community funds as well as from the Legal Services Society of BC.



Voices of Diversity

Reprinted from a past issue of Visions.

The following voices are self-helpers and family members from Chinese-speaking support groups. These groups meet regularly through Greater Vancouver Mental Health Service's Broadway South team. Interpretation kindly offered by team worker Raymond Li.

“”””””””””

“I lived with my wife for almost ten years and faced daily problems with her. Yet I did not know she had ‘schizophrenia.’ Since she started treatment with the mental team my life is becoming more ‘normal’ and a little bit more enjoyable.

I benefit a lot from the monthly support group meeting, because

- I realize that I am not the only one with such problems.
- I meet a lot of friends who are able to share their experiences on how to look after their mentally ill family members.
- The group invites professionals to speak to us. They provide us with good ideas and instill confidence in us as being the most significant persons in helping our loved ones to recover at home.
- The group gives me a chance to express my daily frustrations.
- I can contribute my own experiences and I can also listen to those from other family members and workers at the team.

I am grateful to the team and the support group for their advice and information on various aspects of mental health. I am thankful for enlightening the life of myself and of my entire family.”

John Wu

“”””””””””

“I have been participating in the support group for almost three years and I still get a surprised reaction from many new members, particularly family members, when they find out that I am a client of the team.

I am comfortable in sharing my view on mental health with other members. Speaking from my own experience, I urge others to stress recovery, to focus on a day at a time and not to dwell on negative thoughts. It is important for me to make my life meaningful and to remain in treatment.

I can empathize with the parents in the group. Their vicissitudes in struggling with the ebbs and flows of their sons’ and daughters’ illness serve as a solemn reminder for what I might put my parents through again should I become ill. I am committed to being well and staying well.”

Mary is a client-participant of the support group. She is also a volunteer responsible for organizing the venue for the monthly meeting. Mary is her pseudonym.

“”””””””””

“I feel supported and understood in the group. The atmosphere is very positive and accommodating.

I feel more capable in dealing with my pain. I am also able to change some of my perspectives in looking at my son’s illness as well as those of my life. Thanks to the help of the support group.

My son is still not working although he is mentally stable. It appears to me that he is not motivated to find work. I would like to know more about rehabilitation and I would like to find out how my son can be effectively helped to find employment.”

Mrs. Chan has a son with schizophrenia. She has been a member of the support group for four years.

“”””””””””

“The support group has helped me tremendously. I have learned not to worry excessively and I have learned to look after myself.

I enjoy all the speakers. They are informative and sometimes they are even entertaining.

I have made some good friends in the group. We keep in touch outside the group. A nice telephone conversation with them is often uplifting in spirit.”

Mrs. Low’s son also has schizophrenia. She is one of the original seven members who attended the group since the beginning five years ago. ■

World Assembly on Mental Health

The World Federation for Mental Health will be holding its biennial conference in Vancouver, July 22 - July 27, 2001 at the Vancouver Trade and Convention Centre. Four thousand delegates are expected to arrive in Vancouver representing the following sectors: volunteers, professionals of all disciplines, and users of mental health services.

The Congress will reflect the mission of the World Federation for Mental Health, which is:

- Improving the quality of mental health services and the life circumstances of those who suffer from mental/emotional illness, distress and disability, or who are at risk of such illness or distress
- Promoting and protecting the human rights of persons defined as mentally ill
- Preventing mental/emotional illness, distress, disability and less than optimal function, both in general populations and in vulnerable groups at risk

A call for papers will be out in January. For more details on the upcoming conference or to receive ongoing information contact Peggy Shepard at VenueWest at (604) 681-5226.



Working with Families of a First Nations Ancestry

Heather Baxter

Heather Baxter is the Northwest Regional Coordinator for the BC Schizophrenia Society.

In the Northwest health region, Statistics Canada (1991) estimates that approximately 25% of the population are of First Nations ancestry. The First Nations groups represented in this area are Métis, Nisga'a, Tsimpshian, Haida, Gitsan,

Wetsue'tetan, Iskut, Haisla, Hartley Bay, Hagwilget, Kitkatla, Lax-Kw'alaams, Masset, Metlakatla, Moricetown, Skidegate, Tahltan, Carrier, Kitimaat, Kitselas, Kitsumkalum, Atlin, Cassier, Dease Lake, and other groups (Health Canada, 1995; Young, 1994). Though there are some common cultural beliefs, each group has a different culture. Additionally, there are noteworthy differences in political beliefs within and between bands that can affect smooth delivery of service.

as serious." In my experience, most of the families of First Nations ancestry with whom I work define mental illness differently than I do. We have to spend time to ensure that we are speaking the same language.

Additionally, culture plays an important role in defining any illness. When my culture defines a hallucination as a disease symptom, another culture may define it as a sign of a great and powerful shaman. Furthermore, different members of a family group may have differing opinions whether a biological brain disease such as schizophrenia is an illness or a gift from one's ancestors. Careful understanding and respectful listening to the family are a necessity. Finding commonalities in the family's interpretation to build upon assists in de-emphasizing differences. Some families want to work with a culturally appropriate framework whereas others do not. For example, one family group, with whom I work, wanted to use a medical model approach to facilitate their understanding of the information that the psychiatrists and mental health system were giving them. They said "Give me information so I can talk like the doctors." They followed it up by saying that "This is important!". Thus the family was empowered through their knowledge of medical terminology and the mental health system. In another example, a family wanted to work within their matrilineal support system with little

In my experience when working in First Nations communities, there is a need to establish a common understanding of the definition of mental illness. For example, at a mental health forum put on by one First Nations group, the presentations included AIDS awareness, Fetal Alcohol Syndrome and Fetal Alcohol Effect, Trauma, Alzheimer's Disease, Lupus, Schizophrenia Awareness, Critical Incident Stress, and Stress Management. Some of these topics do not coincide with the BC Ministry of Health's definition of mental health. The 1998 Mental Health Plan (BC Ministry of Health) states "generally illnesses such as schizophrenia, major depression and bipolar disorder represent the most disabling illnesses; however, it is acknowledged that there are others who do not meet this diagnostic criteria, but for whom medical risk and level of impairment, regardless of diagnosis, determines their mental illness

Resources for Consumers and Families

Reading Material:

- From the Australian Transcultural Mental Health Network (order form available from CMHA BC):
 - Mental Health Consumer Participation in a Culturally Diverse Society, December, 1999. (A look at innovative strategies for facilitating the involvement of consumers, carers, and community members of non-English speaking background in the development, evaluation, and management of mental health services.)

Language Specific Support Groups (in Vancouver) for Consumers and Families:

- Cantonese Mutual Sharing and Psychoeducation Group (for family members who have a loved one with schizophrenia)
Organizer: Broadway South Mental Health Team, GVMHS
Meetings: monthly
Contact: Sophia Woo (604) 251-2264
- Cantonese Mutual Sharing (Satellite Family Support Group)
Organizer: Broadway North and South Teams, GVMHS
Meetings: monthly
Contact: Raymond Li (604) 253-5353
- Mandarin Psychoeducation Support Group
Meetings: first Wednesday of every month
Contact: Sophia Woo (604) 251-2264
- Depression Self Help and Support Group for Chinese Speakers
Organizer: Mood Disorder Association
Contact: Maria Cheung (604) 738-4025
- Richmond Depression Self Help and Support Group
Meetings: second Thursday of every month
- Caregiver Support Group for Indo-Canadian Families Dealing with Mental Illness (language availability: Punjabi, Hindi, & Urdu)
Sponsored by: South Team, GVMHS
Meetings: every other Wednesday from 7:00 to 8:30 (except during the summer)
Contact: Rajpal Singh (604) 324-3811
- The Vancouver/Richmond Mental Health Network offers the following services:
 - Asian Self Help Group
 - Latin American Self Help Group
 - Shakti Self Help Group (South Asian women)
 For further details contact Helen Turbett (604) 733-5570



Translated Mental Health Materials:

What's available in BC?

outside assistance from mental health professionals. These examples demonstrate the need for flexibility and respect when dealing with people of First Nations ancestry.

Previous knowledge of inter- and intra-band politics can also play a role in working with families of individuals recovering from a mental illness. Sometimes, to establish an effective liaison with family members, it is advisable to establish a working relationship with the Band Council. This working relationship is established through training sessions with open discussion of issues. Community development strategies for building partnerships with a First Nation community are equally important. In conclusion, working in First Nations' villages requires time to develop a working relationship and respect for the partners involved.

References:

Medical Services Branch. (1995). *A report of the health of First Nations in British Columbia — March 1995*. Vancouver, BC: Pacific Region Medical Services, Medical Services Branch, Health Canada.

Ministry of Health. (1988). *Revitalizing and rebalancing British Columbia's mental health system: The 1998 mental health plan* (Publication No. CH.AM.115) Victoria, BC: Mental Health Services Division, Ministry of Health.

The Tsimshian: Images of the past; view for the present. (1984). M. Seguin (Ed.). Vancouver, BC: UBC Press.

Young, T.K. (1994). *The health of Native Americans: Towards a bio-cultural epidemiology*. New York: Oxford University Press. ■

Canadian Mental Health Association, BC Division

- *Getting Help When and How – Available in Punjabi and Chinese.* [Brochure. Translated by the Prince George Branch]. These can be ordered from the CMHA BC Division or directly from National Office.
- Chinese brochures available from CMHA Vancouver/Burnaby Branch. To order, phone (604) 872-4902
 - Understanding Depression
 - Panic Attacks
 - Stress Management
 - Chinese Canadian Parents and Teenagers: Different Perspectives
 - Anger Management

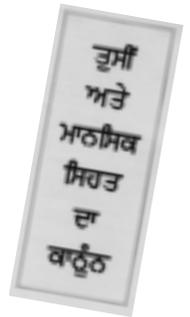
Greater Vancouver Mental Health Services

- Chinese Brochures [Contact Sophia Woo @ (604) 251-2264]
 - What is Schizophrenia?
 - What is Bipolar Disorder?
 - What is Depression?
 - What are Neuroleptics/Antipsychotics?
 - What is Mental Health?
 - What is Anxiety Disorder?
 - What is Geriatric Mental Health?
 - Mental Health Services of GVMHS

- Living Together in the Community — Some commonly asked questions about mental illness and people living in Community Residences
- Videos:
 - What is Schizophrenia? (In Taiwanese)
 - Relaxation Exercise (Progressive Relaxation in Cantonese)
- Spanish Brochures. Contact Norma Sanchez @ (604) 872-8441
 - Bilingual (English and Spanish)
 - Depression
 - Schizophrenia
 - Children and Mental Health
 - Your Feelings After the Baby is Born

- Bilingual Booklet: Neuroleptics
- Translation of Clarke Institute Material on:
 - Schizophrenia Symptoms and Management at Home
 - The Medications
 - Rehabilitation
- Material Translated for BC Schizophrenia Society:
 - Atypical Neuroleptics
 - Do's and Don'ts in the Management of Delusions

- Articles in Spanish only:
 - Depression
 - Bipolar Disorder
 - Eating Disorders
 - PTSD
 - Your Child's Self-Esteem
 - Substance Abuse Prevention by Improving Your Family Life
- Video:
 - Understanding Mental Illnesses. (In Spanish)
- Punjabi Translations
 - Mental Illnesses: A Resource Book in Punjabi Language. Joint Project of Greater Vancouver Mental Health Services Society, Canadian Mental Health Association, BC Division, and Riverview Hospital
 - Living and Working with Schizophrenia (available from South Team, GVMHS, and CMHA BC Division)



Transcultural Mental Health Network

- Translated mental health brochures in 39 languages which can be downloaded from the Web at:

[http:// www.atmhn.unimelb.edu.au/library_information/brochures/brochures.html](http://www.atmhn.unimelb.edu.au/library_information/brochures/brochures.html) ■



Catharine Hume

Catharine Hume is the Coordinator of Special Projects, CMHA BC Division.

Salmon Arm

In November 1998, CMHA BC Division and the Consumer Development Project in the North and South Okanagan region completed a Progress Report on the Salmon Arm and area mental health system. This was a pilot project to evaluate mental health systems from a consumer and family perspective. In this first pilot, we began to include the perspectives of First Nations and ethnocultural communities by

- working with the local First Nations liaison person at the Mental Health Centre to contact local Native bands and request their participation in the Progress Report
- asking respondents — consumers, families, service providers, and other community agencies and organizations — to rate the statement “I feel people within the mental health system are sensitive to peoples’ cultural/ethnic background” on a scale of strongly agree to strongly disagree.

With respect to the first strategy, representatives from two local First Nations bands were interviewed. We found that on-reserve First Nations people had significant concerns about the lack of clarity about the Ministry of Health’s responsibility for mental health services. Both First Nations bands that participated in the Progress Report expressed a need for stronger relationships between the local Mental Health Centre and on-reserve First Nations people. It was strongly felt that the Mental Health Centre needed to become clear about the

Brief Reports from Around the Province

kinds of mental health services that they were supposed to provide to on-reserve First Nations people and that time was needed to develop effective working relationships.

Unfortunately, we received very few responses to the statement about the degree of cultural/ethnic sensitivity of the mental health system and were therefore unable to make recommendations in this area.

We therefore made the following recommendations regarding the provision of mental health services and supports to on-reserve First Nations people:

- Clarify the local mental health system’s responsibility to on-reserve First Nations people.
- Increase liaison time with on-reserve First Nations people.

Since that time the Mental Health Centre has had a member of the Little Shuswap First Nation provide a cultural awareness workshop for Mental Health Centre staff. At the invitation of the Little Shuswap Nation Chief and Council Members, three Mental Health Centre staff participated with other community agency staff in exploring ways that the Mental Health Centre could provide services more effectively to First Nations populations. A follow-up meeting was then held to provide an orientation to Mental Health Centre staff on First Nations cultural issues.

For more information, please contact Catharine Hume at CMHA BC Division 1-800-555-8222.

North Okanagan

CMHA BC Division and the Consumer Development Project has now expanded the Salmon Arm Progress Report to the North Okanagan region. We have attempted to improve our focus on increasing the participation of First Nations and ethnocultural communities in this second Progress Report. In Vernon, we have involved the Immigrant Services Society since the beginning of the process and organized two focus groups for people from immigrant, refugee, or visible minority communities. We also attempted to involve the Okanagan band in our Progress Report, however, the band representative we spoke to was hesitant to be involved in yet another study, feeling that First Nations people had frequently identified what they needed and had received little or no meaningful response. In addition, we have involved counselors at both the First Nations Friendship Centre and the Round Lake Treatment Centre through the distribution of questionnaires.

We have also asked a follow-up question to the statement about the mental health system’s cultural/ethnic sensitivity, asking people to identify their cultural/

ethnic background. We hope to gain more information about people’s experiences of the mental health system from a cultural perspective and, based on feedback we receive, develop recommendations that address the needs of consumers from First Nations and ethnocultural communities.

We are currently in the process of gathering data and will be developing recommendations for the North Okanagan mental health system throughout the spring. A final report will be available in June, 2000.

For more information, please contact Catharine Hume at 1-800-555-8222 or Shelagh Turner at the Consumer Development Project: 1-800-491-9611.

Multicultural Mental Health, Campbell River

The Campbell River and Area Multicultural and Immigrant Services Association (MISA) has, over a six-month period, conducted a community development process to enhance the provision of mental health service to ethnocultural communities within Campbell River. This project was designed and financially supported by the Mental Health Evaluation and Community Consultation Unit at the University of British Columbia (MHECCU).

The community development process, including a needs assessment of ethnocultural consumers and service providers, was conducted to determine

- the barriers to accessing mental health services



- difficulties encountered with existing mental health services
- possible improvements to the system to make it more effective for ethno-cultural consumers and service providers alike.

Most of the information gathered came from people from First Nations, Punjabi, Vietnamese, and Filipino communities. Information was collected in personal interviews, telephone conversations, questionnaires, English as a Second Language classes, and focus groups. Approximately fifty service providers were drawn from all areas of the community that had a relationship to mental health including health, social, justice, spiritual and education sectors. These people were asked to join in small focus groups for information gathering purposes.

From the community development process a series of local initiatives emerged that address a wide range of needs including:

- easy-to-do suggestions like upgrading office signs to welcome consumers in their own language
- coordinating community resources, interpretation and translating services
- cross cultural training delivered broadly throughout the mental health care community
- outreach designed to take services, workshops, and programs to the multicultural communities.

These initiatives have been formulated into an action plan that will be the next phase of ensuring the enhancement of mental health

services for diverse cultures in Campbell River. [Excerpted from the Report Highlights, available from the Mental Health Evaluation and Community Consultation Unit (MHECCU), UBC.]

Multicultural Mental Health Community Development Initiative, Penticton

The goal of this project, which was funded by MHECCU, was to involve the Penticton community in assessing the mental health needs of local minority cultural groups and then developing local responses to them.

The project began in June 1998 with the formation of a local working group. The working group met regularly and designed a survey which was distributed to health care professionals who work with ethnic minorities. A second survey was also created and distributed to consumers of mental health services.

The surveys included definitions of mental health and mental illness. The consumer group tended to focus on actual causes of mental illness whereas the professional group tended to identify symptoms of mental illness. A larger percentage of the consumers (82%) connected isolation with mental illness, whereas only 49% of professionals felt that isolation and mental illness were associated.

Many professionals said they have problems communicating with their patients/clients. Family members are used most often as interpreters. None of the medical

service providers have information or other resources translated into other languages; those who provide services such as counseling tended to have some resources, but not many. Consumers mentioned the lack of bilingual or multilingual professionals, lack of trained interpreters, and lack of translated materials as the biggest barriers to accessing mental health services in the Penticton area. The next significant barrier was the stigma associated with mental illness.

The results of the surveys were analyzed and presented in a community forum. The results of the forum indicate that much more needs to take place in the field of mental health services in the Penticton area. Some recommendations include

- seminars or workshops for service providers on multicultural health (including holistic health or special topics such as post-traumatic stress disorder)
- more access to trained interpreters
- trained cultural advocates
- translated communications regarding health services for minority groups
- and representatives of minority cultural groups serving as advocates or advisors to regional health boards or service providers.

One significant problem encountered during the project was the stigma attached to mental illness. Many members of the minority ethno-cultural community even refused to discuss it. If the project had taken a broader view of the health care needs of the multicultural commu-

nity, including mental health, there would have been greater participation from the various communities.

[Excerpted from the Executive Summary of the Final Report, available from MHECCU.]

Aboriginal Mental Health Working Group

The Aboriginal Mental Health Working Group began meeting in the summer of 1999. The group was started by the Mental Health Evaluation and Community Consultation Unit (MHECCU) and includes representatives from a variety of Aboriginal organizations including United Native Nations, Native Mental Health Association of Canada, First Nations Chiefs Health Committee, Aboriginal Resources Project, and the Vancouver Native Health Society as well as representatives from the Canadian Mental Health Association, Greater Vancouver Mental Health Service, the University of British Columbia, the Health Association of BC, and the Ministry of Health.

The working group's two primary goals are outlined below:

- to define best practices in mental health from an Aboriginal perspective
- to define mental health from an Aboriginal perspective.

The group is also hoping to secure funding to analyze existing data related to Aboriginal mental health.

For more information, please contact Vicki Smye from MHECCU at pager (604) 801-1526. ■



CMHA and Multicultural Organizational Change: A Brief History of the National Cross Cultural Mental Health Project

Vinay Mushiana

Vinay Mushiana is the Coordinator of the Cross Cultural Mental Health Project at the CMHA BC Division.

In 1989, CMHA made a national commitment to undergo a process of multicultural organizational change. This commitment was made in response to the recommendations put forward by the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees in its report *After the Door Has Been Opened: Mental Health Issues Affecting Immigrants and Refugees in Canada* (1988). The report also concluded that the mental health system was largely inaccessible to, and therefore underutilized by, people from diverse ethnocultural groups.

To follow up on the Task Force's findings, CMHA's National Board of Directors formed a National Work Group on Cross Cultural Mental Health Issues, which was resourced and housed by BC Division. In 1992, the Work Group obtained funding from the Department of Canadian Heritage to initiate an organizational change process consisting of four core components:

- **Phase One:** Community Consultation
- **Phase Two:** Internal Assessment
- **Phase Three:** Planning for Change (policy development and action plan)
- **Phase Four:** Change in Action (implementation, monitoring, evaluation)

The main goal of this project

was to ensure that CMHA incorporated the principles of diversity and multiculturalism into all of its operations and worked toward sustaining multicultural organizational change independently of special project funding.

Phases one and two were completed in 1993, the findings and recommendations were summarized in the report *Multicultural Access Within a National Organization: Report on a CMHA Initiative*. The research conducted found that as an organization

- CMHA did not reflect the cultural diversity in the general population in Canada on any level. This included CMHA's boards, staff, volunteers, members, or clients.
- CMHA was not well informed or responsive to the mental health needs of ethnocultural communities, which in turn were unaware of the services available to them through CMHA.
- CMHA's services did not take into account various cultural perspectives on mental health and for the most part were not available in languages other than English or French.

On receiving further funding from Canadian Heritage, phase three was initiated in 1995. A National Coordinator of the Project was hired

and four CMHA sites — the Prince George branch, Thompson Region Office, Nova Scotia Division, and BC Division — were selected from the 47 that expressed an interest in participating in this process. By the end of this phase, each site had, among other initiatives,

- formed a Cross Cultural Committee to guide their work.
- developed and adopted a Multicultural and Anti-racism Policy.
- drafted an Action Plan for Change.
- strengthened or initiated links with local multicultural and Aboriginal communities and organizations.

A full report on the results of phase three is available from the BC Division office.

The final phase of this project began in 1998 and took place over an 18-month period at the four sites. Each site hired a Coordinator of the Project with the National Coordinator of the Project being based at Nova Scotia Division. The main objectives of this phase were to

- implement the Action Plan for Change.
- ensure that policies, procedures, programs, and services consider diverse cultural perspectives and are responsive to the community.
- raise awareness among staff, board, and volunteers of issues relating to diversity and racism

through diversity training sessions and workshops.

- develop a long-term plan to encourage applications from people of diverse ethnocultural backgrounds to our board, staff, and volunteers.
- All sites have now completed phase four and the results of the process are currently being evaluated and documented.

Work at CMHA BC Division

CMHA BC Division has experienced many changes during phase four of this project and is still immersed in the process and committed to further change. Among its many activities and achievements in this phase, BC Division has

- implemented the Action Plan for Change developed in phase three.
- strengthened and broadened relationships with multicultural and immigrant serving agencies, both at a local and provincial level.
- implemented the Multicultural and Anti-racism Policy throughout the organization. This reinforces the Division's commitment to diversity, inclusion, and elimination of systemic barriers.
- developed an Anti-har-



assessment Policy in accordance with the BC Human Rights Code.

- organized a number of training courses for staff, board, and volunteers on issues of anti-racism, diversity, and multicultural organizational change.
- supported branches in this process through training, distribution of research materials, and regular updates on the Project's achievements.
- as host of the CMHA 1999 National Conference, BC Division ensured that cross cultural mental health became one of the main themes of the conference.
- succeeded in making cultural diversity and inclusion a main focus of National Depression Screening Day.

Although there have been significant achievements in this phase of the project, much work and many challenges remain. For instance, the work on National Depression Screening Day is far

from over. There will continue to be concerted efforts to reach out to ethnocultural communities in an effort to increase awareness and participation in the event. In addition, discussions have also commenced regarding the development of a Canadian-based, culturally appropriate, depression screening tool for use in the future.

BC Division has also conducted research on the availability of translated mental health resources across BC. Key areas for development and gaps have been identified. The Division is currently working with a number of mental health and multicultural organizations to explore the possibility of working in partnership to produce translated resources for use across the province.

The Division acknowledges that multicultural organizational change is an ongoing process that requires commitment and sustained effort in order to succeed. The Di-

vision also acknowledges that despite the project coming to the end of its term, there is still much work to be done, both at the policy and program level.

BC in general, and Vancouver in particular, has one of the most culturally dynamic populations in North America. Over the coming years the kaleidoscopic changes in the cultural makeup of the community will generate increasing challenges for organizations and agencies throughout the province. This project has positioned CMHA to meet these challenges and provides the basis for ensuring sensitive and accessible services for all members of the community.

BC Division has derived many benefits from its involvement in the National Cross Cultural Mental Health Project and acknowledges the Department of Canadian Heritage for its support and encouragement throughout this process. ■

REMOVING BARRIERS: Inclusion, Diversity and Social Justice in Health

**"Keeping Canadian Values in Health Care" Symposium
Vancouver, British Columbia
May 25-27, 2000**

Removing Barriers is an initiative on health issues of vulnerable and marginalized communities. The objectives are advocacy, understanding, collaboration, and cooperation on inclusion and diversity within the Canadian health care system. Community groups, social agencies, health institutions and individuals are welcome to participate.

Some workshop topics include:

- Ethnoracial Diversity
- Aboriginal Health
- Youth and Children
- Poverty
- Sexual Orientation
- Women's Health
- Health and Spirituality in a Multifaith Society
- Organizational Change

Deadline for Papers – Feb. 29, 2000

There is also room for a limited number of tabletop, booth, or poster displays.

For further information, please see the Removing Barriers web site at <http://www.obstacles.org>

Committed to BC's Health

National Depression Screening Day

For one in ten British Columbians, depression is a very real part of everyday life. Unfortunately, very few people (less than one-third) will seek help, despite the 80% recovery rate. The Canadian Mental Health Association (CMHA) saw the need to raise awareness of depression and, in 1995, joined dozens of other organizations in North America and became involved with National Depression Screening Day.

National Depression Screening Day (NDS) is held every year in October. The event is part of an education and research program called the National Mental Illness Screening Project based in Massachusetts. In BC, NDS was first implemented as a province-wide project in 1995. At the sites, participants are invited to write a screening test for depression and to speak to a mental health professional about their test results. The mental health professional suggests potential paths of recovery. No diagnosis is given as this event is educational. National Depression Screening Day sites also provide free information.

The main goal of the event is to give participants the tools they need to access help. Another objective is to portray depression as a physical illness no different than diabetes or arthritis, thus reducing the shame or fear associated with mental illnesses. These goals are important

Marie-Claude Lacombe

Marie-Claude is an undergraduate communications student at SFU and the National Depression Screening

Day Coordinator at CMHA BC Division.



for everyone, regardless of a person's cultural background. From the beginning, people involved in the event saw the need to pay special attention to BC's ethnocultural communities. Presently, seven sites in BC are either multicultural or cater to one particular ethnocultural community.

Multicultural sites are sites that cater to more than one ethnocultural group. For example, the Surrey site provided services in seven languages. One of the first sites to offer services in a language other than English was organized by the Vancouver/Burnaby branch of the Canadian Mental Health Association. Stella Lee, Outreach Worker for the Chinese Education Program at the branch, and her volunteer teams opened their first site in 1995. That year, the site welcomed 150 Chinese participants. Over the years, the Vancouver Chinese site has attracted almost 1,100 people.

For the Chinese Education Program, Stella has two volunteer teams: the Mental Health Promotion Group which assesses needs and develops strategies, and the Chinese Community Mental Health Liaison Volunteer Group, which is in charge of carrying out activities such as National Depression Screening Day. Stella knows just how important it is to have the community involved: "You tell them why you are organizing the event and they will help you," she explains. She also pointed out that volunteers should come from every section of

Abbotsford reaches out to the South Asian community

Farther up the Fraser Valley, Abbotsford's Old Sikh Temple was the host of a new site in 1999. Just like the Vancouver Chinese site, this site catered to one ethnocultural community only. Fifty-five South Asians attended the site and were able to write the screening test and receive information on depression in Punjabi, as well as meet with a Punjabi-speaking psychiatrist.

Satwinder Bains, manager for Culture and Health 2000 and site coordinator for National Depression Screening Day, saw that the screening was a great opportunity to work on the elimination of stigma associated with mental illnesses within the South Asian community. Satwinder is happy with the positive response received from Abbotsford's South Asians. "Considering it was the first time we held the site, it was very gratifying to see the numbers," she says. She adds that the community was very open to having the site. "Many were interested in learning more."

The event was publicized through posters and word of mouth. Satwinder also spoke about National Depression Screening Day at the Sikh Temple. In some communities, word of mouth proves to be a very effective communication tool. A survey done of participants at the 1999 Chinese sites in Richmond and Vancouver showed that at least 18% of the participants came after a friend or family member suggested they attend.

Satwinder is already looking forward to National Depression Screening Day 2000. However, for her second year she will prepare two different rooms for men and women. She noted that some women were uncomfortable approaching the psychiatrist when men were present.

National Depression Screening Day 2000 is just around the corner. As the planning process begins, some goals are already quite clear. For the third time, we will focus on attracting participants from ethnocultural communities. Sites will be encouraged to keep their multicultural (or ethnocultural) angle, while other sites will be invited to become more culturally inclusive. CMHA BC Division will also provide the support that sites may need to incorporate multicultural issues including, among other things, providing official National Depression Screening Day posters in different languages.

In 1999, BC Division sent a checklist to all site co-ordinators on how to organize a multicultural site. Other documents were also provided, including one document outlining the cultural makeup of each BC community and another which detailed an example of a successful outreach campaign for another non-profit organization.

It is not by luck that one in four National Depression Screening Day participants in BC used resources in a language other than English; site co-ordinators like Stella and Satwinder have been working hard to make depression and the screening day a hot topic in their communities. ■

National Depression Screening Day 1999 Highlights

- This year, 1,800 people attended.
- There were 28 sites in BC.
- Seven sites offered services in languages other than English.
- The most attended site was the Chinese site in Vancouver with 200 participants.
- Almost 500 participants (25%) used services in a language other than English.
- Resources were available in nine different languages. The site in Surrey provided services in eight languages.
- Some sites were specific to one ethnocultural community. The Abbotsford Old Sikh Temple was open to South Asians while Richmond and Vancouver had Chinese sites.
- 15% of the participants who attended the North Vancouver site used services in Farsi or Mandarin. This is an increase of 10% from last year.

the community, not just from the mental health field. Her volunteers are retired community members, teachers, home-makers, and students, among others.

Now in its sixth year, National Depression Screening Day has become well known in the Chinese community. The Chinese media (television, radio and newspapers) have provided extended coverage over the years. Stella knows just how great the need for help is in the Chinese community and has been able to convince the Chinese media and the community of the importance of the event. She explains that some people in the community may have adjustment problems after having immigrated to Canada or feel isolated; others have family or emotional troubles; still others are feeling down after not being able to find a job.



Diversity, Mental Health, and the Community of Prince George

Prince George, warmly known as the “Northern Capital of BC,” is a community which celebrates its heritage and cultural diversity. Events such as ethnic family nights or Multicultural Canada Day celebrations honour and include our local minority groups. Two immigrant-serving agencies host these events and provide counseling and support for new and existing immigrants. First Nations communities have also built strong support systems through such organizations as the Native Friendship Centre, the Native Health Centre, the Métis Elder Society, the Native Art Gallery, and the Carrier Sekani Tribal Council.

The issues and needs of our diverse communities have long been discussed, yet action is now more visible as local support from mainstream businesses, institutions, and organizations is beginning to reach our minority and First Nations communities. Diversity, organizational change, and the removal of barriers which impede the participation of diverse communities is becoming a priority. For example, the College of New Caledonia began a Diversity Initiative Project in 1997 which focuses on increasing awareness and understanding of diversity within the College and the community it serves. The University of Northern BC has also received funds to initiate a similar project. The Canadian Diabetes Association has made a commitment of change and hosted a work-

shop on the cultural perspectives of living with diabetes.

Such programs and events are constantly improving the support network and ultimately the mental health of our diverse communities. CMHA Prince George has put issues of inclusiveness and access in the forefront since 1996 when they were chosen as a site of CMHA National’s Cross Cultural Mental Health Project. Through this process, CMHA has created culturally sensitive policies, programs, and services with the ultimate goal to remove all systemic barriers. Workshops, programs, and events are ongoing for staff, volunteers, and board members in order to educate them on key issues of cultural diversity and mental health.

A memorable highlight for staff and consumers was their participation in the College of New Caledonia’s Diversity Art Works Mural.

The mural, which is displayed in the Atrium of the College, educates, promotes, and celebrates the diversity of our communities. Of the 500 tiles which beautify the walls, 18 were designed and created by CMHA consumers and staff. The activity was an exercise in personal reflection, creativity, and focused on issues of diversity, multiculturalism, and their meanings. Short statements accompany each tile, which express the artists’ intent of their creation, such as:

“Totem Pole in the Street”
Debra, Stace, and Shea Zsombor
By creating this tile we hon-

our and remember our Cree ancestor. It has helped us explore this part of our ancestry as a family.

“Bird of Prey Perched”
Bill Selody
Though powerful, the eagle is a part of nature working and living in harmony with its surroundings.

“Peace and Love”
Janice Gould
If we all had love and caring for each other we could rise above all the discrimination, hatred, and violence in the world.

CMHA is proud to be a part of such cultural activities and is committed to sustaining partnerships with diverse groups and ensuring that the mental health care needs of all people are met. ■

*Karen Clark
Verbisky*

*Karen is the
Cross Cultural
Coordinator
at CMHA
Prince George.*

Resource List

A more comprehensive resource list can be found on CMHA BC Division’s web site at <http://www.cmha-bc.org>. Also be sure to check out the resource sidebars on pages 10, 15, 23, and 32.

Articles and Reports

A persistent spirit: Towards understanding aboriginal health in British Columbia. (1995). In P. Stephenson, S. Elliot, L. Foster & J. Harris (Eds.), **Canadian Western Geographical Series, 31**.

Toward full inclusion — Gaining the diversity advantage: A guide to planning and carrying out change in Canadian institutions. (1993). Ottawa: Department of Canadian Heritage.

Nymen, B. (1992). **Increasing access: Developing culturally accessible mental health and social services for immigrants and refugees.** Winnipeg: CMHA Manitoba Division.

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Books

Paniaqua, F.A. (1998). **Assessing and Treating Culturally Diverse Clients. A Practical Guide.** Sage Publications.

Albers, P. & Mediane, B. (1983). **The Hidden Half.** Washington, D.C.: University Press of America. [This book examines Native American Women's Issues from a traditional perspective].

Cross cultural caring: A handbook for health professionals in western Canada. (1990) N.Waxler-Morrison, J. Anderson & E. Richardson (Eds.). Vancouver: University of British Columbia Press.

Bowen Stevens, S. (1993). **Community based programs for a multicultural society.** Manitoba: Planned Parenthood.

From poly-versity to uni-versity: Organizations in transition to anti-racism." (1996). In Carl, E.J. (Ed.), **Perspectives on Racism and the Human Services Sector: A Case For Change.** (pp. 196-208). Toronto: University of Toronto Press.

Videos

Befriending demons: Healing across cultures. (1997). A presentation by Dr. Terry Tafoya. (See Guest Editorial, page 3 in this issue) This video can be ordered from The Diversity Office at Mount St. Joseph Hospital, Vancouver: (604) 877-8508. The cost is \$15. The Diversity Office also has a number of other resources and videos relating to diversity and health care.

Hear What We Are Saying; Across Boundaries: An Ethnoracial Mental Health Centre. Toronto. This is an award winning video about systemic racism within the mental health sector in Canada. This Centre provides services to people from ethnoracial communities who experience severe mental health problems. This Centre is the first of its kind operating within an anti-racism framework and has produced a number of resources. For further information and to

order, access their web site at <http://www.web.net/~accbound>

Web Sites

<http://www.mcgill.ca/Psychiatry/transcultural/prr.html>
Division of Social & Transcultural Psychiatry, McGill University, Montreal, Quebec.

[http:// www.atmhn.unimelb.edu.au/](http://www.atmhn.unimelb.edu.au/)
Australian Transcultural Mental Health Network

Organizations

AMSSA (Affiliation of Multicultural Societies and Service Agencies of BC). For more information on this provincial organization and their resources, access their web site at <http://www.amssa.org>

Ministry Responsible for Multiculturalism and Immigration. The Communications Branch of this government organization produces many publications on multiculturalism, immigrant settlement, and anti-racism. Examples of these are

- Guide to Multicultural Policy for Institutions (1995)
- A Profile of Immigration 1986-1996.
- The EMISO Directory 1999 (Directory of Ethnocultural, Multicultural, and Immigrant Service Organizations). To order, call the Communications Branch (604) 660-2204 or access the web site at: <http://www.mrmi.gov.bc.ca>

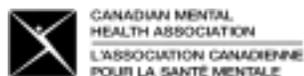
Crisis Lines

Victim Information Line: BC Hate Crime Unit 1-800-563-0808

Chimo Crisis Line	Cantonese	(604) 278-8283
	Mandarin	(604) 279-8882

South Asian Line in Cantonese, Hindi, Korean, Mandarin, Punjabi, Spanish, Urdu, and Vietnamese (604) 596-4357

Multilingual Helpline in Chinese, Spanish, Korean, and Vietnamese (604) 572-4060



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